KAISER PERMANENTE®

Implementation Status: Transparency in Coverage and H.R. 133

December 2021

Regulation Overview

The purpose of this document is to provide Kaiser Permanente employer groups and labor trusts with an update as to how Kaiser Permanente is implementing the Transparency in Coverage and H.R. 133 requirements in light of the guidance from the U.S. Departments of Health and Human Services, Labor and Treasury (IRS) set forth in FAQs Part 49 issued on August 20, 2021.

This document provides:

1. An overview of the key payor-related requirements of TiC and HR133
2. A high-level analysis of the changes introduced in FAQs Part 49
3. An explanation of KP's current implementation efforts and implementation expectations
4. Updated enforcement date for Pharmacy Reporting per interim final ruling (IFR) promulgated, November 17, 2021

Note: Information regarding KP's implementation efforts may change without notice

Summary of Requirements

Requirement Name	High Level Description of Law / Regulation	Compliance Date
HR 133 Gag Clauses	Payers must remove gag clauses on price and quality information in provider contracts.	12/27/2020
HR133 Mental Health Parity	Defined new provisions that strengthen uniformity in mental health and substance use disorder benefits. HR133 codifies agency guidance regarding NQTLs.	2/10/2021
HR 133 Broker Disclosures (Individual)	Payers must disclose all direct or indirect broker compensation to prospective members seeking individual ACA coverage or short-term limited duration insurance in the individual market.	12/27/2021
HR 133 Broker Disclosures (Group)	Brokers must report all direct and indirect compensation received by a health plan to employer groups.	12/27/2021
HR 133 ID Cards	Member ID cards must display deductible and out of pocket maximum information.	1/1/2022
HR 133 Surprise Billing	Requires that emergency services – regardless of where they are provided – be treated as in-network. Also bans out-of-network charges for ancillary care (e.g., anesthesiologist or assistant surgeon) at in-network facilities and bans surprise billing for air ambulance services	1/1/2022
HR 133 Advance EOB	Automatically provide members with an advance EOB upon receiving notification from a provider or facility that a member is scheduled to receive an item or service from that provider.	TBD
HR 133 Provider Directories	Ensure that provider directories are verified every 90 days, updated within 2 business days upon receipt of updated information, and that members are not billed at out of network rates if they were relying on erroneous directory info.	1/1/2022
HR 133 Continuity of Care	Allows members a 90-day period of continued coverage at in-network cost sharing rates to allow for a transition in care when provider changes network status.	1/1/2022
TiC MRF 1&2	Develop and publicly post machine readable files that disclose (1) In-network rates with contracted providers (2) Out of network allowed amounts	7/1/2022
TiC Cost Estimator	Provide members with a tool that enables them to view their cost-sharing liabilities for healthcare services. First phase must include 500 CMS-Designated services. Second phase must include all healthcare services	1/1/2023 & 1/1/2024
HR 133 Pharmacy Reporting	Requires health plans to report information on plan medical costs and prescription drug spending to Government	12/27/2022
TiC MRF 3	Payers must publicly post a machine-readable file for pharmacy cost and spending. **Requirement deferred indefinitely**	TBD

Regulatory Guidance Update

On Friday, August 20, 2021, the Federal Government issued FAQs Part 49 setting forth guidance on TiC and H.R. 133 that provided for enforcement discretion regarding some requirements and introduced the possibility of changes to other requirements.

The guidance provided deferred enforcement dates for specific provisions. The complexity of implementation and the need to provide further guidance on some provisions was also recognized. Kaiser Permanente has analyzed the FAQ updates and developed the following summary:

Enforcement dates moved:

- MRF 1 and 2 → Jul 1, 2022
- Pharmacy Reporting **

Enforcement dates deferred:

