



Surprise Billing – Chap. 263, Laws of 2022 – Consumers

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Balance or Surprise Billing Protections

State BBPA & Federal No Surprises Act

WA Balance Billing Protection Act (2019)

- Effective January 1, 2020
- Comprehensive law – considered a “specified state law” under the federal No Surprises Act (NSA)

Federal No Surprises Act (2020)

- Effective January 1, 2022

E2SHB 1688 (Chap. 263, Laws of 2022)

- Aligns the BBPA and NSA, but retains key BBPA consumer protections
- Effective March 31, 2022

What plans does E2SHB 1688 apply to?

- **Fully-insured health plans** sold in Washington state – includes plans sold through the Exchange (approximately 1.3 million lives)
- Washington state employee health plan (**PEBB**) and new Washington state school employee health plan (**SEBB**) (approximately 600,000 lives)
- **Self-funded health plans that “opt-in”**, i.e. agree to comply with balance billing prohibitions, associated consumer protections and BBPA dispute resolution process
 - ESHB 1688 retains opportunity for self-funded group health plans to opt-in to state BBPA.
 - 380 plans have opted in as of April 2022 (500,000 lives).

NSA is baseline for self-funded group health plans that have not opted into the BBPA – approximately 1.8 million lives.

Coverage of Emergency services

- Emergency services must be covered whether provider is in or out of network and without prior authorization
- Emergency services include screening, stabilization, and post-stabilization, including observation or an inpatient and outpatient stay with respect to the visit during which emergency screening and stabilization services were provided.

Sec. 2, amending RCW 48.43.003 & Sec. 3, amending RCW 48.43.093

Coverage of Emergency services

What care settings do these emergency services protections apply in?

- For all health plans, including self-funded health plans, in hospital emergency rooms and freestanding emergency departments
- And, under state law, for fully insured individual and group health plans, also in behavioral health emergency settings, such as:
 - Crisis triage and stabilization facilities
 - Evaluation and treatment facilities
 - Medical withdrawal management providers
 - Mobile rapid response crisis teams

Balance billing protections apply to....

Service	Facility	Providers
	In-network or out-of-network (OON): <ul style="list-style-type: none">• Hospital• Behavioral health emergency services provider*	<ul style="list-style-type: none">• Screening exam• Examination & treatment to stabilize a patient• Post-stabilization services related to the emergency visit
		In-network or OON air ambulance services
Non-emergency services	In-network: <ul style="list-style-type: none">• Hospital• Ambulatory surgical facility	Services & items furnished to a consumer by OON providers at the facility, equipment/devices, lab services, imaging & pre/post-op care

Balance Billing – Consumer Protections

Can consumers be asked to waive their balance billing protections?

- For health plans subject to BBPA, consumers **cannot be asked** to waive their balance billing protections
- For self-funded group health plans that have not opted into the BBPA, NSA notice and consent provisions apply. But a provider **cannot require** a consumer to waive their protections

Sec. 7(2)(b), amending RCW 48.49.020, & Sec. 10(2) (new section)

Balance Billing – Consumer Protections

What other protections go along with the balance billing prohibition?

- Consumer cost-sharing is the same as if services had been received from an in-network provider. Uses NSA method for calculating consumer cost-sharing at median contracted rate (i.e. “qualified payment amount”).
- Cost-sharing must be applied to the consumer’s deductible and out-of-pocket limit
- For plans covered by state law, any consumer overpayment must be refunded to the consumer, with interest

Sec. 8, amending RCW 48.49.030

Is it an unlawful surprise bill?

If a consumer receives what may be a surprise bill:

- Don't pay it right away, but also don't delay looking into it...
- Contact your health plan – is deductible satisfied? What would in-network cost-sharing be for this service?
- Contact the provider – is this a balance bill?
- If the provider won't waive the bill, file a [complaint](#) with OIC or the [CMS No Surprises HelpDesk](#).
- Under the BBPA:
 - OIC will contact provider. Give them an “opportunity to cure”.
 - If pattern of “unresolved violations” refer to state medical commission or applicable disciplinary authority.
 - If provider is out-of-state or the plan is self-funded and not participating in BBPA, we can refer the complaint to the CMS No Surprises HelpDesk.

Consumer notice of BB protections

OIC has updated the [notice of consumer rights](#).

- Carriers, providers and facilities must begin use of this notice on or before May 6, 2022

Sec. 13, amending RCW 48.49.060, Sec. 14, amending RCW 48.49.070 & Sec. 15, amending RCW 48.49.080:

Consumer notice of BB protections

	Providers and Facilities	Carriers
When consumer schedules non-emergency services (BBPA)	★	
Within 72 hours of a consumer receiving emergency services (BBPA)	★	
When provider/facility requests payment from a consumer, and if payment is not requested, on the date a claim is submitted for payment (NSA)	★	
When a carrier authorizes non-emergency services for a consumer (BBPA)		★
On a consumer's Explanation of Benefits, i.e. whether service is protected from balance billing (BBPA & NSA)		★

Provider Network Transparency

- Providers must include list of health plan provider networks they contract with on the provider's website
- Hospitals and ambulatory surgical centers must give carriers up-to-date information regarding their contracted facility-based providers

RCW 48.49.070 & 48.49.080

OIC Network Access Standards

In 2016, OIC updated its provider [network access standards rule](#).

Goals:

- Establish minimum standards for health plans that ensure consumers can access the health care services promised in their health plan
- Sufficient numbers and types of providers and facilities to assure that, to the extent feasible, all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition.

OIC Network Access Standards

Sec. 18, amending RCW 48.49.150 (as recodified by the act)

- Per current practice: OIC must review a carrier's provider network to determine whether it includes a sufficient number of facility-based providers at a carrier's in-network hospitals and ambulatory surgical facilities.
- New provision for emergency behavioral health services providers:
 - Beginning January 1, 2023, OIC will require carrier's networks to include a sufficient number of contracted BH emergency services providers.

OIC Network Access Standards

For any service covered by a health plan, OIC may allow a carrier to submit an Alternative Access Delivery Request (AADR) to address a gap in their provider network.

Carrier must show:

- No greater cost to enrollees
- Substantial evidence of good faith efforts to contract
- No available alternative provider or facility for the carrier to contract with.
- For services subject to balance billing protections, notice has been provided to OON providers and facilities that deliver services referenced in the AADR
 - Once notice is provided by the carrier, carrier need not reimburse the provider in an amount greater than amount charged at the time notification was provided.

BBPA & Network Access

Section 18(2), amending RCW 48.49.150 (as recodified by the Act):

- For services subject to the balance billing protections, a carrier cannot treat their payment of out-of-network providers or facilities under the BBPA or NSA to satisfy OIC's network access standards, unless expressly authorized by OIC under Section 18.
- For services subject to balance billing protections, carrier can request amendment to an AADR to allow use of BBPA arbitration process to determine payment rates under the AADR if:
 - Request is submitted at least 3 months after the AADR's effective date.
 - Carrier demonstrates substantial evidence of good faith efforts to contract with the provider or facility.

Other No Surprises Act/CAA Protections

Carriers' provider network directories

Accuracy of provider network directory:

Consumer cost-sharing limited to in-network cost-sharing if consumer demonstrates that they relied on the health plan's provider directory and that information was incorrect (Sec. 2799A-5(c) of the PHS Act).

Additional state law provider directory requirements are defined in [statute](#) for mental health and substance use disorder provider directories and [rule](#) for all provider directories.

