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OFFICE OF
INSURANCE COMMISSIONER

Technical Assistance Advisory 2022-01[1]

TO: **Health Carriers**

FROM: **Insurance Commissioner Mike Kreidler**

DATE: **April 4, 2022**

SUBJECT: **OIC's Implementation of E2SHB 1688**

The purpose of this Technical Assistance Advisory ("TAA") is to provide guidance for health carriers[2] on the Office of Insurance Commissioner ("OIC")'s implementation of E2SHB 1688.[3]

Background

Washington's Balance Billing Protection Act ("BBPA") was enacted in 2019, and effective January 1, 2020.[4] In December 2020, Congress enacted the No Surprises Act (NSA), which went into effect on January 1, 2022. E2SHB 1688 ("the Bill") was enacted in 2022, and relates to consumer protection from charges for out-of-network health care services. It aligns state law and the NSA and addresses coverage for treatment of emergency services. The Bill is effective March 31, 2022.

Below are some of the key components of the Bill and applicable sections:

1. *Applicable Plans*

E2SHB 1688 applies to fully insured individual and group health plans offered to residents in Washington state and to Washington state public and school employee health benefit plans (PEBB/SEBB).[5] The prohibition on balance billing, associated consumer protections and provider/carrier dispute resolution processes also apply to self-funded group health plans that have elected to participate in Washington state's balance billing protections.[6]

2. *Surprise billing dataset and study on impact of Balance Billing Protection Act - Sec. 1, amending RCW 43.371.100*

[1] This advisory is a policy statement released to advise the public of OIC's current opinions, approaches, and likely courses of action. It is advisory only. RCW 34.05.230(1).
[2] *See* RCW 48.43.005(28) (defining "health carrier").
[3] *See* Consolidated Appropriations Act ("CAA"), 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020) (enacting several new laws, including the No Surprises Act at div. BB, tit. I, 134 Stat. at 2757-2890).
[4] See OIC's Surprise Billing and BBPA Webpage for more information.
[5] See RCW 48.43.005 definition of "health plan" and RCW 41.05.107.
[6] See RCW 48.49.130.

The Surprise Billing data set will be updated to align with the scope of services protected from balance billing in RCW 48.49.020, as amended by the Bill. Section 1 directs the OIC to conduct biennial analysis, beginning in 2022, of the impact of the BBPA and NSA on payments for in-network and out-of-network services, including an analysis of the volume and percentage of claims of in-network health care providers versus out-of-network providers in Washington state. Sec. 1(3). The first analysis required under Section 1 must be published on the OIC's website on or before December 15, 2022. *Id.*

3. *Emergency Services Coverage – Secs. 2 & 3, amending RCW 48.43.005 & RCW 48.43.093*

Section 2 broadens the definition of emergency services to include covered services related to screening, stabilization, and post-stabilization, which includes observation or an inpatient and outpatient stay with respect to the visit during which screening and stabilization services were provided. Sec. 2(16)(iii). Additionally, emergency services providers include, in addition to a hospital emergency department, mobile rapid response crisis teams, crisis triage and stabilization facilities, evaluation and treatment facilities, agencies certified by the state to provide outpatient crisis services and medical withdrawal management services. Sec. 2(48).

Emergency services must be covered regardless of the network status of a hospital or provider and without prior authorization. Sec. 3(1)(a). Carriers can require notification of a person's stabilization or admission by in-network facilities. Sec. 3(3)(a). They also can require a hospital or behavioral health emergency services provider to notify them within 48 hours of stabilization if a person needs to be stabilized, or by the end of the business day following the day the stabilization occurs, whichever is later. Sec 3(3)(b).

4. *Scope of Balance Billing Protections – Sec. 7, amending RCW 48.49.020 & Sec. 21, adding a new section to Chapter 48.49 RCW*

The Bill amends the BBPA to align the scope of services subject to balance billing protections with the NSA. This includes emergency services, non-emergency health care services performed by nonparticipating providers at certain participating facilities and air ambulance services. Non-emergency services include covered items or services other than emergency services with respect to a visit at a participating health care facility, as provided in the NSA. Sec. 2(46).

The Bill amends applicable provisions of the BBPA to reference "behavioral health emergency services providers" such that balance billing protections and other related consumer protections apply to these services.

Under Section 21, the OIC is required, in collaboration with the Health Care Authority and the Department of Health, and with input from interested groups, to submit a report and any recommendations to the legislature by October 1, 2023, regarding how balance billing for ground

ambulance services[7] can be prevented and whether ground ambulance services should be subject to balance billing restrictions.

5. Consumer Cost Sharing – Sec. 7, amending RCW 48.49.020 & Sec. 8, amending RCW 48.49.030

Consumer cost sharing for services subject to balance billing protections under the NSA will be calculated as provided in the NSA. Sec. 7(2). Section 8 also requires the NSA method for calculating consumer cost-sharing (as known as "qualified payment amount") for behavioral health emergency services.

