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

Jennifer Kreitler, Health Care Consumer Access Manager
Jane Beyer, Senior Health Policy Advisor

OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

State BBPA & Federal No Surprises Act

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

E2SHB 1688 – applicable plans

Sec. 7, amending RCW 48.49.020:

- State regulated private health plans
  - NSA applies to grandfathered health plans
- PEBB/SEBB plans
- 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 as of April 2022.

NSA is baseline for SFGHP's that do not opt-in to BBPA

Coverage of Emergency services

Sec. 2, amending RCW 48.43.003 and Sec. 3, amending RCW 48.43.093:

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

Balance billing prohibition

Sec. 7, amending RCW 48.49.020:

Aligns to NSA:

- Emergency services.
- Non-emergency health care services performed by nonparticipating providers at certain participating facilities: includes covered items or services other than emergency services with respect to a visit at a participating health care facility, as provided in the NSA.

OIC to study and report on how balance billing for ground ambulance services can be prevented and whether these services should be added to the BBPA. Due October 2023.

Balance billing prohibitions apply to….

Service	Facility	Providers
Emergency services, including post-stabilization services	In-network or out-of-network (OON): • Hospital • Behavioral health emergency services provider*	• Screening exam • Examination & treatment to stabilize a patient • Post-stabilization services related to the emergency visit
Air ambulance services		In-network or OON air ambulance services
Non-emergency services	In-network: • 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

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

- 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. Consumers **cannot** be required to waive their protections.

Balance billing – Consumer Protections

Sec. 8, amending RCW 48.49.030:

- 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.

Consumer Notice & Transparency

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

OIC must develop a template for a notice of consumer rights that applies to both the BBPA and the NSA. Notice posted on OIC website.

- OIC determines through rulemaking when and how the notice must be provided to consumers.
- Extends some transparency requirements to behavioral health emergency services providers.
- Revises language related to information that must be submitted to carriers by hospitals & ASF's regarding facility-based providers practicing at the facility, and information that carriers must provide to consumers about these providers.

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)		

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
Sec. 11, amending RCW 48.49.040: If nonparticipating provider and carrier cannot agree on a commercially reasonable payment, BBPA arbitration for all disputes, other than air ambulance. Air ambulance payment disputes use the NSA IDR system. Arbitrations under section 18 use the BBPA arbitration system.	Sec. 11, amending RCW 48.49.040: If nonparticipating provider and carrier cannot agree on a payment amount, use NSA "independent dispute resolution" (IDR) system. Except, BBPA arbitration system is used for: • 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

Arbitrator Minimum Qualifications

Section 11(5), amending RCW 48.49.040:

Arbitrator minimum qualifications

- Amends RCW 48.49.040(2) to provide that BBPA arbitrators "must" have experience in matters related to medical or health care services, rather than "should". Sec. 11(5).
- OIC will review current arbitrators' experience within the next several months for compliance with this new requirement.
- Arbitrators can update their credentials to reflect any engagement in medical or health care services arbitrations and experience in matters related to medical or health care services. Arbitrators should submit any updates on or before May 31, 2022. OIC will review arbitrator qualifications after that date.

Changes to BBPA Arbitration Provisions

Sec. 11, amending RCW 48.49.040:

Claim bundling: Multiple claims may be addressed in a single arbitration proceeding if the claims at issue meet the following requirements:

- The claims must involve identical carrier and provider, provider group, facility, or behavioral health emergency services provider parties. Sec. 11(4)(a).
- The bundled claims must have the same procedural code, or a comparable code under a difference procedural code system. Sec. 114(b).
- Bundled claims must occur within 30 business days of each other. Sec. 11(4)(c).

Changes to BBPA Arbitration, cont'd

- If the parties to a pending arbitration proceeding agree on an out-of-network payment rate at any point before the arbitrator has made their decision, the agreed upon amount will be treated as the out-of-network payment rate for the service(s) at issue. Sec. 11(7).
- Each party's submission must include evidence and methodology for asserting the amount proposed to be paid is or is not commercially reasonable. Sec. 11(6).
- "Baseball arbitration" is retained – the arbitrator will choose the final offer of either the nonparticipating provider or the carrier. Sec. 11(8).
- The arbitrator's decision must include an explanation of the elements of the parties' submissions relied upon to make their decision and why those elements were relevant to their decision. Sec. 11(8)(a).
- The arbitrator's decision is final and binding on the parties and is not subject to judicial review. Sec. 11(11).

Changes to BBPA Arbitration, cont'd

- The Commissioner is given authority to establish arbitrator fee ranges or schedules by rule. Sec. 11(9).
- Arbitrator fees must be paid by the parties to the arbitrator within 30 calendar days following receipt of the arbitrator's decision by the parties. Sec. 11(9).
- If a federal IDR decisionmaker finds that it does not have jurisdiction over a dispute, timeframes related to good faith negotiations and notice for BBPA arbitration are modified. Sec. 11(3)(b).
- OIC annual arbitration reporting requirement expires January 1, 2023.

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 prohibition, notice 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 prohibition, 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 prohibition, a carrier can request to file an amended 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.

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 on a 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.

Enforcement – OIC

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 NSA, and implementing federal regulations that are applicable to or regulate the conduct of carriers issuing health plans or grandfathered health plans to residents of Washington state on or after January 1, 2022.

Enforcement – Department of Health

Providers

Balance Billing Protection Act

- 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)

No Surprises Act

- DOH will enforce No Surprises Act provisions related to providers
- NSA provisions applicable to providers include:
  - §2799B-1
  - §2799B-2
  - §2799B-3
  - §2799B-6
  - §2799B-7
  - §2799B-8
  - §2799B-9

Enforcement – Department of Health

Facilities

Balance Billing Protection Act

- 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 70.230.210 - Ambulatory Surgical Facilities
  - RCW 70.41.510 - Hospitals
  - RCW 70.42.162 - Medical Test Sites
  - RCW 71.24.618 - Behavioral Health Agency

No Surprises Act

- Centers for Medicare and Medicaid Services will be responsible for enforcement of No Surprises Act provisions applicable to facilities and air ambulance providers

Other No Surprises Act/CAA Protections

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 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 FAQs on Good Faith Estimates
- CMS FAQs on 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 transferred to carrier to prepare Advanced Explanation of Benefits (AEOB) to consumers.
- Federal agencies intend to undertake notice and comment rulemaking, including establishing appropriate data transfer standards.
- Until that time, the Departments (and OIC) will defer enforcement of the requirement that plans and issuers must provide an AEOB.
- FAQs about ACA and CAA Implementation Part 49
- OIC TAA

Continuity of Care

§§2799A-3 and 2799B-8 of the PHS Act:

- When a carrier/in-network provider contract is terminated for some or all services:
  - Carrier must notify "continuing care patients" of their right to receive transitional care from the provider for up to 90 days with same terms as if the provider were still in-network.
  - 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.

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: anticipate filing the CR-101 in early May
  - Review of arbitration forms/templates for any needed changes

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?

Jane Beyer
Senior Health Policy Advisor
Jane.Beyer@oic.wa.gov
(360) 725-7043

Jennifer Kreitler
Health Care Consumer Access Manager
Jennifer.Kreitler@oic.wa.gov
(360) 725-7127

Connect with us!

- OIC Surprise Billing website: https://www.insurance.wa.gov/surprise-medical-billing
- Facebook: https://www.facebook.com/WSOIC
- Twitter: https://twitter.com/WA_OIC
- www.insurance.wa.gov