of Tennessee

Consolidated Appropriations Act Overview and FAQs

Updated Sept. 13, 2021

The Consolidated Appropriations Act, 2021 (CAA) became law in December 2020. Since December, BlueCross has worked to develop new operations processes, materials, communications and trainings to allow us to meet the requirements of this health care reform law and help support the needs of our customers and providers impacted by the new regulations.

To help simplify the regulations outlined in the CAA, we've created this overview and FAQs. This document provides a high-level, general summary of several CAA provisions that most directly impact health plans and brokers as we understand them today. Information may change as we gain more clarity around the provisions, after regulations and guidance are issued.

Q: What is the Consolidated Appropriations Act?

The Consolidated Appropriations Act, 2021 (CAA) became federal law in December 2020. Its primary purpose was funding the federal government's operating budget, but it also contained elements that will have a major impact on our operations. In fact, it's the most extensive set of changes for the commercial health insurance industry since the Affordable Care Act passed in March 2010.

Many of the health care requirements outlined in the CAA go into effect on the first day of the plan year beginning on or after January 1, 2022. These requirements fall largely on health insurance issuers, group health plans, health care providers and brokers. The health care provisions include requirements related to ID cards, advance cost estimates for health care services, mental health parity analysis, prohibitions on surprise billing, provider directories, disclosure of broker and consultant compensation, and more.

This document provides a high-level, general summary of several CAA provisions that most directly impact health plans and brokers as we understand them today. Information may change as we gain more clarity around the provisions, after regulations and guidance are issued.

Although the CAA included Medicare- and Medicaid-related provisions, the changes discussed in this overview apply to health insurance issuers in the commercial market and group health plans only. (Medicare Advantage and Medicaid/TennCare enrollees are not affected by these provisions.)

Q: What is BlueCross doing to meet the requirements outlined in the law?

For now, we're focusing on the following requirements of the CAA.

ID Cards – Effective Jan. 1, 2022

Requirement: ID Cards are required to show in-network and out-of-network deductibles, out-of-pocket maximum amounts, and a phone number and website where members can get more information.

What BlueCross is doing:

- We already include some of these details on our member ID cards. Now we're making sure deductibles are included as well as out-of-pocket (OOP) max amounts for plans we administer.
- We're communicating clearly and simply, avoiding using abbreviations when we can, and consistently labeling and placing elements to reduce member and provider confusion.
- We know copay information is important to members, so we're including it whenever possible.
- If a plan carves out pharmacy, information related to it will only include contact information.
- We've engaged members to review the new sample ID cards. Their feedback has helped us refine our concepts and add clarity.

Strengthening Mental Health and Substance Abuse Parity – Effective Feb. 10, 2021

Requirement: The CAA formalized reporting and other responsibilities related to existing behavioral health benefits enacted under the Mental Health Parity and Addiction Equity Act (MHPAEA).

Health insurance issuers and sponsors of group health plans are required to perform and document comparative analyses of the design and application of non-qualitative treatment limitations (NQTLs) applicable to behavioral health services. NQTLs are benefit limitations that are not numeric in nature (for example, cost-sharing and visit limits) and generally relate to medical management techniques such as prior authorization, medical necessity criteria, and concurrent review standards. The CAA requires health insurance issuers and group health plan sponsors make these comparative analyses available to state or federal authorities upon request.

In short, all group health plans – fully insured and self-funded – are required to show that the mental health and substance use disorder benefits are designed and administered comparably to medical and surgical benefits.

What BlueCross is doing:

- We believe BlueCross' fully insured products – including fully-insured group health plan products – already meet these so-called "mental health parity" requirements and comply with state and federal laws that apply to us as a health insurance issuer.
- In contrast, plan sponsors of self-funded group health plans – administered by BlueCross but designed by the plan sponsor – retain final authority and responsibility for their self-funded group health plans. This includes, but is not limited to:
    - the benefit design of the plan
    - compliance with the requirements of ERISA and
    - compliance with any other state and federal laws or regulations applicable to the group or the administration of the plan
- As a third-party administrator for self-funded group health plans, BlueCross performs certain claims payment, medical management and network services for plans as described in the administrative services agreement (ASA).
- Our goal is to work with our plan sponsors, when requested, to assist and/or provide them with information they may need in order to meet their NQTL obligations.

Advance Estimates for Health Care – Enforcement Date Delayed (To Be Determined)

Requirement: Commercial members may request cost estimates for upcoming health care services. This is sometimes referred to as "Advance Explanation of Benefits," which we're calling a Care Estimate. The provider offering the services is required to send us the billing and diagnostic codes and their good faith estimates for any items or services related to a scheduled visit, including anything expected to be offered by another provider or facility. The Care Estimate will include provider rate information, in/out-of-network status, deductible and OOP max status at the time we receive the provider's request, and the expected member financial responsibility. The Care Estimate will also tell members how to find an in-network provider.

After receiving necessary information from the provider, the Care Estimate must be mailed or made available electronically within 1 business day (3 business days if the service is 10 or more days in the future).

What BlueCross is doing:

- We're creating a document that will inform members of a good faith estimate of their cost share for a scheduled service and meet legal requirements.
- Our Care Estimate lets members easily compare estimated amounts provided prior to a service to their final member cost shares once claims are processed.
- We're using member research insights from our existing Commercial Claim Summary (i.e. Explanation of Benefits) to make the new Care Estimate easy to understand.
- It's important that members understand this is a good faith estimate, and that point is reinforced in several locations on the first page.
- We're also including a more detailed view of the estimated costs for each provider. Most of this information is already outlined in the member's Claim Summary, but the new law requires us to note any medical management requirements, for example, if prior authorization is required.

Q: What are some other requirements of the law?

Other requirements of the CAA are more directly tied to providers and brokers, in addition to health insurance issuers and group health plans. These include surprise billing limitations, provider directory requirements, disclosure of broker and consultant compensation and more.

Surprise Billing – Effective Jan. 1, 2022

- The CAA includes new protections that prevent members from getting unexpected bills for certain emergency and ancillary services furnished by out-of-network providers.
- It also outlines protections for (non-emergency) services provided by out-of-network providers furnished at an in-network facility.
- The CAA implements protections against surprise billing by taking the member out of the middle.

Provider Directory – Effective Jan. 1, 2022

- The CAA requires health insurance issuers and sponsors of group health plans to have an accurate provider directory. We send quarterly data verification files to providers and routinely encourage them to make sure the information we have on record is accurate. This effort is,

however, largely dependent on the accuracy and timeliness of the information we receive from providers.
- New requirements outline specific processes to verify and update provider directories, respond to requests for in-network provider information, provide a database of in-network providers and ensure information included in provider directories is accurate.
- If the online directory or our Member Service teams erroneously inform a member that an out-of-network provider or facility is in network, we must apply in-network benefits to the claim and the provider cannot balance bill the member.

Disclosure of Broker and Consultant Compensation – Effective Dec. 27, 2021

- The CAA amends ERISA to require that brokers and consultants disclose their direct and indirect compensation to sponsors of ERISA group health plans.
- It also requires health insurance issuers to disclose direct and indirect agent and broker compensation to individual market consumers at certain times.
- The effective date of this provision is Dec. 27, 2021, but the disclosure requirements do not apply to contracts executed prior to that date until renewal.

Q: What's next?

We're working hard to implement the provisions of the CAA by the various effective dates. We're studying the law to best understand its requirements and anticipate the federal agencies issuing additional regulations and guidance clarifying the law's requirements.

Q: How can I learn more?

We will continue to provide updates through an ongoing series of Health Care Reform field notices.

As well, you can find the complete copy of the CAA here:
https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf