Humana.

FOR EMPLOYERS

FREQUENTLY ASKED QUESTIONS:

No Surprises Act and Transparency in Coverage

*Updated as of August 16, 2024

No Surprises Act

What is the No Surprises Act?

The Consolidated Appropriations Act, 2021, signed into law at the end of 2020, includes the "No Surprises Act" which prohibits hospitals and doctors from issuing surprise medical bills for certain healthcare services. The Act also includes open negotiation and independent dispute resolution (IDR) procedures for health plans and out-of-network healthcare facilities and providers to determine applicable payment rates. The Act took effect on January 1, 2022.

Who is impacted by the No Surprises Act?

Fully-insured and self-funded Group Health Plans, including Grandfathered Plans, and Health Insurance Issuers offering Group or Individual Health insurance coverage.

Key provisions:

Consumer protections

- Health plan members are protected from surprise medical bills stemming from out-of-network emergency care, including air ambulance services, and other services provided by an out-of-network provider at an in-network facility.
- Out-of-network providers are prohibited from balance billing our members for amounts beyond their in-network cost-sharing (deductible, copayment, coinsurance) except in cases where the provider obtains the member's written consent.
- Providers are required to post on their website a notice outlining these balance billing protections and share the notice with health plan members electronically or by mail as requested.
- Members with complex care needs are allowed up to 90-days to transition to a new in-network provider if their existing provider elects to leave the network. Continued care from the terminated provider during this period is covered at the in-network cost-sharing rate.

Transparency obligations

- Providers and facilities are required to inform members of their network status and provide a good faith estimate of charges at least 72 hours in advance of furnishing a scheduled service. Health plans, in turn, are required to provide members with an advance explanation of benefits for scheduled services, which reflects the provider's network status, a good faith cost estimate, and any medical management instruction. This provision has been delayed and waiting further clarification. An update will be provided as soon as this process is finalized.
- Health plans are required to make updated provider network directories available to their members online or within three business days of the request. The implementation of this provision has been delayed and an update will be provided as soon as this process if finalized.
- Health plans are required to offer a price comparison tool for their members that allows comparison of the cost-sharing amounts that would be owed under the plan when services are provided by participating providers.

Will the No Surprises Act affect Humana's health plans?

This will not affect coverage but will bring additional resources and protections forward for members.

What is Humana's stance on the No Surprises Act?

Humana has continually supported federal and state policies designed to insulate our members from unexpected balance billing and believes that empowering consumers with the information they need to make informed healthcare choices is necessary to improve patient care while managing their healthcare costs.

What information will be included in the cost calculator outlined as a key element in the No Surprises Act?

On January 1, 2023, Humana made available to members real-time out-of-pocket cost estimates for covered items and services through MyHumana, a secured member website and tool. Please see the **Transparency in Coverage** section below to learn more about Humana's ongoing effort and commitment to meet the requirements.

ID Cards

What information has changed on member ID cards to meet requirements?

Humana has updated ID templates to:

- Reflect any or all deductibles or maximum out-of-pocket amounts for the member. (GA also includes coinsurance amounts.)
- Include the following disclaimer: "Members: Amounts are not inclusive of all plan member cost sharing. Log in to Humana.com or call Member/Provider Services for plan specifics."

When will new ID cards be available?

All ID card templates were updated January 2022 and new ID cards reflect the legislative requirements.

Can a group request additional customizations to their ID cards?

Yes, however with the new updates, space will be very limited. Humana will review specific customization requests to determine if space on the ID card can accommodate it. All customization requests will be submitted to the ID Card Team via the PSQ system for review.

Will new ID cards be issued to all members?

No, Humana's standard practices for issuing ID cards remain the same.

- All new medical group members were issued newly compliant ID cards starting November 1, 2021.
- For existing groups, who have made benefit changes that will be effective upon renewal, members received a newly compliant ID card starting November 1, 2021.
- Any commercial medical member requesting the issuance of an ID card after January 1, 2022, will receive a newly compliant ID card.

Advanced EOB (AEOB)

What is an advanced EOB (AEOB)?

The No Surprises Act requires health plans and insurers to provide an Advanced Explanation of Benefits (AEOB) when the provider submits a good faith estimate for a scheduled service or item, or upon a member's request. The AEOB will help prevent surprise billings by including a cost estimate for each service in language that is written to be easily understood by the member.

Note: This provision has been delayed and waiting further clarification. An update will be provided as soon as this process is finalized.

