Surprise Billing Overview

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Agenda

1. Overview of Surprise Billing
2. The No Surprises Act: January 1, 2022 Key Provisions
3. Top Provider Considerations

Overview of Surprise Billing

Federal Register Definition of Surprise Billing

"A surprise medical bill is an unexpected bill from a health care provider or facility that occurs when a covered person receives medical services from a provider or facility that, **usually unknown to the participant, beneficiary, or enrollee,** is a **nonparticipating provider or facility** with respect to the individual's coverage."

– Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36874 (July 13, 2021)

Department of Health & Human Services (DHHS) Announcement

"No patient should forgo care for fear of surprise billing," said DHHS Secretary Becerra.

"Health insurance should offer patients peace of mind that they won't be saddled with unexpected costs. The Biden-Harris Administration remains committed to ensuring transparency and affordable care, and with this rule, Americans will get the assurance of no surprises."

Where We Encounter Surprise Billing

Emergency or non-emergency care setting

Patient requires emergency medical transport (road or air) from a nonparticipating provider to a participating facility

Patient receives emergency care at a nonparticipating provider

Patient receives ancillary services at a participating facility from a nonparticipating provider:

Radiology

Laboratory

Anesthesia

Surprise Billing – Real World Surprise

Summary of Coverage and Employee Contribution

Plan Features	Anthem Silver Blue Choice PPO 4000 with HSA	
	IN-NETWORK	OUT-OF-NETWORK
Deductible (Ind/Family)	$4,000 / $8,000	$12,000 / $24,000
Out-of-Pocket Maximum (Ind/Family)	$7,050 / $14,100	$21,150 / $42,300
Coinsurance Percentage	30%	50%
PCP Office Visits	$30 Copay After Deductible	50% After Deductible
Preventive Care	$0 Copay	50% After Deductible
Specialist Office Visits	$60 Copay After Deductible	50% After Deductible
Lab - Office	$25 Copay After Deductible	50% After Deductible
Lab, Diagnostic & Imaging Services	30% After Deductible	50% After Deductible
Emergency Room Care	$350 Copay After Deductible	
Urgent Care	$30 Copay After Deductible	50% After Deductible
Inpatient Hospital Care	30% After Deductible	50% After Deductible
Hospital Outpatient Surgery Facility Fee	30% After Deductible	50% After Deductible
Chiropractic Care	$30 Copay After Deductible	50% After Deductible
Physical, Speech and Occupational Therapy	$30 Copay After Deductible	50% After Deductible
Prescription Drugs (Rx) Tier 1 Pharmacy Tier 1a-1b: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty Tier 2 Pharmacy Tier 1a-1b: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty	After Deductible, $5 Copay / $25 Copay $70 Copay $350 Copay $600 Copay After Deductible, $15 Copay / $35 Copay $80 Copay $400 Copay $700 Copay	50% After Deductible 50% After Deductible 50% After Deductible 50% After Deductible

Shifting the Payment Responsibility

THIS IS NOT A BILL

Your Family's Medical Claims

You can see further details about your claims listed below by going to bcbst.com

Member Name Date of Service Claim Number Provider Name	Total Charge	Network Savings	Paid Provider Processed Date	HRA Paid (If Applicable)		Amount You Owed Provider
	$893.76	$0.00	$0.00 06/23/2021	$0.00	COPAY	$0.00
					DEDUCTIBLE	$97.16
					COINSURANCE	$0.00
					NON-COVERED	$796.60
					OTHER INSURANCE	$0.00
					YOU OWED PROVIDER	$893.76
	$336.75	$0.00	$0.00 06/23/2021	$0.00	COPAY	$0.00
					DEDUCTIBLE	$19.54
					COINSURANCE	$0.00
					NON-COVERED	$317.21
					OTHER INSURANCE	$0.00
					YOU OWED PROVIDER	$336.75
	$93.00	$62.27	$0.00 06/24/2021	$0.00	COPAY	$0.00
					DEDUCTIBLE	$30.73
					COINSURANCE	$0.00
					NON-COVERED	$0.00
					OTHER INSURANCE	$0.00
					YOU OWED PROVIDER	$30.73
	$94.50	$63.46	$0.00 06/24/2021	$0.00	COPAY	$0.00
					DEDUCTIBLE	$31.04
					COINSURANCE	$0.00
					NON-COVERED	$0.00
					OTHER INSURANCE	$0.00
					YOU OWED PROVIDER	$31.04

