UPDATED 10/06/2021

Consolidated Appropriations Act

FOR EMPLOYER GROUPS

BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

The CAA was enacted into law in December 2020. It contains numerous requirements that will affect group health plans, insurers, and providers. Most requirements take effect at the start of a group's legal plan year, beginning 1/1/22. Blue Cross and Blue Shield of Florida is committed to fulfilling the requirements of the law, supporting groups to the best of our ability, and ultimately ensuring a continued positive member experience. Below are updates from our dedicated CAA provision workgroups.

Advanced Explanation of Benefits

The AEOB requirement was originally effective for plan years starting on or after 1/1/22 but the Departments of Labor, Health and Human Services (HHS) and the Treasury (collectively "the Tri-Agencies") issued Frequently Asked Questions (FAQs) on August 20, 2021, which deferred enforcement of this CAA mandate until the Tri-Agencies provide further guidance, including establishing appropriate data transfer standards.

Insurance Cards

New digital ID cards will be available by 1/1/22, for groups with legal plan years beginning on 1/1/22. Members can access their digital ID cards by logging in to *my*BlueCross at **FL.ExploreMyPlan.com.**

Price Comparison Tool

This requirement was originally effective for plan years starting on or after 1/1/22, but on August 20, 2021, the Tri-Agencies announced they will defer enforcement to plan years beginning on or after 1/1/23. This aligns the CAA Price Comparison Tool requirement with the internet-based self-service tool requirement under the Transparency in Coverage Rule.

Providers

Provider Directories: Health plans must establish a public-facing provider directory that contains certain

information and establish a verification process to confirm the accuracy of provider directory information at least every 90 days. **Blue Cross has selected a vendor to assist with the verification process.**

Prohibition on Gag Clauses: This provision prevents the inclusion of clauses that restrict the sharing of cost and quality information in various agreements. **Blue Cross has processes in place to support a group health plan's compliance.**

Continuity of Care: For individuals who are undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or terminally ill, health plans must provide up to 90 days of continued, in-network care if a provider or facility leaves the network without cause.

Reporting

Mental Health Parity: Health plans must perform and document comparative analyses of the design and application of non-quantitative treatment limitations (NQTLs) and make them available to state and federal authorities upon request.

Pharmacy Benefits and Drug Costs: Groups and health plans must report certain annual data to the Department of Health and Human Services, the Department of Labor, and the Department of Treasury (Tri-agencies) including: plan year information; number of enrollees; geographic information; drug utilization; total spending on healthcare services; average monthly premium; rebates; and any reduction in premiums and out-of-pocket costs associated with rebates. The Tri-agencies will aggregate the data and make such data publicly available. No confidential or trade secret information submitted by health plans will be made public.

The first report was originally due 12/27/21 (and by June 1 every year thereafter), but on August 20, 2021, the Tri-Agencies announced they will defer enforcement pending the issuance of regulations or further guidance. It is expected that reporting with respect to 2020 and 2021 data will be due by 12/27/2022.

Broker and Consultant Compensation Disclosure: CAA includes new Employee Retirement Income Security Act (ERISA) requirements applicable to brokers and consultants of self-funded groups. The CAA requires a self-funded group's brokers and/or consultants to disclose compensation and describe services rendered to plans. Brokers and consultants must make these disclosures to the plan fiduciary if direct or indirect compensation for services is expected to exceed $1,000. **Blue Cross does not meet the ERISA definition of a "broker" or "consultant" under these new ERISA requirements. Although ERISA compliance is the responsibility of the self-funded group, Blue Cross is evaluating the extent to which we will be able to provide limited support, as a courtesy.**

Surprise Billing

Coverage Requirements: Health plans must cover services administered in an emergency department (or emergency services administered in a free-standing emergency department) without prior authorization, without respect to the providers' network status and apply in-network cost-sharing; cover non-emergency services performed by an out-of-network provider at certain in-network facilities when the provider has failed to obtain the applicable member notice and consent; and cover out-of-network air ambulance services and apply in-network cost-sharing. **Blue Cross will update the following services for underwritten plans so that out-of-network member cost-sharing mirrors the plan's current in-network cost-sharing exactly.**

- Outpatient Hospital Benefits
  - Emergency Room - Medical Emergency
  - Emergency Room - Accident

- Physician Benefits
  - Emergency Room Physician
- Other Covered Services
  - Ambulance Services