- MRF 3
- Advance EOB
- Price Comparison Tool → January 1, 2023 *

Regulatory updates forthcoming; reasonable, good faith interpretation

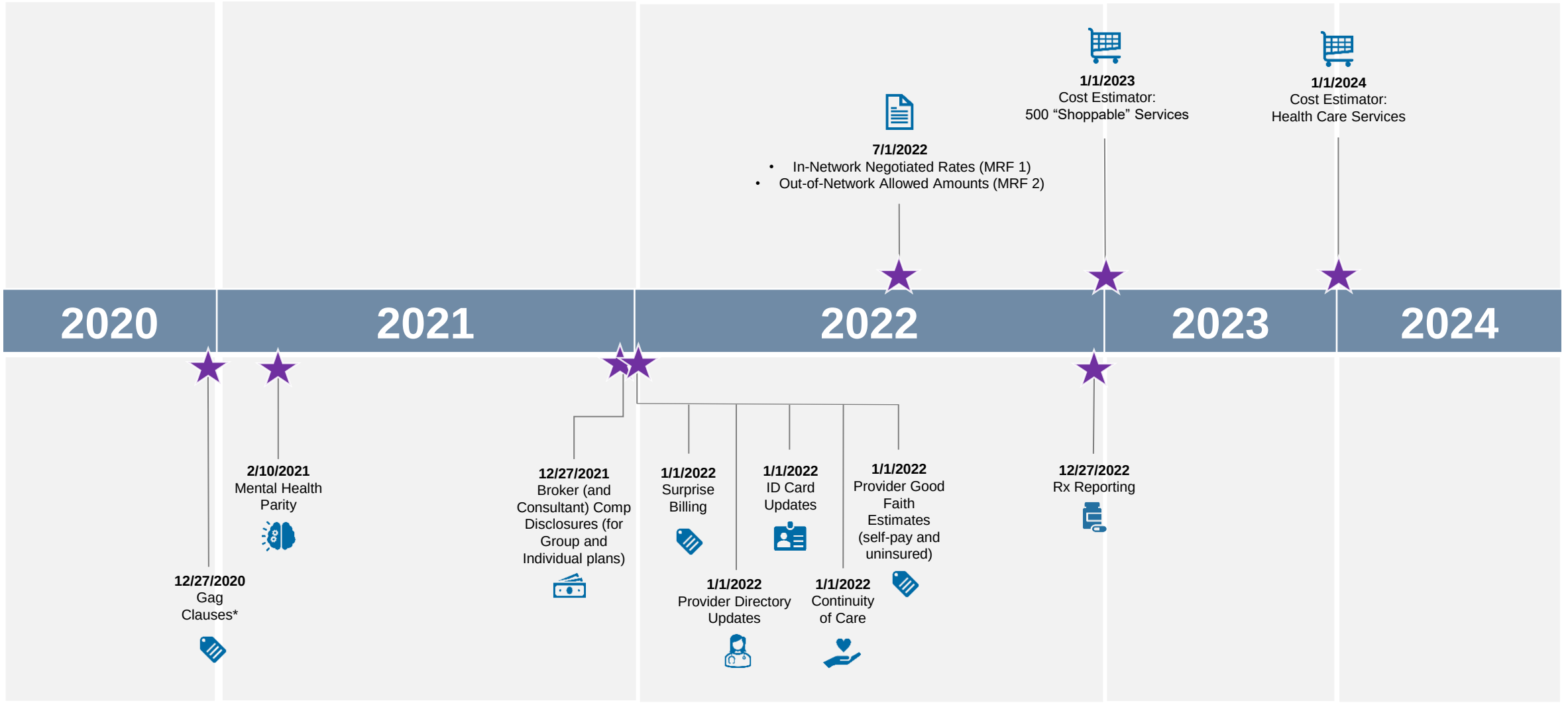
- ID Card Updates
- Provider Directory Updates
- Continuity of Care
- Gag Clauses

Not addressed in FAQ

- Broker Compensation Disclosures
- Mental Health Parity
- Surprise Billing
- Air Ambulance
- Choice of Provider
- Cost Estimator Tool

* Requirements likely to be aligned with Cost Estimator Tool and regulatory timeline
** The federal government has put forth an enforcement date of 12/27/2022

Current Regulatory Timeline



Acronyms:

- CAA – Consolidated Appropriations Act
- MRF – Machine Readable File
- TiC – Transparency in Coverage

