BlueCross BlueShield Arizona

Consolidated Appropriations Act and Transparency Frequently Asked Questions

General

1. Describe how your company will assure that the Plan will be in compliance with federal law and regulations concerning surprise billing and transparency with respect to the services provided by your company.

   Blue Cross® Blue Shield® of Arizona (BCBSAZ) has a cross functional team that is addressing all the components of the Federal No Surprises Act (NSA) and Final Transparency Rules to ensure it complies and can assist its self-insured customers in meeting their obligations.

2. List any subcontractors or third parties who are providing assistance to you in complying with the law and regulations, or who will be involved in work you may perform on behalf of the Plan.

   BCBSAZ is subcontracting with HealthSparq for assistance with machine readable files (MRF) for compliance with the Final Transparency Rule and the advanced explanation of benefits (EOBs). BCBSAZ also will be working the Blue Cross Blue Shield Association (BCBSA) and other Blue plans in connection with these requirements.

3. List any technical specifications that the Plan will need to meet in order to use any solution you intend to offer to comply with the law and regulations, including software, hardware, or other information technology.

   Technical specifications required are still under development. We will communicate any technical specifications later in 2021, as our MRFs are available.

4. Do you expect to be fully compliant with the law and regulations by the statutory and regulatory due dates? If not please explain.

   Yes. BCBSAZ would like to note that federal regulators have deferred enforcement dates due to regulators' inability to issue guidance and standards.

5. Are the fees you propose inclusive of all services related to the law and regulations? If not, please explain what additional costs the Plan may incur.

   Yes.

Transparency Rules

1. Describe your general process for complying with the Transparency in Coverage Final Rule.

   BCBSAZ has a cross-functional team that is addressing all the components of the Transparency in Coverage Final Rule to ensure it complies and can assist its self-insured customers in meeting their obligations.

2. Will you prepare an internet-based self-service tool that makes available to plan participants real time cost-sharing information in accordance with the rule?

   Yes.

a. Do you currently offer an internet-based self-service tool? If so, please describe how it differs from the regulations and how you will revise it.

   Yes, BCBSAZ is still evaluating this requirement.

b. How will you make the tool available to plan participants, through your website, by providing information to plans, or through another option?

   BCBSAZ is still evaluating this requirement.

c. Please provide screenshots of the web portal to be used for the participant cost-sharing disclosures.

   This feature is still in development.

d. How will the required participant notice of disclosure be provided?

   This capability is still in development.

e. How will you respond to individuals who request the information on paper instead of through the website?

   This capability is still in development.

3. Will you provide the Plan with any of the three machine readable files on a monthly basis including in-network rates, out-of-network allowed amounts, and prescription drug negotiated rates? If so, describe which files will be provided.

   MRFs will be available on a website which will be updated monthly and accessible to self-insured plans. The website includes search criteria that will enable a participant to access information for a specific employer and plan. BCBSAZ also intends to enable employers to post a link directly on the employer's site. BCBSAZ will provide in-network (INN) rates and out-of-network (OON) allowed amounts. Once further rules are finalized for the prescription MRF, BCBSAZ intends to make that available when it provides prescription coverage or administration for a group. BCBSAZ will not provide prescription MRFs when a plan utilizes a different pharmacy benefit management (PBM).

   a. Describe the information technology requirements necessary for transmitting files and/or posting them.

      This capability is still being finalized.

   b. If the Plan uses multiple service providers for in-network or out-of-network pricing, will you provide assistance in consolidating the information into one file?

      This is not applicable with our scope of services. BCBSAZ will provide MRFs for those providers that are under claims administered by BCBSAZ.

   c. Will you send information to the Plan or provide another service to the Plan that allows the Plan to link you another website

      Details are still being finalized, but BCBSAZ anticipates directing plans to a website for obtaining the MRFs.

BlueCross BlueShield Arizona

Gag Clause

1. Do any contracts you are a party to contain a claim prohibiting disclosure of pricing terms ("gag clause") which will be prohibited under the No Surprises Act?

   BCBSAZ believes that current contracts do not have any language that would prohibit disclosures protected under federal law. In an abundance of caution, we will amend all provider contracts before year-end to mirror requirements in the federal law.

   a. If yes, please describe and state how you will assure they are removed. Indicate your timeline for removing gag clauses from contracts.

      BCBSAZ anticipates this project will be completed on or before January 1, 2022.