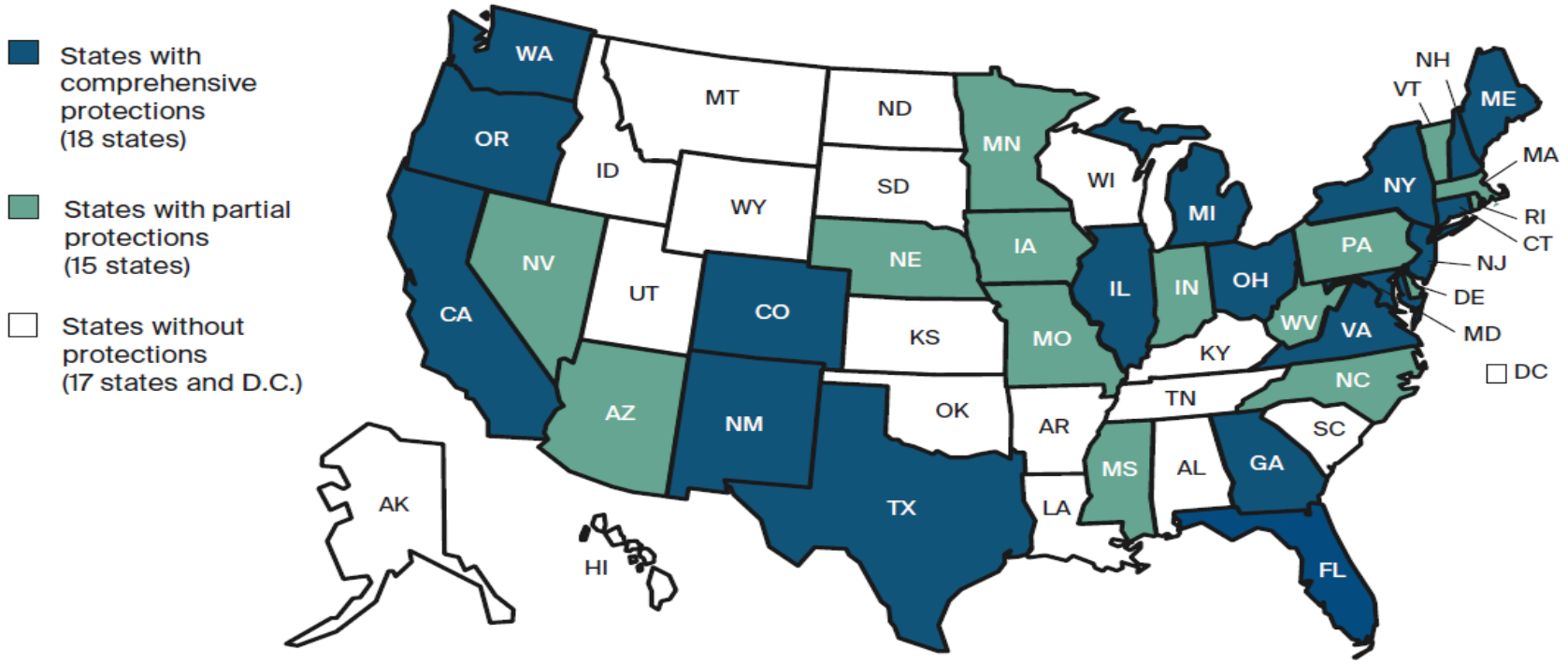
OUT-OF-NETWORK SERVICES
Patient responsible for non-covered and deductible amounts

IN-NETWORK SERVICES
Patient responsible for deductible amounts

The No Surprises Act
January 1, 2022 Key Provisions

Current State Balance Billing Protections

State Laws Protecting Consumers Against Balance Billing, as of February 5, 2021



Data collection and analysis as of February 5, 2021, by researchers at the Center on Health Insurance Reforms, Georgetown University Health Policy Institute.

The Commonwealth Fund

Source: Jack Hoadley, Maanasa Kona, and Kevin Lucia, "States Can Prevent Surprise Bills for Patients Seeking Coronavirus Care," *To the Point* (blog), Commonwealth Fund, Apr. 29, 2020.

No Surprises Act (NSA)

- Addressed surprise medical billing by:
  - Bolstering patient protections against high cost-sharing for out-of-network (both emergency and non-emergency)
  - Outlining a process by which providers receive payment for treatment in situations protected under surprise billing
  - Ensuring patients receive enhanced communications from providers and insurers regarding cost estimates and status of treating providers
  - Requiring enhanced communication between providers and insurers related to situations involving out-of-network care
  - Providing dispute resolution processes for patients, providers and insurers

January 1, 2022 – Key Provisions

- The following provisions went into effect:
  - Balance billing prohibited for services identified under the NSA, including
    - Out-of-network emergency services
    - Non-emergency services rendered by nonparticipating providers in participating healthcare facilities
    - Air ambulance services rendered by nonparticipating air ambulance providers
  - Public disclosure of patient protections against balance billing
  - Provision of good faith estimate for **scheduled** services (uninsured or self-pay)
  - Reporting on provider directories to health plans
  - Refunds to enrollees if billed greater than in-network cost sharing amount
  - Ensuring continuity of care for applicable patients

NSA Key Definitions: 45 CFR 149.30 – GENERAL

Healthcare facility	Provider of air ambulance services	Physician or healthcare provider
• Hospital (as defined in section 1861(e) of the Social Security Act); • Hospital Outpatient Department; • Critical Access Hospital (as defined in section 1861(mm)(1) of the Social Security Act); • Ambulatory Surgical Center described in section 1833(i)(1)(A) of the Social Security Act.	• Entity that is licensed under applicable State and Federal law to provide air ambulance services	• Physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, but *does not include a provider of air ambulance services*

NSA Key Definitions: 45 CFR 149.610 – GOOD FAITH ESTIMATES

Healthcare Facility

- Institution *(such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center)* in any State in which State or applicable local law provides for the licensing of such an institution, that is licensed as such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing.

Healthcare Provider (provider)

- Physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, *including a provider of air ambulance services*.

Notice & Consent

- Notice & Consent only applicable for:
  - Certain post-stabilization services if all the following criteria are met
    - Patient is able to travel (determined by treating physician or provider) using nonmedical or nonemergency medical transportation
    - A participating provider is within "reasonable travel distance"
    - Patient, or authorized representative, is in a condition to receive relevant information and provide "informed consent" (determined by treating physician or provider)
    - Treating provider or facility meets any additional requirements based on applicable state law
  - Non-emergency, non-ancillary (defined in NSA) services at a facility if an in-network provider is available
- Under these circumstances, a patient has the option to provide consent to waive the balance billing restrictions

Notice & Consent

- Notice & Consent not applicable for:
  - Emergency services
  - Non-emergency ancillary services (e.g., anesthesiology, radiology, laboratory, hospitalist services, etc.)
  - Items or services provided due to unforeseen urgent medical needs that arise during care
  - Post-stabilization services that do not meet all criteria outlined previously
  - OON services in facility if there is no participating provider who can provide these services at the facility
- All providers must review applicable state law for additional requirements around notice & consent applicability

