Timeline for Consolidated Appropriations Act (CAA) and Transparency in Coverage Rule (TCR)

BlueCross BlueShield Nebraska

Last Updated July 1, 2022

Feb. 1, 2021

- Mental Health Parity

Dec. 27, 2021

- Broker and Consultant Compensation Disclosure
- Pharmacy Benefits/ Drug Costs Reports
- Prohibition on Gag Clauses on Price and Quality Information

Jan. 1, 2022

- Advance Cost Estimate and Explanation of Benefits (EOB)
- Air Ambulance Reporting
- Continuity of Care
- Insurance Cards
- Prior Authorization for OB-GYN Services
- Provider Directory
- Surprise Billing – Independent Dispute Resolution (IDR)
- Surprise Billing – Qualifying Payment Amounts

July 1, 2022

- Transparency in Coverage – In-Network/ Out-of-Network Machine-Readable Files

Jan. 1, 2023

- Price Comparison Tool
- Transparency in Coverage – Cost Estimating Tool (First 500 Services)

Jan. 1, 2024

- Part D and Other Medicare Drug Pricing
- Transparency in Coverage – Cost Estimating Tool (Remaining Services)

TBD

- Transparency in Coverage – Pharmacy Machine-Readable Files

CAA and TCR Timeline

Mandate	Effective Date	Status	Mandate Description
Advance Cost Estimate and Explanation of Benefits (AEOB)	Jan. 1, 2022	● On hold pending final rule or guidance	Requires individual and group health plans to provide a cost estimate for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the network status of providers, good faith estimates of cost, cost-sharing and progress toward meeting deductibles and out-of-pocket maximums, as well as whether a service is subject to medical management and relevant disclaimers of estimates.
Air Ambulance Reporting	Jan. 1, 2022	● On track for compliance. First report due first quarter 2023.	Requires reporting air ambulance metrics within 90 days of the end of the plan year.
Broker and Consultant Compensation Disclosure	Dec. 27, 2021	✔ Completed	Requires brokers and consultants to disclose to group health plan sponsors any direct or indirect compensation they receive for brokerage services or consulting—terms that are defined very broadly. For individual health insurance coverage and short-term, limited-duration insurance coverage, a health insurance issuer must disclose to enrollees, and report to the Department of Health and Human Services (HHS), any direct or indirect compensation that the issuer pays to an agent or broker associated with plan selection and enrolling individuals in the coverage.
Continuity of Care	Jan. 1, 2022	✔ Completed	For individuals who are undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery or terminally ill, requires a group health plan or health insurance issuer to provide 90 days of continued, in-network care if a provider or facility leaves the network. Also requires the group health plan or health insurance issuer to notify individuals receiving care from one of these providers or facilities of the network change and provide the option to continue care for the transitional period. In addition, providers subject to this provision are required to accept the continued in-network payment as payment in full and otherwise comply with all policies, procedures and quality standards imposed by the plan or issuer.
Insurance Cards	Jan. 1, 2022	✔ Completed New ID cards began mailing in December 2021	Requires group and individual health plans to identify on insurance cards the amount of the in-network and out-of-network deductibles, the in-network and out-of-network out-of-pocket maximum limitations, and a telephone number and website address through which individuals may seek consumer assistance information.
Mental Health Parity	Feb. 1, 2021	✔ Completed	Requires group/individual health plans to perform, document and to provide upon request (which may occur 45 days after enactment of CAA) comparative analyses of the design and application of non-quantitative treatment limitations (NQTL).

