HealthFlex Summit – October 2021

Wespath
BENEFITS | INVESTMENTS

Legal Update

Agenda

- Blue Cross Blue Shield Antitrust Litigation
- No Surprises Act Changes Effective Jan. 1, 2022
- Other Legislative and Regulatory Developments

BCBSA Antitrust Litigation Background

- Blue Cross Blue Shield Association (BCBSA)
  - 35 independent Blue Cross Blue Shield companies, including BCBSIL, one of HealthFlex's third-party administrators
- A class action lawsuit alleging BCBSA and its members violated antitrust law has been pending since 2013
  - Alleges that behavior of BCBSA companies reduced or eliminated competition—resulting in higher prices for individuals and employers
  - Class includes insured plans, self-insured plans, participants of those plans and individuals who purchased a policy directly from a BCBSA company
  - BCBSA has agreed to settle the lawsuit
- On behalf of HealthFlex, **Wespath has joined a group of large plans, including some church plans and union plans, that has opted out and objected to the proposed settlement**

Proposed Settlement

Financial Relief

- Provides $2.67B to class members (reduced by attorneys' fees and expenses)
- Based on a well-regarded economist's model, HealthFlex would receive approximately $21,600
- Class members have the right to opt out and file a separate lawsuit against BCBSA

Injunctive (Non-monetary) Relief

- Requires BCBSA to stop engaging in *some* anticompetitive conduct for a five-year period
- Certain large plans with participants in multiple states will be able to obtain a bid from a second BCBS company going forward
  - Church plans and certain other plans, including plans sponsored by labor unions, are *excluded*
- Class members do *not* have the right to opt out of the injunctive relief, but can file an objection

Releases all antitrust claims against BCBSA, including claims based on future conduct within a five-year period

HealthFlex Action

The coalition of large plans, including HealthFlex, has:

- **Opted out of the financial relief; filed a separate lawsuit against BCBSA**
  - No impact on participants' right to file their own claims and directly receive a portion of the settlement
- **Objected to the injunctive relief**
  - Asked the court to allow us to opt out of the injunctive relief so that we can pursue our own relief
    - If approved, pursue open bidding from BCBSA companies
    - If not approved, ask the court to revise the settlement to add church plans to second bid provisions

The Court is scheduled to approve or reject the proposed settlement after an Oct. 20 hearing; the group's opt-out and objection will be considered as part of that hearing

No Surprises Act

- Passed in December 2020
- Protects participants from “surprise medical bills” from out-of-network (OON) providers
- Creates a dispute resolution process for certain disagreements between plans and providers
- Generally effective on January 1, 2022

Surprise Billing: Scope

The new surprise billing requirements apply to certain OON services

In Scope

- Air ambulance
- OON emergency room services
- OON services at in-network ("IN") facilities

Out-of-Scope

- All other OON services (e.g., elective procedures at OON facilities)

In general, intended to apply to all situations in which a participant does not really have a choice but to use an OON provider

In-Scope OON Charges: New Process

- The plan must pay or deny the claim within 30 days
- The plan must determine the participant's cost sharing amount by using the IN cost-sharing provisions based on a "qualifying payment amount" ("QPA")
  - QPA = plan's median contracted IN rate for the item or service in the applicable geographic area
- If there is a remaining balance, the provider *cannot* balance bill the participant
  - Exception: OON provider of *non*-ER and *non*-ancillary[1] services at IN facility can balance bill the participant if consent was provided at least 72 hours in advance or when the appointment is made
- Participant's payment must count toward participant's IN deductible and out-of-pocket maximum

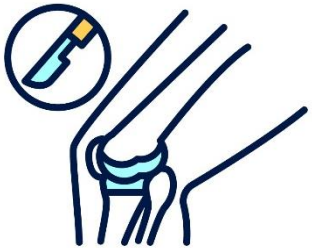
We will post a new, required notice online regarding the Surprise Billing prohibition

[1]Ancillary services includes, e.g., anesthesiology, pathology, radiology, and services provided by assistant surgeons

Example: Remy's Knee Surgery

Facts: Remy is in the H2000 plan and has reached his deductible. Remy had knee surgery at an IN facility. His primary surgeon is an IN provider, but the anesthesiologist and assistant surgeon are OON. These two providers have charged $5,000 total for their services.

Assumptions: In Remy's area, Medicare pays $500 for these services and the QPA (median of IN rates) is $2,500.



