Building Trusted and Valued Relationships

BRMS Response to No Surprises Act

As an administrator for over 40 years and as a plan sponsor ourselves, BRMS spends countless hours studying and implementing all new governmental processes and procedures to ensure you remain compliant. In the case of the No Surprises Act and NQTL, we have elected not to inundate you with each and every new change this new legislation brings. Rest-assured that we are compliant with these new requirements and are engaged in an ongoing process of implementing and partnering with our vendors. Together, we will keep you at the forefront of each and every change ahead of us.

BRMS will support the following requirements of the CAA by the respective enforcement dates

- Facilitate new continuity of care requirements for members during the term of the Agreement
- Provide a price comparison tool
- Support new data requirements for ID cards
- Providers and Balance Bill
- Provide access to provider directories pursuant to updated requirements
- External Appeals
- Maintain network agreements compliant with the CAA prohibitions on gag clauses and provide language to support attestation requirement
- Advanced Explanation of Benefits (AEOB)
- Mental Health Parity and None Quantitative Treatment Limitations
- Provide reports on air ambulance claims and prescription drug benefits and health care costs.
- Provide public access to machine readable files (MRFs)

Supporting Details

CONTINUITY OF CARE

The CAA allows certain patients the opportunity to continue care if their provider or facility is no longer in the insurer/plan network. The plan/issuer must permit members who are continuing care patients with an opportunity to request and election to continue to have benefits provided under the plan/coverage under the same terms and conditions as they would have been covered had no change occurred. The timing starts on the date a notice of the right to elect continuing care is provided to the member and ends either 90 days later or the date on which the patient is no longer undergoing continuing care by that provider or facility. **Benefits during this time are to be treated the same as in network.**

Continuing care includes the following:

- Serious and complex conditions
- Course of institutional or inpatient care
- Scheduled nonelective surgery including post-operative care
- Course of treatment for pregnancy
- Terminally ill patients

PRICE COMPARISON TOOL

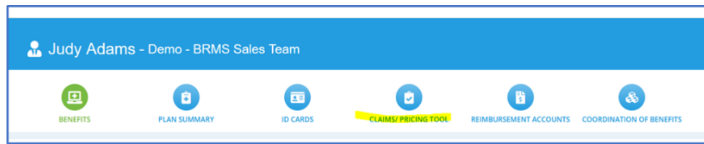
To meet the requirements of the Transparency in Coverage and No Surprises Act, we partnered with Healthcare Bluebook and embedded their platform within our benefit administration system known as My Health Benefits.

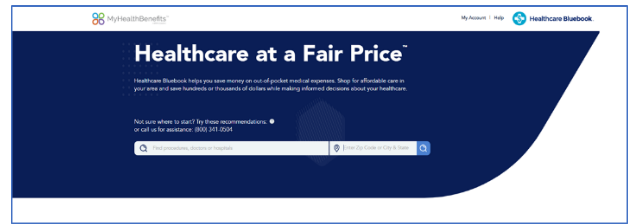
Bluebook Comply addresses all critical mandates, including the online price comparison tool with in-network rates, out-of-network allowed amounts, and member out-of-pocket cost estimates. Our premium solution delivers enhanced value beyond compliance, including provider quality, engagement rewards, and concierge support.

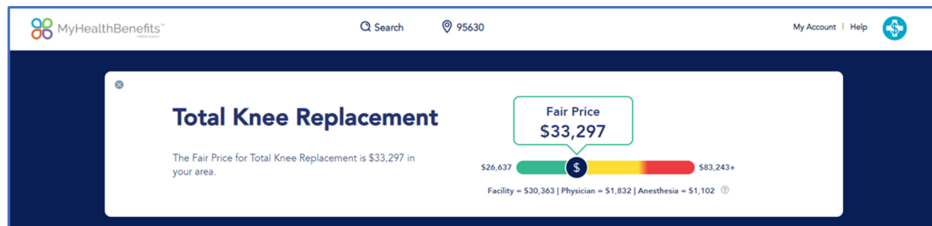
Comply Updates

Transparency in Coverage @ No Surprises Act		My Health Benefits Comply
Machine Readable Files		
	Create/host out-of-network MRFs	X
	Transforms MRFs For Member Consumption	X
	Via online Shopping Tool	
Online Shopping Tool		
	Network Status	X
	Accumulators	X
	In-Network Cost Comparison	X
	Out-of-pocket Cost Sharing Responsibility	X
	Billing Code Responsive	X
	Required Services	X
	Proper Disclaimers	X
Reporting		
	Monthly Utilization	X
Engagement		
	Comply Member Materials	X
	Central Engament Hub	X

EE DASHBOARD DISPLAY — UPDATED WORKFLOW







See your estimated out of pocket cost for these providers

The average price for **Total Knee Replacement** with these providers: $15,376

Cumberland Medical Center

Your **estimated** out of pocket for this procedure: $3,000

Out of Pocket Balances:

Individual deductible **$3,000** maximum:
$1,000 spent — **$2,000** remaining

Individual out-of-pocket **$4,000** maximum:
$1,000 spent — **$3,000** remaining

Family deductible **$6,000** maximum:
$2,000 spent — **$4,000** remaining

Family out-of-pocket **$8,000** maximum:
$2,000 spent — **$6,000** remaining

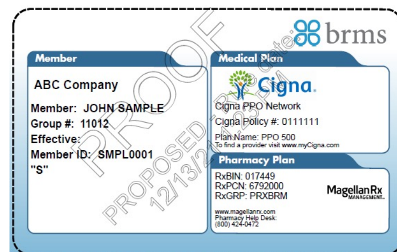
ID CARDS

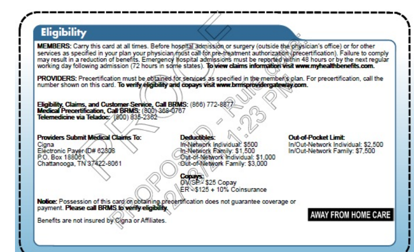
BRMS will update ID Cards to comply with new guidelines under NSA. We will have compliant ID Cards with the new information available electronically through MyHealthBenefits by the plan effective date on or after 1/1/22.

