Independence
Independence Administrators

Consolidated Appropriations Act (CAA) and Transparency in Coverage Rule (TCR) Overview and Frequently Asked Questions

For use with customers, brokers, and consultants

Updated August 24, 2022

Independence Administrators further sharpens efforts on transparency

Independence Administrators continues to implement the Consolidated Appropriations Act (CAA) and the Transparency in Coverage Rule (TCR). The federal government has issued guidance about the CAA and TCR, and Independence Administrators understands that the federal government will be issuing additional guidance. The guidance issued by the federal government will impact Independence Administrators' implementation of the CAA and TCR.

Independence Administrators has an enterprise-wide implementation program in accordance with the requirements of the CAA and TCR applicable to them.

Independence Administrators will continue to update these FAQs as Independence Administrators receive additional guidance and updated FAQs will be communicated via the *Independence Edge* newsletter. Independence Administrators is committed to implementing the requirements of the CAA and TCR applicable to them. s.

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Consolidated Appropriations Act, 2021

The Consolidated Appropriations Act, 2021 (CAA) was signed into law in December 2020. Among other provisions, the CAA includes many provisions that affect how health insurers and group health plans provides health care coverage. Since the CAA was enacted, the federal government issued guidance about the CAA. Recently, the federal government issued guidance that it is delaying enforcement of certain provisions of the CAA and will take a good faith compliance approach to other provisions.

The CAA includes the following provisions:

Surprise Medical Billing Patient Protections. For plan years beginning 1/1/2022 forward, members will be protected from surprise medical bills that could arise from out-of-network emergency care, air ambulance services provided by out-of-network providers, and for out-of-network care provided at in-network facilities.

- **Provider Reimbursement and Independent Dispute Resolution (IDR) Process.** An IDR process between a health plan and provider can be used if the health plan and the provider cannot agree about reimbursement for the provider's services. The federal government will be issuing further guidance about the IDR process.
- **Application of Protections to Ambulance Services.** Members using air (but not ground) ambulance services will be provided similar protections against surprise medical billing, and providers of air ambulance services and health plans will be provided a similar process for resolving disputed claims as outlined above.

Advanced Explanation of Benefits. Upon request, a member can receive an Advanced Explanation of Benefits (AEOB) from a health plan for scheduled services. In the AEOB, a health plan will inform the member about, among other things, the contracted rate for a given item or service, out-of-pocket cost estimates, estimates of incurred amounts toward the member's deductible/cost-sharing limits, whether the service is available from an in-network provider and information on medical management requirements. The federal government recently issued guidance that enforcement of the AEOB requirement will be deferred pending further guidance.

Price Comparison Tool. Cost-sharing information to be made available for services and covered items. Both the TCR and CAA included price comparison tool components. Enforcement of this requirement has been deferred to 2023 pending further guidance.

Continuity of Care. For certain levels of care, health plans are required to give members the opportunity to request a transitional care period if a health provider is removed from the health plan's network following termination of the network contract between the health plan and provider. Further guidance is expected in 2022, however health plans are expected to implement using a good faith, reasonable interpretation until additional guidance is issued.

Enhanced Provider Data Requirements. Requires commercial health 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 to health plans' inquiries for verification. Health plans must also make provider directories available to members. CAA also requires that health plans establish a response protocol to respond to member requests as to whether a certain provider or facility is in-network. If a member provides documentation that they received incorrect information from the

provider directory or from the response protocol established by the CAA, the member will only be responsible for in-network cost-sharing. Further guidance is expected in 2022, however health plans are expected to implement using a good faith, reasonable interpretation until further guidance is issued.

Changes to ID Cards. Health plans must include in clear writing on any physical or electronic identification cards that are issued to members or enrollees in the health plan or coverage:

1) any in-network and out-of-network deductibles applicable to the health plan,
2) any maximum out of pocket limits applicable to the health plan,
3) telephone number, and internet website address where an individual can seek assistance.

Health plans may design their ID cards using various methods to comply with the law, including the use of Quick Response (QR) codes to display information beyond the applicable major medical deductible and applicable out-of-pocket maximum. The federal government will not issue guidance addressing ID cards prior to the 1/1/2022 compliance date; however, the federal government does intend to issue guidance. In the interim, the federal government expects issuers to use a good faith, reasonable interpretation of the law.

Broker and Consultant Compensation Disclosure. Administrators servicing plans shall disclose to the plan fiduciary a description of the services to be provided and all direct and indirect compensation they expect to receive in connection with the services to be provided. This is in advance of the date on which the contract or arrangement is entered into or extended or renewed.

Pharmacy Benefit and Drug Cost Reporting. Requires health plans to report information on health plan medical costs and prescription drug spending. This requirement will not be enforced pending further guidance by the federal government; however, health plans are encouraged to start working to begin reporting by 12/27/2022 for 2020 and 2021 plan years.

Air Ambulance Reporting. Requires health plans to submit two years of claims data to be compiled by the Department of Health and Human Services for the publication of a comprehensive report.

External Review/Complaint Process. Allows for external review process to determine whether surprise billing protections are applicable when there is an adverse determination by the health plan.

Remove Gag Clauses on Price and Quality Information. Effective 12/27/2020, prohibits gag clauses on price and quality information to prevent health plans from entering into contracts with providers, networks or associations of providers, third-party administrators, or other service providers offering access to a network of providers that prohibit health plans from disclosing provider-specific cost or quality information. Additional guidance is expected in 2022 on how health plans and issuers should submit their attestations.

Mental Health and Substance Abuse Parity. Effective 2/10/2021, requires group & individual health plans and Medicaid managed care organizations to perform, document and provide upon request, comparative analyses of the design and application of non-quantitative treatment limitations (NQTL).

Consolidated Appropriations Act, 2021 (CAA) Questions and Answers

Q: Will Independence Administrators be in compliance with the CAA by 1/1/2022?
A: Independence Administrators is committed to meeting the requirements of the CAA applicable to them.

Q: [Updated as of 8.24.22] **How will the requirements outlined in the CAA impact contracts with groups? Which provisions from the CAA will be addressed in contracts with group health plans?**
A: The CAA will not change Independence Administrators Administrative and Network Services Contract. The CAA does impose certain requirements on the plan sponsor/plan fiduciary of the self-funded health benefit plan.

Advanced EOB (AEOB)

Q: What are Independence Administrators' plans for accommodating the CAA requirement to provide AEOBs to members in 2022?
A: For participating providers, Independence Administrators is using the PEAR Portal; for non-participating providers, the request for AEOBs can be made via a customer service request.

Q: Even though enforcement is deferred until further guidance, are you continuing to develop solutions based on available guidance should this go into effect in the near future?
A: Independence Administrators will comply with the law.

Q. How will Independence Administrators obtain and maintain member email addresses to send these AEOBs electronically?
A: Independence Administrators will maintain members' email addresses through Independence Administrators' current member portal. If members do not have access to the member portal, they can sign up on ibxtpa.com or contact customer service at the number on the back of their ID card to update their preferred method of communication.

