SPECIAL eBULLETIN

FOR PROFESSIONAL AND FACILITY PROVIDERS **October 20, 2021**

NO SURPRISES ACT – UPCOMING CHANGES

In December 2020, Congress passed the No Surprises Act as part of the Consolidated Appropriations Act (CAA) which will take effect on **January 1, 2022**. The No Surprises Act is intended to provide greater consumer protections to patients by addressing surprise medical bills at the federal level.

The No Surprises Act requires health plans to implement changes that will impact both members and providers. The following changes will affect what is required of providers in Highmark's network. This includes:

- Eliminating surprise medical bills
- Expanding continuity of care protections
- Adding provider directory requirements
- Providing members with "advanced" explanation of benefits (AEOB)

The following changes will take effect on January 1, 2022. They apply to members in Highmark's commercial fully insured, self-funded (ASO) and Affordable Care Act (ACA) plans. They do not apply to the Children's Health Insurance Plan (CHIP), Medicare Advantage, or Medigap plans.

BALANCE BILLING

Highmark will pay out-of-network providers directly when they render the following services to our members:

- Emergency services provided by out-of-network providers to members who are receiving care in a hospital or freestanding emergency department
- Non-emergency services performed by an out-of-network provider at an in-network facility (with certain exceptions, as noted below)[1]
- Out-of-network air ambulance services[2]

With regards to the above, out-of-network providers may bill patients for network cost sharing (deductible, copayment, coinsurance), but may not balance bill patients for amounts exceeding Highmark's out-of-network allowance for these services.[3]

Section continued on next page.

This information is issued on behalf of Highmark Blue Shield and its affiliated Blue companies, which are independent licensees of the Blue Cross Blue Shield Association. Highmark Inc. d/b/a Highmark Blue Shield and certain of its affiliated Blue companies serve Blue Shield members in 21 counties in central Pennsylvania and 13 counties in northeastern New York. As a partner in joint operating agreements, Highmark Blue Shield also provides services in conjunction with a separate health plan in southeastern Pennsylvania. Highmark Inc. or certain of its affiliated Blue companies also serve Blue Cross Blue Shield members in 29 counties in western Pennsylvania, 13 counties in northeastern Pennsylvania, the state of West Virginia plus Washington County, Ohio, the state of Delaware and 8 counties in western New York. All references to Highmark in this document are references to Highmark Inc. d/b/a Highmark Blue Shield and/or to one or more of its affiliated Blue companies.

Out-of-network providers who are not satisfied with Highmark's payment may attempt to negotiate a higher reimbursement from Highmark.[4] Members may file a complaint or appeal if they have been balance billed when they should not have been consistent with the No Surprises Act.

Providers who are contracted with Highmark for some products, but not for the product in which the member is enrolled, are considered out-of-network providers for purposes of the No Surprises Act.

CONTINUITY OF CARE

There may be cases where a member is receiving care from a network provider that subsequently becomes an out-of-network provider relative to the member's plan. In those instances, members undergoing continuous care for certain conditions may continue to receive services at the network level of benefits from that now out-of-network provider for a period of up to 90 days or until the treatment is concluded, whichever is sooner.[5]

If the patient chooses to continue with their current provider during the continuity of care period, the provider is required to accept the previous in-network payment and cost-sharing amounts and continue to meet all previously applicable terms and conditions.

The No Surprises Act defines continuing care patients as those who, with respect to the provider:

- Have an acute illness serious enough to require specialized medical treatment to avoid death or permanent harm
- Have a chronic illness that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized care
- Are receiving institutional or inpatient care
- Are scheduled to undergo nonelective surgery, including postoperative care
- Are pregnant and undergoing treatment for pregnancy
- Are/were determined to be terminally ill and are receiving treatment for such illness

PROVIDER DIRECTORY

To accurately inform our members of the "in-network" status of a provider or facility, Highmark must update its provider directory within 48 hours of receiving provider information changes.

Providers must verify certain provider data every 90 days including:

- Practitioner name
- Specialty
- Address
- Phone number
- Digital contact information

Providers who do not respond to Highmark's outreach every 90 days for this information **will be removed from Highmark's provider directory** until we are able to verify their provider information.

