Consolidated Appropriations Act

Frequently Asked Questions

Below are answers to commonly asked questions regarding the Consolidated Appropriations Act of 2020 (CAA), enacted on December 27, 2020, also referred to as the **No Surprises Act**. CAA resulted in several mandated actions by carriers – most beginning on January 1, 2022.

Member ID Cards

Q: What changes to the member ID card are required by the No Surprises Act?

A: Beginning January 1, 2022, all carriers must display the following information on ID cards to help members better understand their out-of-pocket costs:

- Any deductible, in and out of network, applicable to the plan or coverage
- Any out-of-pocket maximum limitation, in and out of network, applicable to the plan or coverage
- A telephone number and website address that a member can use to seek consumer assistance information, such as finding in-network providers, hospitals and urgent care centers

Q: When will members start receiving their new cards?

A: Group members will begin receiving new ID cards at 2022 renewal—regardless of plan changes.

Q: Are there deadlines for accounts to submit benefit changes to meet the ID card re-carding requirement?

A: No. All group members will be mailed a new ID card before the start of their new plan year in 2022.

Q: Are there any members who will not be issued a new ID card in 2022?

A: Yes. Standalone dental and vision, Medicare Advantage, Medicaid and FEP PPO members are not included in this mandate and are not part of this re-carding.

Q: What if a member doesn't receive their new card?

A: They should call the Member Services number on the back of their current ID card.

Q: What should members do after they receive their new card?

A: Destroy their old card and start using their new one immediately.

Surprise Billing

Q: How does CAA protect members from surprise medical bills?

A: When a member has an emergency medical condition and receives emergency services from an out-of-network provider or facility, the most the provider or facility may bill members is their plan's in-network cost-sharing amount (such as copayments and coinsurance). Members can't be balanced billed for these emergency services. This includes services received after the member is in stable condition, unless the member provided written consent and gave up their protections not to be balance billed for these post-stabilization services.

When a member receives services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill is the plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill and may not ask the member to give up their protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

Air ambulance services are also protected from balance billing.

Q: What are the impacts to the member in these emergency and non-emergency situations?

A: Members would be responsible for in-network cost sharing only, including any applicable deductibles, copayment or coinsurance in emergency situations and certain non-emergency situations where the member cannot choose an in-network provider or facility. This applies to air ambulance providers as well.

Q: What are the impacts to providers in these emergency and non-emergency situations?

A: Providers are prohibited from balance billing members, except in limited circumstances with notice and consent. Providers and carriers are also provided access to an independent dispute resolution process if payment agreement cannot be reached.

Q: What steps is CareFirst taking to implement these changes?

A: To comply with the Surprise Billing portion of CAA, CareFirst has updated its adjudication platform to process applicable claims, using qualified payment amounts to determine member cost share and expanding and refining our negotiation and arbitration process to work with out-of-network providers.

Q: How has CareFirst communicated these changes to out-of-network providers?

A: Messaging has been added to the Notice of Payment and information is available on our publicly accessible website, https://provider.carefirst.com/providers/mandates-policies/surprise-billing-out-of-network-provider-notice.page?.

Provider Directory Updates

Q: How does CAA impact provider directories?

A: Beginning January 1, 2022, providers will be required to update their directory information every 90 days. If a provider doesn't update their information during the specified timeframe, they may be required to provide refunds to members when their data is inaccurate and will be removed from our directory if they are non-responsive.

Q: How quickly will a provider's information be updated?

A: Health plans are required to update provider directories within two days* of receiving updated provider information.
*Select updates will not be reflected in the directory until validated.

Q: If a member calls about a discrepancy with the provider directory, how soon will they hear from CareFirst?

A: CareFirst will respond to the member's question within one business day. We will also retain any communications about directory inquiries for at least two years.

Q: What happens if a member sees a doctor and realizes there is a discrepancy with the information found in the provider directory?

A: If a member provides CareFirst with documentation that they received incorrect information about the participating status of a provider from the provider directory, they are only responsible for in-network cost-sharing.

Machine-readable files

Q: Does the Transparency in Coverage (TiC) final rule apply to all plans?

A: The TiC final rule applies to non-grandfathered individual and group health plans. The rule does not apply to grandfathered plans or excepted benefits like stand-alone dental and vision coverage, Medicare supplement policies, hospital indemnity and other similar limited benefit plans. The rule also doesn't apply to programs outside of the commercial market like Medicare Advantage and Medicaid.

Q: Will the machine-readable files be available, and where will they be posted?

A: CareFirst is on track to meet the July 1 deadline. The target date for the webpage to go live with the machine-readable files is July 1, 2022, and the URL will be https://individual.carefirst.com/individuals-families/mandates-policies/machine-readable-file.page.

CareFirst will not host files for plans that use NetLease.

Q: What about the machine-readable file for drug pricing that was required in the final rule?

A: The Departments released additional guidance in August 2021 that delayed the implementation of the two MRFs from January 1 to July 1, 2022, and put this third file for drug pricing on hold indefinitely, pending additional guidance at a later date.

Q: How does a member use the file to look up pricing?

A: Machine-readable files are meant to feed technology-based tools. They are NOT meant to be used by members to look up pricing. Members currently have access to the Treatment Cost Estimator Tool in *My Account,* and CareFirst is working on the necessary enhancements required by the final rule to be in place by January 1, 2023.

Q: What is the 20-claim minimum rule related to the out-of-network file?

A: For the out-of-network file, entities are required to report historical allowed amounts and billed charges for specific items and services by providers. To protect privacy, regulations require that this data be omitted if there are fewer than 20 different claims for a particular item or service and provider combination for a plan.

Q: Is there a cost for hosting the machine-readable files?

A: These files are very large terabytes of data. There is a cost associated with creating, hosting and maintaining files of this size. Costs of this nature are accounted in premiums for our insured plans. For 2022, we're absorbing the costs for self-funded plans. However, our approach for 2023 and forward is still being considered.

Q: Can a self-funded employer group host the machine-readable files on their company website?

A: To meet the compliance date of July 1, 2022, CareFirst will host the files for all applicable plans. If a self-funded group wants to host the files on its own website, they may reach out to their CareFirst Sales Consultant for more information.

Q: What about CFA and NCAS groups?

A: The files hosted by CareFirst will include a PPO file for CFA Blue and additional files sent to CareFirst for NCAS.

Q: How will groups access the machine-readable files hosted on CareFirst's site?

A: Please find instructions on how to access machine readable files here. As a reminder, MRF files contain raw data require technology-based tools to interpret and analyze. An EIN is required to access the files.