Good Faith Estimate

§2799B-6 of PHS Act – Uninsured and self-pay individuals

- All providers and facilities that schedule items or services for an uninsured or self-pay individual (i.e. individual will not be submitting a claim for the service) or receive a request for a Good Faith Estimate (GFE) from an uninsured (or self-pay) individual must provide such individual with a GFE. No specific specialties, facility types, or sites of service are exempt from this requirement.
- Patient-provider dispute resolution (PPDR) process: the uninsured (or self-pay) individual can use if the actual billed charges exceed the GFE by at least \$400.
- [CMS FAQ's re Good Faith Estimates](#)
- [CMS FAQ's re Good Faith Estimates – Part 2](#)

Advanced Explanation of Benefits

§2799B-6 of PHS Act – Insured individuals who intend to submit a claim for coverage:

- Providers and facilities to provide GFE to insured individuals.
- GFE transfer to carrier to prepare Advanced Explanation of Benefits (AEOB) to consumers.
- Federal agencies will undertake notice and comment rulemaking to implement this provision, including appropriate data transfer standards.
- Until that time, the Departments (and OIC) will defer enforcement of the requirement that plans and issuers must provide an Advanced Explanation of Benefits.
- [FAQ's About ACA and CAA Implementation Part 49](#)
- [OIC TAA](#)

Continuity of Care

§§ 2799A-3 and 2799B-8 of the Public Health Service Act

When is this protection triggered?

- Expiration or nonrenewal of provider contract with a health plan.
- Change in terms of the provider contract resulting in termination of a service/benefit.
- Health plan contract is terminated resulting in loss of benefits for a particular provider.

Continuity of Care

When a termination occurs, health plan must:

- Notify “continuing care patients” of their right to receive transitional care for 90 days with same terms as if the provider were in-network.
- Provide consumers an opportunity to notify the plan of their need for continuing care.
- Permit the consumer to use the continuity of care benefit.

What is a “continuing care patient”?

- Undergoing course of treatment for a serious and complex condition
- Undergoing inpatient or institutional care
- Scheduled for nonelective surgery (and post-operative care)
- Pregnant
- Terminal illness

Continuity of Care

- Provider must accept payment from the health plan as payment in full and adhere to all health plan policies and quality standards during transitional care period.
- Federal rulemaking pending, but until fully implemented, federal agencies expect carriers and providers to implement using a good faith, reasonable interpretation of the statute

Information on Health Plan ID card

§ 2799A-1(e) of the PHS Act:

Health plans are required to include, in clear writing, on physical or electronic health plan ID card:

- Health plan deductible
- Out-of-pocket maximum
- Consumer assistance phone number and website

Gag Clause Prohibition

Prohibition on gag clauses (§201 of the CAA of 2021)

Health plans and carriers cannot enter into contracts with providers/provider networks if the contract would directly or indirectly restrict the plan or issuer from:

- Providing provider-specific cost or quality-of-care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor or consumers.
- Upon request, electronically accessing de-identified claims and encounter information or data for each plan enrollee, consistent with federal health information privacy, GINA and the ADA.

Enforcement

Enforcement

Office of the Insurance Commissioner:

- Sections 5 (Chap. 48.43 RCW) & Section 19 (Chap. 48.49 RCW) give OIC authority to enforce provisions of the Consolidated Appropriations Act of 2021, including the No Surprises Act, and implementing federal regulations that are applicable to carriers offering health plans or grandfathered health plans to residents of Washington state on or after January 1, 2022.
- We always encourage consumers to [file complaints](#) if they believe their health plan may have violated the law.
- Consumers also have the option to [file a complaint](#) with the federal NSA Help Desk, e.g. for self-funded health plans.

Enforcement – Department of Health

Providers

Balance Billing Protection Act	No Surprises Act
<ul style="list-style-type: none">• DOH receives referrals from OIC for violations of RCW 48.49.020 and 48.49.030• DOH investigates referrals from OIC• If DOH finds that evidence supports a violation, DOH will proceed with enforcement under RCW 18.130.180(21)	<ul style="list-style-type: none">• DOH will enforce No Surprises Act provisions related to providers• NSA provisions applicable to providers include:<ul style="list-style-type: none">§2799B-1§2799B-2§2799B-3§2799B-6§2799B-7§2799B-8§2799B-9

