Stakeholder Draft

Chapter 284-43B WAC
BALANCE BILLING

NEW SECTION

WAC 284-43B-010 Definitions. (1) The definitions in RCW 48.43.005 apply throughout this chapter unless the context clearly requires otherwise, or the term is defined otherwise in subsection (2) of this section.

(2) The following definitions shall apply throughout this chapter:

(a) "Facility" means a hospital licensed under chapter 70.41 RCW or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(b) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations. A single case agreement between a provider or facility and a carrier executed under WAC 284-170-200 does not constitute a contract under this subsection.

(c) "Median in-network contracted rate for the same or similar service in the same or similar geographical area" means the median amount negotiated for participation in the carrier's health plan network with in-network providers of emergency or surgical or ancillary services furnished in the same or similar geographic area, excluding any in-network copayment or coinsurance imposed with respect to the enrollee. If there is more than one amount negotiated with the health plan's in-network providers for the emergency or surgical or ancillary service in the same or similar geographic area, the median in-network contracted rate is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the enrollee. In determining the median described in the preceding sentence, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If no per-service amount has been negotiated with any in-network providers for a particular service, the median amount must be calculated based upon the service that is most similar to the service provided.

(d) "Offer to pay," "carrier payment," or "payment notification" means a claim that has been adjudicated and paid by a carrier to an

out-of-network or nonparticipating provider for emergency services or for surgical or ancillary services provided at an in-network facility.

(e) "Surgical or ancillary services" means surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

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NEW SECTION

WAC 284-43B-020 Balance billing prohibition and consumer cost-sharing. (1) If an enrollee receives any emergency services, or nonemergency surgical or ancillary services at an in-network facility from an out-of-network provider:

(a) The enrollee satisfies his or her obligation to pay for the health care services if he or she pays the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The enrollee's obligation must be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area. The carrier must provide an explanation of benefits to the enrollee and the out-of-

network provider that reflects the cost-sharing amount determined under this subsection.

(b) The carrier, out-of-network provider, or out-of-network facility, and an agent, trustee, or assignee of the carrier, out-of-network provider, or out-of-network facility must ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection.

(c)(i) For emergency services provided to an enrollee, the out-of-network provider or out-of-network facility, and an agent, trustee, or assignee of the out-of-network provider or out-of-network facility may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest;

(ii) For emergency services provided to an enrollee in an emergency department or upon admission to an out-of-network hospital located and licensed in Oregon or Idaho, the carrier must hold an enrollee harmless from balance billing; and

(iii) For nonemergency surgical or ancillary services provided at an in-network facility, the out-of-network provider and an agent,

trustee, or assignee of the out-of-network provider may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest.

(d) For emergency services and nonemergency surgical or ancillary services provided at an in-network facility, the carrier must treat any cost-sharing amounts determined under (a) of this subsection paid by the enrollee for an out-of-network provider or facility's services in the same manner as cost-sharing for health care services provided by an in-network provider or facility and must apply any cost-sharing amounts paid by the enrollee for such services toward the enrollee's maximum out-of-pocket payment obligation.

(e) If the enrollee pays an out-of-network provider or out-of-network facility an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection, the provider or facility must refund any amount in excess of the in-network cost-sharing amount to the enrollee within thirty business days of the provider or facility's receipt of the enrollee's payment. Simple interest must be paid to the enrollee for any unrefunded payments at a

rate of twelve percent beginning on the first calendar day after the thirty business days.

(2) The carrier must make payments for health care services described in section 6, chapter 427, Laws of 2019, provided by an out-of-network provider or facility directly to the provider or facility, rather than the enrollee.

(3) A health care provider or facility may not require a patient at any time, for any procedure, service, or supply, to sign or execute by electronic means, any document that would attempt to avoid, waive, or alter any provision of this section.

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NEW SECTION

WAC 284-43B-030 Out-of-network claim payment and dispute resolution. The allowed amount paid to an out-of-network provider for health care services described under section 6, chapter 427, Laws of 2019, shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area.

