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Kaiser Foundation Health Plan of the Northwest
Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.

June 16, 2020

Jane Beyer, Senior Health Policy Advisor
Washington State Office of the Insurance Commissioner
P.O. Box 40258
Olympia, WA 98504-0258
Submitted via email to: rulescoordinator@oic.wa.gov

Re: Comments on Balance Billing Protection Act Proposal to Begin Rulemaking CR-101 (R 2020-07)

Dear Jane:

Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and Kaiser Foundation Health Plan of Washington Options, Inc. (collectively "Kaiser Permanente"), appreciate the opportunity to provide feedback to the Office of the Insurance Commissioner ("OIC") on the CR-101 proposal to begin rulemaking, continuing the implementation the Balance Billing Protection Act (BBPA). Kaiser Permanente is an integrated health care system that covers and cares for more than 700,000 members in Washington State. We are committed to delivering affordable, coordinated, and high-quality care and coverage that supports not only our members but also the communities we serve.

Since the initial set of regulations were finalized implementing the BBPA, Kaiser Permanente has identified additional areas where regulatory clarity will be helpful. In particular, we believe there is significant opportunity to improve the dispute resolution and arbitration process. Although we would prefer to avoid arbitration altogether, we recognize that some disputes will require arbitration, and our goal is to ensure a process that operates smoothly and is fair for all parties involved.

The scope of claims should be finalized before arbitration begins, with assistance from the OIC.

The success in passing the BBPA during the 2019 legislative session was due in part to the OIC's willingness to play a limited role in the dispute resolution process. While we recognize the OIC is not directly involved in the arbitration itself, we believe there are additional steps the OIC can take prior to arbitration to ensure the parties have a common understanding of the dispute and the scope of the claims involved.

In our initial experience with the dispute process under the BBPA, the OIC has been a helpful partner by intaking notices to initiate arbitration from provider groups and rejecting those claims that do not meet the timeliness standards under the BBPA. We understand this is a new process for all parties involved, including the OIC, and appreciate the OIC's willingness to improve this process moving forward. To that end, we believe the OIC should work with both the health carrier/self-funded administrator ("health carrier") and provider groups to certify and finalize the set of claims that are eligible to be arbitrated, before the arbitration begins.

Although the OIC has correctly rejected claims that do not meet timeliness standards under the BBPA, we have noticed that claims attributable to non-participating self-funded groups and claims involving a separate health carrier entity have been certified for arbitration in error. Similarly, we have experienced provider groups that falsely claim they have provided notice to the health carrier of their intent to pursue arbitration. We strongly believe the accurate scope of claims should be resolved prior to the arbitration process, with assistance from the OIC. The initiating party should also be required to enclose a copy of their mandated notice with the arbitration initiation form, so that the OIC can easily verify if the requisite notice was indeed provided to the other party as attested on the form.

If the OIC expects the parties to use the arbitration and arbitrator to resolve disputes about proper notice and/or which claims should or should not be included, the costs of arbitration will quickly escalate. For example, an arbitrator may request briefing from the parties, schedule a hearing, and issue a written decision on these points, all the while charging hundreds of dollars an hour for his or her time. Setting aside the parties' associated attorney's fees, just getting a decision from an arbitrator on these fundamental preliminary issues could easily cost several thousand dollars. We believe it is the BBPA's intent for the parties to resolve payment disputes during arbitration, and we do not believe the law intended for the arbitration and arbitrator to resolve disputes over proper notice and the applicable claims.

Having the OIC work with providers and health carriers to certify that proper notice has been given and finalize the claims that may move forward to arbitration will create a much more efficient and effective process. This collaborative effort will save time, reduce costs, and ensure that arbitrators can focus on their statutory role in determining which payment offer is commercially reasonable.

Additional regulations should clarify the role of third-party entities acting on behalf of health care provider groups.

As Kaiser Permanente has encountered our first set of payment disputes related to claims within the scope of the BBPA, we have learned that these disputes are being initiated not by the provider groups themselves, but by a third-party entity that presumably contracts with the provider groups to provide revenue cycle and practice management support.

The BBPA and accompanying regulations do not expressly permit providers to use third-party entities to handle disputes or initiate arbitration on their behalf. Specifically, the BBPA only references "out-of-network providers" or "facilities," for example, stating that "the carrier, out-of-network provider, or out-of-network facility shall initiate arbitration" (RCW 48.49.040(1)(a)). There are no references to third-party entities or permitted delegation agreements.

If the OIC is inclined to permit third-party entities to engage in dispute resolution or arbitration under the BBPA on behalf of provider groups, the regulations should recognize this and delineate specific requirements that the third-party entities must meet to demonstrate their contractual relationship with the provider groups. Third-party entities should be required to produce written documentation that they have authority to act on behalf of the provider groups implicated in the dispute. Without such documentation, health carriers will have no way of

knowing whether the third-party entity is authorized to negotiate or act on behalf of the provider group.

Additionally, although a third-party entity may contract with multiple provider groups and ultimately attempt to dispute claims attributable to their distinct provider group clients, the statute and regulations are clear that any arbitration involving multiple claims must "involve identical carrier and provider or facility parties" (RCW 48.49.040(1)(b)(i) & WAC 284-43B-030(5)(b)(i)). If the OIC chooses to recognize the ability of third-party entities to act on behalf of provider groups, the regulations should clearly state that separate arbitrations are still required for each provider group, and that consolidation is not permitted simply because a common third-party entity is managing the dispute.

Furthermore, while the parties are required to execute a non-disclosure agreement as part of the arbitration process, permitting a third-party entity to act on behalf of multiple provider groups will undoubtedly make it difficult for the third-party entity to ensure confidential information from one dispute is not used or disclosed in another dispute involving a separate provider group. If the OIC enacts regulations that recognize the role of third-party entities in the BBPA dispute process, such regulations should clearly prohibit the third-party entity's use of any confidential or proprietary information learned in one dispute from use in subsequent disputes.

The OIC BBPA webpage should list the relevant contact information for each health carrier.

Kaiser Permanente recognizes that health carriers urged the OIC, during the initial rulemaking process to implement the BBPA, to incorporate a list of health carrier contacts on the OIC's BBPA webpage that clearly identifies where and to whom providers should send their disputes or notices to initiate arbitration. Although the OIC previously declined to house this information, we again strongly recommend the OIC incorporate such a list on their BBPA webpage.

While Kaiser Permanente has a dedicated e-mail box for providers to send notice of their intention to initiate arbitration, we are still encountering providers who remain confused on where to send their notice. It is clear that providers would benefit from a single resource that lists the contact information for each health carrier where the provider should send their notice to initiate arbitration.

The OIC's BBPA webpage already contains important information relied upon by the parties, including the BBPA data set, list of participating self-funded plan sponsors, and arbitrator information. Adding a list of health carrier contacts to this webpage will significantly reduce confusion for providers and ensure that health carriers are receiving proper notice. This is an easy step to improve the process for all parties involved.

We thank you for the opportunity to provide comments in anticipation of additional rulemaking to implement the BBPA. We have appreciated the OIC's willingness to adjust its processes as all parties continue to work through this new experience and look forward to our continued collaboration. Please do not hesitate to contact us with questions.

Sincerely,

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