Transparency in Coverage Regulation and Consolidated Appropriations Act

External FAQs for HealthLink

For purposes of this document, TPA refers to both a third-party administrator and a self-administered plan.

Last Update: April 2025 (gray highlight indicates updates)

***The information in this document does not constitute legal advice.
Customers should consult their legal team for further questions or advice.****

Transparency in Coverage – Final Regulation

General

HealthLink supports its clients in their efforts to help consumers make informed health care decisions. In August 2021, the Department of Labor, in conjunction with the Departments of Health and Human Services (HHS) and the Treasury, (known collectively as the Tri-Agencies) issued updated guidance related to implementation of the Consolidated Appropriations Act (CAA) and Transparency in Coverage (TIC) final rule. The guidance delayed enforcement and provided good faith compliance safe harbors related to the implementation of a number of provisions of the CAA and TIC.

The TIC regulation (Regulation) requires health insurers and group health plans (Health Plans) to make an internet-based self-service tool available to enrollees beginning on January 1, 2023, that contains personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered healthcare items and services, Health Plans expanded those tools to cover all items and services by January 1, 2024. CMS has indicated it will issue additional guidance on this provision and how it relates to the CAA price comparison requirements. The rule also required Health Plans to make public machine-readable files (MRF) beginning on July 1, 2022 (delayed from January 1, 2022) that contain the negotiated rates with in- network providers for all covered items and services as well as historical payments to and billed charges from out-of-network providers. The requirement to post an MRF containing the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level is pending technical requirements and an implementation timeline, which the Tri-Agencies will provide in future guidance. The purpose of the rule is to provide transparency that federal regulators believe will promote consumer choice and competition among providers. In instances where rates cannot be disclosed in specified amounts (e.g., dollar), the Tri-Agencies will use a case-by-case approach to determine whether enforcement is appropriate.

What areas will HealthLink take responsibility for and make updates to be in compliance?
HealthLink has developed Machine Readable Files for in-network rates only. The file is available on HealthLink.com for direct access or the TPA can provide a link for public website.

How will carve-out situations be handled?
In situations where a group has a vendor other than HealthLink for certain services (e.g., Pharmacy), HealthLink's pricing and rate information will not apply. Therefore, the group may need to make additional arrangements.

Will HealthLink be amending par-provider contracts to allow for the disclosure of rates for the purpose of satisfying the transparency requirements?
HealthLink's participating provider contracts permit the disclosure of proprietary information where required by law or regulation, but only as it relates to the scope of the specific mandate and not beyond what is required by law.

What areas does HealthLink feel are already in compliance with no change needed? Where are the current tools relative to the requirements as they are outlined by effective dates?
HealthLink has provided Machine Readable Files for in-network rates only to be used as a resource but will defer to the TPA for the transparency tool.

List any subcontractors or third parties who are providing assistance to you in complying with the law and regulations, or who will be involved in work you may perform on behalf of the Plan.
HealthLink does not plan to use subcontractors for the machine-readable file. Use of subcontractors for other services will be determined once regulations are issued.

What plans are subject to the Transparency Rule?
According to the Regulation, the Transparency Rule applies to health insurance issuers in the group and individual markets. It also applies to group health plans, including group health plans that are fully-insured, as well as those that are self-funded. It also applies to Qualified Health Plan issuers and the Federal Employees Health Benefits Program. The Rule does not, however, apply to Medicare, Medicare Advantage, Medicare Supplement, Medicaid MCO coverage, or vision or dental only plans. Nor does the Transparency Rule apply to grandfathered health plans or to short term, limited duration insurance.

Machine Readable Files

What is a machine-readable file?
A machine-readable file is defined as 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, while ensuring no semantic meaning is lost. The final rules require each machine-readable file to use a non-proprietary, open format. The machine-readable files for the data we administer and maintain are made accessible through HealthLink.com. Clients can link to those files; but due to the size of the files, we do not provide the data directly to our clients for them to put on their websites. HealthLink only publishes the data it maintains, so if a plan uses a third-party vendor, such as a PBM, then the group should work with that vendor to determine whether it is providing a similar solution.

We post the data attributable to in-network HealthLink rates only, since that is based on our contracted fee schedules.