No Surprises Act

1. Describe your process for paying for Emergency Services, Non-Emergency Services provided at an In-Network Facility, and Air Ambulance Services ("Covered Services") under the No Surprises Act (NSA).

   For claims in scope for the NSA, BCBSAZ will send the initial payment to the provider and will include contact information.

   a. Are there any subcontractors used in determining the amount to pay for Covered Services? If so, please name them and describe the services being provided.

      No. BCBSAZ, or the Blue Plan in whose area the service is provided, will determine the recognized amount or qualifying payment amount and BCBSAZ will calculate the participant cost sharing.

   b. Will you establish the Qualifying Payment Amount, Recognized Amount, and Out-of-Network Rates for the Covered Services? Please describe your process for setting these rates and assuring participant cost-sharing is based on them.

      Yes. BCBSAZ, or the Blue Plan in whose area the service is provided, will establish these rates. To the extent that a provider challenges the initial payment amount, BCBSAZ will negotiate that amount with the provider up to and including arbitration, to reach the OON rate. BCBSAZ will calculate participant cost-sharing in accordance with the requirements of the NSA.

2. Have you assured that the Plan will pay for emergency services without prior authorization, without additional administrative requirements for nonparticipating providers and facilities, and without being solely based on diagnostic codes?

   BCBSAZ understands these requirements and has a cross-functional team that is addressing all the components of the No Surprised Act to ensure we comply and can assist our self-insured customers in meeting their obligations.

3. If you are providing any preferred Network providers, describe how PPO contracts will be revised and what communications you will make to those providers concerning the Act.

   BCBSAZ is sending a participation agreement amendment to all its network providers to add the NSA language relating to no gag clauses. In compliance with URAC accreditation standards, we currently have similar language in our provider contracts, but we will be updating it with all the NSA

details. The amendment will be sent to providers in October and the process will be completed by early December. In addition to the contract amendment, we are updating our Provider Operating Guide, an extension of the provider participation agreement, with policies and procedures related to the NSA. These include revised requirements for provider demographic updates and continuity-of-care benefits. We are in the process of updating our ID card templates in compliance with NSA requirements and samples of these will be added to the 2022 Provider Operating Guide. We also are implementing procedures to create online functionality for receipt of provider billing estimates and advance EOBs. We cannot finalize those operational changes until we receive further federal guidance and rules, which federal regulators have indicated will not occur until 2022. We will communicate this to providers in advance of our go-live date.

   a. Describe any provider or facility billing processes and how they will be affected by the No Surprises Act.

      BCBSAZ is updating our Provider Operating Guide, an extension of the provider participation agreement, with information about the NSA and the process for determining and disputing the amount of reimbursement for out-of-network (OON) services that are in-scope for NSA balance billing protections. For plan and policy years starting on and after January 1, 2022 (and on 2022 renewal dates for existing clients), we will follow the requirements of the NSA in reimbursing OON providers for emergency, air ambulance, and other professional services that are in scope for the NSA. In most cases, the initial payment to the provider will also be based on the lesser of billed charges or the qualifying payment amount (QPA), minus the member cost-share amount. Providers have the right to dispute the initial payment amount. If the provider disputes the amount, the parties attempt to negotiate resolution. If the parties can't agree, the dispute is referred to an independent federal arbitrator.

4. Are there any State laws that affect your determination of the Recognized Amount for this Plan? If so please describe.

   The Arizona State law will not affect the determination of the recognized amount or the initial payment to the provider. In Arizona, the recognized amount will be equal to the lesser of billed charges or the qualifying payment amount. The Blue Plans, in whose service area any out of state services are provided, will determine the recognized amount, taking into consideration state laws that apply to their service areas.

   a. If you cover participants in Nevada, New Jersey, Washington State or Virginia, please address whether you recommend the plan opt-in to State laws.

      The Blue Plans, in whose service area any out of state services are provided, will determine the recognized amount, taking into consideration state laws that apply to their service areas.

5. Is there an All-Payer Model Agreement that affects your determination of the Recognized Amount for this plan? If so, please describe.

   Please see previous responses.

6. Are there any areas in which you do not have sufficient information to calculate the contracted rate?

   BCBSAZ is still analyzing the rates for some codes. It will be a very low percentage of codes for which there is insufficient data to calculate the QPA and for those situations, the Rule outlines how to calculate the rates.

7. Plan sponsors may choose whether to use the contracted rate for their plans or all self-insured plans administered by the same entity. Please describe whether there is any financial difference between two choices with respect to your provider contracts, and describer any recommendations with respect to this decision.

