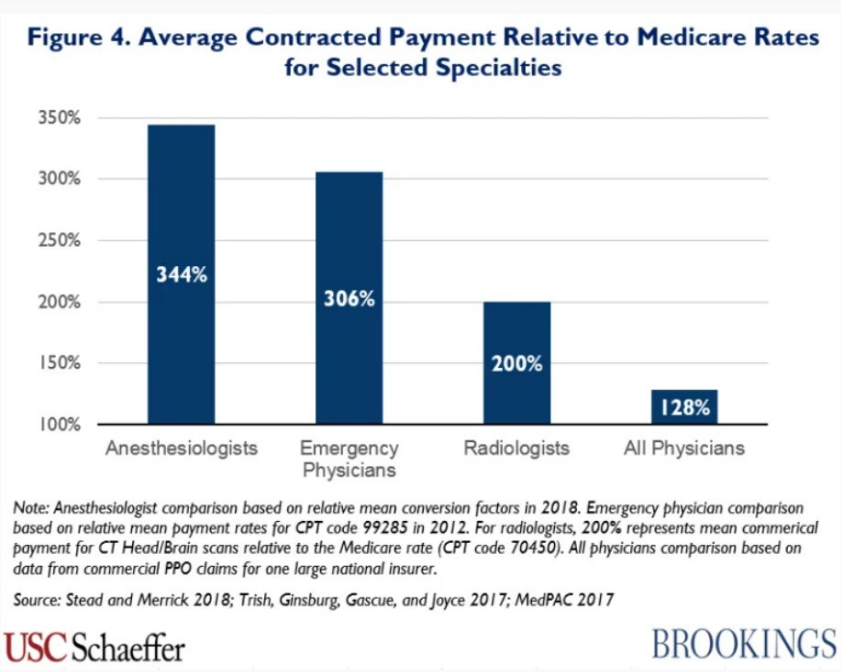
**SURPRISE BILLING**

There is no surprise that both Federal and State Legislative branches will once again this year grapple with the challenges of passing legislation to curb "Surprise Billing."

Surprise billing occurs when medical services are provided "at" an in-network facility, but certain services are performed by "out-of-network" providers. These out-of-network providers typically fall into the following specialties:

- Radiologists
- Anesthesiologists
- Pathologists and
- Emergency Room physicians
- Hospitalists & Cardiologists may also fall into this category

A chart prepared by Brookings addresses this issue. Their chart (below) gives a visual perspective of the charges often involved. https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/



**SURPRISE BILLING EXPLAINED:**

The issue arises when a member presents at an in-network facility but has a procedure where an out-of-network provider is involved. This presents two distinctly different problems for members.

1. Cost-share *(deductibles, coinsurance, etc.)* are different between in-network charges and out-of-network charges.
2. In-network providers are, by contract, not allowed to bill members for amounts over the contracted or negotiated rates.
    a. Out-of-network providers do not have contracts with the insurance company and thus are not prevented from billing the member.

Only PPO and POS plans (like Alliant) have out-of-network benefits. HMO members typically have no coverage for out-of-network providers and charges and therefore **must pay out of their own pocket.** Peterson-Kaiser Family Foundation recently found that 39% of non-elderly adults said they received an unexpected medical bill in the last 12 months. https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/)
One illustration would be a surgery where the surgeon who pre-authorized the procedure (and the facility) are in-network but the anesthesiologist for the procedure is out-of-network. Claims sent to the insurance company then fall into two-categories:

1) those paid according to contracted rates (the in-network side), and
2) those paid according to an issuer-formula (MAC or Maximum Allowed Cost)

Claims paid at the MAC, may or may not (and likely do not) cover the out-of-network provider's full-billed charges and some providers bill members the balance. Surprise!

*Example:*
*Caroline has knee surgery and her surgeon and the hospital where the surgery is performed is in-network. The surgeon performing the surgery is in-network. The anesthesiologist that attends to Caroline is out of network. Upon presenting Caroline's insurance carrier with claims for this procedure, the claims are paid in accordance with whether the provider/facility is in or out of network.*
*The hospital and the surgeon are paid in accordance with their contract. The anesthesiologist is paid as out-of-network, since there is no contractual relationship. Therefore, Caroline is subject to her in-network deductible and in-network co-insurance for the claims related to the hospital and surgeon but is also subject to her out-of-network deductible and co-insurance for the anesthesiologist claims.*

This is the dilemma of surprise billing. It is a national issue and concern and will likely only be solved through legislation.

**ALLIANT HEALTH PLANS**

In years past, the frequency of surprise bills was minimal. Many times, the difference in billed charges and the MAC (allowed amounts) was insignificant. Many health plans, including Alliant, would pay the full billed charge after attempting to negotiate with the out-of-network provider. As hospital/physician consolidation increased so did the issue of surprise billing. Certain groups of physicians banded together (such as Anesthesiologists & Emergency Room physicians) and simply would not contract with managed care companies.

As surprise billing escalated, common-sense and fairness intervened to curb excessive billing. To mitigate excessive charges, virtually every insurance carrier in the United States began protocols that paid out-of-network providers a fair amount (versus a fully billed amount).

**NON-EMERGENT CLAIMS AND SURPRISE BILLS**

For several years, the method used by Alliant to pay these bills has been in place. The process is explained in the Certificate of Coverage.

*For Covered Services you receive from Out-of-Network Providers (other than emergency services), the MAC for this plan will be one of the following as determined by Alliant:*

- *An amount based on our out-of-network fee schedule/rate, which we have established at our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Alliant, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or*

- *An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors:*
  *(1) the complexity or severity of treatment;*
  *(2) level of skill and experience required for the treatment; or*
  *(3) comparable providers' fees and costs to deliver care; or*

- *An amount negotiated by us or a third- party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or*

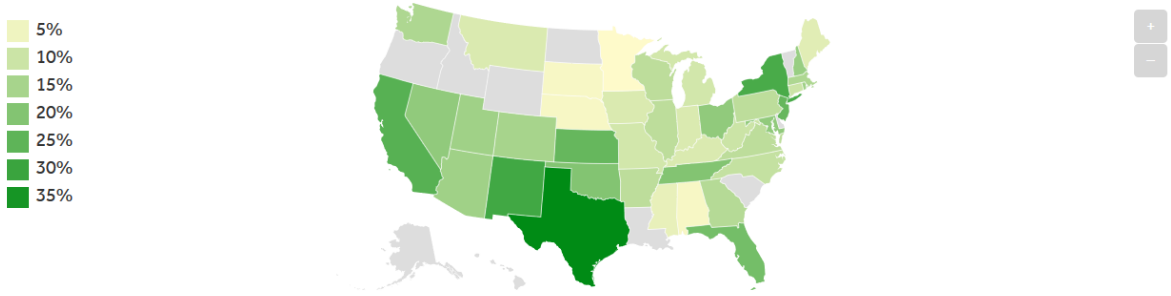
- *An amount equal to the total charges billed by the Provider, but only if such charges are less than the MAC calculated by using one of the methods described above.*

**EMERGENCY CLAIMS AND SURPRISE BILLS**

Surprise billing may also occur in emergency situations. Typically, it is the same scenario as above, except a member may be transported to an out-of-network facility and seen by out-of-network providers. The same Peterson-Kaiser Foundation articles referenced above also shows data regarding emergency claims that result in surprise billing.

## On average, 18% of emergency visits result in at least one out-of-network charge, but the rate varies by state

Among people with large employer coverage, the share of emergency visits with at least one out-of-network charge, 2017




States shaded gray have insufficient data

This specific situation is also defined in Alliant's Certificate of Coverage:

*The MAC for out-of-network Emergency Medical Services are calculated as described in the Department of Labor Regulation 29 CFR 2590.715-2719A(b)(3)(i)(A), (B) & (C); with respect to emergency services will calculate cost sharing as:*

- *The amount negotiated with In-Network Providers for the emergency service furnished, excluding any in-network Copayment or Coinsurance imposed;*
- *The amount for the emergency services calculated using the same method as described above for Out-Of-Network services, excluding any in-network Copayment or Coinsurance imposed; or*
- *The amount that would be paid under Medicare for the emergency service, excluding any In-Network Copayment or Coinsurance imposed.*

**CURRENT STATUS:**

Alliant's Certificate of Coverage provides this language to members:

*Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our MAC. You are responsible for paying the difference between the MAC and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call customer service at (866) 403-2785 for help in finding an In-Network Provider or visit our website at AlliantPlans.com.*

**Although not required, Alliant processes these claims as though they were in-network, which is a significant benefit to members.**

*Example:*
*Caroline has knee surgery at an in-network facility and the surgeon is an in-network provider; but the anesthesiologist is an out-of-network provider.*
*The bill comes to Alliant (in summary for this illustration):*

| | **Billed Amount** | **Contract Amount** |
|---|---|---|
| **Facility** (In-network) | $7,000 | $3,000 |
| **Surgeon** (In-network) | $5,000 | $2,000 |
| **Anesthesiologist** (out-of-network) | $4,000 | N/A |

