Consolidated Appropriations Act

What you need to know about upcoming changes in the health insurance industry.

In late December 2020, Congress passed the Consolidated Appropriations Act (CAA). This law was designed to help reduce some barriers within the healthcare industry. Providers and health insurance companies are required to put several measures in place including making the cost of care available on Plan and provider websites, eliminate surprise billing, and provide continuity of care when a provider/facility leaves the network. These changes apply to individual and group health plans (grandfathered and non-grandfathered).

Originally, changes were required to be implemented by Jan. 1, 2022. Over the past several months, a number of required changes have been delayed by the federal government while they work out details of the requirements. Blue Cross and Blue Shield of Kansas (BCBSKS) has multiple teams working to finalize implementation of measures required to be in effect by Jan. 1, 2022 and continuing in good faith to move forward on the delayed requirements.

For more detailed information and frequently asked questions, visit bcbsks.com/caa.

Balance Billing: Surprise bills must be covered at in-network rates.

Health plans must negotiate surprise medical bills on behalf of patients who receive emergency services rendered by out-of-network providers/facilities, air ambulance services, and services provided by out-of-network providers at in-network hospitals or facilities. The new law lifts the burden off patients so they are held harmless and not balance billed for provider charges that exceed the in-network rate.

Health plans must keep their provider directories up to date, and verify they are accurate no less than every 90 days.

Additionally, carriers must also establish a “response protocol” system, allowing them to respond to covered individuals, within a newly required one-business-day timeframe, when asked whether a provider or facility is considered “in-network.”

2022
Jan. 1

Changes go into effect Jan. 1, 2022, unless otherwise noted.

Health plans must provide price comparison tools to consumers.

These tools, which must be available by phone and internet, allow covered individuals and in-network providers to compare expected cost-sharing amounts for covered services. The new BCBSKS price comparison tool will be rolled out in early 2022.

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Health plans must provide advanced Explanation of Benefits (EOBs) to consumers upon request, and to consumers proactively before scheduled care.

Health plans must provide advanced EOBs explaining benefits and estimates of cost-sharing before scheduled care. They must furnish such good-faith estimates, within three business days, of what the plan will pay and what the patient cost might be for covered services (whether the provider is in-network or out-of-network). For services scheduled within 10 days, the advanced EOB must be distributed within one business day. (Delayed until mid-2022.)

Providers must also furnish good-faith estimates of expected charges for services — including related billing and diagnostic codes in advance of a service.

Providers are also expected to furnish charges for services that are reasonably expected alongside the scheduled services. (Delayed indefinitely.)

Health plans must notify individuals when a provider/facility leaves its network and must provide related transitional continuity of care to patients in some circumstances.

For patients receiving certain types of ongoing care from affected providers or facilities, health plans must provide up to 90-days of transitional coverage (or until treatment ends) by those providers, at in-network rates. Such transitional coverage is generally available for patients being treated for serious/complex health conditions, inpatient care, non-elective surgery, pregnancy and terminal illness. Members impacted by provider network changes will be sent a letter and opt-in form to see if they qualify for continuity of care with their provider.

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Carriers must update and re-release physical and digital ID cards.

For plan years beginning January 2022 or later, these cards must list plan deductibles and out-of-pocket maximum limits. BCBSKS has made the required changes and will begin distributing cards based on enrollment and renewal dates.

Health plans must make available in-network negotiated rates and out-of-pocket (OOP) costs.

The in-network negotiated rates with providers will be available in regularly updated, machine-readable files located on bcbsks.com. Personalized OOP cost information will be made available, upon request. The OOP cost information will be made available in two waves – an initial list of 500 services for plan years that begin on or after Jan. 1, 2022, and the remainder of all items and services for plan years that begin on or after Jan. 1, 2023.

Health plans must update some pharmacy reporting procedures.

Health plans are required to report on pharmacy benefits and drug costs. Plans will be required to annually report a number of plan details to the Departments of Health and Human Services, Labor and the United States Treasury. (Delayed until Dec. 27, 2022.)

Health plans will be required to strengthen parity in mental health and substance use disorder benefits.

Health plans are required to strengthen parity in mental health and substance use disorder benefits. Under the new requirements, individual and group health plans, including self-funded group health plans, must conduct and document a comparative analysis of their non-quantitative treatment limits (processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan) for mental health, substance use disorder and medical surgical benefits. The new mental health parity requirements went into effect on February 10, 2021.

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