CAA and TCR Timeline

Mandate	Effective Date	Status	Mandate Description
Part D and Other Medicare Drug Pricing	Jan. 1, 2024	• On hold due to the 2024 delivery date	Beneficiary Real-Time Benefit Tool: Requires Part D sponsors to implement one or more electronic real-time benefit tools that meet certain requirements and standards, such as integrating with electronic prescribing and electronic health records, and transmitting information on clinically appropriate alternatives, cost-sharing, negotiated prices and formulary status. The legislation does not specify an implementation date but refers to a "time determined appropriate by the Secretary" after HHS has developed a standard. The legislation also includes a rule of construction that nothing in this subsection shall be construed to allow a prescription drug plan sponsor to use a real-time benefit tool to steer individuals without their consent to a particular pharmacy or pharmacy type over their preferred pharmacy. Permanently authorizes the Limited Income Newly Eligible Transition (LI NET) demonstration effective Jan. 1, 2024. This program provides immediate, temporary Part D coverage for certain low-income beneficiaries while their eligibility is processed. Provides the Executive Directors of MedPAC and MACPAC access to certain Medicare Part D payment and pharmaceutical manufacturer rebate data for purposes of monitoring, analysis and making program recommendations. Prohibits disclosure, including to individual MedPAC and MACPAC commissioners, on specific rebate amounts, direct or indirect remuneration or information from submitted bids. Lastly, it requires all manufacturers of drugs covered under Part B to report average sales price (ASP) data to HHS beginning Jan. 1, 2022. This specifically adds a new requirement for manufacturers that do not have a rebate agreement under Medicaid.
Pharmacy Benefits/Drug Costs Reports	Dec. 27, 2021	• On track for compliance. First report due Dec. 27, 2022.	Requires group and individual health plans to report annual data to HHS, the Department of Labor, and the Department of Treasury (Tri-agencies) on drug utilization, spending and rebates. Reporting includes total spending on health care services by type. No confidential or trade secret information submitted by health plans will be made public.
Price Comparison Tool	Jan. 1, 2023	• On hold pending final rule or guidance	Requires group health plans and health insurance issuers to maintain a price comparison tool available via phone and website that allows enrolled individuals and participating providers to compare cost-sharing for items and services by any participating provider.
Prior Authorization for OB-GYN Services	Jan. 1, 2022	✔ Completed	Prohibits plans/issuers from requiring prior authorization for OB-GYN services for in-network providers.
Prohibition on Gag Clauses on Price and Quality Information	Dec. 27, 2021	✔ Completed	Prevents the inclusion of gag clauses on cost or quality information in payer-provider contracting. Precludes payers from entering into contracts with providers that prohibit payers from disclosing provider-specific costs or quality information to referring providers, the plan sponsor, enrollees and/or individuals eligible to become enrollees.

CAA and TCR Timeline

Mandate	Effective Date	Status	Mandate Description
Provider Directory	Jan. 1, 2022	✔ Completed	Requires commercial plans to establish a verification process to confirm provider directory information at least every 90 days, including removing providers or facilities who are non-responsive. Plans must also develop a response protocol to respond to member network questions. Members who receive inaccurate information that a provider is in-network can only be liable for in-network cost sharing.
Surprise Billing – Independent Dispute Resolution (IDR)	Jan. 1, 2022	✔ Completed	Gives plans and providers (including air ambulance providers) 30 days to negotiate a payment after an initial payment or a denial is issued by the plan. If a decision is not reached, gives plans and providers four days to access an independent dispute resolution (IDR) process. Permits plans and providers to continue negotiations up until the IDR entity (arbiter) makes a final decision.
Surprise Billing – Qualifying Payment Amounts	Jan. 1, 2022	✔ Completed	Provides for patients to be responsible for only in-network cost-sharing amounts, including deductibles, in emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider (including air ambulance providers). Prohibits providers from balance billing except in limited circumstances with patient notice and consent.
Transparency in Coverage – Cost Estimating Tool (First 500 Services)	Jan. 1, 2023	● On track for compliance.	Requires the establishment of a web-based, self-service tool to allow members to get real-time, accurate estimates of cost-sharing liability for specific services, furnished by specific providers, at specific locations.
Transparency in Coverage – Cost Estimating Tool (Remaining services)	Jan. 1, 2024	● On hold due to the 2024 delivery date	Requires the establishment of a web-based, self-service tool to allow members to get real-time, accurate estimates of cost-sharing liability for specific services, furnished by specific providers, at specific locations.
Transparency in Coverage - In-Network/Out-of-Network Machine-Readable Files	July 1, 2022	✔ Completed	Requires certain cost and claims data available through posted machine-readable files (In Network, Out of Network and Pharmacy File) posted monthly to a public website. The nature of the machine-readable files is such that a group or third party (vendor) working on the group's behalf can access the files and use their program/system to sort and filter the data to their specific benefit plan.
Transparency in Coverage - Pharmacy Machine-Readable Files	TBD	● On hold pending final rule or guidance	Requires certain cost and claims data available through posted machine-readable files (In Network, Out of Network and Pharmacy File) posted monthly to a public website. The nature of the machine-readable files is such that a group or third party (vendor) working on the group's behalf can access the files and use their program/system to sort and filter the data to their specific benefit plan.

Note: This information is subject to change based on new government guidance.

✔ = BCBSNE has implemented

● = BCBSNE is on track to meet the mandate effective date or good faith compliance

● = On hold for reasons listed