Will you build and manage the publicly accessible website with all required machine-readable files on behalf of your employer clients?
The machine-readable files for the data we administer and maintain are made accessible through healthlink.com. The data is posted in compliance with the requirements. Clients can link to those files; but due to the size of the files, we do not provide the data directly to our clients for them to put on their websites. HealthLink only publishes the data it maintains, so if a plan uses another vendor, such as a PBM, then the group should work with that vendor to determine whether it is providing a similar solution.

What are machine-readable files intended to be used for?
According to the preamble to the Transparency in Coverage rule, the purpose of the files is to allow "the public to have access to health coverage information that can be used to understand health care pricing and potentially dampen the rise in health care spending." The government expects private entities to create apps or websites to enable consumers to view and compare this rate information. Once again, the files are "machine readable," so consumers must rely on someone with a computer program and system capability to digest the files and render them viewable.

How often will the machine-readable files be updated?
The files are updated monthly on the last day of each month.

Will there be a cost for compliance with the machine-readable file requirement?
There will be no additional charge for this specifically. However, the new regulations may be taken into consideration when determining our administrative fees.

Will you create these files and/or the website internally or utilize a subcontractor? If you are using a subcontractor, will you offshore?
We create these files internally.

Will the publicly available files be accessed through the current participant portal or be located in a new portal? Can plan sponsors link to the files?
These files are accessible through healthlink.com, a publicly available website. Plan sponsors may link to those files as desired.

How will client-specific machine-readable files be accessed on healthlink.com?
Beginning July 1, 2022, HealthLink has been publishing the machine-readable files for in-network rates we maintain. These files are published on HealthLink.com and can be accessed using this link: (https://www.healthlink.com/machine-readable-file/search). This link can be added to the group health plan's public website to fulfill the group health plan posting requirement. This link allows you to search for files using an Employer Identification Number (EIN).

What is an EIN?
An Employer Identification Number (EIN) is a unique nine-digit identification code issued by the Internal Revenue Service (IRS) to a business. The CMS file layout requires group rate information to be loaded using the group EIN.

How will you monitor and validate your processes to ensure the ongoing accuracy of the data in the files?
Quality Audit (QA) processes are an integral part of our monthly file postings. Validation occurs at all points in the process including ensuring the source data from the multiple systems is being pulled in correctly, validating results of the data from the source system pull, and validation of data as it appears in production.

May a group health plan that does not have its own website satisfy the requirements of the TIC Final Rules with respect to posting the Allowed Amount file and the In-network Rate file on a public website of the plan, if the plan's service provider posts the Allowed Amount file and the In-network rate file on its public website on behalf of the group health plan?
Per CMS FAQ #37 published on 6/17/22 (https://www.cms.gov/healthplan-price-transparency/resources/technical-clarification), if a group health plan does not have a public website, the plan may satisfy the requirements for posting the Allowed Amount file and the In-Network file by entering into a written agreement under which a service provider (such as a TPA) posts the Allowed Amount file and the In-network Rate file on its public website on behalf of the plan. However, if a plan enters into an agreement under which a service provider agrees to post the Allowed Amount file and the In-network Rate file on its public website on behalf of the plan, and the service provider fails to do so, the plan violates these disclosure requirements.

How do I know which file to pick for my product?
For the files posted by HealthLink, the JSON File naming convention reflects the brand (HealthLink, UniCare or ANTH) and product name (e.g., PPO, HM2).

Please describe how HealthLink will respond to questions regarding the files.
Please contact your HealthLink Sales and Account Management team for any specific questions regarding the files. Your Account Manager will ensure that the question is routed to the appropriate team for response.

Will you provide the plan with any of the three machine readable files on a monthly basis including in- network rates, out-of-network allowed amounts, and prescription drug negotiated rates (for drugs dispensed under the medical plan)?
No, the in-network machine-readable files only are made available on healthlink.com.

How do you handle rates for providers that have been terminated?
Terminated providers will be dropped each month and new provider records will be added. Changes will be reflected in the files the month after the termination.

Will the machine-readable files be archived and how will the archived files be accessed?
The files will be archived according to the legal retention period of 10 years. If a regulator requests information associated with a file, please reach out to us and we will work with the regulator to get the information they need. The client also has the ability to download and archive.

Cost Transparency Tool

The Transparency in Coverage regulation required health insurers and group health plans to make an internet-based self-service tool available to enrollees beginning on January 1, 2023, that contains personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered health care items and services; health plans expanded those tools to cover all items and services effective January 1, 2024.

