We're here to help

Transparency in Coverage and Consolidated Appropriations Act

EMI Health is committed to helping our groups navigate the complex Transparency and CAA legislation. We are actively working toward compliance with all provisions and supporting our self-funded groups in their compliance efforts. As final regulations are released, we will provide our brokers and covered groups with ongoing updates.

2022 Provision Highlights

Balance billing protections (effective 01/01/2022)

- The legislation establishes standards to protect patients from balance billing for certain items and services provided by out-of-network providers. Beginning with plan years on and after 01/01/2022, health plans are required to provide in-network cost share for unexpected out-of-network services:
  - Emergency items and services
  - Certain medical items and services performed by out-of-network providers in an in-network facility
  - Air ambulance items and services
- Payment is to be made based on recognized or qualifying payment amounts (QPA) for in-network rates for the same service in the geographic area.

What EMI Health is doing:

- EMI Health receives QPAs for applicable claims from its leased networks outside of Utah and calculates QPAs for Utah providers. EMI Health is also developing a unified solution using Fair Health data.

Independent dispute resolution (effective 01/01/2022)

- The legislation requires providers and health plans to negotiate bills, so that patients are not balance-billed. If the health plan and provider are unable to reach an agreement within 30 days, an Independent Dispute Resolution (IDR) process has been established.

What EMI Health is doing:

- With support from the entities providing the QPA, EMI Health will administer the IDR process for health plans, including self-funded plans.

Disclosure requirements (effective 01/01/2022)

- Insurers and health plans must provide notices related to surprise billing on their websites and member Explanation of Benefit (EOB) documents.

What EMI Health is doing:

- The Department of Labor provided a model notice, which EMI Health has posted on its website at https://emihealth.com/AdditionalResources/NoSurpriseActDisclosure. Covered groups may link to that notice or create their own. EMI Health prints the required notice on applicable EOBs.

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Provider directory (good faith compliance 01/01/2022)

- The legislation requires that health plans provide up-to-date provider directories on a public website and that the entries include electronic contact information for providers. Health plans are required to make updates within two business days of being notified of a change and must have a process in place to verify each provider's information every 90 days. In addition, health plans are required to respond to member requests for a provider's network status within one business day. Final rules on this provision have not yet been released; in the meantime, good faith compliance efforts are required. Members who rely on incorrect directory information may be entitled to receive services at the in-network benefit level.

What EMI Health is doing:

- EMI Health maintains a provider directory on our public website. Data is verified and updated regularly. Processes for including electronic contact information and making updates within two business days are being developed. EMI Health's provider directory meets the good faith compliance requirements. EMI Health encourages members to make use of the electronic provider directory but will provide a PDF or printed directory upon request.

Expanded ID card information (effective 01/01/2022)

- The legislation requires that ID cards include in-network and out-of-network deductibles and out-of-pocket maximums, as well as telephone numbers and the website address where members may obtain support and provider network information.

What EMI Health is doing:

- EMI Health's ID card templates have been modified to include all required fields. Cards issued on or after 01/01/2022 meet the new requirements. ID cards are issued to new subscribers upon enrollment and to all subscribers upon the group's renewal.

Continuity of care (effective 01/01/2022)

- If a provider's status changes from in-network to out-of-network, members with certain serious ongoing medical conditions may request to continue receiving care from that provider at the in-network cost share for 90 days or until the patient is no longer undergoing continuing care if that is less than 90 days.

What EMI Health is doing:

- When a provider's network participation terminates, EMI Health notifies members who have seen that provider within the past 12 months of the change in network status. That letter includes information regarding continuation of care and the application process.

Public disclosures: machine readable files (effective 07/01/2022)

- Insurers and health plans are required to create and publish the following machine-readable files on a public site and update them monthly:
  - In-network negotiated rates for all items and services
  - Allowed amounts for out-of-network items and services
  - Negotiated rates and historical prices for in-network prescription drugs (delayed pending rulemaking)

What EMI Health is doing:

- Working with our leased networks, EMI Health will create and publish the machine-readable files (MRF) for health plans, including self-funded plans, by the 07/01/2022 deadline. When additional guidance is released regarding prescription information, EMI Health will work with our Pharmacy Benefit Manager (PBM) to provide those files as well.

Pharmacy benefits and cost reporting (first report due 12/27/2022)

- The legislation requires reporting of the following prescription drug spending and medical cost data annually:
  - Claims paid for the 50 most frequently dispensed brand prescriptions
  - Amount spent for the 50 most costly prescription drugs
  - Amount spent for the 50 prescription drugs with the greatest prior-year spend
  - Total health care spend broken down into categories
  - Premiums and rebates

What EMI Health is doing:

- EMI Health is working with our PBM to collect the required data and provide the appropriate reporting on behalf of our health plans, including self-funded plans.

Future and Pended Provisions

Price transparency tools (effective 01/01/2023)

- The legislation requires health plans to provide members with a benefit cost estimator tool that compares personalized out-of-pocket costs for covered services, beginning with 500 items, services, and prescription drugs that will be identified in the final rule. In 2024, the tool must be expanded to provide costs for all covered medical items, services, and prescription drugs.

What EMI Health is doing:

- EMI Health currently provides the Smart Cost Calculator within the member portal. With this online tool, which pulls from actual claims data, members can search facilities, providers, and specific procedures to better understand costs and ratings. This tool will be enhanced to read the MRFs, allowing expanded procedure searches.

Advance cost estimate (EOB) (delayed pending further guidance)

- This provision requires providers to confirm coverage for a patient and send a notice to the health plan of the estimated costs associated with any services scheduled. Upon receipt of such a notification, the health plan is required to send an Advance EOB to the member.

What EMI Health is doing:

- EMI Health is working with our claims system vendor to implement an Advance EOB function.