Provider Directory

What are the provider directory requirements within the No Surprises Act?

- Plans must establish a provider directory verification process and establish a procedure for removing providers or facilities with unverifiable information as of January 1, 2022.
- No less than every 90 days, plans must verify and update their provider directory database.

- Plans are required to update their directory within 2 business days of receiving a provider update.

External Review

What are the external review requirements within the No Surprises Act?

- Adverse determinations related to compliance with surprise billing and cost-sharing protections are subject to the states or federal external review process upon exhaustion of the internal appeal process.

Prescription Drug Data Collection (RxDC)

What prescription drug and healthcare spending information must insurers and employers submit to Federal Agencies to comply with the prescription drug data collection reporting requirements?

Please view our FAQ addressing the prescription drug data collection report.

Transparency in Coverage Rule

What is the Transparency in Coverage rule?

Transparency in Coverage (TiC) rule was finalized by The Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (the Departments). The final rules require that group health plans and health insurance issuers 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 furnished by a particular provider.

Plans and issuers must make this information available on an internet website and, if requested, in paper form, thereby allowing a participant, beneficiary, or enrollee (or his or her authorized representative) to obtain an estimate and understanding of the individual's out-of-pocket expenses and effectively shop for items and services.

Plans and issuers must also disclose in-network provider negotiated rates and historical out-of-network allowed amount information through two machine-readable files posted on an internet website.

These two distinct elements, cost estimation tools and machine-readable files are enforced throughout 2022, 2023 and 2024. Here is a high-level timeline of the Transparency in Coverage enforcement dates:

- **July 1, 2022:** Requires publication of machine-readable files (MRF) on a publicly available website displaying in-network and out-of-network rates.
- **January 1, 2023:** Plans and payers must make available an online cost estimation tool for "shoppable" provider services.
- **January 1, 2024:** Plans and payers must make available an online cost estimation tool for all services covered.

Machine-Readable Files

What are Machine-Readable Files?

A machine-readable file (MRF) is a document with content that can be readily processed by computers and displayed in a standardized format for members to access. These formats are dictated by CMS and currently are limited to JSON and/or XML.

As of July 1, 2022, Humana has made available online to the public machine-readable files that include detailed price information regarding in-network and out-of-network medical:

- Negotiated rate file for all covered items and services between the payer and in-network providers displayed in a dollar amount.
- Allowed amount file showing both the historical payments to, and historical charges from, out-of-network providers.

Humana has met this requirement and has displayed these data files in a standardized format and will provide monthly updates.

Where are the Machine-Readable Files be located?

Humana has published the machine-readable files on the following public facing webpage: Plan and Issuer Price Transparency (humana.com). There are no access restrictions and this information is available to anyone who would like to view it. Individuals will also be able to select the in-network or out-of-network icons to view commercial medical rates.

- Humana has posted medical rates on behalf of its fully-insured and self-insured/ASO groups to the public facing webpage.
- The requirements of the Transparency in Coverage Final Rule apply to both insurers and group health plans, including self-insured group health plans. Therefore, the self-insured group health plan is responsible for ensuring MRFs, which represent their medical contracted networks, are displayed on a publicly available website. Self-insured plans can meet their obligation by properly linking to their plan's information through the Humana website or download the information and make their own arrangements to host the information.

Will historical files be available for reference if needed?

Humana does not have plans to make historical data available. The information is public and available to download each month.

Which groups are impacted by the Transparency in Coverage rule?

All Humana Commercial groups are impacted by the Transparency in Coverage rule, regardless of funding type (fully-insured and self-funded). Exceptions are:

- Grandfathered plans
- Excepted benefits
- Short-term & limited-duration insurance
- Health reimbursement arrangements or
- Other account-based group health plans

How does Transparency in Coverage impact fully-insured employers?

Humana has posted MRFs for its fully-insured groups to a public-facing website. Please contact your Humana representative for more information on the website information.

How does Transparency in Coverage impact self-insured employers?

The requirements of the Transparency in Coverage Final Rule apply to both insurers and group health plans, including self-insured group health plans. Therefore, the self-insured group health plan is responsible for ensuring MRFs, which represent their medical contracted networks, are displayed on a publicly available website.

Humana believes that publishing these files on our publicly available website meets the requirement on behalf of the self-insured groups we serve.

What guidance is Humana giving to self-insured employers?

As of July 1, 2022, Humana included all custom fee schedules within our MRF publication. Self-insured plans can link to their plan's information through the Humana website, or download the information and make their own arrangements to host the information.

If a self-insured group does not want Humana to host the group's MRF files and wants to host their own MRFs or have an external party host them, please send a notification to your client executive or single point of contact to discuss further.

Do fully-insured plans need to post the required Machine-Readable Files under the Federal Transparency in Coverage regulations?

No. While the Transparency in Coverage regulations require both fully-insured plans and Humana, as an insurer, to provide the machine-readable files, the special rule to those regulations designed to prevent unnecessary duplication of disclosures allows fully-insured plans to shift responsibility to Humana to provide the disclosures. Humana will produce and post the required machine-readable files for fully-insured plans, and these plans have received a communication confirming this process.

Cost Transparency Tool

What are the cost transparency requirements under the Transparency in Coverage rule?

Humana was required to provide a digital tool with personalized, real-time cost-share estimates for 500 covered services for insured commercial members by January 1, 2023 and for all services by January 1, 2024. Humana made the cost transparency tool available through MyHumana, our secured member website on January 1, 2023 and expanded cost estimates for all services on January 1, 2024.

What data does the tool include and what should members expect?

The tool provides personalized data that includes:

- Cost estimates that account for member copays, deductibles, coinsurance and maximum out-of-pocket costs
- Costs for medical services and is based on the member's plan design and status of their deductible
- Quality scores for providers and facilities
- Patient review scores
- Ability to filter data based on provider specialty and distance and set their preferred maximum distance as a preference in their profile; members can also sort results by cost, distance, ratings, reviews or alphabetically

Prescription drug pricing will continue to be provided through the MyHumana drug pricing tool which is compliant with Transparency in Coverage requirements.

On February 21, 2024, a cyberattack on Change Healthcare (CHC) impacted functionality of Humana's cost transparency tool. Unfortunately ,CHC has been unable to restore the functionality of the tool. Humana is monitoring the situation and is instructing members to call the number listed on MyHumana.com for additional support obtaining cost estimates.

Gag Clause Prohibition Compliance Attestation (GCPCA)

The Gag Clause Prohibition Compliance requirement under the Consolidated Appropriations Act, 2021 (CAA) mandates that all group medical health plan sponsors complete and submit their own attestation via the process established by the Tri-Agencies by December 31, 2023 and annually each year after. Please see Humana's notice and details to health plan sponsors outlining the GCPCA. For more information from CMS on the requirements, please see **Gag Clause Prohibition Compliance Attestation | CMS**.

Why does Humana not submit the Gag Clause attestation on the plan sponsor's behalf?

Per the Gag Clause Prohibition Compliance Attestation (GCPCA) instructions, Humana will submit an attestation to CMS for its own compliance, however Humana will not be submitting on behalf of group health plan sponsors. After reviewing the information required in the GCPCA template, Humana discovered that it does not have all the required point-of-contact information for group health plan sponsors from 2020 to 2024. Given this limitation, group health plans must submit an attestation on their own behalf to ensure CMS receives correct information for each group.

Additional challenges exist when health plan sponsors that have other provider agreements beyond the agreements managed by Humana. Humana has no insight into the existence or content of other provider agreements, and these must be identified individually in the group's attestation submission.

Humana attests that its provider agreements are compliant with the Gag Clause Prohibition.

If the group health plan only uses Humana for its covered plan benefits, then a submission to CMS confirming compliance is all that would be required from the group.

Groups that used Humana for part of the year and another carrier for the remaining portion of the year, will need to consult with their new carrier to determine how their GCPCA information will be submitted and how to supplement their submission with Humana's attestation. The CMS GCPCA User Manuel includes additional instructions and figures for plans or other responsible entities to list each Entity using the excel template. Additional instructions for completing and submitting the Responsible Entity Excel Template for multiple-entity attestations are in Section 14 and Section 17 of the Manual.

We apologize for the inconvenience this may cause, but Humana is not obligated by CMS to submit attestations on the group health plans' behalf and wants to ensure all information CMS receives is as accurate as possible.

Air Ambulance Requirement

Is there an update on the air ambulance reporting requirement?

The regulation that will establish the effective date of the air ambulance reporting requirement has not been finalized. In November 2023, CMS indicated it is in the process of finalizing new air ambulance requirements and is expecting to publish the requirements in 2024.

As the requirements and actions to achieve them continue to evolve, we will continue to provide updates and guidance to you as quickly as possible. If you have any questions, please reach out to your Humana account representative.

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.

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