The CAA also required plans to make available to members a price comparison tool to enable a member to compare the amount of cost-sharing the individual would be responsible for paying under the plan with respect to a specific item or service by a participating provider and non-participating providers.

We expect that TPAs can access the machine-readable files in order to get pricing to produce their own cost- transparency tool.

Will HealthLink make the tool available to plan participants?
No, HealthLink can partner with the TPA to ensure they have the information required for the member inquiry.

Consolidated Appropriations Act (CAA) - Law pending final regulations

General

The CAA represents the most significant changes to the private insurance market since the Affordable Care Act. The law:

- Requires plans to develop and make available price transparency tools, good faith estimates and an advanced explanation of benefits
- Restricts "surprise billing"
- Prohibits "gag clauses" in healthcare contracts
- Adds new mandates for ID cards, provider directories and continuity ofcare.

These provisions are described in more detail below but note that much of the important detail of this law will be determined by regulations that will be released in future rulemaking.

HealthLink is working alongside other stakeholders to assess the operational complexities and timelines for implementation and continues to make recommendations to the Tri-Agencies who must develop these regulations.

Who does this law apply to?
All types of client plans, including self-funded clients as well as health insurance issuers in the individual and group markets.

What types of plans are excluded from the scope of the CAA?

- Short-Term Limited Duration plans
- Government Plans (e.g., Medicare, Medicaid)
- Retiree Only Plans
- Account Based Plans (e.g., HRA, HSA) *Note: The underlying health plan (e.g., High Deductible Health Plan (HDHP) is in the scope of the CAA.*
- Excepted Benefits (e.g., Standalone Dental or Vision)

What is the effective date of the Law?
The CAA included numerous provisions, the majority of which became effective January 1, 2022.

The requirement for plans to provide a good faith estimate of charges and an Advance Explanation of Benefits (AEOB) when notified of a scheduled service by a provider are delayed, pending future regulatory guidance, with no final date set.

The Tri-Agencies also announced they would issue regulations to implement the ID card, provider directory, gag clauses on price and quality data, and continuity of care requirements, but would not do so prior to January 1, 2022. Plans are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date.

How will HealthLink address the FAQs that the Tri-Agencies release such as CAA FAQ, Part 69?
HealthLink has a dedicated public policy team that monitors updates at the federal/state level. In addition, HealthLink has a compliance team that briefs federal/state mandates for implementation and ongoing compliance. As new mandates are identified and FAQs to existing mandates released, HealthLink determines the lines of business impacted, organize project management to complete tasks, and develops controls/monitoring. HealthLink also works in conjunction with trade associations to ensure best practices. As needed, HealthLink creates internal reference materials for account management – as well as external communications for brokers/clients – on key items.

Specific to CAA FAQ 69:

We have reviewed the Department of Labor's (DOL) FAQs About Consolidated Appropriations Act, 2021 Implementation Part 69 released January 14, 2025 ("FAQs Part 69"), with respect to access to claims and encounter data and information and our current processes and requirements is compliant with both the specific requirements of the Gag Clause Prohibition of the FAQs Part 69. It is important to note the FAQs Part 69 did not establish any new requirements but rather set forth the DOL's interpretation or certain aspects of the Gag Clause Prohibition. As noted in the FAQs Part 69, plan service providers may impose reasonable restrictions on the public disclosure and use of data.

Will there be a cost for compliance with the CAA?
The cost of compliance will be taken into consideration when determining our administrative fees.

Will you support the plan's communication to members on these changes and new resources?
We continue to communicate our implementation activities pertaining to these laws. Such communications are available on HealthLink.com under Employers and TPAs pages.

Are any subcontractors or third parties providing assistance to you in complying with the law and regulations, or who will be involved in work you may perform on behalf of the Plan?
HealthLink does not plan to use subcontractors. Use of subcontractors for other services will be determined once regulations are finalized.

Price Comparison Tool

The CAA requires plans to make available to members a price comparison tool to enable a member to compare the amount of cost-sharing the individual would be responsible for paying under the plan with respect to a specific item or service by a participating provider and non-participating providers.

The intent is to align the requirements of the Transparency in Pricing regulation with the Price Comparison tool requirements of the CAA.

