Update on the Transparency in Coverage Rule and Consolidated Appropriations Act

Wellmark Blue Cross and Blue Shield continues to work toward compliance in the remaining provisions of the Transparency in Coverage Rule (TCR) and the Consolidated Appropriations Act (CAA). Below are important updates on our work, as well as information following new final rules and clarifications from the federal government.

Wellmark is committed to complying with all applicable deadlines and making good-faith efforts to comply based on our understanding of the law as written. We continue to operate based on the latest guidance. However, the federal government continues to release rules about how requirements should be implemented and enforced.

Important CAA updates below

Based on recent additional guidance from the federal government, there are important updates below on the Gag Clause Provision under CAA and progress toward compliance with Price Comparison Tool requirements by Jan. 1, 2024.

To ensure you receive these important updates, those provisions have been pulled out from the complete chart and highlighted below. The additional chart outlining "What Wellmark is doing" for remaining provisions is still available below and have not changed since our last communication to you.

Gag clause prohibition

Requirement	Compliance date	What Wellmark is doing
Gag Clause Prohibition and Attestation *(CAA Sec. 201)*	Dec. 27, 2020; good-faith compliance	Section 201 of the Consolidated Appropriations Act (CAA) requires that insurers and group health plans complete a Gag Clause Prohibition Compliance Attestation (GCPCA) to certify compliance with Internal Revenue Code (Code) section 9824, Employee Retirement Income Security Act (ERISA) section 724, and Public Health Service (PHS) Act section 2799A-9, as added by section 201 of Title II (Transparency) of Division BB of the CAA. The first annual attestation is due no later than Dec. 31, 2023. Wellmark acts as an insurer for fully insured employer group health plans and as a third-party administrator for self-funded employer group health plans. Wellmark's fully insured and self-funded group health plan customers use Wellmark's provider network for their health plans. Wellmark's Group Insurance Policy agreements, Administrative Services Agreements, and our provider network agreements fully comply with the gag clause prohibition statutes mentioned above. Wellmark's agreements with employer group customers and providers

Requirement	Compliance date	What Wellmark is doing
		permit Wellmark to share data to group health plan customers. Wellmark agreements permit the group health plan to share data through a consumer engagement tool and with its business associates. Often Wellmark shares the data directly to group's business associates at the group health plan's direction, under a confidentiality and data use agreement. **Self-funded groups will be required to submit their own GCPCA to the Centers for Medicare and Medicaid Services (CMS).** To support their attestation, Wellmark is providing a Compliance Statement in which we make a representation outlining Wellmark's compliance with the gag clause prohibition requirements under CAA. The representation is limited to the scope of services that Wellmark performs as a third-party administrator. For example, if a self-funded group uses a different pharmacy benefit manager (PBM), Wellmark's representation will not apply to those services. A separate representation may be provided by the groups PBM. This GCPCA requirement applies to all self-funded group health plans, including non-federal governmental plans, and must be completed by Dec. 31, 2023. For information on filing the attestation, groups should visit CMS.gov site on GCPCA, which includes an FAQ, user manual, instructions and templates. **Please note:** The first attestation applies to the period beginning Dec. 27, 2020, through the attestation date of Dec. 31, 2023. Self-funded group health plans will need to file this attestation annually on Dec. 31, and covers the preceding year. **Confirmation of Compliance with Gag Clause Prohibition statement** While this is a change from what was previously communicated, this better aligns with recent clarifications on the tool from CMS as well as the market expectations. **For fully insured plans, Wellmark is prepared to submit attestations as an insurer on behalf of all fully insured health plans.** Wellmark will file a GCPCA that covers any group health plan that was active during the period beginning Dec. 27, 2020, through the attestation date of Dec. 31, 2023. If you have questions, please contact your Wellmark representative.

