

## **Announcement for Group Administrators Upfront Member Collection Policy**

September 24, 2009

Effective October 1, 2009, Blue Cross and Blue Shield of North Carolina is revising our upfront member collection policy for members who have Blue Options HSA<sup>SM</sup>, Blue Options HRA<sup>SM</sup> and any Blue Options<sup>SM</sup> non-copayment plans.

### **What's changing?**

Beginning October 1, 2009, for Blue Options HSA<sup>SM</sup> and Blue Options HRA<sup>SM</sup>, as well as any Blue Options<sup>SM</sup> non-copayment plans, providers are no longer limited to collecting up to \$50 for an office visit or up to \$500 for services received at a facility. Providers may now collect the member liability based on the benefits of the member's specific plan and the provider's current fee schedules for elective or scheduled care.

### **Why are we making this change?**

Collecting the patient's share of the bill has become increasingly important in recent years as more cost has shifted to members. For the products designated above, many patients have higher deductibles than in the past and also pay a percentage of the remaining bill. This change to our collection policy allows us to leverage our technology and partner with our providers to reduce the administrative expenses that can add to the total cost of health care.

### **What's required of the providers?**

If a provider office maintains a policy to collect the estimated patient financial responsibility at the time of service, they are required to:

- Collect only according to negotiated network fee schedules in place at the time of service.
- Collect only an amount determined to be accurate with reasonable certainty through validation using BCBSNC provider tools.
- Refund any overpayment owed to the member as soon as identified, but no more than 45 days after they receive our payment for the service in question.

### **What does this mean for copayment plans?**

Blue Care<sup>®</sup>, Blue Options<sup>SM</sup>, Blue Advantage<sup>®</sup>, and State Health Plan members should expect to pay their applicable copayment for office services as usual. When deductible and/or coinsurance apply, providers can use the above guidelines to request member liability prior to treatment.

**Does this apply to emergency and urgent care?**

For emergency services, providers cannot require any upfront payment from the member until the provider receives the BCBSNC Explanation of Payment (EOP).

For urgent care services, providers can use the above guidelines to require payment of member liability at time of service or after treatment.

**How is maternity care handled?**

The professional provider may request payment upfront for total global maternity services before delivery for the designated plans. Providers should follow the above guidelines and may set up a payment plan with the member. Facilities will bill after delivery and cannot require payment until they receive the EOP from BCBSNC.

**What if the member cannot make payment at time of service?**

Providers recognize that members may need help paying large and sometimes unexpected medical bills. Many providers offer different payment plans, and members should discuss payment options with their providers.

**What are providers and members being told about this change?**

Providers have been educated about this change both electronically and through the BCBSNC Network Management field staff.

Members who call BCBSNC Customer Service with questions regarding their provider requesting payment at time of service will be educated by the customer service professional (CSP). The CSPs have received training about the process change and how it impacts different types of service.

**Additional Questions**

If you have questions about the new member collection policy, please contact your Blue Cross and Blue Shield of North Carolina representative.

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