Provider Directory

The CAA requires 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. Plans must also develop a response protocol to respond to member network questions. Members who receive inaccurate information that a provider is in-network can only be liable for in-network cost-sharing.

On August 20, 2021, the Tri-Agencies announced they would issue regulations to implement the provider directory requirements. These regulations or other regulatory guidance have not yet been issued. However, Health Plans are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date with a primary focus on ensuring members who rely on provider directory information that inaccurately depicts a provider's network status are only liable for in-network cost sharing amounts. HealthLink has moved forward with a focus on good faith compliance while awaiting additional regulatory guidance.

Will a provider directory be available and kept up-to-date?
Yes.

Will directory be available electronically and/or printed?
Yes, this is current state.

Will you accept responsibility for directory inaccuracies resulting in added plan cost?
The indemnification provision in the HealthLink payor agreement may apply.

Will you comply with the provider directory requirements on behalf of your groups?
Yes, however, much of the important detail of CAA provisions will be determined by future regulatory guidance.

How often will you update the directory?
Those processes will be determined as a part of our design based on implementation guidance from the final regulations.

Will you notify TPAs of the update?
No.

Will the versions be dated, so TPAs will know the updates are current?
The provider directories reflect the date of the last update.

How will access to the directory be provided (i.e., directly or via a plan sponsor website)?
The provider directory is available through our website.

Mental Health Parity

What do the Strengthening Parity in Mental Health (MH) and Substance Use Disorders (SUD) provisions do?

Included as part of the Consolidated Appropriations Act of 2021 (commonly referred to as the Consolidated Appropriations Act (CAA)) were several measures intended to strengthen parity in MH/SUD benefits, specifically with Non-Quantitative Treatment Limitations (NQTLs). Importantly, if a group health plan that provides both Medical/Surgical (MS) benefits and Mental Health/Substance Use Disorder (MH/SUD) benefits and imposes NQTLs on MH/SUD benefits, the plan has to perform testing and make testing results available to the Tri-Agencies, or any state authority, upon request within 45 days of enactment of the Act (generally, no later than February 10, 2021). Plans must also document and make available the following information:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and MS benefits to which each such term applies in each respective benefits classification.
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and MS benefits.
3. The evidentiary standards used for the factors identified in 2 above when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and MS benefits.
4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MS benefits in the benefits classification.
5. The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described above that indicate that the plan or coverage is or is not in compliance.

The Mental Health Parity and Addiction Equity Act (MHPAEA) currently requires NQTL testing, but the CAA creates more formal analyses and reporting. As of February 10, 2021, the DOL can request a comparative analysis report from group health plans. The DOL will be issuing regulations on these new requirements.

What is a Non-Quantitative Treatment Limitation (NQTL)?

Mental Health Parity looks at two types of treatment limitations – quantitative and non-quantitative. Quantitative treatment limitations are the limits that apply to the coverage in the benefit booklets, such as cost-sharing and visit limits. Non-quantitative treatment limitations are behind-the-scenes administrative activities that take place but may impact coverage. Examples include credentialing, how we determine the amounts to pay providers, utilization management, creation of medical policies and case management. The law requires that we treat behavioral health conditions no less favorably than we do medical conditions.

Who does this law apply to?

The law applies to all types of group plans, including self-funded clients.

How will HealthLink comply with this law?

HealthLink has created NQTL analysis for its applicable standard processes and procedures (e.g., Credentialing, Case Management, Utilization Review, etc.), which are available free of charge upon request.

Are you able to conduct and provide a detailed written comparative analysis of the design and application of the Non-Quantitative Treatment Limitations (NQTLs) as contemplated by the Consolidated Appropriations Act?

Yes, for plans that utilize HealthLink's claims administration and our standard policies and procedures. HealthLink has used the U.S. Department of Labor (DOL) self-compliance tool to analyze its compliance with the NQTL requirements.

Does the HealthLink NQTL analysis apply to all plans subject to the law, whether fully insured or self- funded groups?

HealthLink does not have any fully-insured business. To the extent a self-funded group utilizes HealthLink's claims administration and our standard processes and procedures for the administration of the Plan (e.g., credentialing), HealthLink's NQTL summaries will be applicable to any inquiries. However, if a group deviates from HealthLink's standard procedures (e.g., modifies the prior authorization list) or doesn't use HealthLink as a vendor for all of its plan administration (e.g. utilization management), then NQTL analysis would be the responsibility of the group or its other vendor(s).