Q. Please provide a sample AEOB.
A: Independence Administrators will share a sample AEOB when additional guidance is issued by the federal government.

Q: Will Independence Administrators incorporate data from carve-out vendors, such as pharmacy benefit managers into AEOBs?
A: Among other requirements of the AEOB, Independence Administrators is required to provide a good faith estimate of the member's requested item or services according to their coverage. Independence Administrators will comply with the requirements for the benefits administered by Independence Administrators. Independence Administrators is only incorporating its data and the data of Independence Administrators preferred vendors, which does not include non-preferred pharmacy benefit managers. If a group offers benefits outside of Independence Administrators, they should work directly with their vendors.

Q: What impact, if any, will these changes have on the administrative fees?
A: Independence Administrators is still evaluating any impacts to its administrative fees and will communicate any impacts once determined.

Q: Will Independence Administrators share data with third parties, such as Castlight and Healthcare Bluebook, to enable the production of AEOBs?

A: Pending further guidance from the federal government, Independence Administrators is focusing on implementing the AEOB requirement. Independence Administrators will consider this in the future.

Cost Comparison Tool

This has been delayed until 2023 with the intent to align with the TCR price transparency tool requirements.

Q: Will Independence Administrators' current cost comparison tool(s) be used as a price transparency tool?
A: Yes.

Q: Do you intend to build and manage a price transparency tool on behalf of Independence Administrators groups?
A: Yes.

Q: [Updated as of 8.24.22] **Will Independence Administrators comply with the requirements to provide price comparison guidance by phone and website (tool), allowing members to compare cost-sharing applicable under the plan with respect to the furnishing of a specific item or service, taking into account the plan year, geographic region and providers?**
A: Independence Administrators will comply with the law as required and provide a standard implementation. Independence Administrators' current tool is already compliant for the majority of Independence Administrators' business.

Q: When will Independence Administrators' platform be ready to launch?
A: Independence Administrators will comply with the law.

Q: How will the cost comparison tool be made available to consumers (e.g., online self-service and/or by phone)?
A: The cost comparison tool will be made available in the same manner it is today through ibxtpa.com and the Independence Administrators mobile app. Independence Administrators can also produce cost estimates on behalf of members by calling customer service (i.e., by phone).

Q: What are the benefits of the care cost estimator tool? What are the search capabilities in the price comparison tool?
A: The care cost estimator tool helps members save money and avoid unplanned expenses by allowing them to search and compare providers by estimated price based on their health plan. This tool will display provider details, quality information such as reviews, and the estimated out-of-pocket costs for a wide range of common procedures and office visits.

ID Cards

Q: Will Independence Administrators issue new ID cards to display in-network/out-of-network applicable deductibles and out-of-network out of pocket limits, telephone number, and internet website address?
A: Yes. As of 1/1/2022*, ID cards are being re-issued based on the member/group renewal date (on or after 1/1/2022*) and are available on the portal. Members of large groups with benefit changes will also receive updated cards upon renewal, unless the group decides otherwise.

*1/1/2022, ID cards will be available in the new formats on the portal. They will be re-issued based on customer decision for large group customers.

Q: Will there be any additional fees?

A: There will not be any additional fees related to the new ID cards.

Q: Please confirm no file changes/interfaces will be needed.

A: At this time, Independence Administrators does not anticipate any file changes or interfaces will be needed. There will be a modification to the existing file sent to Independence Administrators' ID card vendor.

Q: Can Independence Administrators share a mockup of the ID cards?

A: Mockups of ID cards are available and can be shared upon request.

Q: Will virtual ID cards that meet requirements be available starting 1/1/2022?

A: They will be available on or before the group's renewal date on the member portal and mobile app.

Q: Will cards be printed for newly enrolled members and/or members making changes be compliant with the new regulations?

A: Yes, all new members will receive new ID cards upon enrollment. Existing members will receive the new ID Cards if their groups are making benefit changes – based on renewal date. For example, a group that renews with benefit change on 1/1/2022 will receive new ID cards in late December. A group that renews with benefit change on 3/1/2022 will receive their ID cards in February.

Q: What date does Independence Administrators need renewal decisions to produce ID cards in a timely fashion?

A: ID card generation is dependent upon receipt of benefit changes from a group and a clean enrollment file. The typical SLA to guarantee cards in hand prior to the effective date is 30 days in advance of renewal and 10 days upon receipt of a clean enrollment file. This could be longer than 10 days due to projected mail delays at the post office. The sooner Independence Administrators has a decision, the quicker the card will come.

Q: Will members receive new ID cards even if there were no benefit changes to their plan for the coming year?

A: No, only members of the groups with benefit changes will receive new ID Cards. However, new digital ID Cards will be available on the member portal and mobile app.

Continuity of Care

Q: [Updated as of 8.24.22] **Will Independence Administrators be in compliance by the effective date?**

A: Independence Administrators' is committed to implementing the requirements of the CAA applicable to them.

Q: [Updated as of 8.24.22] **What is the process to ensure continuity of care?**

A: Independence Administrators will notify members when a contracted provider leaves the network. Members with a Continuity of Care issue are directed to call Customer Experience Clinical Services will review members for continuity of care and the claims system will be updated to review claims for those members and adjudicate accordingly.

Q: [Updated as of 8.24.22] **Do members receive a network disruption letter that indicates options for continuity of care in certain instances and action they need to take?**
A: Members will receive a letter when a contracted provider leaves the network. Members with a Continuity of Care issue are directed to call Customer Experience.

Q: [Updated as of 8.24.22] **Will Independence Administrators identify individuals that qualify as "continuing care" and send them any required notices?**
A: Independence Administrators will notify members when a contracted provider leaves the network. Members with a Continuation of Care issue are directed call Customer Experience. Clinical Services will review members for continuity of care and the claims system will be updated to review claims for those members and adjudicate accordingly.

Q: [Updated as of 8.24.22] **Will Independence Administrators allow certain members to receive up to 90 days of continued coverage at in-network cost-sharing rates when their provider moves out-of-network, as well as the parameters for coverage?**
A: Up to 90 calendar days of continuity of care will be offered to the member through the current period of active treatment for an acute condition or through the acute phase of a chronic condition, after which they must seek care from a provider within the network specified by their plan. Continuity of care determinations are made based on medical necessity.

Provider Directories

Q: [Updated as of 8.24.22] **Will Independence Administrators be in compliance by the effective date?**
A: Independence Administrators is committed to meeting the requirements applicable to them.

Q: Has Independence Administrators established a protocol for responding to requests?
A: Independence Administrators will continue to use the existing protocols in place to respond to member requests.

Q: [Updated as of 8.24.22] **Are there additional fees?**
A: There are no additional fees for Provider Directory

Q: What is being done to ensure frequent data updates?
A: Internal processes are being modified to update the required fields in the provider directory based on requirements of the CAA.

