Consolidated Appropriations Act & Transparency in Coverage Final Rule

The **Consolidated Appropriations Act (CAA) of 2021 and the Transparency in Coverage Final Rule** will impact most of our members starting Jan. 1, 2022. As providers caring for our members, you will be impacted as well.

Background: Congress passed the CAA in December 2020. It includes the No Surprises Act (NSA), which addresses surprise medical billing for certain services. It also has requirements for health insurers and group health plans to provide information and tools for consumers to better navigate their health care.

The Departments of Health and Human Services (HHS), Labor and Treasury (the departments) released the **Transparency in Coverage Final Rule** in October 2020. The rule requires certain health care price information to be made available to help consumers and other stakeholders make health care decisions.

Below are highlights of changes that may impact you. This isn't a comprehensive review of all requirements. Some details may change if the federal government issues regulations or guidance. Watch News and Updates for more information.

Provider Directory Information Verification

The Consolidated Appropriations Act (CAA) requires provider directory information to be verified **every 90 days**. Providers and insurers have roles in fulfilling this requirement to maintain an accurate directory.

What this means for you: Starting Jan. 1, 2022, you must:

- Verify your Provider Finder® directory information in **every 90 days**
- Update your information when it changes, including if you come in or go out of a network

Providers should verify and update your information with us and other insurers every 90 days. You can submit your changes via the Demographic Change Form or, if you are adding additional networks, use Provider Onboarding Form. Also, watch for information coming soon in our News and Updates or *Blue Review* newsletter regarding the **Provider Data Management** tool that will provide easy access to update your information via Availity®. We won't accept changes by email, phone or fax. Updates will be reflected in our Provider Finder.

Under CAA, **we are required to remove providers from our directory** whose data we are unable to verify within 90 days. If you don't verify your details every 90 days, we will reach out to you by **email** and ask that you **quickly respond** by following the unique link in the email. It will take you to a secure landing page where you can update your information.

If you leave a network, please update your directory information immediately. If you are incorrectly identified as an in-network provider, it may limit member cost-sharing to in-network levels.

New Information on Member ID Cards

The Consolidated Appropriations Act requires that member ID cards include **deductible information** and **out-of-pocket maximums**. We will provide all members with updated **electronic ID cards** that include this information.

New Information on Member ID Cards, cont.

How to access ID cards

- **You** can view, download and print most members' electronic cards by completing an eligibility and benefits inquiry and using Availity's View Member ID Card.

- **Members** can access their card several ways:
  - Through the BCBSTX application
  - By printing a copy of their updated electronic ID card, including deductible and out-of-pocket information from Blue Access for Members℠ (BAM)
  - By requesting a physical card from customer service

We will mail new cards that include deductible and out-of-pocket information to current members whose benefit plan changes in 2022. We'll also send cards with updated information to new members whose plans go into effect in 2022.

Gag Clauses (effective Dec. 27, 2020)

Requirement of the Transparency in Coverage Final Rule

CAA prohibits health insurers and group health plans from agreements with providers that include gag clauses related to provider cost and quality information. If any of our contracts include such CAA gag clause language, the contract language will be remediated, and in the interim, the language will be considered unenforceable as a matter of law.

Health Care Price Information in Machine Readable Files

Requirement of the Transparency in Coverage Final Rule

Health insurers are required to publicly display certain health care price information via machine-readable files on their websites beginning in 2022. These machine-readable files will include negotiated rates with in-network providers, allowed amounts for out-of-network providers and may include prescription-drug pricing. The Departments of Health and Human Services (HHS), Labor and Treasury have issued guidance indicating they will delay their enforcement of the machine-readable file requirements until July 1, 2022.

What this means for you

- These files will include your federal Taxpayer Identification Number (TIN), in addition to your National Provider Identifier.
- It is very important, if you are using your **Social Security number as your TIN**, we encourage you to register for a new TIN and update us through the Demographic Change Form. When it becomes available, you will also be able to use the **Provider Data Management** tool on Availity to submit your new TIN.

Surprise Billing Provisions of No Surprises Act

Requirement of the Consolidated Appropriations Act (plan years on or after Jan. 1, 2022)

The No Surprises Act (NSA) is part of the Consolidated Appropriations Act (CAA). Under NSA, most out-of-network providers will no longer be allowed to balance bill patients for:

- Emergency services
- Out-of-network care during a visit to an in-network facility
- Out-of-network air ambulance services, if patients' benefit plan covers in-network air ambulance

Surprise Billing Provisions of No Surprises Act, cont.

For items and services subject to NSA requirements, member cost-share will be calculated based on the lesser of a new qualified payment amount or the provider's billed charge. The qualified payment amount is a new median contract rate calculation set forth by the NSA and related interim rules.

Generally, if a non-participating provider isn't satisfied with a payment on items or services subject to NSA, they can first initiate a negotiation with the plan and, if the negotiation fails, pursue binding dispute resolution (IDR). Through this process, the parties submit their respective offers and other required information, and the IDR entity selects one of the parties' offers as the outcome, which determines whether any additional amount will be paid to the provider.

The NSA and related interim rules state that some of its provisions such as member cost-share requirements, claim payment deadlines and availability of the federal IDR process, do not apply if a state law provides a method for determining the total amount payable to the provider for that item or service.

To Request a Claim Review and Initiate a Negotiation

Claims for the following services may be eligible for payment review under NSA if you don't have a contract with us:

- Emergency services or stabilization for an emergency
- Services provided by non-participating providers at a contracted facility
- Air ambulance services

To initiate the process:

- Log on to Availity® to check a claim for NSA-eligible services. Eligible services will also be
- noted on your Provider Claims Summary.
- If you want to dispute the payment amount, you may open negotiations through Availity
- within 30 business days of the date the claim is finalized.

Emergency Services

CAA expanded the current definition of emergency services. Emergency services continue to be defined by the prudent layperson standard. If a plan covers services in an emergency department or independent freestanding emergency room, the following services will be included as emergency services under NSA:

- Screening and ancillary services necessary to evaluate the emergency condition (participating and non-participating)
- Services to stabilize the patient (participating and non-participating)
- Post-stabilization outpatient observation or an inpatient or outpatient stay, if the plan would cover the services (non-participating only)