ADVANCED EOBS

As part of the No Surprises Act, plans and insurers that are notified of a scheduled service will be required to provide members with an advanced EOB. An advanced EOB is a good faith estimate of the cost, cost sharing, and the member's current unsatisfied deductible and out-of-pocket maximums for a proposed covered service from a provider before the service is rendered. When additional direction is provided by federal regulatory agencies, Highmark will update providers with information regarding how members may request an advanced EOB.

ADDITIONAL INFORMATION

As regulators continue to work out final details, Highmark will update our providers as to how these changes will be implemented. Continue to check **Highmark's Provider Resource Center** for updates.

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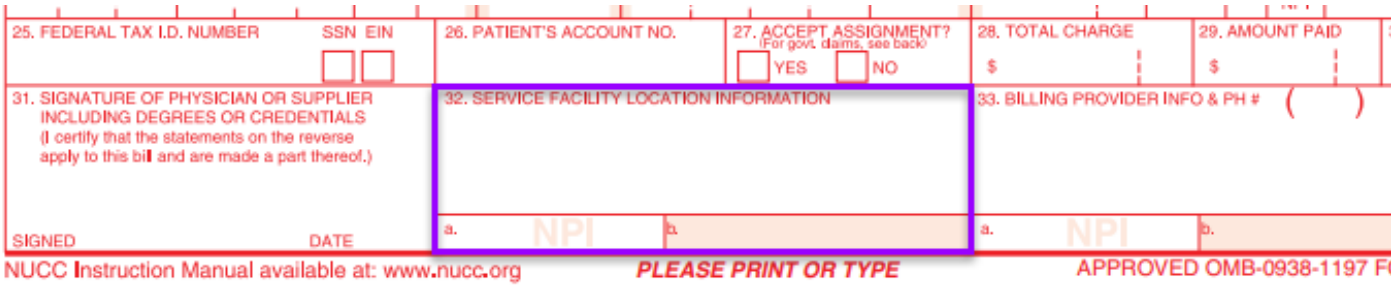
[1]To ensure that Highmark can properly identify claims involving members who receive non-emergency out-of-network services in connection with an in-network facility visit, professional providers must include the facility NPI and Service Facility Name in the Service Facility Loop (Box 32) on all submitted claims. See image below:



- To locate the facility NPI, click here.
- **IMPORTANT:** To fill in the service facility location, you must include the full street address without abbreviating North, South, East, or West.
    - Example: 123 S 42nd Street must be spelled out as 123 South 42nd Street.

[2]Highmark will continue to pay members directly for services received from out-of-network ground and water ambulance service providers.

[3]Certain narrow exceptions to the prohibition on balance billing have been established, as follows:

- Out-of-network providers in non-emergency care situations may balance bill the member **if they present written notice to and the patient agrees to be balanced billed.** The notice must include disclosure of their network status, a list of in-network providers at the facility, information about prior authorization or care management limitations, and an estimate of charges 72 hours prior to receiving the out-of-network services. The patient must provide consent to receive the out-of-network care **after they receive the notice and disclosure**.
    - This exception does not apply in the case of providers who furnish ancillary services (emergency medicine, anesthesiology, pathology, radiology, neonatology, and other services defined by the Department of Health and Human Services (HHS) as well as diagnostic services not included in a list to be defined and maintained by HHS) at the in-network facility.
    - The notice and consent option cannot be used in instances where the out-of-network provider is the only provider at the in-network facility who can perform the service (i.e., the patient cannot choose someone in-network).

[4]If the out-of-network provider is not satisfied with the payment Highmark authorizes, they may attempt to negotiate a higher reimbursement with us. If Highmark and the out-of-network provider are not able to negotiate and agree on the final payment, either party may access a new Independent Dispute Resolution (IDR) process created by the No Surprises Act to resolve the dispute. The details of the IDR process are still being developed by the regulatory agencies.

[5]Continuity of care does not include contract terminations based upon failure of the provider to meet applicable quality standards or fraud.