Q: What is the process to confirm a member relied on inaccurate provider directory information from the carrier website, and what steps will Independence Administrators take so that cost—sharing required by the law is applied to the claims for services for emergency care, from an out-of-network provider at an in-network hospital or ambulatory surgical center or from an out-of-network air ambulance provider?
A: Independence Administrators has an existing process, performed by Customer Service to make sure cost-sharing reflects the participating status of the provider, based on member request. The member must provide proof he/she received incorrect information on the provider's participation status. Proof of an incorrect provider directory entry should be either that the online provider directory is still displaying an out-of-network provider as in-network, or the member has print screen/printout of the directory listing the out-of-network provider as in-network.

Q: Will the required balance billing disclosure be present on the site and EOBs by the effective date?
A: Public sites and EOBs contain the balance billing disclosure, outlined in the CAA.

Q: Will you notify employers of directory updates?
A: Independence Administrators will be compliant with the applicable federal and state requirements for managing and presentment of provider directory information, but due to the frequency and volume of provider data changes, Independence Administrators will not be able to support account notification when updates have been made.

Q: If data will be provided through Plan-hosted website, will employers have the option to request a data feed for their employer-hosted website?
A: There are no plans to support new feeds to employer hosted websites.

Q: How will access to the directory be provided (i.e., directly or via an employer website)?
A: Independence Administrators' provider directory is available on Independence Administrators' public sites and on the member portal.

Q: If the provider directory information is outdated and a member utilizes the incorrect information in seeking in-network care, please confirm how Independence Administrators will administer the claim at the in-network level?
A: Independence Administrators will update the online provider directory as required by the CAA. Independence Administrators updates the online provider directory daily. Members who rely on information which is incorrect will not be liable beyond the in-network level of benefits and applicable cost-share. Such circumstances likely do not become known unless the member inquires and/or appeals a benefit determination in accordance with the health plan rules and procedures.

Broker and Consultant Compensation Disclosure

Q: Will Independence Administrators be in compliance with the new disclosure requirements related to broker compensation by the effective date?
A: Independence Administrators is currently in compliance as all broker-related fees are between the broker and plan fiduciary.

Surprise Billing

Q: [Updated as of 8.24.22] **The CAA requires health plans to reimburse out-of-network providers and facilities in the situations where balance billing is prohibited. Will you be offering services to support this?**
A: Independence Administrators has made changes to its claims processing to recognize the specific claim types based on the definitions set forth in the CAA Out-of-network providers will be reimbursed following the regulations within the CAA.

Q: What should a member do if they receive a surprise medical bill that is otherwise prohibited under the new regulations?
A: Your Rights and Protections Against Surprise Medical Bills is available on https://www.ibxtpa.com/members/index.html. Members may also call the customer service number on their ID card and may submit an appeal for the surprise medical bill which is also available for External Review.

Q: Will Independence Administrators partially or fully reimburse member balance billing if a group health plan wants to extend balance billing protection beyond those services subject to the CAA's protections? Describe available options.

A: Independence Administrators adjudicates claims based on the direction of the plan sponsor. Changes from the plan sponsor outside of the CAA would need to be evaluated for implementation.

Q: [Updated as of 8.24.22] **Describe any services in support of compliance with CAA surprise billing protections that will be subcontracted or outsourced to third parties. List the name of each party and services provided by each.**
A: Independence Administrators is not using a subcontractor for CAA Surprise Billing.

Q: Please confirm balance billing will be prohibited for air ambulance.
A: The air ambulance claims will be processed according to the requirements of the CAA.

Q: For an air ambulance provided by a nonparticipating provider, please confirm Independence Administrators will determine the cost-sharing on the lesser of the QPA or the billed amount.
A: The payment for air ambulance services is based on the requirements of the CAA.

Q: Describe the steps Independence Administrators has taken to ensure compliance with the CAA's requirements regarding balance billing for OON emergency claims.
A: Consistent with the requirements of the CAA, Independence Administrators made certain revisions to its claims processing system so that the specific out-of-network claims described in the CAA will process as required by the CAA and subsequent regulatory guidance issued by the federal government. In addition, Independence Administrators has developed a communication plan to inform customers and providers about the CAA.

Q: Describe the steps Independence Administrators has taken to ensure compliance with the CAA's requirements regarding balance billing for out-of-network services provided at in-network facilities.
A: Consistent with the requirements of the CAA, Independence Administrators made certain revisions to its claims processing system so that the specific out-of-network claims described in the CAA will process as required by the CAA and subsequent regulatory guidance issued by the federal government. In addition, Independence Administrators has developed a communication plan to inform customers and providers about the CAA.

Q. For the out-of-network services protected from surprise medical billing (i.e., emergency room, air ambulance, and non-emergent services received by an OON provider at an IN facility), can Independence Administrators confirm the amount that Independence Administrators is using for the initial payment to the OON providers? Is Independence Administrators using the Qualifying Payment Amount or the allowable charge?
A: The QPA methodology used by Independence Administrators complies with the requirements of the CAA.

Q: As related to Independence Administrators' out-of-network claims administration and cost containment programs for services NOT subject to the CAA's surprise billing protections, describe any recent or anticipated forthcoming changes to your capabilities, program offering, fee structure, or other features. Include all program updates, regardless of whether in parallel to changes for services subject to CAA protections.
A: Independence Administrators is not planning any changes to the surprise billing protections other than changes required by the CAA.

Q: Will Independence Administrators administer "involuntary" OON claims subject to the CAA's surprise billing protections?
A: Consistent with the requirements of the No Surprises provision of the CAA, Independence Administrators made certain revisions to its claims processing system so that the specific out-of-network claims described in the No Surprises provision of the CAA will process as required by the CAA and subsequent regulatory guidance issued by the federal government. In addition, Independence Administrators has developed a communication plan to inform customers and providers about the No Surprises provision of the CAA.

Q: For coverage of non-emergency services provided by nonparticipating providers at a participating facility, please confirm the member will pay the in-network cost-share and the cost-share will count toward the in-network and out-of-network deductibles (if applicable).
A: Yes, Independence Administrators will process the claims based on the requirements of the CAA.

Q: Please confirm the definition of "visit" and "facilities" for emergency services and nonemergency services by nonparticipating providers in participating facilities will be administered according to the IFR definitions.
A: The IFR definitions of "visit" and "facilities" will comply with the CAA.

Q: Please confirm Independence Administrators will be calculating the "recognized amount" to determine the cost-sharing for emergency services furnished by a nonparticipating emergency facility, and for non-emergency services furnished by nonparticipating providers in a participating health care facility.
A: Independence Administrators will calculate the recognized amount based on the requirements of the CAA.