(1) Within thirty calendar days of receipt of a claim from an out-of-network provider or facility, the carrier shall offer to pay

the provider or facility a commercially reasonable amount. Payment of an adjudicated claim shall be considered an offer to pay. The date of receipt by the provider or facility of the carrier's offer to pay is five calendar days after a transmittal of the offer is mailed to the provider or facility, or the date of transmittal of an electronic notice of payment. The claim submitted by the out-of-network provider or facility to the carrier must contain sufficient information necessary to process the claim. A carrier may not require submission of a clean claim, as defined in WAC 284-170-431(3), as a condition of making an offer to pay the claim.

(2) If the out-of-network provider or facility wants to dispute the carrier's offer to pay, the provider or facility must notify the carrier no later than thirty calendar days after receipt of the offer to pay or payment notification from the carrier. A carrier may not require a provider or facility to reject or return payment of the adjudicated claim as a condition of putting the payment into dispute.

(3) If the out-of-network provider or facility disputes the carrier's offer to pay, the carrier and provider or facility have thirty calendar days after the provider or facility receives the offer to pay to negotiate in good faith.

(4) If the carrier and the out-of-network provider or facility do not agree to a commercially reasonable payment amount within the thirty-calendar day period under subsection (3) of this section, and the carrier, out-of-network provider or out-of-network facility chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration, as provided in section 8, chapter 427, Laws of 2019.

(5)(a) To initiate arbitration, the carrier, provider, or facility must provide written notification to the commissioner and the noninitiating party no later than ten calendar days following completion of the period of good faith negotiation under subsection (3) of this section.

(b) If an out-of-network provider or out-of-network facility chooses to address multiple claims in a single arbitration proceeding as provided in section 8, chapter 427, Laws of 2019, notification must be provided no later than ten calendar days following completion of the period of good faith negotiation under subsection (3) of this section for the most recent claim that is to be addressed through the arbitration.

(c) Within seven calendar days of receipt of notification from the initiating party, the commissioner must provide the parties with a

list of approved arbitrators or entities that provide arbitration. The arbitrator selection process must be completed within twenty calendar days of receipt of the original list of arbitrators from the commissioner, as follows:

(i) If the parties are unable to agree on an arbitrator from the original list sent by the commissioner, they must notify the commissioner within five calendar days of receipt of the original list of arbitrators. The commissioner must send the parties a list of five arbitrators within five calendar days of receipt of notice from the parties under this subsection.

(ii) If, after the opportunity to veto up to two of the five named arbitrators on the list of five arbitrators sent by the commissioner to the parties, more than one arbitrator remains on the list, the parties must notify the commissioner within five calendar days of receipt of the list of five arbitrators. The commissioner will choose the arbitrator from among the remaining arbitrators on the list.

(d) For purposes of this subsection, the date of receipt of a list of arbitrators is the date of electronic transmittal of the list to the parties by the commissioner. The date of receipt of notice from

the parties to the commissioner is the date of electronic transmittal of the notice to the commissioner by the parties.

(6) If a noninitiating party fails to timely respond without good cause to a notice initiating arbitration, the initiating party will choose the arbitrator.

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NEW SECTION

WAC 284-43B-040 Enrollee notice regarding poststabilization services. When an enrollee receives emergency services at an out-of-network facility, the carrier must take the following actions to minimize the risk that an enrollee will be balance billed for poststabilization services provided at the out-of-network facility:

(1) Once an enrollee who has received emergency services is stabilized, the carrier must provide a written notice to the enrollee in person at the point of service, informing the enrollee:

(a) That the facility and some providers that practice at the facility are out-of-network health care providers;

(b) The range of the estimated amount that the out-of-network facility or provider may charge the enrollee for continued services;

(c) That the enrollee can be safely transferred to an in-network facility. The notice must include a list of in-network facilities in the relevant geographic area that could appropriately care for the enrollee; and

(d) Information about whether prior authorization or other care management limitations may be required in advance of receiving in-network services at the facility.

(2) The enrollee must acknowledge in writing, that the out-of-network services provided after the enrollee has been stabilized may not be covered, or may be covered at a higher out-of-network cost-sharing amount than if the service were provided at an in-network facility and that the enrollee may be balance billed amounts in excess of their applicable cost-sharing amount under their health plan.