6. Waiver of Rights Secs. – Sec. 10, adding a new section to Chapter 48.49 RCW & Sec. 7, amending RCW 48.49.020

The Bill prohibits consumers from being asked to waive their balance billing protections. Sec. 7(2)(b) and Sec. 10(2).

7. Out of Network Claim Payment Standard - Sec. 9, adding a new section to Chapter 48.49 RCW

Section 9 states the allowed amount paid to an out-of-network provider for health care services described under RCW 48.49.020(1), other than air ambulance services shall be a "commercially reasonable amount" based on payments for the same or similar services provided in a similar geographic area. Sec. 9(1). This is required until July 1, 2023, or a later date determined by the OIC. *Id*. At that point, transition to NSA payment standard is required. Sec. 9(1).

8. Dispute Resolution - Sec. 11, amending RCW 48.49.040 and Sec. 18, amending RCW 48.49.150

Under Sec. 11, BBPA arbitration is required until July 1, 2023, or a later date determined by the OIC. Sec. 11(1),(2). On July 1, 2023, or a later date determined by the OIC, carriers are required to transition to NSA "independent dispute resolution" (IDR) system if out-of-network provider and carrier cannot agree on a commercially reasonable payment. *Id*. Upon transition to NSA independent dispute resolution system, if behavioral health emergency services payment disputes can be addressed using federal IDR system, carriers shall use that system. If not possible, the BBPA dispute resolution process will continue to be used. Sec. 11(2). Air ambulance payment disputes shall use the NSA IDR system. Sec. 11(14).

Sec. 11 revises existing BBPA arbitration provisions, including some provisions to align the NSA more closely with state law:

- Sec. 11 (4): Permits multiple claims to be addressed in a single arbitration proceeding if the claims at issue meet the following requirements:

[7] "Ground ambulance services" is defined under Sec. 21, (4) of the Bill to mean "organizations licensed by the department of health that operate one or more ground vehicles designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation."

  - 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. 11(4)(b).
  - Bundled claims must occur within 30 business days of each other. Sec. 11(4)(c).

- Sec. 11 (5): Amends RCW 48.49.040(2) to provide that the arbitrators on the OIC's required list "must" have experience in matters related to medical or health care services. Accordingly, OIC plans to review current arbitrators' experience within the next several months for compliance with this new requirement.
- Sec. 11(7): 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(13)(a): "Baseball arbitration" is retained, such that the arbitrator will choose the final offer of either the nonparticipating provider or the carrier.
- Sec. 11(8)(a): 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(11): The arbitrator's decision is final and binding on the parties and is not subject to judicial review.
- Sec. (11)(9): The OIC is given authority to establish arbitrator fee ranges or schedules by rule. 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(3)(b): 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.

Sections 11 and 18 provide for use of the BBPA arbitration process in limited circumstances for services that are subject to balance billing protections when a carrier and an out-of-network provider or facility cannot reach agreement on a contract and an amended alternative access delivery request (AADR) has been approved by the OIC. The OIC must approve use of this arbitration process. The Bill includes some provisions that apply specifically to arbitration proceedings in these circumstances, some of which are listed below:

- Sec. 11(13)(a): The issue before the arbitrator is the commercially reasonable payment for services addressed in the AADR.
- Sec. 18(13)(b): During the period from the effective date of the amended AADR to issuance of the arbitrator's decision, the allowed amount paid to providers or facilities for services addressed in the amended AADR, shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area.

- Sec. 11(13)(a): The arbitrator shall issue a decision related to whether payment for services should be made at the final offer amount of the carrier or the out-of-network provider or facility. The arbitrator's decision is final and binding on the parties for services rendered to enrollees from the effective date of the amended AADR to the expiration date of the AADR or the date the parties enter into a provider contract and provider compensation agreement, whichever occurs first.
- Sec. 11(13)(c): For these disputes, the BBPA arbitration process will continue to be used, rather than transitioning to the NSA IDR system in 2023.

9. Network Adequacy - Sec. 18

Under Sec. 18, when determining the adequacy of a carrier's provider network, the OIC must review the network to determine whether it includes a sufficient number of facility-based providers at the carrier's in-network hospitals and ambulatory surgical facilities. Sec. 18(1). The OIC may allow carriers to submit an alternate access delivery request (AADR) to address a gap in their provider network. The AADR must meet the requirements detailed under Sec. 18(2).