Will HealthLink provide required NQTL documentation?

For plans that utilize HealthLink's claims administration, HealthLink will provide our NQTL analysis upon request, which reflects our standard processes and procedures. This NQTL analysis can be provided to groups, members, regulators or providers. It will be updated periodically. However, HealthLink will not provide any analysis for NQTLs that are within the group's responsibility (e.g., benefit exclusions, etc.).

What action is HealthLink taking from the finalized rule on Mental Health Parity?

The effective date of the final rule is January 1, 2025, for group health plans, except for the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related requirements in the provisions for comparative analyses, which apply on the first day of the first plan year beginning on or after January 1, 2026.

We are working collaboratively with coalition partners and trade associations to evaluate the impact of the rule, including whether recent SCOTUS decisions will provide new grounds for a legal challenge of the rule. Regardless of the proposal and its impact, HealthLink recognizes the importance of mental health services and substance abuse services and remains committed to ensuring client access to such services of care.

Advance Explanation of Benefits (AEOB)

The CAA requires health plans to provide an advance explanation of benefits (AEOB) for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the network status of those providers, good faith estimates of cost, cost-sharing and progress towards meeting deductibles and out-of-pocket maximums, as well as whether a service is subject to medical management and relevant disclaimers of estimates.

On August 20, 2021, the Tri-Agencies announced an indefinite delay in enforcement of the AEOB requirements. No new enforcement date was set.

Surprise Medical Billing

The CAA includes the "No Surprises Act" which mandates that patients are only responsible for only in-network cost-sharing amounts, including deductibles, in emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider (including air ambulance providers). The law also prohibits providers from balance billing except in limited circumstances with patient notice and consent. The act also requires an independent dispute resolution process for providers and plans who cannot reach an agreement on payment.

Much of the important detail of these provisions will be determined by regulations that will be released and may be impacted by various court cases. The information provided below incorporates the regulations that were issued on July 1, 2021, and September 30, 2021. On August 19, 2022, the Tri-Agencies issued "Requirements for Surprise Billing: Final Rules." We are expecting another final rule on this provision. For plans that utilize HealthLink's claims administration, we are implementing good faith, reasonable interpretation recalculations of the Qualifying Payment Amount ("QPA"). HealthLink continues to monitor additional developments on this topic.

What is the Qualifying Payment Amount (QPA)?
The QPA is the lesser of the median contracted rate in the metropolitan service area (MSA) for same or similar services and a same or similar provider or billed charge.

Will HealthLink determine the Qualifying Payment Amount?
To the extent that HealthLink is the claims administrator and determines the QPAs on behalf of the plan, we will assist. If not, the plan's TPA or its vendor/partner will determine member cost-sharing.

Does the No Surprises Act apply to ground ambulance as well as air ambulance?
No, the law applies only to air ambulance.

The CAA will require health plans to reimburse out-of-network (OON) providers and facilities in the situations where balance billing is prohibited. Will HealthLink offer services to support this?
For HealthLink, the TPA is responsible for paying the provider directly.

Will HealthLink handle the IDR process for the group?
HealthLink will not handle the IDR process. The plan sponsor will be responsible for the IDR process.

Will you assist clients in negotiations with out-of-network (OON) providers prior to the start of arbitration?

To the extent that HealthLink is handling the IDR process, we will negotiate with the OON providers. However, the group will be charged any fees related to IDR. If not, the plan's TPA or its vendor/partner will handle the IDR process and related fees.

Do you have a list of certified IDR entities?

The list of certified IDR entities is available at https://www.cms.gov/nosurprises/Help-resolve-paymentdisputes/certified-IDRE-list

What can the client expect in regard to IDR fees and expenses?
CMS issued the following guidance on the ranges of fees that can be expected for Independent Dispute Resolution for calendar year 2023, 2024 and 2025:

