Treasury Final Rules 85 FR 72158 TiC Transparency in Coverage Overview – July 1st 2022

Under the final rules, health plans are required to disclose in-network pricing for medical services and allowable amounts for out-of-network services using machine-readable files (MRFs) and post on an internet site. These files are very large and complex files that are unlikely to be usable by members. Future plans are to make them easier to digest by the public. This pricing information has more requirements starting January 1st 2023, and January 1, 2024.

Health Care Price Transparency – Hospitals. The new rules require hospitals **to publish standard charges for all their services and items and to make the prices for the 300 most common services accessible in a consumer-friendly format.** The rule took effect January 1st 2021 but in 2022, just 14% of hospitals were in compliance.

Consolidated Appropriations Act, 2021 (H.R.133) Disclosure

We receive compensation directly from the insurance carrier which is set by the carrier and is the same percent whether a policy is purchased direct from the carrier or through an agent.

There is no difference in premium regardless of the agent/agency used and premiums are set and regulated by the Department of Insurance and Department of Managed Health Care.

In California we work with the following group medical plans and they pay us directly based on premium for each case to install, manage and service their plans.

Aetna	5% First $1,000,000 | 1% over $1,000,000
Anthem	5% First $1,000,000 | 0.8% over $1,000,000
Blue Shield	5%
Cal Choice	5%
Health Net	5%
Kaiser	5% First $1,000,000 | 1% over $1,000,000
United Healthcare	5%

We cannot provide legal advice but within our scope and our E&O Professional Liability Insurance parameters and state licensures we will assist with PPACA, HIPAA, COBRA, ERISA laws, Coordination of Benefits, Employee benefit administration, payroll deduction calculations, open enrollments, annual reviews and marketplace checks. claims assistance, carrier troubleshooting, Medicare regulations, provider network adequacy and access, employee benefit communications and questions.

Insurance ID Cards

Will be required to include in network and out of network deductibles and out of pocket maximum. Some carriers already include this but it is now a requirement. Pending further rules, implementation by carriers will be based on good faith to make ID cards compliant.

Good Faith Estimates

Healthcare Providers will be required to provide a "Good Faith Estimate" for requested services three days in advance of the service and not later than one day after scheduling of the service. Enforcement has been delayed, with further rulemaking expected in late 2022. The Federal Government could provide a standardized form or providers may be free to create their own. More details to come…

Accurate Provider Directories

Health Plans will be required to have up to date directories online. Plans must verify and update information every 90 days. Health Plans are required to respond to an individual who requests information on a provider's network status within one business day by telephone, by email or in print per the individual's request.

Advanced Explanation of Benefits (EOB)

Upon receiving a good faith estimate form a provider, Health Plans must create and share an Advanced Explanation of Benefits notification in clear and understandable language. The notice must include the status of the provider, a good faith estimate of what the plan will be paying and the amount of any cost sharing the member will be responsible for paying.

Self Service Online Cost Estimator Tools & The No Surprises Act

Health Plans must create consumer facing cost estimators (due beginning January 1, 2023) including the plan's negotiated rates – for all services covered under the plan. To be implement ed in two phases. First a published list of 500 items prescribed by the Feds and then for all services starting January 1st 2024. We expect this to be available only thru the member registering on the plan website so the tool knows the plan enrolled in.

This item is similar to the Federal No Surprises Act, within 2021's federal CAA law (Consolidated Appropriations Act). The NSA also requires telephone support from the carriers to provide price comparisons. The NSA also deals with out of network "surprise bills" for services and deals with providers billing amounts that are arbitrarily arrived at. The CAA NSA has developed methods for healthcare providers and payers to work together to arrive at a fair and reasonable billable charge for out of network services. For those who have ever had an air ambulance ride, this should be very helpful.

The above are highlights. Please let me know if questions.

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