Price Comparison Tool

Requirement	Compliance date	What Wellmark is doing
South Dakota transparency law (*SDCL 58-17K*) • Prescription drug file • In-network allowed amount • Out-of-network allowed amount	• Jan. 1, 2022 • Jan. 1, 2024 • Jan. 1, 2024	The South Dakota legislature passed a transparency law similar to the Federal TCR. Wellmark, along with pharmacy benefits manager, CVS Caremark has made the South Dakota prescription drug file available on Wellmark.com under "Important Things to Know." The page will also house other, important transparency information when future machine-readable files are available. Wellmark will work toward compliance with the remaining components of the South Dakota legislation in conjunction with our implementation of the machine-readable files under the Federal TCR requirements (see below).
Price Comparison Tool *(TCR and CAA Sec. 114)* • Estimates for **500** items and services (TCR) • Estimates for **all** items & services (CAA and TCR)	• Jan. 1, 2023 • Jan. 1, 2024 *Delayed CAA enforcement to align with TCR*	Wellmark continues to make progress on expanding the current cost tool with estimates for all items and services, as required by CAA and TCR by Jan. 1, 2024. The myWellmark cost tool will continue to operate as outlined below. **Please note:** The incorporation of estimates for all items and services **does not include a solution for groups with carveout pharmacy benefits managers (PBMs).** These groups would need to provide a cost tool solution for their members. The myWellmark cost tool allows users to search for cost estimates services based on either: • Actual, historical claims data (*default view*) • In-network negotiated rates for all items and services Members using the cost tool on myWellmark have the option to choose how the cost information is displayed (historical claims data or negotiated rates) by selecting their preferred option from a drop-down menu in the search window. Members can also select to print or send a PDF via email.

What Wellmark is doing to comply with CAA and TCR

The table below outlines critical provisions of TCR and CAA that have passed and how Wellmark currently complies with the requirements. However, there are some instances that no final rules have been released. While the current process may change based on the release of final rules, the previously communicated process below has not changed since our last update. Please note, the compliance date for advanced explanation of benefits is still to be determined.

We encourage all employers to understand their obligation to comply with TCR and CAA. Groups should consult their legal professional to determine how their organization will comply with these laws and assess any risks. While Wellmark is committed to good faith compliance and we firmly believe our solutions will meet the needs for most employer groups. All employer groups must determine their compliance approach based on their own interpretation of the requirements.

Requirement	Compliance date	What Wellmark is doing
Mental Health Parity *(CAA Sec. 203)* Requires insurers and self-funded plans to provide documentation, upon regulator request, demonstrating compliance with the Mental Health Parity and Addiction Equity Act's nonquantitative treatment limitation ("NQTL") requirements.	Feb. 10, 2021; already in effect	Wellmark has prepared NQTL documentation in the event of receiving a regulator request.
Broker Compensation Disclosure *(CAA Sec. 202)* Brokers and consultants must disclose any compensation they expect to receive from a group health plan, or from Wellmark, for brokerage and consulting services.	Sales activity beginning Dec. 27, 2021	In the Individual and Family market, agents are required to use Wellmark's Individual Marketing Compensation Disclosure template to disclose compensation they receive from Wellmark for selling Wellmark plans. The disclosure must be provided by the agent prior to final plan selection. The disclosure must also be provided by Wellmark with confirmation of enrollment, and again with a notice of renewal. The template is available on Producer Connection on Wellmark.com. In the group market agents, brokers, and consultants are responsible for providing disclosure of compensation for brokerage and consulting services provided to the group health plan. This includes direct and indirect compensation, including commission or consulting fees. The obligation to comply with the broker compensation disclosure requirements in the group market falls solely on the broker/consultant. Wellmark has developed a sample template for producers to use. It is available on Producer Connection. Agents serving small groups may use Wellmark's template or may use another compliant disclosure form that they choose. • Iowa Small Group Compensation Disclosure sample • South Dakota Small Group Compensation Disclosure sample
No Surprise Billing *(CAA Sec. 102-106, 110)* Establishes new claims payment requirements regarding patient liability and balance billing for certain out-of-network (OON) emergency services, OON providers at in-network facilities, and OON air ambulance services.	Jan. 1, 2022	The No Surprises Act (CAA Sec. 102-106, 110) applies to plan years that begin on or after Jan. 1, 2022. Wellmark implemented these provisions on Jan. 1, 2022, regardless of plan year. Wellmark also made benefit coding changes for any custom benefits to align with the No Surprises Act for out-of-network provider payments and certain emergency services that must be covered under the act. The cost share amount for out-of-network services subject to the act will be based off the lesser of the billed charge or the Qualified Payment Amount (QPA), which is generally the insurer's median 2019 in-network contract rate for a covered item or service and will be adjusted for inflation in subsequent years. Additionally, if an out-of-network provider is not satisfied with the payment amount under the No Surprises Act, they can enter into a negotiation period, or Independent Dispute