Under the CAA, online and printed ID cards must consider federal, state and corporate standards and include:

- In-network and out-of-network deductibles applicable to the plan coverage.
- In-network and out-of-network out-of-pocket maximum limitations applicable to the plan coverage.
- Telephone numbers and the website address where members may obtain support and network facility and provider information.

Members who call in and request a physical ID card will have one printed and mailed to them. We will also work with our clients to determine if new physical cards should be issued out to all members of the plan at renewal(s). **See sample CIGNA card:**





PROVIDERS AND BALANCE BILLING

BRMS will work with health plans interested in modifying their benefit plans since employees will no longer be impacted by balance bills for the situations covered under the No Surprises Act. BRMS will provide end-to-end process for negotiating surprise medical bills with providers and administering the IDR process for health plans consistent with the No Surprises Act (NSA).

These services include:

- Intake of dispute and determination if dispute is eligible for IDR based on applicable law.
- Engage provider in formal negotiation process. Monitor and administer the negotiation process in accordance with required timelines.
    - If negotiations fail and provider invokes formal arbitration in required time frame, then BRMS will:
        - Prepares and submits IDR the final offer and any additional information to the IDR entity.
        - Engages as needed to defend QPA/par median methodology.
        - Monitors and administers required timelines and compliance with IDR rules/guidelines.
        - If provider offer is accepted by IDR entity, BRMS will handle payment of arbitration fee, and claim payment adjustment through customer's claim funding account.

DIRECTORIES

BRMS works with many leased networks for our clients. The leased networks will manage provider network requirements for their contracted providers. BRMS will provide members links to these directories via MyHealthBenefits.

EXTERNAL APPEALS

The Rule implements provisions of the No Surprises Act, which was signed into law about a year ago and will take effect in early 2022. The Act helps protect patients from surprise medical bills when they seek care from medical providers outside the patients' insurance networks. The Act also establishes an independent dispute resolution ("IDR") process designed to resolve disagreements between providers and insurers (while leaving patients out of the disputes) over the appropriate rate of reimbursement for out of network services.

BRMS has partnered with Zelis to price the out of network services at what is deemed to be the appropriate reimbursement rate for the out of network services. As part of the IDR (Independent Dispute Resolution) process, Zelis will price the original claims at the what they determine to be the reasonable reimbursement rate and provider any supporting documentation that is needed to defend our clients in the required times frames that are outlined with this act.

Zelis has been a leader in developing these tools and processes to ensure that all legislation requirements and processes are in place to accommodate all of these requirements. Zelis also has a full dedicated compliance team that will be specifically working on these appeals if they are received.

ADVANCED EXPLANATION OF BENEFITS (INTAKE AND DELIVERY)

Under the Advance EOB provisions of the CAA, providers are required to confirm coverage and send a notice to the patient's insurer/health plan of the estimated costs associated with any services scheduled three or more days in advance.

Upon receipt of such notification from a provider or facility, insurers/health plans are required to send an Advance EOB to the member through mail or electronic means.

In FAQ 49, the Tri-Agencies delayed implementation of the Advance EOB requirements pending additional rulemaking BRMS will be monitoring progress and will be prepared by working with our partners to ensure we comply with the new laws.

MENTAL HEALTH PARITY AND NON-QUANTITATIVE TREATMENT LIMITATIONS

This CAA provision went into effect in Q1 2021. If a client receives notice from the federal government that they will be conducting a regulatory MHPAEA Audit on their plan and upon request BRMS will provide standard NQTL documentation to assist clients with their analysis. BRMS has successfully gone through this process with a current client.

PHARMACY BENEFITS AND COST REPORTING

In FAQ 49, the Tri-Agencies delayed implementation of the Pharmacy Benefits and Health Care Cost Reporting requirements pending additional rulemaking. The CAA requires reporting of specific prescription drug spending and certain medical cost data annually to the Tri-Agencies, including:

- Claims paid for the top 50 brand prescriptions most frequently dispensed
- Annual amount spent by top 50 most costly prescription drugs by total plan/coverage spend
- Amount spent for the top 50 prescription drugs with the greatest prior year plan spend
- Total health care spend
- Premiums and rebates

MACHINE READABLE FILES (MRFS)

MRFs are required to follow the Centers for Medicare & Medicaid Services (CMS) defined layout and are in the CMS approved format (JSON). They are not meant for a consumer-friendly search of rates, benefits, or cost sharing, which is why most people may ask "What is an MRF?" An MRF is a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention.

BRMS is working closely with our carriers and MRF partner, Healthcare Bluebook, to collect in-network MRFs and out of network MRFs to display them in a way that is publicly accessible. A link will be displayed on the MHB (www.myhealthbenefits.com) login page that takes the user to a page of links that will take them out to a carrier site to obtain the MRF or display the actual MRF. This will be publicly accessible, meaning no login to MHB will be required to access this page. The current enforcement date for this regulation is July 1, 2022 and BRMS is on track to meet that timeline.

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This information is intended to provide general information on CAA and Transparency In Coverage rule and does not constitute medical, legal or tax advice nor does it constitute a binding obligation of BRMS with respect to any matter discussed herein. Please note, in addition to federal law, states may have additional or differing requirements. Please contact your BRMS Account Executive for additional details.