BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
bcbsvt.com

Administrative Services Only

The Consolidated Appropriations Act

WHY THIS MATTERS

The upcoming plan year will come with some changes to your plan and its operations in order to comply with the consumer protections and other new obligations put forth in the Consolidated Appropriations Act also known as the "no surprises act." We want you to understand the steps we're taking and the services we can provide as the administrator of your employee group health plan.

The overview

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA) (H.R. 133; Public Law No. 116-260) was signed into law. The $1.4 trillion funding package funded the federal government through Sept. 30, 2021, combined with nearly $900 billion in funding for COVID-19 relief, protections for patients from surprise medical bills and several other health-related requirements. The CAA includes important consumer protections and we've outlined them on the following pages.

Questions? Please contact your account manager.

Surprise Billing Ban

Effective for plan years starting January 1, 2022

The No Surprises Act protects patients from so-called "surprise" bills in certain situations where a provider bills a member for the difference between what the insurer paid and the amount the provider bills ("balance bill"). The No Surprises Act prevents providers from balance billing patients in two situations:

- Emergency Services
- Services delivered at in-network facilities by out of network providers, including labs

When a claim is received from an out of network provider, the payer has 30 days to deny or pay the claim. If the provider is dissatisfied with the payment received, the payer and the provider must engage in 30 days of "good faith negotiation." If that is unsuccessful, either the payer or the provider can initiate the "independent dispute resolution" (IDR) process.

The IDR process will determine a final payment amount for the disputed service. This amount is binding on the parties and such awards can be challenged in court under limited circumstances. Regardless of what happens at the IDR, the member pays no more than the initially calculated cost-share. The member is not involved in the IDR process at all.

Rules about the IDR process from the U.S Department of Health and Human services are forthcoming, so many details remain to be determined.

There are some situations where providers can ask patients to waive their rights under the CAA and we anticipate the need for member support to ensure that providers do not seek a waiver when they are prohibited from doing so.

Please note because the rule is still being clarified, support and cost to administer this is still under review.

What are ASO groups required to do?

Group health plans must cover services that trigger these CAA Balance Billing protections and cost share amounts must be determined using the "qualifying payment amount" (QPA), a complex calculation based on 2019 contracted rates. Self-funded plans can use the contracted rates of their plan administrator to calculate the qualifying payment amount.

How does this affect your employees?

When the protections are triggered, patients are responsible for no more than in-network cost-sharing amounts, including deductibles, co-insurance and co-pays.

What is Blue Cross required to do?

As the administrator of your employee's group health plan, Blue Cross will ensure procedures are in place to satisfy your obligations to timely pay or deny a claim. We will also represent your interests in the IDR process and ensure members are not involved at all.

ID Card Requirements for plan years starting January 1, 2022

Group and individual health plans must identify on insurance cards the amount of the in-network and out-of-network deductibles, the in-network and out-of-network out-of-pocket maximum, and a phone number and website address for consumer assistance information.

What are ASO groups required to do?

You will be required to update member ID cards to reflect the required changes.

How does this affect your employees?

Your employees and their dependents will receive new ID cards on or after January 1, 2022. Please let them know they can expect new cards.

What is Blue Cross required to do?

We are adding fields to the ID card to help your employees understand their in-network and out-of-network cost-sharing amounts. Our ID cards already display the customer service team's phone number and our website address. This will remain in place for 2022. We will be reissuing member ID cards, upon renewal, beginning with the January 1, 2022 renewal.

Price Comparison Tool for plan years starting January 1, 2022

Group health plans and health insurance issuers are required to maintain a "price comparison tool" available via phone and website that allows enrolled individuals to compare cost-sharing for items and services by any participating provider.

Note: The federal government has delayed implementation of this requirement as it seeks to align the CAA mandates with the newly stated "Transparency in Coverage Rule" which becomes effective January 1, 2023.

What are ASO groups required to do?

Since members can already access our price comparison tool by signing into our Member Resource Center www.bcbsvt.com/mrc or by calling our customer service team, you do not need to do anything further to ensure compliance with the CAA requirement. **We will not know whether the Transparency in Coverage rules will require additional changes until the federal government begins rulemaking.**

How does this affect your employees?

Please encourage your employees to create an account on our Member Resource Center. Once they have an account, they can use the tool to estimate the cost of upcoming care.

What is Blue Cross required to do?

We have a price-comparison tool available today on our Member Resource Center. Members can access our price comparison tool by signing into our Member Resource Center www.bcbsvt.com/mrc or by calling our customer service team.

Provider Directories for plan years starting January 1, 2022

The CAA requires that group health plans and issuers offering group and individual health plans must establish a verification process to confirm provider directory information at least every 90 days. Group health Plans must establish a response protocol to respond to member network questions within one business day and retain communications for at least two years.

What are ASO groups required to do?

At this time, it does not appear you need to do anything to ensure compliance with the CAA requirement.

How does this affect your employees?