Fee Type	Applies[ii] for disputes initiated between: 8/1/23 - 1/21/24	Applies[iii] for disputes initiated between: 1/22/24-12/31/24	Applies[iii] for disputes initiated on or after 1/1/25
Administrative fee	**$50**	**$115**	**$115**
IDRE Fee	Single dispute: **$200-$700** Batched dispute: **$268-$298**	Single dispute: **$375-$800** Batched dispute: **$490-$1,170**	Single dispute: **$200-$840** Batched dispute: **$268-$1,173**
IDRE Fee Tier Batching - based on the number of line items	2-20 lines:100%* 21-50 lines: 110% 51-80 lines: 120% >80 lines: 130%	Fixed fee range: $75-$250, *starting with the 26th line item*.	Fixed fee range: **$75-$250**, *starting with the 26th line item*

**The percentage applies to the approved batched determination fee and increases with the amount of line items included per batch.*

i IDR Administrative Fee Guidance 2023 FAQs
ii October 2022 Fee Guidance Calendar Year 2023
iii IDR Process Fees Final Rule(12/21/23) Updated CIDRE Fees

Is there a defined timeline for the Negotiation and IDR Process?
Yes, CMS defines a specified timeline for the negotiations and IDR process including a 30-business day open negotiation period prior to IDR. See the link below for details on the timeline: https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period

Are CIDRE decisions appealable?
Per the NSA and implementing regulations, the decision of the CIDRE is binding on all parties except in the case of fraud and cannot be appealed. Additionally, neither the NSA nor the implementing regulations provide any process for challenging CIDRE jurisdiction or the decision when the CIDRE issues a decision on an ineligible dispute. The only remedy that appears available to a group health plan who feels that a CIDRE issued a decision on a dispute not subject to the NSA is to seek to enjoin enforcement of the CIDRE award. However, the group health plan should contact their own legal counsel for advice.

ID Card Requirements

The CAA requires health plans to provide information on ID cards regarding the amount of the in-network and out-of-network deductibles, the in-network and out-of-network out-of-pocket maximum limitations, and a telephone number and Internet website address through which individuals may seek consumer assistance information.

On August 20, 2021, the Tri-Agencies announced they will issue regulations to implement the ID card requirements. These regulations or other regulatory guidance has not yet been issued. However, Plans and issuers are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022,
compliance date.

ID cards are the responsibility of the group health plan or their TPA.

Prohibition on Gag Clauses

Attestation:

The CAA Gag Clause provision prohibits group health plans and health insurance issuers offering group health insurance coverage from entering into an agreement between a plan or issuer and a healthcare provider, network or association of providers, third-party administrator, or another service provider offering access to a network of providers that would directly or indirectly restrict a plan or issuer from disclosing or accessing certain price and quality information. In addition, group health plans and issuers are required annually to submit an attestation to confirm compliance with the prohibition on gag clauses.

We are providing clients and TPAs with the following confirmation of compliance, that will allow you to complete the attestation on the CMS HIOS portal:

> *HealthLink represents that the participation agreements with the healthcare providers in its networks are consistent with the requirements set forth in Section 201 of the Consolidated Appropriations Act, 2021.*

This attestation statement applies only to the business and information that we administer and maintain.

Clients need to complete the required attestation by December 31 for each year. Please reference the following CMS link for submission instructions on how to complete this attestation: https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance

HealthLink's standard provider contract language includes a provision stating that the parties will comply with applicable law. Therefore, any "gag clause" in the agreements will cease to apply as of the law's effective date.

Have your participating provider contracts been revised to remove any language that restricts cost information sharing except for reasonable restrictions as permitted by the CAA, to allow plan sponsors to complete the attestation required?
HealthLink provider contracts are administered to comply with the law, including the restrictions place on Gag Clauses by the CAA.

Does HealthLink have an annual (e.g., 2024) confirmation of compliance with the gag clause provision, for the business and information that HealthLink administers and maintains on behalf of clients?
HealthLink represents that the administrative services provided under its Administrative Services agreements are consistent with the requirements set forth in Section 201 of the Consolidated Appropriations Act, 2021.

Data Sharing:

With the recent issuance of CAA FAQ Part 69, it appears that clients are entitled to access all data; how will HealthLink handle data requests?

Each request is reviewed on a case by case basis, however, please note that one of the primary ways HealthLink protects our proprietary data is by avoiding unnecessary and unprotected disclosures to self-insured group health plans that are not required by law, or where the law allows HealthLink to protect the business value of HealthLink's proprietary data by adding reasonable controls on the use and release of the proprietary data. ERISA does not create a banket right for self-insured health plans to obtain HealthLink's proprietary information for any purpose, at any frequency desired by the self-insured health plans, and without any confidentiality protections.