*Caroline is insured under a $3,000 HDHP 100% coinsurance plan (for ease of illustration) and this is the only claim thus far on her coverage.*

- *Caroline's in-network deductible is $3,000 and 100% coinsurance.*
- *Caroline's out-of-network deductible is $20,000 and 60% co-insurance.*

| | **Charges** (Contract Amount where applicable) | **Deductible/Co-insurance Amount Paid** |
|---|---|---|
| **In-network charges** | $5,000 (see total of contract amount above) | $3,000 Caroline pays deductible<br><br>$2,000 is paid by Alliant |
| **Out-of-network charges** | $4,000 | $4,000 Caroline pays her deductible<br><br>$0 is paid by Alliant |

*Caroline's knee surgery bill is a total of $9,000. Based on the method above, this results in Caroline paying a total of $7,000 for her knee surgery with Alliant paying $2,000.*

**ALLIANT HEALTH PLANS INTERVENES:**

**Although not obligated by regulation, Alliant processes these out-of-network claims and applies them to the in-network benefit level:**

| | **Deductible/ Co-insurance** | **Amount Paid** |
|---|---|---|
| **In-network charges** | $5,000 (see total of contract amount above) | $3,000 Caroline pays her deductible<br><br>$2,000 is paid by Alliant |
| **Out-of-network charges treated as in-network** | $0 | Since claim is paid under in-network status, no out-of-network deductible or coinsurance is applied.<br><br>Alliant pays $2,000 (MAC) and Caroline *may be* billed the surprise billing difference of $2,000. |

*Under this method, Caroline's surgery remains $9,000; but since AHP treats the out-of-network claim as in-network, Caroline now pays $5,000 and Alliant pays $4,000. <u>This saves Caroline significantly, even though it doesn't eliminate the surprise billing dilemma.</u>*

**DAYS OF OLD**

In past years, a member may have appealed a claim where a surprise bill was involved. On occasion, the amount paid or billed may have changed. There were a variety of reasons for this, but the frequency and increased charge amounts of surprise billing prevents that outcome from becoming assumed or status-quo.
Appealing a claim payment when surprise billing is involved usually results in the appeal being denied, since amounts paid are legitimate and proper. Members certainly should appeal if they feel an improper process or amount has been used in determining the payment. But be aware that if the claim was properly paid, appealing the outcome without providing new information, will only result in a denial of the appeal and serve as a point of frustration.

**AHP MEMBER ADVOCATE**

To assist members that experience a surprise bill, Alliant has added a staff position known as a Member Advocate. Where possible the Member Advocate can help (not eliminate) the surprise billing burden placed on a member.

Surprise billing situations typically fall into three categories:

1. Where Alliant is aware of out-of-network facilities/providers that are open to negotiation, the Member Advocate may intervene and negotiate the surprise bill on behalf of the member, who will benefit from any successful negotiation.
2. Where Alliant the provider/facility is unknown, the Member Advocate may enlist the member's help in negotiating a reduction in the surprise billing amount.
3. Where Alliant has knowledge that the provider/facility will not negotiate, members will be provided with educational tips and suggestions on how to handle the surprise billing dilemma.

**SUMMARY:**

Currently, there is no federal law that protects consumers from surprise billing; although there are presently numerous pieces of legislation at both the federal and state level that could positively impact the surprise billing dilemma. In the meantime, Alliant's Member Advocate is ready to assist where possible. This is a frustrating reality for all that have health insurance. Members should attempt to remain informed of in-network providers and, when possible, avoid utilizing providers that require payment of the difference between a reasonable amount allowed (MAC) and their billed charge. AHIP has a great article providing sound advice and insight into this issue facing us all. https://www.ahip.org/wp-content/uploads/surprise_billing_issue_brief_2019.pdf

Alliant understands that many emergency situations do not allow for consideration of which facility/provider is providing care. Elective care is a different scenario and members should take care to ask questions about all providers involved in their procedure as to their network status.

Alliant continues to diligently approach providers that are out-of-network in order to eliminate surprise billing. Our network continues to grow and provide protection from surprise billing. A contract was recently executed with Apollo for their anesthesia, emergency room and hospitalist providers in many areas of Georgia and Tennessee. This contract took over 2-years to negotiate and complete but will go a long way in helping solve some of these surprise billing situations.

Understanding the surprise billing challenge will not eliminate it; but a more thorough understanding may help avoid the pitfalls of this present-day, health care challenge.