Transparency in Coverage and Consolidated Appropriations Act FAQs

In late 2020, the Departments of Health and Human Services, Labor, and Treasury released the Transparency in Coverage Final Rules (TIC) and the Consolidated Appropriations Act (CAA) was signed into law. These two initiatives provide new consumer protections under the No Surprises Act, as described below, and include extensive transparency reforms intended to help consumers make informed decisions about their health care.

WGAT is diligently working to implement all of the regulations outlined in the TIC and the CAA, and are closely monitoring them and making adjustments as new regulatory guidance is released. It is our goal to ensure that you receive all of the benefits guaranteed under the new federal guidelines, and that you're able to utilize the new transparency tools to enhance your health care experience.

The transparency provisions of the CAA and TIC are described below, with FAQs to help explain how these changes will affect you, your providers, and your health plan coverage.

Cost Comparison Tool

The Transparency in Coverage regulation requires 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 must expand those tools to cover all items and services by January 1, 2024.

The CAA also 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. Enforcement of the price comparison tool mandate has been delayed until January 1, 2023. The intent is to align the TIC and CAA requirements. Additional rulemaking guidance is expected.

What is WGAT doing to meet this requirement?

WGAT is actively developing and will implement the Price Comparison Tool for the Cedar Plan by the January 1, 2023 enforcement date. This major technological implementation will enable our members to compare cost-sharing amounts for specific network providers in a specific region.

Provider Directory

The CAA requires plans 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.

What is WGAT doing to meet this requirement?

WGAT's provider directories are available on our website at https://www.wgat.com/find-a-provider/. The provider directory for the Cedar plan is updated monthly; other directories are updated by our network partners and are updated at least every 90 days. We have developed an internal member response protocol to respond to member network questions.

If a member receives services from an out-of-network provider because the directory incorrectly listed the provider as in-network, will the member be responsible for the additional out-of-network charges?

If a member provides documentation that he or she was provided inaccurate information from a plan or insurer about a provider's network status prior to treatment, the plan will pay the relevant claims as if they were in-network.

Advanced Explanation of Benefits (AEOBs)

The CAA requires plans that receive pre-service notifications from providers must, at least three days in advance of the scheduled service, provide notice to the member receiving treatment that includes:

- Whether the provider or facility is a participating provider;
- The estimate included in the notification from the provider;
- A good faith estimate of the amount the plan will pay for the services;
- A good faith estimate of the participant's cost share;
- A good faith estimate of the amount that the participant has incurred toward deductibles and out-of-pocket maximums;
- For services that are subject to medical management, a disclaimer that such medical management is a prerequisite for coverage;
- A disclaimer that the information provided is only an estimate and is subject to change; and
- Any other information deemed appropriate by the plan.

When will the AEOB be available for WGAT members?

WGAT is currently working on developing the advanced explanation of benefits for scheduled services; however, the required date for implementation has been deferred by federal agencies pending further rulemaking. Once guidance is received, we will begin implementation of the AEOBs.

Surprise Billing Protections

The CAA includes the "No Surprises Act", which requires that patients not be billed more than the in-network cost-sharing amounts, including deductibles, for services received from a participating facility or non-participating emergency room unless the patient receives notice of a provider's non-network status in advance and consents to the non-network treatment and cost. Protections extend to certain non-emergency situations where patients do not have the ability to choose an in-network provider (including air ambulance providers).

The act also mandates an independent dispute resolution (IDR) process for providers and plans who cannot reach an agreement on payment in situations where balance billing is prohibited. Disputing parties must engage in a 30 business-day open negotiation period to attempt to reach an agreement regarding the total out-of-network rate (including any cost sharing). Once the open negotiation period has ended, either party can initiate the IDR process within 4 days. The IDR process will be administered by an arbitrator who will take into consideration payment amounts offered by each party as well as additional considerations, then make a binding decision.

The No Surprises Act applies to grandfathered as well as non-grandfathered health plans.

When do the consumer protections under the No Surprises Act take effect?

The protections related to surprise billing take effect with plan years beginning on or after January 1, 2022. For WGAT members, the effective date will be July 1, 2022, when the new plan year begins.

Under what situations is balance billing prohibited?

Facilities or providers may not balance bill for more than the network cost-sharing amount:

- for emergency services received in a non-participating facility;
- for certain ancillary services performed in a participating facility by out-of-network radiologists, pathologists, emergency medicine providers, anesthesiologists, providers of diagnostic and neonatal services, assistant surgeons, hospitalists, and intensivists;
- for services provided by a non-participating provider in a participating facility when there is no participating provider who can furnish such services;
- for services provided by a non-participating provider or facility without the patient's informed consent. For consent to be valid, the patient must (i) be given notice of network status and an estimate of charges 72 hours in advance of services, and (ii) consent in writing to the out-of-network care. For appointments with less than 72 hours' notice, notice must be given the day the appointment is made.

Who should members contact if they are balance billed?