Enforcement – Department of Health

Facilities

Balance Billing Protection Act	No Surprises Act
<ul style="list-style-type: none">• DOH receives referrals from OIC for violations of RCW 48.49.020 and 48.49.030• DOH investigates referrals from OIC• If DOH finds that evidence supports a violation, DOH will proceed with enforcement under<ul style="list-style-type: none">RCW 70.230.210 - Ambulatory Surgical FacilitiesRCW 70.41.510 - HospitalsRCW 70.42.162 - Medical Test SitesRCW 71.24.618 - Behavioral Health Agency	<ul style="list-style-type: none">• Centers for Medicare and Medicaid Services will be responsible for enforcement of No Surprises Act provisions applicable to facilities and air ambulance providers

Next Steps

- Complete webinar series and post webinars to OIC website
- BBPA Surprise Billing Dataset:
 - Expand data set to include additional services, in consultation with carriers, providers and other interested parties.
- Rulemaking

Appendix: Carrier/Provider provisions

Nonparticipating Provider Payment

Prior to July 1, 2023 or later date determined by the Commissioner	As of July 1, 2023 or later date determined by the Commissioner
Sec. 9, new section added to Chap. 48.49 RCW BBPA: “Commercially reasonable amount”	Sec. 9, new section added to Chap. 48.49 RCW Transition to NSA provisions

Dispute Resolution System

Prior to July 1, 2023 or later date determined by the Commissioner	As of July 1, 2023 or later date determined by the Commissioner
<p>Sec. 11, amending RCW 48.49.040:</p> <p>If nonparticipating provider and carrier cannot agree on a commercially reasonable payment, BBPA arbitration for <u>all disputes, other than air ambulance</u>.</p> <p>Air ambulance payment disputes use the NSA IDR system.</p> <p>Arbitrations under section 18 use the BBPA arbitration system.</p>	<p>Sec. 11, amending RCW 48.49.040:</p> <p>If nonparticipating provider and carrier cannot agree on a payment amount, use NSA “independent dispute resolution” (IDR) system.</p> <p><u>Except</u>, BBPA arbitration system is used for:</p> <ul style="list-style-type: none">• Disputes involving behavioral health emergency services providers, if CMS does not allow use of the NSA IDR system for these disputes• Arbitrations under section 18

Arbitration under Section 18

Section 11(13), amending RCW 48.49.040

- Issue in arbitration is commercially reasonable payment for services addressed in the AADR.
- “Baseball arbitration”, i.e. arbitrator chooses either the carrier’s or provider’s final offer amount.
- Decision is final and binding on parties, and applies from effective date of amended AADR to either expiration of the AADR or the parties reach an agreement through contract.
- BBPA arbitration will continue to be used for these disputes, even after state transitions to federal IDR system.
- Pending arbitrator’s decision, carrier’s allowed amount paid to provider is commercially reasonable amount.

WA's Experience with Arbitration

2020:

- 71 arbitration requests submitted to OIC:
 - Range of claims per dispute: 1 – 88.
 - Several were for a single claim, but large majority were bundled claims.
 - Total number of claims disputed: over 835.
 - Large majority were emergency or anesthesiology services.
- Of the 71 arbitration requests:
 - 20 were rejected (most due to being untimely).
 - 10 settled.
 - 8 withdrew.
 - 14 open/pending decision/status update.
 - 19 Arbitrator decisions: All decided in favor of providers.

WA's Experience with Arbitration

2021:

- 10 arbitration requests submitted to OIC:
 - Range of claims per dispute: 1 – 172.
 - Large majority were bundled claims.
 - Total number of claims disputed: approx. 675.
 - All were emergency or anesthesiology services.
- Of the 10 arbitration requests:
 - 1 was rejected (due to being untimely).
 - 8 Arbitrator decisions: 5 for the carrier; 2 for the provider and one split decision regarding bundled claims.

Resources

[CMS No Surprises Act website](#)

[Consolidated Appropriations Act](#)

Regulations:

- [Requirements Related to Surprise Billing; Part 1](#)
- [Requirements Related to Surprise Billing; Part 2](#)

Washington State law

- [E2SHB 1688 \(Chapter 263, Laws of 2022\)](#)
- [Summary of E2SHB 1688](#)

Questions?

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