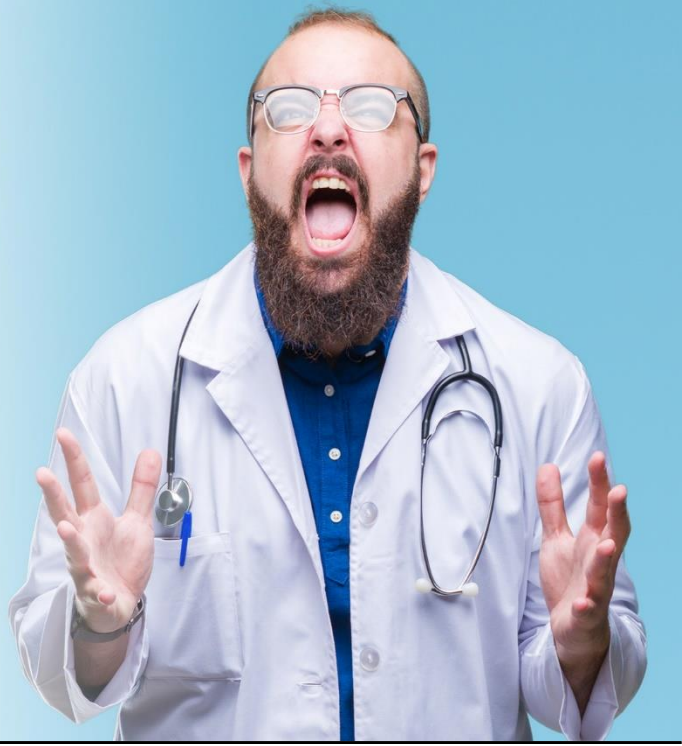
Current Process	New Process
• HealthFlex pays **$1,000** (50% of the allowed amount, which is 400% of the Medicare rate) • Remy pays **$4,000** (the total bill minus the plan's payment) • Remy's payment counts towards the OON out-of-pocket maximum	• HealthFlex pays **$1,750** (70% of the QPA) • Remy pays **$750** (30% of the QPA) • The OON providers are prohibited from billing Remy for the remaining balance • Remy's payment counts towards IN out-of-pocket maximum

What if the provider wants more?

If the plan and provider cannot agree on amount paid by the plan within 30 days, a party may submit the dispute to new, binding **independent dispute resolution (IDR) process** within 4 days

New IDR process:

- Both parties are required to submit a final offer
- IDR arbitrator *must* consider the median IN rate (and other relevant facts), but *may not* consider Medicare/Medicaid rates or the provider's usual/customary or billed charges
- Arbitrator selects one of the offers within 30 days
- Losing party must pay all fees associated with the IDR process
- The outcome has no impact on the participant's cost-sharing