Non-emergency services performed by an out-of-network provider at certain in-network facilities (except if the member notice and consent requirements are fulfilled) will be covered. Cost-sharing will be no greater than the amount that would have been paid to an in-network provider. **This approach is the least disruptive to members and will serve as the standard to bring underwritten plans into compliance.**

Accumulators: Many plan designs include calendar year deductibles and out-of-pocket maximums for in-network and out-of-network providers that apply independently of each other. This means that amounts applied towards the in-network calendar year deductible and/or in-network out-of-pocket maximum do not count towards the out-of-network calendar year deductible and/or out-of-network out-of-pocket maximum; nor do amounts applied towards the out-of-network calendar year deductible and/or out-of-network out-of-pocket maximum count towards the in-network calendar year deductible and/or in-network out-of-pocket maximum. Under the CAA, the cost-sharing amounts (deductibles, copayments and coinsurance) that members are required to pay for out-of-network services will apply to the in-network calendar year deductible and/or the in-network out-of-pocket maximum.

Qualifying Payment Amount: The qualifying payment amount (QPA) is a calculation that may apply to cost-sharing calculations required under the CAA, as well as the Independent Dispute Resolution Process discussed below. The QPA is one of the amounts that may be used to calculate the member's cost sharing for out-of-network emergency services, out-of-network air ambulance services and, when applicable, non-emergency services provided by out-of-network providers at certain in-network facilities.

Independent Dispute Resolution: Since the Surprise Billing provisions of the CAA prohibits certain out-of-network providers from balance billing members, an arbitration process, known as Independent Dispute Resolution (IDR), was developed to ensure appropriate payments are being made to those out-of-network providers. The IDR:

- Gives plans and providers (including air ambulance providers) 30 days to negotiate a payment after an initial payment or a denial is issued by the plan. If a decision is not reached, gives plans and providers four days to access an IDR process. Permits plans and providers to continue negotiations up until the IDR entity (arbiter) makes a final decision.
- By 12/27/21 (one year post-enactment), requires the Tri-agencies to establish an IDR process, including a process to certify the IDR entities for a five-year period and a process to select entities for individual IDR requests.

- Permits items and services to be batched for submission, provided they are furnished by the same provider or facility, involve the same plan, include items and services related to the treatment of a similar condition, and the items and services were furnished within 30 days of each other. Provides for bundled payments to be considered a single determination.

- Prohibits the party that submits an item or service for IDR to submit the same item or service for 90 days if it involves the same opposing party (i.e. the same plan or the same provider). Tasks the Tri-agencies with examining the impacts of this waiting period and submitting an interim report to Congress no later than two years after implementation and a final report no later than four years after implementation.
- Requires the party whose offer is not chosen to be responsible for the costs of arbitration and, if a settlement is reached before the IDR determination is made, requires the two parties to split the costs.

Balance Billing: This provision prohibits out-of-network facilities providing emergency services, out-of-network providers at certain in-network facilities (when member notice and consent has not been obtained), and air ambulance services from balance billing members, with limitations. Balance billing is allowed in certain circumstances under the CAA. The primary example is when a provider has provided the appropriate notice to the member and obtained their informed consent for non-emergency services provided by an out-of-network provider at an in-network facility. If the provider fulfills the notice and consent requirements, then the claim can continue to be treated as traditional out-of-network and the provider can balance bill.

Air Ambulance Reporting: This provision requires air ambulance providers, as well as plans, to submit to the Tri-agencies a number of metrics on air ambulance services within 90 days of the end of a year. The initial reporting deadline is dependent on the release of certain regulations.

Prior Authorization for OB-GYN Services: Health plans are prohibited from requiring prior authorization for obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services. **This provision is already required under ACA guidelines, and Blue Cross is in compliance.**

External Review: Health plans must allow for an external review to determine whether surprise billing protections are applicable when there is an adverse determination by a plan or issuer.

Access to Pediatric Care: Health plans must allow child members to have an in-network pediatrician assigned as their PCP. **This provision is already required under ACA guidelines, and Blue Cross is in compliance.**

Medicare

This provision requires Part D sponsors to implement one or more electronic real-time benefit tools that meet certain requirements and standards beginning 1/1/23; immediately expands access to mental health services in Medicare through telehealth, including from the beneficiary's home, beyond the end of the COVID-19 public health emergency; and eliminates coverage gaps in Medicare by requiring that Part D coverage begin the first of the month following an individual's enrollment beginning 1/1/23.

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