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		Resolution (IDR) if negotiation is unsuccessful. Wellmark will handle negotiations and IDR on behalf of self-funded groups and has designed a process to gather input from the group. There are fees associated with the IDR process, including a $50 non-refundable administrative fee for all parties, and an IDR fee between $200–$670 (exact amount set by the IDR entity) paid by the losing party. More information about the process and when groups may be responsible for fees was included in the February *News From Blue*. The Federal IDR Portal went live on April 15, 2022. Parties whose open negotiation period on claims expired prior to that date will have 15 business days after April 15, 2022, to file an IDR for those claims. **New (June 2022):** Wellmark communicated in May that groups should post a notice of member rights regarding surprise bills. The notice outlines the requirements and prohibitions of a provider or facility under the law. The Wellmark communication included links to the Department of Labor (DOL) resources and a DOL model notice to customize as needed. The Wellmark notice is also available on Wellmark.com/finder. **New (August 2022):** On Aug. 19, 2022, the Tri-Agencies released the Requirements Related to Surprise Billing final rule. The revised rule targets specific issues, including the weight that an Independent Dispute Resolution Entity (IDRE) should give the QPA, the requirement for the IDRE to issue a written decision, and a plan or issuer's use of down-coding in the QPA calculation. Wellmark is reviewing the rules and will make any necessary adjustments to its Surprise Billing processes. **New (June 2023):** There have been several lawsuits challenging the provisions of the Surprise Billing interim and final rules that required the IDR entity to give more consideration to QPA than other factors. Those portions of the rules have been struck. There had been various pauses to the IDR process for certain timeframes due to the court rulings, but all IDRs have now resumed for all time periods. Additional detail can be found here. There are still other pending lawsuits challenging various portions of the Surprise Billing rules and IDR. Wellmark is continuing to monitor those. The IDR process has suffered delays due to the extremely high number of disputes filed and the difficulty of determining eligibility of disputes for the IDR process. In the first year of being live, there were over 330,000 disputes filed—about 14 times more than anticipated. The process is starting to run more smoothly now with decisions being issued faster. The CMS IDR reports can be found here. The administrative IDR fee (owed by both parties to each dispute) for 2023 also rose from $50 to $350 to cover the costs of the process. Wellmark has had an extremely low volume of IDRs for claims in its service area due to the breadth of our provider network.

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Transparency on ID Cards *(CAA Sec. 107)* The CAA requires ID cards to include in- and out-of-network deductibles and out-of-pocket maximums (OPMs) and information to find a network provider.	Jan. 1, 2022; good-faith compliance	Wellmark made updates to ensure all ID cards comply with the rule: **Electronic ID cards:** All electronic ID cards include the CAA information as of Jan. 1, 2022. **Physical ID cards:** New physical ID cards are being distributed based on Wellmark's current business rules for issuing new cards. Most small group ACA, small group grandfathered and grandmothered, individual and midsize markets experience product changes each year and a majority of those members received new ID cards that include the CAA information. For large groups (101+) cards will be issued at renewal to new members and members who change plans in accordance with current business practice. For any groups that make plan changes at renewal that would require new ID cards for all members, the new ID cards will include the CAA information. **Coverage letter:** A new coverage letter replaced the temporary ID cards. The coverage letter now contains all the relevant ID card information to access health care services before receiving their physical ID card. The letter can be accessed through Employer Connection or View Eligibility and Benefits in secure portals of Wellmark.com.
Continuity of Care *(CAA Sec. 113)* Allows certain patients the opportunity to continue care if their provider/facility is no longer in their health plan's network.	Jan. 1, 2022; good-faith compliance	Wellmark's Continuity of Care process aligns with the three triggering events for eligibility: 1. Provider is no longer in the network. 2. Benefits under a plan with respect to a certain provider are terminated or changed with respect to a provider. 3. Group changes health insurers and provider is no longer in new carrier's network. (Note: This trigger does not apply to self-funded groups.) **For triggers one and two,** Wellmark will identify members with serious or complex conditions and send a letter notifying them of Continuity of Care eligibility. Members will need to take action to receive the benefit by completing the form that came with the initial letter and submitting it to Wellmark. Our processes for paying claims, servicing customers and addressing member and provider appeals have also been updated to reflect the requirements. **For prompt three,** the process varies based on whether a group is leaving Wellmark, or if a group is new to Wellmark. • **For groups leaving Wellmark:** Wellmark will identify members with serious or complex conditions and provide an extract to the group for use with the new insurer. The departing group will be responsible for notifying Wellmark prior to termination and providing the list to their new carrier. We have also outlined a process for new groups coming to Wellmark to inform potential continuing care patients of their rights to receive in-network coverage if their provider is not in Wellmark's network.