Q: Please confirm if Independence Administrators will be supporting the disclosure requirement as outlined by the IFR. Specifically, please confirm that Independence Administrators will make publicly available, post on a public website of the plan or issuer and include on each explanation of benefits for an item or service with respect to which the surprise medical billing requirements apply.
A: Independence Administrators' public sites and EOBs will contain the balance billing disclosure, outlined in the CAA.

Q: How will Independence Administrators notify members of its Public Disclosure files on its website?
A: Independence Administrators has posted the disclosures on its website as required.

Q: Will Independence Administrators be in compliance by the effective date?
A: Independence Administrators is committed to meeting the requirements applicable to them.

Q: [Updated as of 8.24.22] **Will groups be notified of appeals by the provider?**
A: Independence Administrators will not notify the customers in the event of provider requested negotiations. In the event negotiation is successful, and provider agreed to proposed payment, claim will be adjusted to the agreed upon amount.

Q: How will shared savings arrangements be impacted by the Surprise Billing requirements?
A: Shared savings arrangements are implemented with participating providers and there is specific language that prohibits surprise billing in the provider contracts.

Q: Please explain the impact, if any, on the administrative fees as a result of these changes.
A: There will be no impact to administrative fees, but any custom requests may incur fees.

Independent Dispute Resolution (IDR)

Q: [Updated as of 8.24.22] **What is the process for IDR?**
A: Independence Administrators will participate in Independent Dispute Resolution (IDR) per the regulation when initial negotiation failed and upon a provider's request. IDR will be administered by CMS approved IDR entities through new CMS Portal. Independence Administrators will not notify the customers in the event of provider requested negotiations. In the event negotiation is successful, and provider agreed to proposed payment, claim will be adjusted to the agreed upon amount. t. Independence Administrators is working on the process to support self-funded customers and there will be a cost associated. Once the cost is finalized, Independence Administrators will notify Independence Administrators customers.

Q: Which entities will fulfill the role of IDR? Is this different from the entity that Independence Administrators currently contract with to negotiate disputed claims?
A: CMS has published a list of approved entities which can be found at https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list. CMS is expected to update the list with additional entities, as they become certified. For external reviews, Independence Administrators contracts with several Independent Review Organizations (IROs) which are not the same as the Independent Dispute Resolution (IDR) entities.

Q: Does Independence Administrators anticipate agreeing to select any/all certified entities or to use a select group of entities based upon particular criteria? Describe the potential criteria and selection considerations if known at this time.
A: Independence Administrators is reviewing and will follow the published guidance and future guidance, if applicable, regarding the Independent Dispute Resolution (IDR) process.

CMS has published a list of approved entities which can be found at https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list. CMS is expected to update the list with additional entities, as they become certified.

Q: How will Independence Administrators ensure members are protected from balance bills where legislation requires that protection? Specifically, when plan members encounter these situations: Seek out-of-network emergency care

- **Transported by an out-of-network air ambulance**
- **Receive non-emergency care at an in-network hospital but are unknowingly treated by an out-of-network physician or laboratory**

A: Consistent with the requirements of the No Surprises provision of the Consolidated Appropriations Act (CAA), Independence Administrators made certain revisions to Independence Administrators' claims processing system so that the specific out-of-network claims described in the No Surprises provision of the CAA will process as required by the CAA and subsequent regulatory guidance issued by the federal government.

If a member receives a balance bill for a No Surprises Claim, the member may call the customer service number on their ID card and may submit an appeal for the surprise medical bill which is also available for External Review

Q: Can you confirm whether Independence Administrators will be supporting self-funded customers with the IDR process, and whether there is a cost?

A: Independence Administrators is working on the process to support self-funded customers and there will be a cost associated. Once the cost is finalized, Independence Administrators will notify Independence Administrators' customers. The self-funded customer will be responsible for all fees and costs associated with the IDR process.

Q: For claims undergoing IDR, confirm Independence Administrators will make the following payments on behalf of the plan sponsor:

- **Administrative fee payable to the certified IDR entity**
- **Cost of IDR process when plan sponsor is determined to be the non-prevailing (losing) party**

A: Subject to the federal government issuing additional guidance, Independence Administrators intends to negotiate with the provider and respond to provider-initiated IDR on the customer's behalf, including all fees and costs required by the IDR process. The self-funded customer will be responsible for all fees and costs associated with the IDR process. Independence Administrators will support self-funded customers and there will be a cost associated for this support. Once Independence Administrators' cost for providing the service is finalized, Independence Administrators will notify its customers.

Q: Is there anything the customer needs to do to prepare for an IDR? Or should the customer anticipate this to be handled entirely by Independence Administrators?

A: No, customers do not need to do anything to prepare for an IDR. Independence Administrators is handling.

Q: Will Independence Administrators be automatically supporting customers on the IDR process, or do customers need to make an active election?

A: Subject to the federal government issuing additional guidance, Independence Administrators is intending to negotiate with the provider and respond to provider-initiated IDR on the customer's behalf.

Q: How will customers be notified that a provider is seeking payment beyond out-of-network allowable charges?

A: The current assumption is that Independence Administrators will negotiate with the provider and respond to provider-initiated IDR on the customer's behalf. Independence Administrators does not notify customers proactively of any inquiries.

Q: Will Third-Party Administrator negotiate with the provider on a customer's behalf?

A: Subject to the federal government issuing additional guidance, Independence Administrators is intending to negotiate with the provider and respond to provider-initiated IDR on the customer's behalf.

Q: Does Third-Party Administrator initiate the IDR review on a customer's behalf?

A: Subject to the federal government issuing additional guidance, Independence Administrators is intending to negotiate with the provider and respond to provider-initiated IDR on the customer's behalf.

Q: [Updated as of 8.24.22] **What processes will be put in place so that the customer is are aware of potential additional spend and when additional action may need to be taken?**
A: Independence Administrators will negotiate with the provider and respond to provider-initiated IDR on the customer's behalf. Customers will not receive notification that this process is occurring. In the event IRD is decided for the provider, the claim will be adjusted to the amount identified by the IRD Entity.

Q: What are the IDR Process timelines outlined in the September 30, 2021 Rule?
A: Important Open Negotiation and Independent Dispute Resolution Deadlines

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate independent dispute resolution process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified independent dispute resolution entity selection	3 business days after the independent dispute resolution initiation date
Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	6 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

Mental Health Parity and Addiction Equity Act - CAA

Q: [Updated as of 8.24.22] **Will Independence Administrators be offering services to support the requirements for health plans to conduct comparative analyses of the nonquantitative treatment limitations (NQTLs) used for medical and surgical benefits, as compared to mental health and substance use disorder benefits?**
A: The Third-Party Administrator's self-funded customers are responsible for compliance with applicable law including mental health parity (MHP) and are responsible for the nonquantitative treatment limitations (NQTLs) assessment for their Group Health Plan(s). As a third-party administrator for the self-funded customer, Independence Administrators will assist Independence Administrators' self-funded customer's efforts to document the NQTL's by reviewing NQTLs that are not tied to specific Group Health Plan designs. The third-party administrator is not providing any MHP testing nor MHP analysis nor NQTL analysis specific to a customers' Group Health Plan(s).