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 as a means to satisfy OIC's network access standards. Sec. 18(2)(b). However, if an AADR has been granted and a carrier meets the following requirements, a carrier may ask the OIC to amend its AADR to allow use of the BBPA dispute resolution process to determine the amount that will be paid to out-of-network providers or facilities for the services referenced in the AADR. Sec. 18(2)(b). The carrier must meet the following requirements:

- The carrier's request to amend the AADR is made at least 3 months after the effective date of the AADR at issue; and
- During that 3-month period, the carrier has demonstrated substantial good faith efforts on its part to contract with out-of-network providers or facilities to deliver the services referenced in the AADR. Sec. 18(2)(b)(i).

For services subject to balance billing protections, a carrier must notify out-of-network providers that deliver the services referenced in the AADR within 5 days of submitting the AADR to OIC. Sec. 18(2)(b). Once a carrier has notified an out-of-network provider or facility that delivers the services referenced in an AADR, a carrier is not responsible for reimbursing a provider's or facility's charges in excess of the amount charged by the provider or facility for the same or similar service at the time the notification was provided. Sec. 18(2)(b)(ii). The provider or facility must accept this reimbursement as payment in full. *Id.*

10. Consumer Appeals to Independent Review Organization (IRO) - Sec. 4, amending RCW 48.43.535

Sec. 4(2) adds an NSA provision which provides consumers an opportunity to appeal a carrier's adverse decision related to its obligations under the NSA.

Rulemaking

The OIC plans to conduct rulemaking in the next several months. Rulemaking will address several of the topics discussed in this TAA.

OIC Enforcement

Aside from a few deferments described in the next section, OIC will enforce E2SHB 1688[8] and other federal NSA provisions not specifically addressed in E2SHB 1688 pertaining to health carriers for health plans starting on or after January 1, 2022.[9] Where there is any conflict between the provisions of E2SHB 1688 and OIC's regulations previously adopted to implement the BBPA, the provisions of E2SHB 1688 govern.

Additionally, the following provisions of the NSA, are not specifically discussed in the bill, however, the OIC notes health carriers are required to comply with them:

- Requirements for in-network cost-sharing for enrollees that relied on an issuer's databases, response protocols, or provider directory representations that a provider was in-network.[10]
- Prohibition on balance billing for "continuing care patients" for 90 days after a provider becomes OON.[11]

The NSA preempts state laws only when those laws impose a requirement that "prevents the application" of the NSA.[12] Based upon this principle and a few NSA provisions expressly deferring to state law, OIC will continue to enforce related state laws related to provider directories.[13]

Deferred Enforcement

OIC will defer enforcement against some entities due to jurisdictional limitations, and with respect to some provisions of the NSA. This decision is in alignment with deferment recently announced by the Departments of Health and Human Services, Labor, and Treasury (collectively referred to as "the Departments"). Due to jurisdiction limitations, the OIC will defer to other state or federal agencies for enforcement regarding the following entities:

- Air ambulances;[14]
- Self-funded group health plans that have not elected to participate in the BBPA; and

[8] See sections 5 and 19 of E2SHB 1688.
[9] *See* WAC 284-43-0140 ("Health carriers shall comply with all Washington state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits.")
[10] *See* section 116(b) of the No Surprises Act.
[11] *See* section 113 of the No Surprises Act.
[12] *See* 42 U.S.C. § 300gg-23(a)(1); 86 Fed. Reg. at 36,886.
[13] *See* section 116(a) of the No Surprises Act (deferring to state laws relating to provider directories).
[14] *See* 86 Fed. Reg. at 36,885.

- Health providers and facilities.[15]

Additionally, OIC will defer enforcement for some of the NSA provisions in accordance with the deferred enforcement policy announced by the Departments, Aug. 20, 2021, in a set of Frequently Asked Questions ("FAQs").[16] In accordance with these FAQs, the OIC will defer enforcement for the following NSA provisions:

- Requirements for making available a price comparison tool (by internet website, in paper form, or telephone). Deferment will be up until plan years (in the individual market, policy years) beginning on or after January 1, 2023.[17]
- Requirements for providing an Advanced Explanation of Benefits.[18] Deferment will be until regulations fully implementing this requirement are adopted and applicable.[19]

The OIC will continue to enforce any state law counterpart to these NSA provisions, including, but not limited to the following:

- Requirements for transparency tools for price and quality information.[20]
- Requirements for enrollee notification upon termination of a provider by a health carrier.[21]

The Departments also detailed provisions of the NSA[22] that issuers must implement using a good faith, reasonable interpretation of the law, without the guidance of regulations. OIC will enforce the following provisions in the same manner as announced by the Departments:

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[15] Pursuant RCW 48.49.100, OIC will continue to give providers and facilities an opportunity to cure violations of RCW 48.49.020 or 48.49.030.