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Provider Directory *(CAA Sec. 116)* Requires an online provider directory be available to members and updated every 90 days.	Jan. 1, 2022; good-faith compliance	Wellmark now requests that providers validate their information every 90 days. Failure to validate will result in their information being removed from our provider directories. Please note, failure to respond to the first validation request does not remove them from Wellmark's provider network. It will not impact claims payment at network rates. Providers will be added back to the directory once information is verified. If members have questions regarding a provider's network status, they can contact Wellmark customer service who can provide information over the phone and in writing.
Machine-readable files *(TCR)* The federal rule focuses on public access to three machine-readable files and monthly updates. • In-network allowed amount • Out-of-network allowed amount • Prescription drug	• July 1, 2022 • July 1, 2022 • TBD	The machine-readable files that are required under the TCR went live on Wellmark.com on July 1, 2022. Wellmark worked with our vendor, HealthSparq, to build files that include allowed or paid amounts for standardized benefits, in good faith compliance with TCR requirements. Fully insured employer groups are not required to post links to the files or take action to comply with this rule. Wellmark posted the files on behalf of fully insured groups. All self-funded employer groups (except for grandfathered plans) should have a link to their files on their public-facing website (not an internal website). The June 30 Blue Briefings includes details and instructions to access and post links. New self-funded groups will need to post a generic MRF link until a group-specific version is available once an employer identification number (EIN) is available. Wellmark will provide these links each month via Blue Briefings. More instructions about how to download the unique file format for machine-readable files was distributed via Blue Briefings on July 14. The Centers for Medicare and Medicaid Services (CMS) recently clarified how self-funded groups should identify their plan name or plan sponsor when posting machine-readable files. • **Plan sponsor name:** The name of the plan sponsor should be the name of the entity that sponsors the health plan. If it is unclear which entity sponsors the plan (e.g., a corporate affiliate sponsors a plan under which employees from several different affiliates are covered), the plan sponsor name on the Form 5500 should be used. • **Plan name:** The plan name is the name of the specific coverage option. While CMS doesn't provide specific guidance, using names from the Form 5500 would be appropriate. Self-funded groups could also consider using the same description for distinct plans that are provided to employees during open enrollment (e.g., PPO, EPO or POS options). All MRFs found on Wellmark.com will continue to be identified by employer identification number or EIN. The plan sponsor and plan name will not appear within the MRFs listing on Wellmark.com. As a result, from a compliance standpoint, it is important that self-funded groups include the name of the plan

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		sponsor and plan name when posting their machine-readable files. The display text on the group's company website should indicate the plan name as described above.
Pharmacy & Medical Reporting *(CAA Sec. 204)* Requires insurers and self-funded plans to provide pharmacy benefit and cost reporting to the Departments of Health and Human Services, Labor and Treasury (the "Tri-Agencies").	Dec. 27, 2022	Wellmark successfully submitted its Section 204 filing for calendar year 2022 on behalf of its fully insured and self-funded groups before the June 1, 2023, deadline, specifically: • D1: Premium and life years • D2: Spending by category (medical plan) • P1: Individual and Student Markets • P2: List of Group Health Plans Wellmark has also confirmed that CVS has successfully submitted its portion of the Section 204 filing prior to the deadline (specifically D3-D8, with the corresponding P1 and P2 files) on behalf of Wellmark's fully insured groups and those self-funded groups who obtain pharmacy benefits administration through Wellmark. The D1 report for 2022 incorporated information submitted to Wellmark by group health plans through the data collection tool on Employer Connection. Groups that did not provide the employee contribution amounts to Wellmark were not included in the employee or employer contribution calculations on the D1 file. Groups who did not submit information via the tool will be identified on a list and provided to CMS upon request. As a reminder, the data collection process will be an annual request. More information regarding data collection for the 2023 calendar-year report will be shared in early 2024.
Advanced Explanation of Benefits (EOBs) *(CAA Sec. 111)* Requires insurers and self-funded plans to provide advance EOBs estimating costs before scheduled health care services are provided.	TBD, deferred enforcement	The most recent FAQ delayed the enforcement of this requirement until further rule making is complete. The federal government recently requested information from health plans and issuers regarding Advanced EOBs, so additional guidance on this requirement is anticipated. Wellmark will continue to analyze the requirements as they are currently written and await additional guidance and rulemaking to ensure compliance by the determined date.

Wellmark's commitment to compliance

Wellmark is a company with integrity, and we are focused on doing the right thing at all times. While a great deal of work has been done to comply with provisions to date, we know there is still more to do. Additionally many of these requirements will become annual processes. We also expect more final rules to be released that could impact the work we've already done and the work we have yet to do. Wellmark continues to act in good faith updating our processes and implementing solutions that help bring plans in compliance. Wellmark is committed to keeping you informed as we learn more and make progress.