# Transparency in Coverage and Consolidated Appropriations Act, 2021

**UPDATE FOR GEOBLUE® CLIENTS AND BROKERS**

GeoBlue

At the end of 2020, Congress passed several healthcare reforms as part of the Consolidated Appropriations Act. These reforms—also referred to as the No Surprises Act—aim to curtail balance billing and out-of-network charges without advance notice. With the introduction of additional rulemaking throughout 2021, GeoBlue is working to implement the No Surprises Act for its corporate expat portfolio nationwide, and its New York and California ACA student health insurance plans by the applicable enforcement deadlines.

## Overview and Status of Key Provisions

| | Details | Status |
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| **Section 57:** Gag Clause Prohibition Compliance Attestation (GCPCA) | Group health plans and health insurance issuers offering group or individual health insurance coverage must annually submit a Gag Clause Prohibition Compliance Attestation (GCPCA) to the Department of Health and Human Services (HHS). This attestation states that U.S. provider networks contract with providers who are compliant with the ruling. | **In Progress**<br>GeoBlue uses the Blue Card PPO whereby provider contracts reside with the local Blue plans. As a result, GCPCA compliance sits at the local Blue plan level. GeoBlue is taking a number of measures in regard to assisting our clients for compliance to GCPCA by 12/31/2023. |
| **Section 103:** Independent Dispute Resolution (IDR) | IDR refers to a 30-day open negotiation period for providers and issuers to settle out-of-network claims. If unresolved they may proceed with the IDR arbitration process in which one offer will prevail. The process is administered by independent, unbiased entities with no affiliation to providers or issuers. | **Implemented**<br>We are prepared to follow the IDR process and are working with our Blue Cross® Blue Shield® Association and tri-agencies partners to finalize our procedures. |
| **Section 110:** External Review of Surprise Medical Bills | Provides consumer protection through application of health plan external review in case of certain surprise medical bills. | **Implemented**<br>We will follow established external review processes as applicable when external appeal is requested. |
| **Section 113:** Continuity of Care (COC) | If a provider changes network status, patients with complex care needs have up to a 90-day period of continued coverage at in-network cost sharing rates to allow for a transition of care to an in-network provider or until the patient is no longer a continuing care patient. | **Implemented**<br>Solution approach and member notification have been developed and implemented, pending final rulemaking. |
| **Section 116:** Provider Directory Information | Requires health plans to have up-to-date directories of their in-network providers. The directories must be available to patients online, or within one business day of an inquiry. If the patient provides documentation that they received incorrect information, the patient must only be responsible for in-network cost-sharing. | **Implemented**<br>GeoBlue is satisfying this requirement in coordination with the Blue Cross Blue Shield Association and our host Blue Plan partners. |

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| **Section 202:** Broker Compensation Reporting | Requires disclosures to customers on any commissions service providers, such as brokers or benefits consultants, may receive. In the group health plan context, this obligation rests largely with those hired to find or design group health plans. Brokers or consultants are required to disclose information about the compensation they can expect to receive, describe the services they'll be compensated for, and identify who will be providing the compensation. Disclosures should be made "reasonably in advance of the date" the contract is made, renewed or extended. Brokers consult with their plan clients to understand what lead time is expected. | **Implemented**<br>This is a broker requirement that has been communicated. We have included updated language in our broker agreements. |
| **Section 203:** Parity NQTL Program | Requires that plans perform, and provide to a regulator or participant on request, a comparative analysis for any nonquantitative treatment limitation (NQTL) applied to mental health/substance use disorder (MH/SUD) benefits. | **Implemented**<br>GeoBlue is satisfying this requirement in coordination with our underwriting partner, 4 Ever Life. |
| Machine-readable file requirements (MRF) | Requires health plans or issuers to publish three separate machine-readable files: (1) negotiated rates for all covered items and services between the plan or issuer and in-network providers; (2) historical payments to, and billed charges from, out-of-network providers; and (3) in-network negotiated rates and historical payment net prices for all covered prescription drugs at the pharmacy location level.<br>Per the August 20 announcement from the Tri-Agencies, the Departments will defer enforcement of the machine-readable file requirements until July 2022 for the in-network and out-of-network files, and pending further rulemaking for the prescription drug file. | **Implemented**<br>GeoBlue satisfied the requirement to publish in-network and out-of-network files. |
| **Section 107:** ID Cards | Requires health plans to include the following on their plan or insurance IDs issued to enrollees:<br>• Amount of the in-network and out-of-network deductibles<br>• Out-of-pocket maximum limitations | **Implemented**<br>GeoBlue satisfied the requirement to include additional information on digital ID cards. |
| **Section 114:** Cost Comparison Tool | Requires health plans to offer a price comparison tool for consumers and make information available by phone. The tool (to the extent practicable) must allow an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider. | **Implemented**<br>GeoBlue satisfied the requirement and will continue to update per federal guidelines. |

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| Reporting on Pharmacy Benefits and Drug Costs | Requires group and individual health plans to report annual data to HHS, the Department of Labor and the Department of Treasury on drug utilization and spending trends. The report includes total spending on health care services by type (e.g. hospital, primary care, prescription drugs, etc.). Health plans will be required to include information on how rebates from manufacturers impact premiums and out-of-pocket costs, the amount of rebates by therapeutic class and the amount of rebates for each of the 25 drugs yielding the highest amount of rebates. Requires HHS to produce a publicly available aggregate report on these prescription drug data and trends (no drug-or plan-specific information will be made public) 18 months after the first report is received and bi-annually thereafter. No confidential or trade secret information submitted by health plans will be included in these reports. | **Implemented**<br>GeoBlue has completed initial reporting prior to the federal enforcement date and will continue to provide reporting in accordance with federal submission timelines. |

*GeoBlue files all reports under Worldwide Insurance Services, LLC and EIN number 54-186-7679. GeoBlue will report on behalf of self-insured groups as well, using the group's entity name and EIN number.*

To learn more, visit **about.geo-blue.com/transparency-in-coverage**



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