The third-party administrators' generic analysis of the NQTLs will be provided to a self-funded customer, upon request, if the self-funded customer is responding to a regulator and the generic analysis matches the customers Group Health Plan. Where the third-party administrator is the nominated claim fiduciary for the plan and responsible for medical management and the plan does not contract separately for behavioral health or with providers, much of the generic NQTLs prepared may be applicable to the self-

funded Group Health Plan. To the extent a self-funded customer, for their self-funded Group Health Plan, has customized their Prior Authorization List or has carved out behavioral health to another third party administrator or uses a vendor for Medical Management, or any other functions or benefits to which the self-funded Group Health Plan has separate contracts with Vendors, Providers or Facilities, or uses a PBM that is not FutureScripts®*, or has customized the FutureScripts® Select Drug Formulary or the Premium Formulary, the self-funded customer should analyze its Group Health Plan to determine compliance with mental health parity and provide its NQTL analyses to regulators.

*FutureScripts® is an independent company that provides pharmacy benefit management services.

Q: Are there additional fees to perform this analysis?
A: Independence Administrators does not provide QTL courtesy testing for the Self-funded Group Health Plans.

Q: Will you provide an analysis of all financial requirements and NQTLs applicable to the plan, in accordance with mental health parity rules? If not, can a customer request Independence Administrators' support for testing?
A: Self-funded customers are responsible for their own compliance and to conduct the NQTL analysis required by law, but Independence Administrators will assist with a customer's efforts to document the NQTLs if customers receive a subpoena or request from a regulator and the generic analysis matches the customers Group Health Plan.

Q: Will Independence Administrators confirm if it is proactively performing testing for self-funded customers?
A: Independence Administrators is not providing any MHP testing nor MHP analysis nor NQTL analysis specific to a customers' Group Health Plan(s). Self-funded customers should analyze their health plans and consult their Legal counsel to determine compliance with federal mental health parity.

Q: In the event of DOL investigation of customer's plan, will you provide the appropriate documentation or substantiation for purposes of demonstrating MHPAEA compliance?
A: Independence Administrators will assist the customer 's efforts to document the NQTs in response to a DOL subpoena if the generic analysis matches the customers Group Health Plan.

Q: Will you communicate to the customer sponsor about any detected MHPAEA violations and the necessary corrective actions taken to resolve the issue? How soon will the information be communicated to customer?
A: Independence Administrators will notify the customer if there is a final finding of noncompliance with MHPAEA by a regulator.

Q: What is Independence Administrators' expected timing in accordance with the new requirements? What is the impact of these changes, if any, on administrative fees?
A: Independence Administrators continuously reviews and updates NQTL comparative documents. Independence Administrators does not charge for supporting DOL inquiries and DOL requests of information and NQTL documentation.

Q: [Updated as of 8.24.22] **Upon an official request from a regulator, will Independence Administrators perform the comparative analysis required by the CAA to show compliance with**

federal mental health parity? If yes, is there an additional fee for this service and what is the standard turn-around time to deliver the analysis?
A: The self-funded customer is responsible for compliance with applicable law including mental health parity (MHP) and are responsible for the nonquantitative treatment limitations (NQTLs) assessment for their Group Health Plan(s). Independence Administrators will assist the self-funded customer's efforts to document the NQTL's by reviewing NQTLs that are not tied to specific Group Health Plan designs. Independence Administrator is not providing any MHP testing nor MHP analysis nor NQTL analysis specific to a customers' Group Health Plan(s).

Independence Administrators generic analysis of the NQTLs will be provided to a self-funded customer, upon request, if the self-funded customer is responding to a regulator and the generic analysis matches the customers Group Health Plan. Where Independence Administrators is the nominated claim fiduciary for the plan and responsible for medical management and the plan does not contract separately for behavioral health or with providers, much of the generic NQTLs prepared may be applicable to the self-funded Group Health Plan. To the extent a self-funded customer, for their self-funded Group Health Plan, has customized their Prior Authorization List or has carved out behavioral health to another third party administrator or uses a vendor for Medical Management, or any other functions or benefits to which the self-funded Group Health Plan has separate contracts with Vendors, Providers or Facilities, or uses a PBM that is not FutureScripts, or has customized the FutureScripts Select Drug Formulary or the Premium Formulary, the self-funded customer should analyze its Group Health Plan to determine compliance with mental health parity and provide its NQTL analyses to regulators.

Q: Will Independence Administrators also be available to assist the customer/regulator with any subsequent follow up questions?
A: Yes, Independence Administrators will be available to assist the customer/regulator with any subsequent follow up questions.

Q: Please confirm the customer will not be charged for this support.
A: There will be no charge at this time for the standard analysis.

Reporting Requirements

Q: [Updated as of 8.24.22] **The Rx Benefits and Cost Reporting requirements outline the reporting of specific prescription drug spend and certain medical cost data annually. For the top 50 drugs: Paid claims for most frequently dispensed, Annual amount spent by total plan/coverage spend, Greatest prior year plan spend, Total health care spend, and Premiums and rebates. Will Independence Administrators plan to produce reports for self-funded customers that meet these requirements?**
A. Independence Administrators will produce reports as required by the CAA and TCR for self-funded customers whose PBM is FutureScripts®. For self-funded customers whose PBM is not FutureScripts, we will report only on the data we currently have within our system. Compliance with all associated regulatory requirements and attestations is the responsibility of the self-funded groups health plan. Enforcement of this requirement has been deferred to December 27, 2022.

Q: Are there additional fees?
A: Independence Administrators is evaluating any impacts to its administrative fees and will communicate any impacts once determined.

Q: Will Independence Administrators furnish regular reporting to plan sponsor itemizing the claim counts and fees and pass-through charges?

A: Reporting to plan sponsors is not planned at this time as there is no requirement to provide this reporting.

General Questions

Q: [Updated as of 8.24.22] **Please describe how Independence Administrators is coordinating the cross-functional, enterprise-wide implementation of the CAA and TCR requirements.**
A: Independence Administrators has established an enterprise-wide implementation program in accordance with the requirements applicable to them. The requirements for implementing the CAA and TCR are evolving.

Q: Will Independence Administrators post notice of the NSA requirements and include such notice in all EOBs for affected items and services?

A: Independence Administrators public sites and EOBs will contain the balance billing disclosure, outlined in the CAA.

Q: [Updated as of 8.24.22] **How and when will updates on Independence Administrators' compliance with the various requirements of the CAA and TCR be disseminated to customers?**
A: As is Independence Administrators' standard practice, Independence Administrators will share information about the requirements for CAA and TCR via Independence Edge communications.

Q: How will Independence Administrators use price transparency as an opportunity to improve the consumer experience?
A: Independence Administrators will promote and use price transparency to help members better understand their benefits and cost-sharing.