If you receive a balance bill from your provider, or believe that the prohibition against balance billing has been violated, contact the Centers for Medicare Medicaid Services No Surprises Help Desk at (800) 985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or complaint. You can also submit a complaint online at https://idm.cms.gov.

What is required of providers under the No Surprises Act?

Health care providers and facilities are required to make prohibition on balance billing language publicly available, post on a public website of the provider facility (if applicable), and provide a one-page notice that includes information in clear and understandable language regarding:

1. The restriction on providers and facilities regarding balance billing in certain circumstances,
2. Any applicable state law protections against balance billing, and
3. How to report violations of balance billing restrictions.

WGAT has added this language to its website and EOBs.

How does the independent dispute resolution process (IDR) affect plan participants and their payment responsibilities under the plan?

IDR is a process intended to help resolve payment disputes between the plan and out-of-network providers who do not have a contract with the plan to provide services at a specific rate. It should not affect the amount paid by plan participants, who will not be charged more than the in-network cost sharing amounts for services covered under the No Surprises Act.

Patient Deductible

Cost-sharing payments made with respect to non-network emergency services (including air ambulance) or non-emergency services performed by non-par providers in par facilities will be counted toward the member's network deductible and out-of-pocket maximum in the same manner as if the services were provided by a network provider. In addition, if a member relies on an incorrect provider directory and receives services from a provider that is no longer in the network, any payments made will be counted toward the member's network deductible and out-of-pocket maximum.

When will the plan begin applying in-network deductibles and out-of-pocket maximums to eligible out-of-network services?

Effective January 1, 2022, out-of-network surprise bills began accruing to the member's network deductible and out-of-pocket maximum.

Continuity of Care

The CAA allows patients with specific medical conditions or needs to continue care with their provider for up to 90 days at network cost-sharing rates if the provider leaves the plan's network. This provision applies to patients who:

- Are pregnant;
- Are undergoing treatment for serious and complex conditions;
- Are currently hospitalized as an inpatient;
- Are scheduled for non-elective surgery; or
- Have a terminal illness.

What do patients need to do to ensure that they receive continuity of care as required under the CAA?

Continuity of care is automatic for patients who meet one of the conditions described above. All non-participating provider claims are reviewed to evaluate if the provider was previously participating and if the patient qualifies for the extension. The patient is not required to "opt in" or request continuity of care.

ID Card Requirements

The CAA requires that health plan identification cards include the participant's in- and out-of-network deductible and out-of-pocket maximum amounts, as well as a telephone number or website address where the participant can obtain additional plan-related information.

WGAT has taken this opportunity to make a number of changes to improve the format of its cards. Our new card design features a more streamlined look for easier readability for both members and providers.

When will new ID cards be issued?

The CAA requires that new ID cards be made available to WGAT participants before the beginning of the July 1,2022 plan year. WGAT has worked to ensure that ID cards have already been distributed to members.

Claims Adjudication

Health plans must make an initial payment or denial of claims to the billing provider or facility within 30 days of receipt of the claim.

What is WGAT doing to meet this requirement?

WGAT has and will continue to pay or deny claims within 30 days of receipt.

Expansion of External Review

Plans must accommodate requests for external review when the applicability of surprise billing protections are in question.

Does this requirement represent a change to WGAT's current external review process?

No. The regulations do not change the external review process. They merely expand the list of adverse benefit determinations eligible for external review to include a determination that surprise billing protections do not apply to the claim in question.

Machine Readable Files

Non-grandfathered health plans must disclose, on a public website, three machine-readable files disclosing health care rates. A machine-readable file is a file of data or information that can be imported or read by a computer system for further processing without human intervention. Two of the files, containing provider rates for covered medical items and services and out-of-network allowed amounts and billed charges for covered medical items and services, must be made public beginning on July 1, 2022. The requirement for the third file, which contains prescription drug rates, has been postponed until further notice.

What is WGAT doing to meet this requirement?

WGAT has made the required machine readable files for in-network and out-of-network medical items and services public on HealthView for the required deadline of July 1, 2022. We continue to work with our network partners to link their files, accessible through their websites, to the HealthView website as they become available.

Can these files be used to estimate costs for health care services?

The machine readable files are intended to be read or processed by a computer system. They follow the Centers for Medicare & Medicaid Services (CMS) defined layout and are not meant for a consumer-friendly search of rates, benefits, or cost sharing. The price comparison tool, which will be available on or before January 1, 2023, will allow participants to compare cost sharing among participating providers for particular services and items in a specific geographic location.

Conclusion

Newly-enacted federal regulations greatly expand health care transparency rights by requiring providers and health plans to make health care costs available to consumers and prohibiting surprise billing for emergency services received from out-of-network facilities and non-emergency services received from non-network providers in network facilities. WGAT is working to implement these regulations and doing everything we can to ensure that your rights are protected. If you have questions about this document or the No Surprises Act, feel free to contact us at (800) 777-7898.