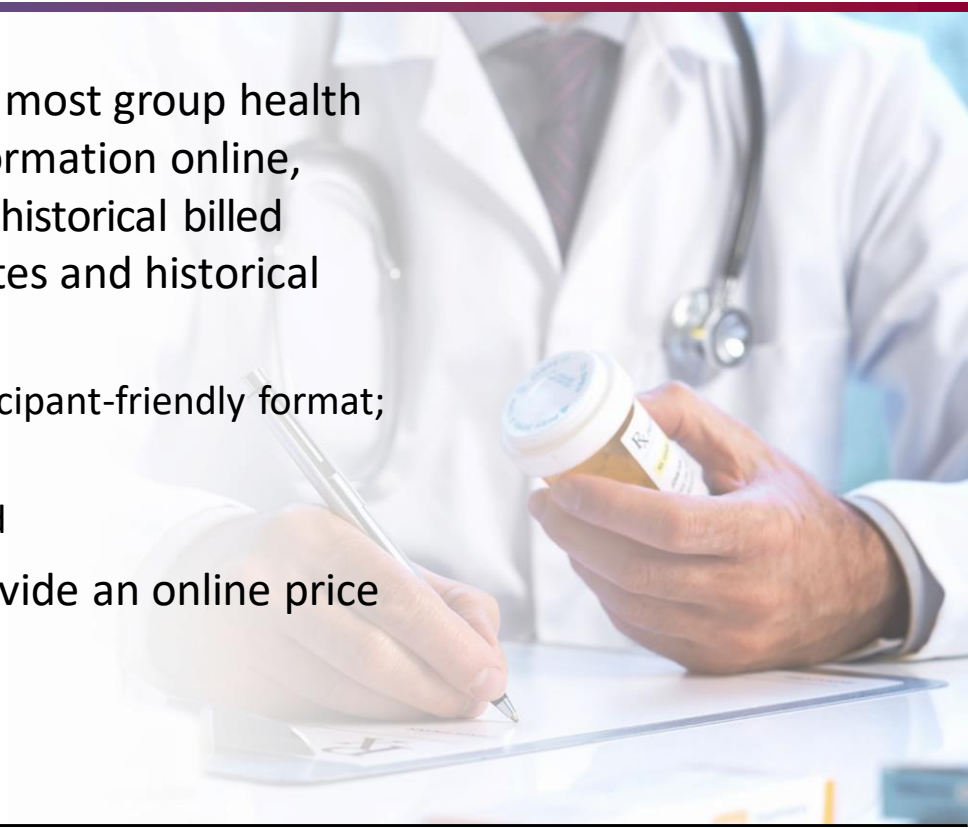


Other Related Developments

Other recent legislation and regulations have focused on price transparency

- Since January 1, 2021, all hospitals are required to post a list of their standard charges for items and services online
  - Certain data must be in a searchable, consumer-friendly format; the rest can be in a machine-readable file
  - Recent media reports indicate a majority of hospitals have not yet complied with the new requirement

Other Related Developments (cont.)