Q: Will Independence Administrators support group customers' communication to their employees on these changes and new resources?
A: Independence Administrators will communicate changes and new resources to our customers. Self-funded customers will still be responsible for communicating to their employees and sharing materials and information as it becomes available.

Q: [Updated as of 8.24.22] **If a group health plan uses a third-party vendor to generate price comparison and/or cost-sharing estimates, would Independence Administrators share member-level accumulator information and other necessary data elements at no additional charge with the EOB vendor once appropriate data-sharing agreements are in place? If no, explain.**
A: No. Independence Administrators' responses to requests for member-level accumulator information and other data elements will need to be evaluated and if accepted will be provided at an additional charge to cover Independence Administrators' costs associated with providing the response.

Independence Administrators' standard transparency tools as required by the TCR and CAA will be available at no additional cost.

Q: [Updated as of 8.24.22] **List any third-party vendors or subcontractors Independence Administrators plans to use to support group health plans in complying with the requirements of the CAA and TCR.**
A: The following vendors are involved:

- enGen
- HealthSparq (recently purchased by KyruusFirstHealth

- MultiPlan/PHCS

Q: How will Independence Administrators use price transparency as an opportunity to improve the consumer experience?

A: Independence Administrators will promote and use price transparency to help members better understand their benefits and cost-sharing.

Transparency in Coverage Final Rule (TCR)

On November 12, 2020, the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the Departments) published the "Transparency in Coverage" final rule (Final Rule), imposing new requirements on group health plans and health insurers in the individual and group markets to disclose cost-sharing information, in-network provider negotiated rates, historical out-of-network allowed amounts, and drug pricing information. It also applies to Qualified Health Plan (QHP) issuers and the Federal Employees Health Benefits Program. The Rule follows the Hospital Price Transparency final rule, which required hospitals to make public a variety of pricing information and went into effect on January 1, 2021.

The Final Rule does not apply to Medicare Advantage, Medicare Supplement, Medicaid MCO coverage, or vision- or dental-only plans. Nor does it apply to grandfathered health plans; account-based group health plans, such as HRAs, including individual-coverage HRAs; or health FSAs, healthcare-sharing ministries, or short-term limited duration insurance plans.

The Rule's core requirements are to:

- Disclose to the public: 1) in-network provider negotiated rates, 2) historical out-of-network allowed amounts, and 3) drug pricing information, which has been postponed, pending further rulemaking, through three separate machine-readable files posted on an internet website
- Disclose cost-sharing information upon request to a participant, beneficiary, or enrollee – including an estimate of the individual's cost-sharing liability for covered items or services via an online tool, and in paper if requested; and

The Rule adopts a three-year, phased-in approach for compliance with the Rule, which requires Plans and Issuers to provide:

- Public access to in-network provider negotiated rates and historical out-of-network allowed amounts for plan years that begin on or after July 1, 2022;
- Cost-sharing information to participants, beneficiaries, or enrollees for all covered items and services for plan years that begin on or after January 1, 2024; and
- Pending further rulemaking, public access to drug pricing information.

The Rule also allows health insurance issuers to receive credit in their Medical Loss Ratio calculations for programs that create shared-savings for members resulting from their shopping for, and receiving care from lower-cost, higher-value providers.

Resources

CMS Transparency in Coverage Fact Sheet

Transparency in Coverage Final Rule (TCR)

Q: [Updated as of 8.24.22] **Does the Transparency in Coverage rule apply to insurers and group health plans?**

A: Yes, the rule applies to health insurers and group health plans. The plan sponsor is responsible for implementing the requirement for self-funded group health plans. Self-funded groups may contact a third-party administrator to help implement the requirements of the rule.

Machine-Readable Files

Q: [Updated as of 8.24.22] **What are the requirements for July 1, 2022?**

A: Enforcement for Machine Readable Files (MRFs) was delayed from January 1, 2022, to July 1, 2022, for negotiated in-network rates as well as out-of-network allowed amounts and billed charges. Enforcement for prescription drug costs (negotiated rates and historical net pricing) was deferred pending additional rulemaking.

Q: [New as of 8.24.22] **What does it mean for you as the employer?**

A: As an employer, it is important to be mindful of the appropriate ways to leverage and consume this newly available data, ensuring that you do not draw false conclusions through an "apples to oranges" comparison.

While this data may pose challenges, there is ample opportunity for employers to leverage this data to support consumerism within their populations. When used in conjunction with the transparency tools offered by Independence Administrators, members will receive insights as to the cost of services for a specified provider before care is rendered, helping them to select lower cost providers and reducing cost for both the employer and the member in the long term.

Q: [New as of 8.24.22] **What are some complexities that require an element of interpretation with these MRFs?**

A: As an example of the complexity in comparing costs, consider the following example: A provider is paid for the entire emergency room visit (doctor visit, labs, x-ray etc.) using a single bundled payment, while another provider is paid for each component separately. This difference in reimbursement structure would not be readily apparent in the MRFs and could lead to inaccurate conclusions regarding the two providers relative cost.

Q: [Updated as of 8.24.22] **Please describe the process for delivering links to required MRFs to self-insured plan sponsors.**

A: Independence Administrators will produce in-network and out-of-network machine readable files (MRFs) for each customer. Self-funded customers will be provided links to the appropriate file for each of their plans. Independence Administrators will send a monthly email to the self-funded customer's mandate email address with the link or links the customer can post to their public website. Independence Administrators will utilize the CMS Github Table of Content (ToC) option which will reduce the number of links required.

Q: [New as of 7.6.22] **Will Independence Administrators be posting all the MRFs to a single page or will there be customer-specific pages?**

A: Independence Administrators will provide self-funded customers with a URL to the required MRF which a customer can post to their public website. To do that, Independence Administrators requires

the name and email address of the person the customer wants to receive the unique URL for the MRFs. This person will serve as the customer's MRF contact. This contact will receive the URL link(s) email.

Q: [New as of 7.6.22] **What should a self-funded customer do once they receive their URL link(s)?**
A: Self-funded customers will need to post the URL link(s) on the customer's public website by July 1, 2022. The URL link is not expected to change. The data files will be automatically refreshed each month. If you are working with a third-party vendor for the MRFs, please check with the vendor regarding a name and email address.

Q: [Updated 8.24.22] **What format should the data be displayed according to the requirements? Indicate which file format Independence Administrators will utilize.**
A: For self-funded customers, the name of the MRF Index will follow this format: **https://storage.googleapis.com/ihg-dart-edw-mrf-prod-public/ia/YYYY-MM-DD_09876_index.json.**

Q: [New as of 7.6.22] **What is a "JSON" file?**
A: The JSON (JavaScript Object Notation) format is a technical standard data interchange format. It is primarily used for transmitting data between a web application and a server. These files must be opened using a specialized JSON file reader. If a JSON file, which has a .JSON file extension, is opened using a standard business application (such as Microsoft Word), the file contents will appear as a large series of alpha numeric characters that will not be able to be clearly read or understood. If opened by a non-JSON file reader, the file may look similar to the graphic below. For more information, visit https://www.cms.gov/healthplan-price-transparency.
Example JSON format:

Q: [New as of 7.6.22] **Who are the intended audiences for MRFs?**
A: The files are expected to be used by researchers, government entities and data aggregators to develop comparative data across health insurance issuers. While made available to the general public as required by regulation, the MRFs are not intended for use by members or customer non-technical business users.