(3) The notice under subsection (1) of this section shall be in a format determined by the commissioner to give a reasonable layperson clear comprehension of the terms of the agreement, including all possible enrollee financial responsibilities. The notice must:

(a) Not exceed one page in length;

(b) Be readily identifiable as a contract of consent;

(c) Clearly state that consent to potential out-of-network charges is optional and that the enrollee has the choice to transfer to an in-network facility;

(d) Include a range of the estimated amount that the out-of-network provider or providers will charge the enrollee for such services involved; and

(e) Be available in the five most common languages in the Washington state geographic area served by the carrier, with the carrier making a good faith effort to provide oral notice in the enrollee's primary language if it is not one of such five languages.

(4) A carrier shall maintain documentation of notice given to an enrollee pursuant to this section and the enrollee's confirmation of receipt of such information in the enrollee's patient record for two years after the date of service.

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NEW SECTION

WAC 284-43B-050 Determining whether an enrollee's health plan is subject to the requirements of the act. Carriers must make available through electronic and other methods of communication generally used

by a provider or facility to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the requirements of this act. This process shall be standardized across carriers. Development of the standardized process shall occur through the designated lead organization for administrative simplification in Washington state.

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NEW SECTION

WAC 284-43B-060 Notice of consumer rights and transparency.

(1) The commissioner shall develop a standard template for a notice of consumer rights under the Balance Billing Protection Act. The notice may be modified periodically, as determined necessary by the commissioner. The notice template will be posted on the public web site of the office of the insurance commissioner.

(2) The standard template for the notice of consumer rights under the Balance Billing Protection Act must be provided to consumers enrolled in any health plan issued in Washington state as follows:

(a) Carriers must:

(i) Include the notice in any communication to an enrollee, in electronic or any other format, that authorizes nonemergency surgery or any other procedure at an in-network facility;

(ii) Post the notice on their web site in a prominent and relevant location, such as in a location that addresses coverage of emergency services and prior authorization requirements for nonemergency surgery or other procedures performed at in-network facilities;

(iii) Provide the notice to any enrollee upon request.

(b) Health care facilities and providers must:

(i) For any facility or provider that is owned and operated independently from all other businesses and that has more than fifty employees, upon confirming that a patient's health plan is subject to the Balance Billing Protection Act, include the notice in any communication to a patient, in electronic or any other format, confirming the scheduling of nonemergency surgery or a procedure at a facility;

(ii) Post the notice on their web site, if the provider or facility maintains a web site, in a prominent and relevant location near the list of the carrier health plan provider networks with which the provider or facility is an in-network provider; and

(iii) Provide the notice upon request of a patient.

(3) When processing a claim that is subject to the balance billing prohibition in section 6, chapter 427, Laws of 2019, the carrier must indicate on any form used by the carrier to notify enrollees of the amount the carrier has paid on the claim:

(a) Whether the claim is subject to the prohibition in the act; and

(b) The center for medicare and medicaid services individual national provider identifier number and any applicable organization national provider identifier number for the facility or provider that is the provider of services on the claim.

(4) A facility or health care provider meets its obligation under section 11 or 12, chapter 427, Laws of 2019, to include a listing on its web site of the carrier health plan provider networks with which the facility or health care provider contracts by posting this information on its web site within seven calendar days of receipt of a fully executed contract from a carrier.

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NEW SECTION

WAC 284-43B-070 Enforcement. (1) If the commissioner has cause to believe that any health facility or provider has engaged in a pattern of unresolved violations of section 6 or 7, chapter 427, Laws of 2019, the commissioner may submit information to the department of health or the appropriate disciplining authority for action.

(2) In determining whether there is cause to believe that a health care provider or facility has engaged in a pattern of unresolved violations, the commissioner shall consider, but is not limited to, consideration of the following:

(a) Whether there is cause to believe that the health care provider or facility has committed two or more violations of section 6 or 7, chapter 427, Laws of 2019;

(b) Whether the health care provider or facility has been nonresponsive to questions or requests for information from the commissioner related to one or more complaints alleging a violation of section 6 or 7, chapter 427, Laws of 2019; and

(c) Whether, subsequent to correction of previous violations, additional violations have occurred.

(3) Prior to submitting information to the department of health or the appropriate disciplining authority, the commissioner may provide the health care provider or facility with an opportunity to

cure the alleged violations or explain why the actions in question did not violate section 6 or 7, chapter 427, Laws of 2019.