*** NOTE: Enforcement dates are pending on the following:**
CAA – Gag Clauses (attestation date)

Regulation Components: Transparency in Coverage

RULE COMPONENTS				
Machine Readable File: In-network negotiated rates (MRF 1)	**Machine Readable File: Out-of-network allowed amounts (MRF 2)**	**Cost Estimator: 500 shoppable services**	**Cost Estimator: All services**	**Machine Readable File: Rx drug prices (MRF 3)**
Enforcement: 7/1/2022	**Enforcement**: 7/1/2022	**Enforcement**: 1/1/2023	**Enforcement**: 1/1/2024	**Enforcement**: TBD
CURRENT STATE				
Kaiser Permanente is in the process of developing the required in-network rate files for each region. KP is on track to meet the 7/1/2022 deadline to publicly post these files.	Kaiser Permanente is in the process of developing the required out of network allowed amount files. KP is on track to meet the 7/1/2022 deadline to publicly post these files.	Kaiser Permanente has a tool in place that provides members with some of the functionality required by the Transparency in Coverage tool. KP is in the process of expanding the scope and functionality of the existing tool to meet the CMS requirements for the 500 shoppable services and plans to deploy the enhanced tool by 1/1/2023.	Following expansion of KP's existing tool to include the 500 shoppable services (see left), the project team will commence work to once again expand the tool to provide all covered medical services. Anticipated go live will be January 1, 2024.	CMS has indefinitely deferred this requirement until further examination and determination as to the appropriateness and feasibility of this requirement. Given the uncertainties surrounding MRF 3 – KP has suspended work on this initiative pending more regulatory clarity.

Regulation Components: Consolidated Appropriations Act (cont...)

RULE COMPONENTS				
Gag Clauses*	**Mental Health Parity**	**Broker Compensation Disclosures**	**Surprise Billing***	**ID Card Updates***
Enforcement: 12/27/2020	**Enforcement**: 2/10/2021	**Enforcement**: 12/27/2021	**Enforcement:** 1/1/2022	**Enforcement:** 1/1/2022
CURRENT STATE				
KP reviewed all relevant provider contracts and did not identify any updates needed to provider contracts on account of HR-133 gag clause restrictions. The Federal Government is expected to provide additional guidance regarding compliance attestation.	KP continues to implement its multi-step comparative analysis on the four NQTL areas prioritized by the DOL in FAQ 45 and will respond to regulators and employers upon request. KP is monitoring all additional guidance as issued by the Federal Government.	KP has split the Broker Disclosure requirements of H.R. 133 into two distinct workstreams due to the significant differences in requirements for group vs. individual disclosures. We are supporting brokers in obtaining the compensation information that they must disclosure to group health plans. KP will notify individual members and comply with all individual market disclosure requirements.	KP's regulatory team has been actively monitoring and interpreting additional regulatory guidance as it is released, including the guidance on the IDR process. KP is actively working to meet requirements under the No Surprises Act including protections from: (1) Surprise medical bills for emergency services and post- stabilization services (to the extent covered) (2) Surprise medical bills for air ambulance services	KP is in the process of updating digital and physical ID Cards. Member communication regarding the new ID cards will commence in the fall of 2021 so that they may access their digital cards and make requests for a new physical card.

Consolidated Appropriations Act Components (cont...)

RULE COMPONENTS				
Provider Directory Updates*	**Continuity of Care***	**Rx Reporting**	**Price Comparison Tool***	**Advanced EOBs & Good Faith Estimates***
Impacts: Payers, Providers **Timing**: 1/1/2022	**Impacts**: Payers **Timing**: 1/1/2022	**Impacts**: Payers **Timing**: 12/27/2022	**Impacts**: Payers **Timing**: 1/1/2023	**Impacts**: Payers, Providers **Timing**: TBD (1/1/2022 for self-pay and uninsured)
SUMMARY				
Requires both payers and providers to provide timely updates to directories and protects patients from excess charges stemming from erroneous provider directory information.	If a provider and/or facility moves from in-network to out-of-network during the time a patient with complex care needs (including pregnancy) is receiving treatment, payer must continue to provide services through the completion of the course of care or up to 90-days, whichever is shorter.	Payers will be required to submit informational prescription reports to federal regulators (the first one will be due no later than December 27, 2022), and subsequent reports no later than June 1 of each subsequent year.	Payers must create a tool that allows members to compare the amount they are responsible for paying for a specific service. *Note: The price comparison tool requirement from the Consolidated Appropriations Act (H.R. 133) overlaps with the cost estimator tool requirement of the Transparency in Coverage regulation. HHS is expected to provide more clarity on the differences in scope between the two requirements.*	Payers must provide members an advanced explanation of benefits including: 1) provider network status, 2) contracted rate of service in question, 3) covered providers, and 4) the amount for which the payer is responsible, the amount for which the member is responsible, and the amount that will count towards the member's deductible and/or maximum out-of-pocket limit(s) *Note: Facilities and providers must transmit good faith estimates only to uninsured and self-pay patients beginning January 1, 2022.*

* Part of No Surprises Act