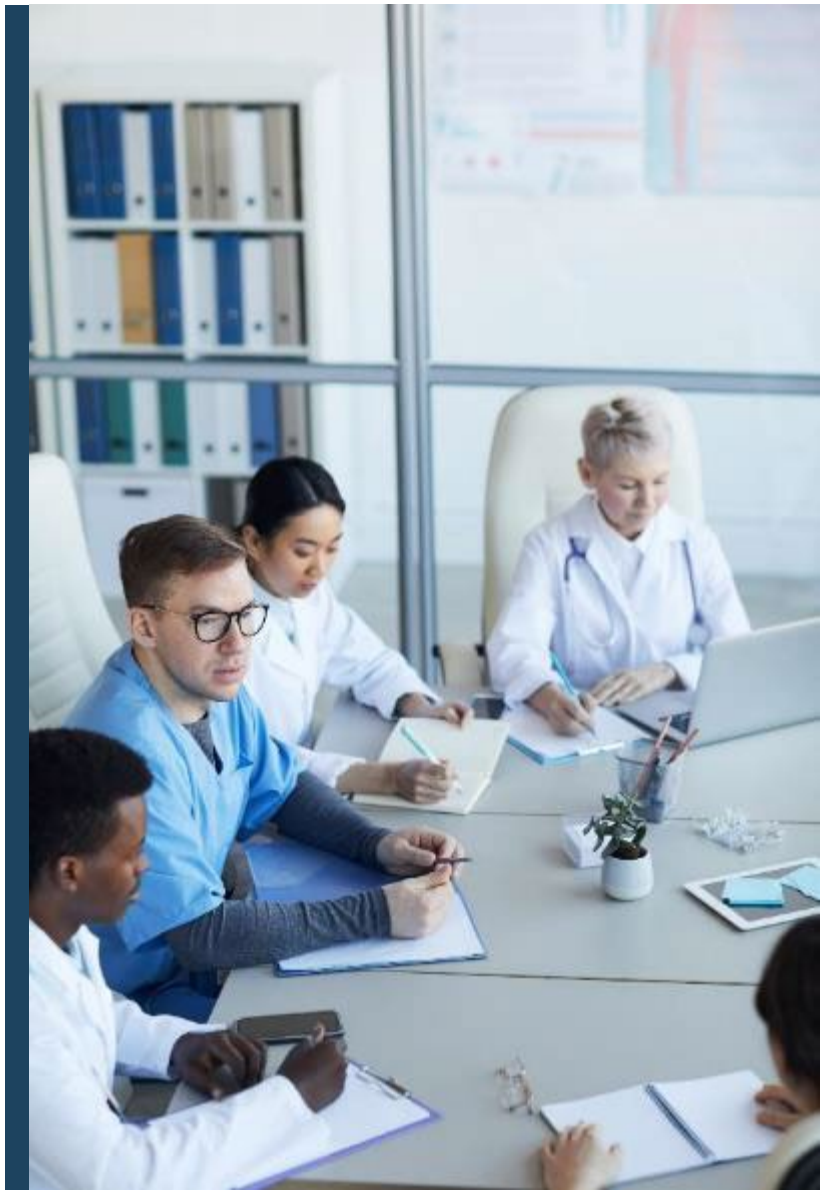
Upcoming Items

- Good faith estimates & Advanced EOBs for insured patients
- Enforcement of provisions of the NSA and applicable regulations (state and federal)
  - States are primarily responsible for enforcement; however, feds can step in for any provisions the state "fails to substantially enforce"
  - CMS is in the process of issuing state-specific letters clarifying state/federal enforcement relationship
- Implementation of dispute resolution processes
  - Patient-Provider
  - Provider-Insurer
- Additional clarification – regulations and guidance

Top Provider Considerations

Top Provider Considerations

1. Balance billing restrictions in certain situations in which surprise billing is likely to occur
2. Dispute resolution process
   a) Provider/Insurer (IDR)
   b) Provider/Patient (PPDR)
3. Facility/provider collaboration strategy
4. Hospital/facility communication to patients and insurers



1. Balance Billing Restrictions

- Cannot balance bill for:
  - Out-of-network emergency services (definition expanded to include certain post-stabilization services related to an emergency visit)
  - Ancillary services provided by an out-of-network provider within an in-network facility
  - Out-of-network air ambulance services

Exception: Balance billing restrictions not applicable for certain non-emergency services if patient is notified of out-of-network status and provider receives patient consent to waive balance billing protections.

2a. Independent Dispute Resolution – Provider/Insurer

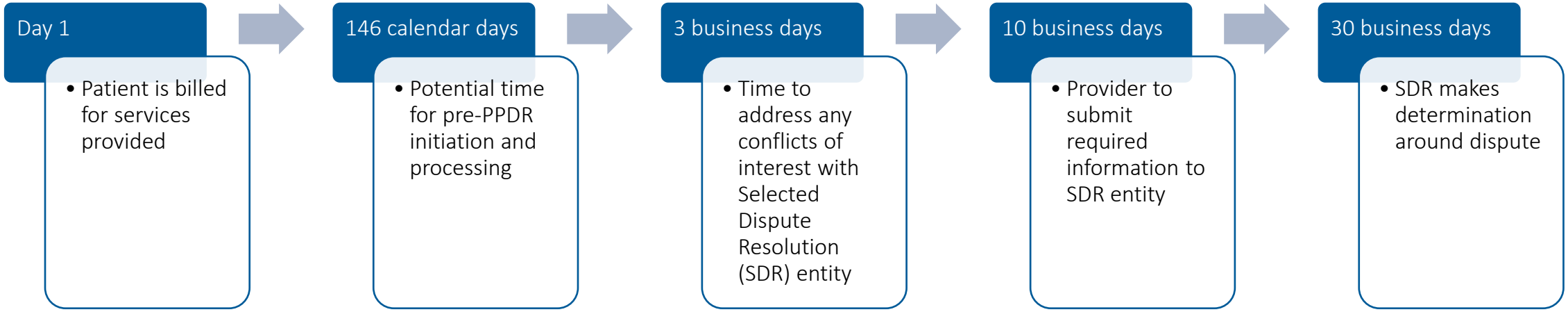
Impact

- ✔ Increased collection time
- ✔ Enhanced data analysis
- ✔ Additional administrative time

Source: https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate independent dispute resolution process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified independent dispute resolution entity selection	3 business days after the independent dispute resolution initiation date
Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	6 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

2b. Patient-Provider Dispute Resolution – Provider/Patient



Note: Provider and patient may negotiate separately during PPDR process but must inform SDR should settlement be reached *prior to* SDR determination

3. Hospital/Provider Collaboration Strategy

- Leveraging revenue cycle and negotiating capabilities within the hospital setting
- Evaluating hospital-provider agreements
- Payer contract reviews and potential impacts
- Staff and provider education
- Communication technology and systems

4. Hospital/Facility Communication to Patients and Insurers

- Hospital/Facilities must be able to:
  - Communicate expected costs to patients/insurers in a timely manner
  - Coordinate with co-providers and co-facilities to develop cost estimates
  - Publicly disclose patient's rights under federal and state law regarding balance billing
  - Notify insurers of changes in provider directory information

Q&A

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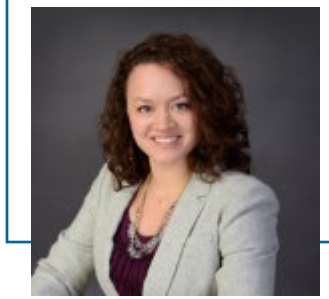

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