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NEW SECTION

WAC 284-43B-080 Self-funded group health plan opt in. (1) A self-funded group health plan that elects to participate in sections 6 through 8, chapter 427, Laws of 2019, shall provide notice to the commissioner of their election decision on a form prescribed by the commissioner. Submission of the completed form will be considered an attestation that the self-funded group health plan has elected to participate in and be bound by sections 6 through 8, chapter 427, laws of 2019. The form will be posted on the commissioner's public web site for use by self-funded group health plans.

(2) A self-funded group health plan's election occurs on an annual basis. The plan may elect to initiate its participation on January 1st of any year or on the first day of the self-funded group health plan's plan year. The plan will be presumed to have elected to continue to participate unless the commissioner receives notice from the plan that it is terminating its election on either December 31st

of a calendar year or the last day of its plan year. Notices under this subsection must be submitted to the commissioner at least thirty days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

(3) Self-funded group health plan sponsors and their third party administrators may develop their own internal processes related to member notification, member appeals and other functions associated with their fiduciary duty to enrollees under the Employee Retirement Income Security Act of 1974 (ERISA).

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NEW SECTION

WAC 284-43B-090 Effective date. Chapter 284-43B WAC takes effect on January 1, 2020.

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AMENDATORY SECTION (Amending WSR 16-14-106, filed 7/6/16, effective 8/6/16)

WAC 284-170-480 Participating provider—Filing and approval. (1) An issuer must file for prior approval all participating provider agreements

and facility agreements thirty calendar days prior to use. If a carrier negotiates a provider or facility contract or a compensation agreement that deviates from an approved agreement, then the issuer must file that negotiated contract or agreement with the commissioner for approval thirty days before use. The commissioner must receive the filings electronically in accordance with chapters 284-44A, 284-46A, and 284-58 WAC.

(2)(a) An issuer may file a provider or facility contract tem-plate with the commissioner. A "contract template" is a sample con-tract and compensation agreement form that the issuer will use to con-tract with multiple providers or facilities. A contract template must be issued exactly as approved.

(i) When an issuer modifies the contract template, an issuer must refile the modified contract template for approval. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material. The modified template must be issued to providers and facilities upon approval.

(ii) Alternatively, issuers may file the modified contract tem-plate for prospective contracting and a contract addendum or amendment that would be issued to currently contracted providers or facilities for prior approval. The filing must include any correspondence that will be sent to a provider or facility that explains the amendment or addendum. The correspondence must provide sufficient information to clearly inform the provider or facility what the changes to the con-tract will be. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material.

(iii) Changes to a previously filed and approved provider compensation agreement modifying the compensation amount or terms related to compensation must be filed and are deemed approved upon filing if there are no other changes to the previously approved provider contract or compensation agreement.

(b)(i) All negotiated contracts and compensation agreements must be filed with the commissioner for approval thirty calendar days prior to use and include all contract documents between the parties.

(ii) If the only negotiated change is to the compensation amount or terms related to compensation, it must be filed and is deemed approved upon filing.

(3) If the commissioner takes no action within thirty calendar days after submission, the form is deemed approved except that the commissioner may extend the approval period an additional fifteen calendar days upon giving notice before the expiration of the initial thirty-day period. Approval may be subsequently withdrawn for cause.

(4) The issuer must maintain provider and facility contracts at its principal place of business in the state, or the issuer must have access to all contracts and provide copies to facilitate regulatory review upon twenty days prior written notice from the commissioner.

(5) Nothing in this section relieves the issuer of the responsibility detailed in WAC 284-170-280 (3)(b) to ensure that all provider and facility contracts are current and signed if the provider or facility

is listed in the network filed for approval with the commissioner.

(6) If an issuer enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the issuer must file the reimbursement agreement with the com-missioner thirty days prior to the effective date of the agreement, and identify the number of enrollees in the service area in which the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner to result in discrimination against or rationing of medically necessary services for enrollees with a specific covered condition or disease. If the commissioner fails to notify the issuer that the agreement is disapproved within thirty days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause.

(7) Provider contracts and compensation agreements must clearly set forth the carrier provider networks and applicable compensation agreements associated with those networks for the provider or facility to understand their participation as an in-network provider and the reimbursement to be paid. A health carrier may meet this requirement by including a list or other acceptable format to the commissioner so that a reasonable person will understand how the carrier offers participation and reimburses services in each provider network.

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