Q: [Updated as of 8.24.22] **If a plan sponsor does not want to post the links on their own public website, will Independence Administrators create an employer-specific website for them?**

A: No.

Q: [Updated as of 8.24.22] **If a plan sponsor requests it, will Independence Administrators send updated links to third-parties who create employer-specific websites to post links to the MRFs?**
A: No.

Q: [New as of 7.6.22] **When will the machine-readable files first be delivered to customers?**
A: Independence Administrators provided the files by July 1.

Q: [New as of 7.6.22] **When will the files be updated each month? (e.g. by the 15th of every month, 2nd Tuesday of the month). Will Independence Administrators push notification to the customer when the files update?**
A: The files will be updated by the 10th of every month. Self-funded customers will receive an email once the files are ready.

Q: [Updated as of 8.24.22] **Will the files include plan-specific information (e.g. plan name, number, sponsor EIN) as required by the regulations?**
A: Yes.

Q: [Updated as of 8.24.22] **Will Independence Administrators be providing a Table of Contents file to post multiple networks/plans? If yes, will there be plan-specific information included?**
A: Yes, each customer will have a Table of Contents.

Q: [Updated as of 8.24.22] **Will files differ by customers if both customers have the same network arrangement, and how will they differ?**
A: Yes, the files will differ depending on the Customers networks.

Q: [New as of 7.6.22] **Will in-network files cover the entire US, or will they only be a limited geography (e.g. states/markets in which the customer operates or states/markets in which the responding Blues Plan operates)? If geographies are limited will another entity be providing in-network files for remaining geographies?**
A: The in-network MRF ToC will contain National blue in-network MRF links.

Q: [Updated as of 8.24.22] **Will Independence Administrators combine multiple applicable networks for in-network files if the plan uses different networks in different locations (e.g. BlueCard PPO and Select/Alt networks in specific markets)?**
A: The in-network MRF ToC will contain National blue in-network MRF links.

Q: [Updated as of 8.24.22] **How will special cost arrangements (such as domestic networks for hospital employers) be handled in an employer's machine-readable file?**
A: Independence Administrators will not be incorporating external data for non-preferred, customer specific vendors. Customers should work directly with those vendors to receive the necessary data.

Q: [Updated as of 8.24.22] **How will Independence Administrators treat carve-out arrangements (e.g. On-site clinics, carve-out surgical networks, virtual care)? Will these be included in the Machine-Readable Files?**
A: Independence Administrators will not be incorporating external data for non-preferred, customer-specific vendors. Customers should work directly with those vendors to receive necessary data.

Q: [Updated as of 8.24.22] **Will Independence Administrators maintain the monthly MRFs on behalf of each employer?**
A: Yes.

Q: [New as of 7.6.22] **For very large files, will a checksum or hash value be posted to help confirm that files have not been corrupted in posting/transfer?**
A: No.

Q: [New as of 7.6.22] **Will files be validated using the CMS schema validator prior to posting? (https://github.com/CMSgov/price-transparency-guide-validator)**
A: Yes.

Q: [New as of 7.6.22] **Describe the quality assurance process that will be in place to ensure accuracy of the information provided in the MRFs.**
A: Independence Administrators has two stages of testing, system testing and user acceptance testing. As part of the system testing, the testing team will test the layout of the files as well as data validation. The user acceptance testing will include multiple business areas reviewing and testing the data as needed.

Q: [New as of 7.6.22] **Will there be any additional fees associated with the Machine-Readable Files?**
A: There will be no additional fees for the standard files. Any special requests will need to be discussed with your Account Management team and any fees evaluated.

Q: [New as of 7.6.22] **Do you have tech support in the case that there are issues with missing files, website downtime, etc.? How can we get in touch?**
A: Customers will contact their Account Management team with any issues experiences. The Account Management team will work with teams internally to get the issue resolved.

Q: [Updated as of 8.24.22] **Please confirm if the files will be posted to Independence Administrators' website. If not yet available, please confirm where and when it will be posted.**
A: The files will not be posted to Independence Administrators' website. We will provide self-funded customers with a URL to the required MRF which a customer can post to their public website Each self-funded customers will be directed to a customer specific link that follows this pattern: **https://www.ibxtpa.com/transparency-in-coverage/09876?key=xxxxxxx.** Upon clicking on the link, the customer will get to the actual index file: **https://storage.googleapis.com/ihg-dart-edw-mrf-prod-public/ia/YYYY-MM-DD_09876_index.json.** The customer would then copy the link and post on their public website. The customer will receive a monthly notice that the link to the JSON file has been updated.

Q: Will the files satisfy all technical specifications as described on github.com?
A: The files will comply with all required specifications per the CMS GitHub site.

Q: [New as of 8.24.22] **Will the link to the MRFs change each month or will the link stay the same? If they are changing, how will the new links be provided each month?**
A: The link will stay the same.

Q: Does anyone wanting to access the machine-readable file have to open a user account?
A: MRFs will be publicly available to all users. Account logins and passwords will not be required.

Q: [Updated as of 8.24.22] **In addition to creating the Machine-Readable files, will Independence Administrators retain historical copies of the Machine-Readable Files to help customers satisfy ERISA's record retention requirements?**
A: Independence Administrators will retain MRF data for 10 years. Each self-funded ERISA plan sponsor will need to maintain information in its possession according to the appropriate time frame.

Q: [Updated as of 8.24.22] **What is Independence Administrators' approach to supporting plan sponsors in satisfying their internal data retention policy, in the event of audit or contract termination.**
A: All machine-readable files will be retained for 10 years in accordance with our policy. We generally are not aware of each plan sponsor's data retention policy.

Q. Please delineate the impact, if any, on the administrative fees as a result of these changes.
A: Independence Administrators is working to determine the impact on administrative fees for self-funded plans and will share once available.

Q: [Updated as of 8.24.22] **Can Independence Administrators confirm whether Independence Administrators will produce and host the files for self-funded customers, and whether there is a cost? If there is a cost to host the files, can wellness credits or other similar funds be used toward the cost?**
A: Independence Administrators will not host the files for self-funded customers. Independence Administrators will provide links to the self-funded customer for the MRF files. Data will be updated monthly, as required.

Q: [Updated as of 8.24.22] **Will Independence Administrators incorporate external data (e.g., PBM, specialty network, etc.)?**
A: No, Independence Administrators will only incorporate data from Independence Administrators' preferred vendor partners (i.e., FutureScripts). Customers should work directly with their vendors to receive necessary data.