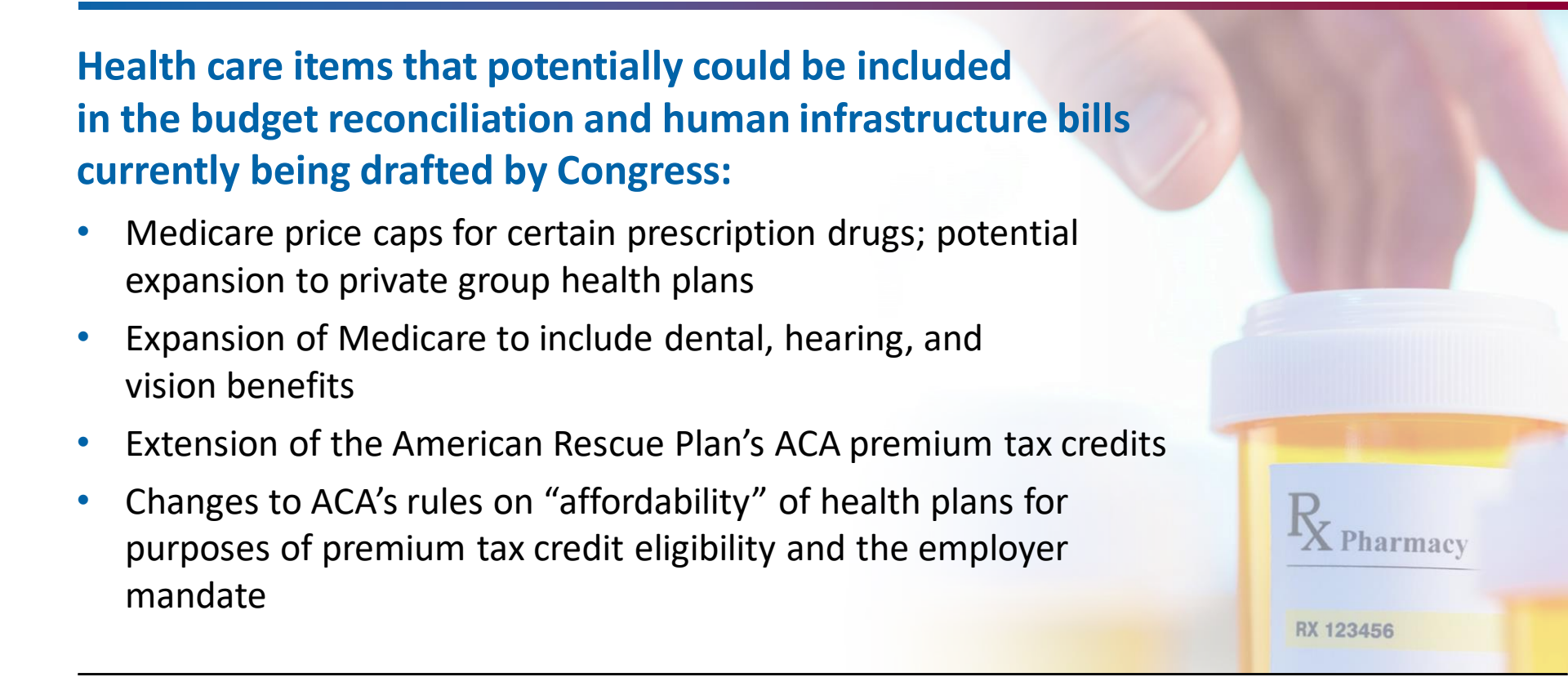


- Over the next several years, insurers and most group health plans will be required to post certain information online, including IN provider rates, OON provider historical billed and allowed amounts, and negotiated rates and historical net prices for prescription drugs
  - Certain data must be in a searchable, participant-friendly format; the rest can be in a machine-readable file
  - Church plans may be completely exempted
- Effective January 1, 2023, plans must provide an online price comparison tool for participants

Looking Ahead…

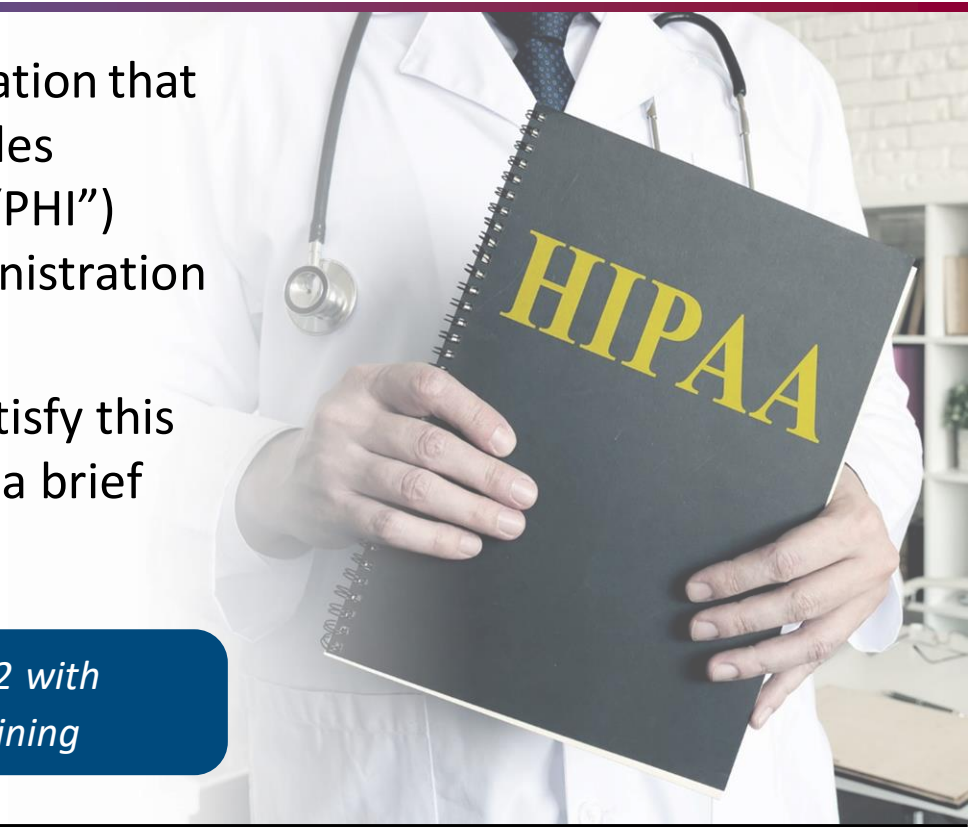
Health care items that potentially could be included in the budget reconciliation and human infrastructure bills currently being drafted by Congress:

- Medicare price caps for certain prescription drugs; potential expansion to private group health plans
- Expansion of Medicare to include dental, hearing, and vision benefits
- Extension of the American Rescue Plan's ACA premium tax credits
- Changes to ACA's rules on "affordability" of health plans for purposes of premium tax credit eligibility and the employer mandate



Coming in 2022

- Individuals who may receive information that is protected by the HIPAA privacy rules ("protected health information" or "PHI") in connection with health plan administration must receive HIPAA training
- Starting in 2022, we will help you satisfy this requirement each year by providing a brief online training session



Keep an eye out for an email in early 2022 with instructions for how to complete the training

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