   Based on BCBSAZ's provider contracts, there would be an immaterial difference if BCBSAZ were to use the contracted rates for a Plan sponsor's plans versus all self-insured plans that BCBSAZ administers. The administrative complexity and costs would be exponentially higher to administer Plan-specific median contract rates.

8. Providers and facilities are required to provide patients with Notice and Obtain consent under certain circumstances involving:

   - A nonparticipating provider or emergency facility when furnishing certain post-stabilization services, or
   - A nonparticipating provider or facility when furnishing non-emergency services (other than ancillary services) at certain participating health care facilities.

   BCBSAZ acknowledges.

   a. How will you determine whether the patient consented to services from an out-of-network provider at an In-Network facility, and is therefore not reimbursed under the No Surprises Act?

      The provider is required to provide a copy of the signed Notice and Consent to BCBSAZ. In the absence of a signed Notice and Consent form, claims in scope for the NSA will be processed in accordance with the Act.

9. What support will you provide to the Plan if a health care provider or facility elects to negotiate an out-of-network payment amount or elects to conduct Independent Dispute Resolution (IDR)?

   The provider is required to provide a copy of the signed Notice and Consent to BCBSAZ. In the absence of a signed Notice and Consent form, claims in scope for the NSA will be processed in accordance with the Act.

   a. Will you prepare the IDR submission on behalf of the Plan at no additional cost?

      BCBSAZ will support and coordinate negotiations and IDR on behalf of our self-insured plans.

   b. Will you pay IDR fees on behalf of the Plan, including general assessments and fees if the Plan is unsuccessful?

      Yes.

   c. Will the IDR submission be approved by the Plan or will the process be delegated to your company?

      Yes. The self-insured plan will be responsible for the additional payment to the provider if a new reimbursement is determined for the service. Please refer to the answer above.

10. How will you assist the Plan to pay for IDR, including the general assessment and specific charges for individual IDRs?

    It is the expectation that BCBSAZ will handle the payment and charge it back to the group.

11. Will you assist the Plan in providing a compliant process for plan participants who have a complaint about bills under the NSA?

    Yes. There is a federal complaint process and BCBSAZ will assist the member as needed.

12. Describe how the No Surprises Act will affect payment of Air Ambulance services under the Plan, and whether you will propose plan changes to this benefit?

    Under the NSA, BCBSAZ will make payments directly to a non-contracted air ambulance provider, taking into consideration the qualifying payment amount and the participant's cost share. The participant's cost share will be calculated at INN level of benefit utilizing the qualifying payment amount. BCBSAZ does not propose changes to this benefit.

13. The Act requires ID cards to contain information about deductibles and out-of-pocket maximums. Describe what changes are needed to ID cards and how you will provide the new cards.

    BCBSAZ has already developed compliant ID cards. New ID cards, reflecting these changes, will be issued upon renewal starting January 1, 2022.

14. Describe how you will provide plan participants with an Advanced Explanation of Benefits as required under ERISA Section 716(f); PHSA Section 2799A-1(f).

    The details on the advanced EOBs are still being evaluated as final rulemaking is still in development.

    a. What process will be used to accept provider notification of expected charges and services?

       Please refer to our response above.

    b. Describe how you will provide the Advanced EOB to participants, i.e., via electronic means or mail as requested by the participant.

       Please refer to our response above.

    c. Describe how you will provide reports assuring that the Advanced EOB process is performing as required by law.

       Please refer to our response above.

15. If you provide a preferred provider network:

    a. Describe how you will implement the required to allow continuation of care for individuals when their health care provider is terminated from the Network, under ERISA Section 718 and PHSA Section 2799A-3.

       BCBSAZ will notify its members that a provider from whom they have had services is terminated from the network. The notification also will include information that they may have continuing care rights and to contact BCBSAZ. If the individual does have continuing care rights, BCBSAZ will continue to process in-scope claims at INN level of benefits, and the provider will continue to accept the BCBSAZ contracted rate, for up to ninety days.

    b. Describe how patients will be protected from being billed at an out-of-network rate and how the patient will be provided with notice under the law.

       BCBSAZ will provide the required notice of the law's protections on azblue.com and on the member health statements.

c. Describe how you will provide plan participants with a provider directory, and how you will verify its accuracy at least every 90 days.