Q: How will the requirements outlined in the TCR impact contracts with groups? Which provisions from the TCR will be addressed in plan-sponsor contracts?
A: Independence Administrators' agreements already state that Independence Administrators will comply with all applicable laws.

Q: This will be required for prescription drugs that run through the medical plan. Do you foresee any issues?
A: At this point, Independence Administrators does not anticipate any issues with including prescription drugs administered through the medical plan.

Q: Once additional guidance is released on the prescription drug file, will this file be prepared for prescription drugs that go through the medical plan?
A: If the Tri-agencies mandate the prescription drug file, only Pharmacy rates will be present on the Rx file. Medical drug rates will be available through the In Network Rate file.

Q: [Updated as of 8.24.22] **How will Independence Administrators respond to questions regarding any missing values such as NPI, procedure codes, etc.?**
A: Independence Administrators will update data as needed and will develop a process to respond to inquiries regarding the files.

Gag Clause

Q: [Updated as of 8.24.22] **Does the current Independence Administrators contract have a Gag clause prohibiting the disclosure of provider-specific cost or quality information to referring providers, us as the plan sponsor or members/individuals eligible to become members?**

A: Independence Administrators agreements with providers are compliant with the Gag clause per the CAA.

Q: Does Independence Administrators have the ability to support attestation of compliance with the CAA's prohibition on gag clauses on behalf of self-funded plan sponsors.
A: Additional guidance is expected later in 2022 on how plans can submit their attestations.

Q: [Updated as of 8.24.22] **Is Independence Administrators compliant with the CAA's prohibition on gag clauses that restrict sharing of price and quality data by providers?**
A: Yes. Independence Administrators agreements with providers are compliant with the Gag clause per the CAA.

Q: Will there be any additional fees?
A: There will not be any additional fees related to implementation of the prohibition on gag clauses.

Provider Contracts

Q: Is Independence Administrators prepared to report compliance with the new requirements that group health plans cannot enter into a services agreement that, directly or indirectly, restricts the group health plan from disclosing provider-specific costs, quality of care information, or electronically accessing de-identified claims data?
A: Independence Administrators' current contract templates comply with the provisions. Independence Administrators continues to enhance Independence Administrators' communications strategy to notify providers and outline the required changes for any legacy contracts.

Q: What is Independence Administrators' expected timing in accordance with the new regulations?
A: Independence Administrators' Provider Communications team published Advisory and Amendment language in May 2021 describing Independence Administrators' compliance with the provision and an amendment notice for any legacy contracts.

Q: What impact, if any, will these changes have on the administrative fees?
A: There will be no impact to administrative fees.

Q: How will insights on market pricing affect provider contract negotiation strategies?
A: To be determined. There may be providers who attempt to take advantage of the public data and compare this to their reimbursement; however, Independence Administrators is prepared to enter each negotiation with discussion items that are only relevant to that provider.

Q: What are the implications of transparency requirements for value-based care arrangements (compared to fee-for-service)?
A: Independence Administrators does not foresee any implications as the fee-for-service rates are the rates that are required to be published.

Q: Do Independence Administrators' online provider directories comply with the requirements of the CAA?
A: Independence Administrators' online provider directories comply with the CAA's requirements.

Q: Describe the process by which the accuracy of Independence Administrators' provider directories is maintained in order to ensure ongoing compliance with the requirements of the CAA.

A: Internal processes are being modified to update the required fields in the provider directory based on the CAA's requirements.

Miscellaneous Questions

Q: Please share Independence Administrators' intention to comply with the Secretary of Labor's standardized reporting format for voluntary reporting to State All Payer Claims Databases.
A: Independence Administrators will comply with all mandatory requirements of the CAA and Transparency in Coverage Federal Rule that is applicable to them. Reporting to a State All Payer Claims Database is voluntary and not mandated.

Q: Who has primary accountability at Independence Administrators to ensure the TCR and CAA requirements are met (title not name)?
A: Vice President, Marketing and Sr. Vice President, Operations

Q: What is the process and cadence for reporting progress to senior leadership within Independence Administrators (e.g., quarterly report outs to CEO, Board of Directors, etc.)?
A: Independence Administrators distributes weekly project status reports and has monthly meetings with Senior Leadership.

Q: Does Independence Administrators have an active risk mitigation strategy in place if the TCR and CAA requirements are not met? If not, what is the timeline for implementation of said strategy?
A: Independence Administrators is actively identifying, evaluating and managing risks with these initiatives.

Q: [Updated as of 8.24.22] **What is Independence Administrators' communication plan for those not digitally engaged when trying to send updates about the new regulations?**
A: Independence Administrators is actively developing a communication strategy for all customers. Additionally, Independence Administrators plans to post detailed information on Independence Administrators' corporate website.

Q: [Updated as of 8.24.22] **While the requirement for pharmacy benefit and drug cost reporting has been delayed, it is expected that further guidance will be issued, and plans should prepare to comply by December 27, 2022. Is Independence Administrators continuing to develop this file based on current guidance and make adjustments when further guidance is issued?**
A: Independence Administrators is continuing to develop the process based on current requirements. The process will be adjusted once additional guidance is issued.

Q: [Updated as of 8.24.22] **Does Independence Administrators expect to be a "reporting entity" and is Independence Administrators able to support aggregate reporting at the state level of all required medical data elements on behalf of customers pursuant to the RxDC instructions provided by CMS in late November (RxDC reporting instructions (PDF))?**

This includes (not limited to):

- **Total spending**
- **Spending categories (hospital, primary care, specialty care, clinical health services and equipment, and wellness services, prescription drug spend under the medical plan)**
- **Rx totals for spending for drugs covered under a non-pharmacy benefit**

A: Independence Administrators will be a “reporting entity” and will produce reports based on RxDC reporting instructions. Independence Administrators plans to report on the data that we have within our systems during the timeframes required for the report. Compliance with all associated regulatory requirements and attestations is the responsibility of the self-funded groups health plan.,

Q: [Updated as of 8.24.22] **If a customer sends Independence Administrators information that Independence Administrators does not have in its possession (e.g., Group Health Plan List information, average monthly employee/employer/total premium, ASO fees, etc.), will Independence Administrators be able to submit that information on the customer’s behalf?**
A: No Independence Administrators plans to report on the data that we have within our systems during the timeframes required for the report. Compliance with all associated regulatory requirements and attestations is the responsibility of the self-funded groups health plan.

Q: Assuming Independence Administrators can be a reporting entity, please describe how Independence Administrators will notify customers after submitting the reporting. The CMS instructions note that CMS will not be able to notify the plan that data has been submitted on their behalf.
A: Independence Administrators is not considering notifying its self-funded customers of the RxDC submission.

Q: As a service provider, is Independence Administrators providing any brokerage or consulting services as defined by the statute?
A: No.