If a member provides documentation that they received incorrect provider information related to whether or not the provider is in-network, the member will only be responsible for in-network cost-sharing.

What is Blue Cross required to do?

As the administrator of your group health plan, we will ensure our provider directory management and processes will be compliant with this requirement.

What are network providers required to do?

Network providers are obligated to update Blue Cross provider directory information and protect their patients from harm resulting from incorrect information.

Mental Health Parity for plan years starting January 1, 2022

The CAA requires group health plans and health insurers to document comparative analyses of the design and application of nonquantitative treatment limits (NQTLs). NQTL analysis must be made available to state and federal authorities upon request. If HHS finds the plan to be non-compliant, the plan will be obligated to specify the actions it will take to come into compliance and provide a new comparative analysis demonstrating compliance within 45 days of HHS's initial determination of non-compliance. HHS will produce a publicly available report one year after enactment and every Oct. 1 thereafter.

What are ASO groups required to do?

Group health plans are required to prepare and make NQTLs available. Blue Cross performs this function on your behalf as the administrator of your employee group health plan. If you would like a copy of your NQTL analyses, please contact your account manager.

How does this affect your employees?

The NQTL analysis will be made available to employees upon request.

What is Blue Cross required to do?

Blue Cross takes seriously the importance of meeting or exceeding parity standards between mental health and physical health. As the administrator of your employee group health plan, Blue Cross has taken the necessary steps to ensure you remain compliant with federal mental health parity requirements.

Machine Readable Files, effective for plans issuing on or after July 1, 2022

Although not part of the CAA, the Transparency in Coverage Rule (TCR) requires that insurers and group health plans share negotiated prices for services in publicly available "machine-readable files."

Please note no new charges will apply at this time. Cost to administer are still under review and charges for delivering and hosting MRFs will be evaluated at a later date.

What are ASO groups required to do?

You do not need to take any additional action to be compliant with this aspect of the TCR.

How does this affect your employees?

This will not affect your employees.

What is Blue Cross required to do?

We can produce this information and we are prepared to publish these prices on behalf of groups for benefits we administered. A link will be provided to groups before July 1st.

Advanced Explanation of Benefits, effective pending formal rulemaking

The Advanced Explanation of Benefits will provide greater price transparency and allow for greater financial planning for health care consumers.

What are ASO groups required to do?

At this time, it does not appear you need to take any action to be compliant with this aspect of the CAA. If you have any questions, please reach out to your account managers.

How does this affect your employees?

Once this process is put in place, your employees will see greater transparency about how much medical services cost and who pays what over the course of time for care. It will help people estimate the cost of care and provide insight into the way the health care system works.

What are network providers required to do?

The CAA requires providers and facilities to estimate the charge for a scheduled service when an appointment is made or shortly thereafter. Once a provider has produced a cost estimate for a scheduled service, providers must communicate the estimate to Blue Cross.

What is Blue Cross required to do?

Once Blue Cross receives an estimate from a provider or request from a member, we must deliver information to the member including:

- Our cost estimate (both how much the provider will receive and the member's cost share)
- Where the member is in their deducible and out-of-pocket maximum
- Whether the provider is in network
- Whether the service is subject to prior approval

Since the rule clarification is still in progress, support and the cost to administer these enhancements are still under review.

Prescription Drug Benefit Reporting

By June 1st of each year, plans and issuers must report certain prescription drug data from the prior calendar year. Data will include information on coverage, number of participants, the 50 most frequently dispensed brand drugs, total paid claims for these drugs, and the impact of rebates on premiums and fees. The first round of reporting for the calendar years of 2020 and 2021 is delayed until December 27, 2022.

What are ASO groups required to do?

If your organization uses a pharmacy benefit manager other than Vermont Blue Rx, you need to work directly with that pharmacy benefit manager to produce the required reports.

How does this affect your employees?

This will not affect your employees.

What is Blue Cross required to do?

We will be providing the reporting to employers & groups that use Vermont Blue Rx as their pharmacy benefit manager.

Stop Loss Coverage Reporting

Each year, groups and insurers are required to report certain information concerning stop loss coverage. The first round of reporting for the calendar years of 2020 and 2021 is delayed until December 2022.

What are ASO groups required to do?

If Blue Cross does not manage your stop loss coverage or have access to the information, you or your stop-loss insurer are required to report this information to CMS. For more information about what to report and by when, view the CAA document, Section 204 of Division BB, Title II which starts on page H.R. 133-1737. For assistance with additional questions, contact your stop-loss carrier.

What is Blue Cross required to do?

We will be providing the reporting to CMS that we manage stop loss coverage for.

Where to go for more information

Please contact your account manager if you have questions on the steps we're taking and the services we can provide as the administrator of your employees' group health plan. We also encourage you to work with counsel to evaluate the impacts and legal obligations of this new law on your employees' group health plan. Notably, under this federal legislation, states are explicitly given enforcement authority over group health plan compliance of some CAA provisions, even though group health plans are typically primarily regulated by the U.S. Department of Labor.