Consistent with HealthLink's agreements with self-funded group health plan customers, and consistent with applicable law including ERISA Section 724, HealthLink releases proprietary information to a self-funded group health plan – or a third party designated by the self-insured group health plan – only after the self-insured group health plan or third party sufficiently describes the plan administrative function to be supported by the proprietary data and, as applicable, the self-insured group health plan or third party enters into an appropriate confidentiality agreement with HealthLink. That, in turn, allows HealthLink to maintain the confidentiality of the proprietary data after its release.

Continuity of Care

The CAA requires health plans to provide in-network coverage for 90 days of continued care to members whose provider or facility leaves the health plan's network when the member is undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or terminally ill.

On August 20, 2021, the Tri-Agencies released FAQs noting that they will issue regulations to implement the continuity of care requirements. Plans and issuers were expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date.

Describe how you will implement the requirement to allow continuation of care for individuals when their health care provider is terminated from the Network, under ERISA Section 718 and PHSA Section 2799A-3.

We anticipate that much of this requirement will be coordinated by the TPA, however we recognize that HealthLink will need to work with our TPA partners to ensure notification when a provider has left the network. We currently have a process for notifying TPAs, if desired, of providers leaving the network and will continue to work with TPAs to expand that notification process.

Pharmacy and Other Health Reporting

The Consolidated Appropriations Act (CAA) requires health insurers offering group or individual health coverage and self-funded group health plans to report annual data to the Tri-Agencies on drug utilization and spending trends. The reporting must include total spending on healthcare services by type, such as for hospital, primary care, or prescription drugs. The reporting must also include rebate information and its effect on member costs.

The required reporting templates include:

- Plan Lists (Individual and Student, Group Health Plan List, and FEHB Plan List)
- Data Files (reporting of aggregated data based on state and market segment)
    - Premium and Life-Years Reporting
    - Spending by Category Reporting
    - Top 50 Most Frequent Brand Drugs Reporting
    - Top 50 Most Costly Drugs Reporting
    - Top 50 Drugs by Spending Increase Reporting
    - Rx Totals Reporting
    - Rx Rebates by Therapeutic Class Reporting
    - Rx Rebates for the Top 25 Drugs Reporting
- Narrative Response

On August 20, 2021, the Tri-Agencies announced a delay in enforcement of the pharmacy and other health reporting requirements until the issuance of new regulations. The new compliance date was December 27, 2022, for reporting years 2020 and 2021. Future years reporting will be due on June 1 annually (i.e., 2024 data will be due on June 1, 2024).

According to the reporting instructions, the reports may be submitted by different entities based on the information required in the report. For example, for a self-funded group, the Group Health Plan or TPA may submit the Spending by Category reporting, while the PBM submits pharmacy related reports such as the Top 50 Most Costly Drugs report.

Who is required to complete the reporting for HealthLink business?
Please consult with your TPA and any carve-out vendors you work with for guidance regarding the reporting submission.

Air Ambulance Reporting
The Consolidated Appropriations Act requires group health plans and health insurance issuers to report information about claims data for air ambulance services and such other information regarding air ambulance services as specified by the Secretary of HHS.

The CAA also requires providers of air ambulance services to submit information regarding air ambulance services, including air ambulance providers' transportation and medical costs, information on each provider's bases and aircraft, the number of air ambulance transports by payor and other information about transports, data on claims denials, and other information specified by the Secretary of HHS.

A proposed regulation on the Air Ambulance reporting provision of the Consolidated Appropriations Act was issued on September 16, 2021, with a request for comments/feedback.

When is the Air Ambulance Reporting due?
According to the proposed regulation, the reporting is required for two years only. While the proposed regulation indicated a March 31, 2023, initial filing date, at this time there is no final regulation providing the needed details for submission. The CAA statue does not require submission of this reporting until a final regulation is issued.

How will the reporting be used?
The Secretary of HHS, in consultation with the Secretary of Transportation, will issue a comprehensive public report summarizing the data and providing an assessment of the state and certain aspects and characteristics of the air ambulance market.

Will HealthLink submit the reporting on behalf of clients?
No. Please contact your TPA for information regarding the submission of Air Ambulance reporting.

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