   BCBSAZ provides plan participants with an online provider directory that is easily accessible through our website at azblue.com/directory. We verify accuracy of the directory information by proactively reaching out to all providers for verification at least every 90 days. If the provider is unresponsive, we will temporarily remove that provider's listing(s) from the directory until the provider completes the verification process. Our customer service team provides provider directory listings to members upon requests either through email or mail.

d. Describe your process to notify participants of a provider's network status upon request within one business day.

   Plan participants may access our online directory at any time to check a provider's network status. If a member calls us to verify a provider's network status, we will respond to the inquiry within one business day. BCBSAZ does not send written confirmation if a member calls in to check providers' network status.

e. What process will be used to accept provider notification of expected changes and services?

   When BCBSAZ receives an in-scope claim, BCBSAZ will process the claims at the INN level of benefits. The provider will continue to accept the BCBSAZ contracted rate, for up to ninety days.

16. Will you provide a price comparison tool via internet websites and via telephone that allow a participant to compare the amount of cost sharing that they will be responsible for by participating provider and geographic region?

    Yes.

    a. Describe the price comparison tool in detail, and whether any subcontractors are used to produce it.

       This capability is still being finalized.

    b. Describe who will provide the telephone tool and at what location?

       This service is still being finalized.

    c. Is there a dedicated team for the Plan's participants to provide the tool and assist with its use?

       This service is still being finalized.

    d. What internet website will be used for the price comparison tool, and will the Plan need to provide its own website to link to the tool or will your company provide that site?

       This capability is still being finalized.

17. Describe your process for addressing participant or provider complaints that may be made against the plan under the Act.

    BCBSAZ anticipates utilizing our standard appeals and grievance policy and procedures.

18. Do you provide the plan's external review services? If so, how will you incorporate emergency services and air ambulance services into the external review process?

BCBSAZ does provide the full appeals process including, the external review level of appeal. BCBSAZ does use four URAC-accredited independent review organizations (IROs) for self-funded external reviews. The services identified will be treated like other services. If BCBSAZ denies the claim within the initial 30-day payment period, the member will have the right to dispute the adverse benefit determination.

19. If the plan is non-grandfathered, describe how you will support the additional External Appeals requirements for Covered Services? Do you provide a contract with an Independent Review Organization for external review?

    BCBSAZ's appeals process complies with state and federal laws and accreditation standards. Members can file appeals, or their treating providers can file appeals on their behalf. The appeals process applies to adverse benefits determinations for services not yet provided and adverse benefit determinations of claims for services already provided. Members have either one or two internal levels of appeal depending on the product, and one external level of appeal. The external level of appeal is performed by an IRO for self-funded clients, or by the Arizona Department of Insurance and Financial Institutions (DIFI) for fully insured clients.

    The time frames and process may vary with pre-service and post-service appeals, depending on the type of plan. Turnaround times may be altered to meet the needs of self-funded groups.

    Enrollees and practitioners are notified of appeal rights and the appeals process in writing through various channels (e.g., benefit booklet, Internet, BCBSAZ's Provider Operations Guide and healthcare appeals packet), and with each claim or prior authorization of an adverse determination.

    BCBSAZ's EOB statement also contains specific information on our appeal process.

    BCBSAZ conducts the first one or two levels of appeals in-house; however, members may request an IRO review for any level. BCBSAZ contracts with four (4) URAC-accredited IROs, and coordination may include level one same specialty peer review. BCBSAZ sends the appeal to an IRO for the external review process, using either the grandfathered or non-grandfathered Affordable Care Act-compliant process or if the case is governed under the Arizona DIFI, the case is sent to the Arizona DIFI for external review.

    NOTE: BCBSAZ includes IRO fees in our administrative fees.

20. Do you provide prescription drug benefits? If so, how will you assist the plan in reporting prescription drug costs and other information to the federal government effective December 27, 2021?

    Yes. Most self-insured plans use the BCBSAZ integrated PBM. We will assist plans in meeting their reporting requirement when tour integrated PBM is used. For self-insured plans that carves-out PBM administration, the group will need to work directly with its PBM on reporting. Final rules on the prescription reporting are still being determined.

    a. Describe your process for reporting prescription drug cost information to the federal government.

       Details are still being finalized pending final rulemaking.

    b. Describe whether you will accept responsibility for fulfilling all cost reporting obligations and if not, which ones you will not fulfill.

Details are still being finalized pending final rulemaking.

c. State any additional costs for this reporting service.

BCBSAZ does not anticipate additional cost for supporting this service for its integrated PBM self-insured plans.