[16] *See* "FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 ("FAQs")," Aug. 20, 2021, *available at*: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FAQs%20About%20ACA%20%26%20CAA%20Implementation%20Part%2049_MM%20508_08-20-21.pdf. Additionally, the Departments announced deferment of a few non-FNSA provisions, namely the requirement that issuers publish machine-readable files relating to prescription drug pricing. *Id.* at 1 (citing 85 Fed. Reg. 72,158 (Nov. 12, 2020); 26 C.F.R. § 54.9815-2715A3(b)(1)(iii), 29 C.F.R. § 2590.715-2715A3(b)(1)(iii), and 45 C.F.R. § 147.212(b)(1)(iii)). Deferment will be until regulations to fully implement this requirement are adopted and applicable. *Id.* at 1-2 (describing deferment). The Departments will defer enforcement of the requirement to publish the remaining machine-readable files until July 1, 2022. *Id.* at 2. OIC will similarly defer enforcement.

[17] *Id.* at 3-4 (citing Internal Revenue Code ("Code") § 9819, Employee Retirement Income Security Act ("ERISA") § 719, and Public Health Service ("PHS") Act § 2799A-4, as added by section 114 of the No Surprises Act).

[18] *Id.* at 6 (citing Code § 9816(f), ERISA § 716(f), and PHS Act § 2799A-1(f), as added by section 111 of the No Surprises Act).

[19] *Id.* at 7 (describing deferment).

[20] *See* RCW 48.43.007.

[21] WAC 284-170-421(10).

[22] Additionally, the Departments detailed a few non-FNSA provisions it will expect issuers to implement using a good faith, reasonable interpretation of the law, including requirements prohibiting gag clauses. *See* FAQs at 7 (citing Code § 9824, ERISA § 724, and PHS Act § 2799A-9, as added by section 201 of division BB, title II, of CAA). OIC will enforce these provisions in the same manner as the Departments.

- Requirements to include on any insurance identification card issued to enrollees, any applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek assistance.[23]
- Requirements to establish a process to update and verify the accuracy of provider directory information and to establish a protocol for responding to requests by telephone and electronic communication from an enrollee about a provider's network participation status.[24]
- Prohibition on cost-sharing when an enrollee relied on the issuer's provider directory or response protocol.[25]
- Requirements to make certain disclosures regarding balance billing protections to enrollees.[26]
- Requirements to apply continuity of care protections.[27]

Consumer Notice

The OIC is required to develop standard template language for a notice of consumer rights that notifies consumers of their rights under both the BBPA and the NSA. Sec. 13(1). The OIC determines by rule when and how the notice must be provided to consumers by health carriers, health care providers, and health care facilities. Sec. 18(3).[28]

The OIC is developing a consumer notice for balance billing rights that satisfies both the NSA and E2SHB 1688[29] OIC's consumer notice should be used for fully insured health plans, PEBB/SEBB plans, and self-funded ERISA plans that have opted into the BBPA. Under the BBPA, this notice must be provided to enrollees in any communication that authorizes nonemergency surgical or ancillary services at an in-network facility.[30] Also, the issuer must indicate on the enrollee's explanation of benefits whether the service is subject to balance billing protections.[31] OIC will continue to enforce these BBPA consumer notice requirements against health carriers.

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[23] *Id.* at 4-5 (citing Code § 9816(e), ERISA § 716(e), and PHS Act § 2799A–1(e), as added by section 107 of the No Surprises Act).
[24] *Id.* at 7-8 (citing Code § 9820(a) and (b), ERISA § 720(a) and (b), and PHS Act § 2799A-5(a) and (b), as added by section 116(a) of the No Surprises Act). However, given the deferment to state law in section 116(a) of the No Surprises Act, OIC will only enforce these FNSA provisions against health carriers for plans and services not subject to the BBPA but subject to OIC's jurisdiction, e.g., grandfathered health plans.
[25] *Id.*
[26] *Id.* at 8-9 (citing Code § 9820(c), ERISA § 720(c), and PHS Act § 2799A-5(c), as added by section 116(c) of the No Surprises Act).
[27] *Id.* at 9 (citing Code § 9818, ERISA § 718, and PHS Act § 2799A-3 and 2799B-8, as added by section 113 of the No Surprises Act).
[28] See WAC 284-43B-050
[29] The draft notice has been circulated for review and comment. When the E2SHB 1688 Consumer Notice is finalized, it will be posted on OIC's website and shared through a GovDelivery notice; *see also* Code § 9820(c), ERISA § 720(c), and PHS Act § 2799A-5(c), as added by section 116(c) of the No Surprises Act.
[30] *See* WAC 284-43B-050(2)(a)(i).
[31] *See* WAC 284-43B-050(4)(a).

Please direct any questions about this advisory to Jane Beyer, Senior Health Policy Advisor, who may be contacted at janeb@oic.wa.gov and phone number 360-725-7043.