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

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OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

E2SHB 1688 (Chap. 263, Laws of 2022)

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 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.

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):

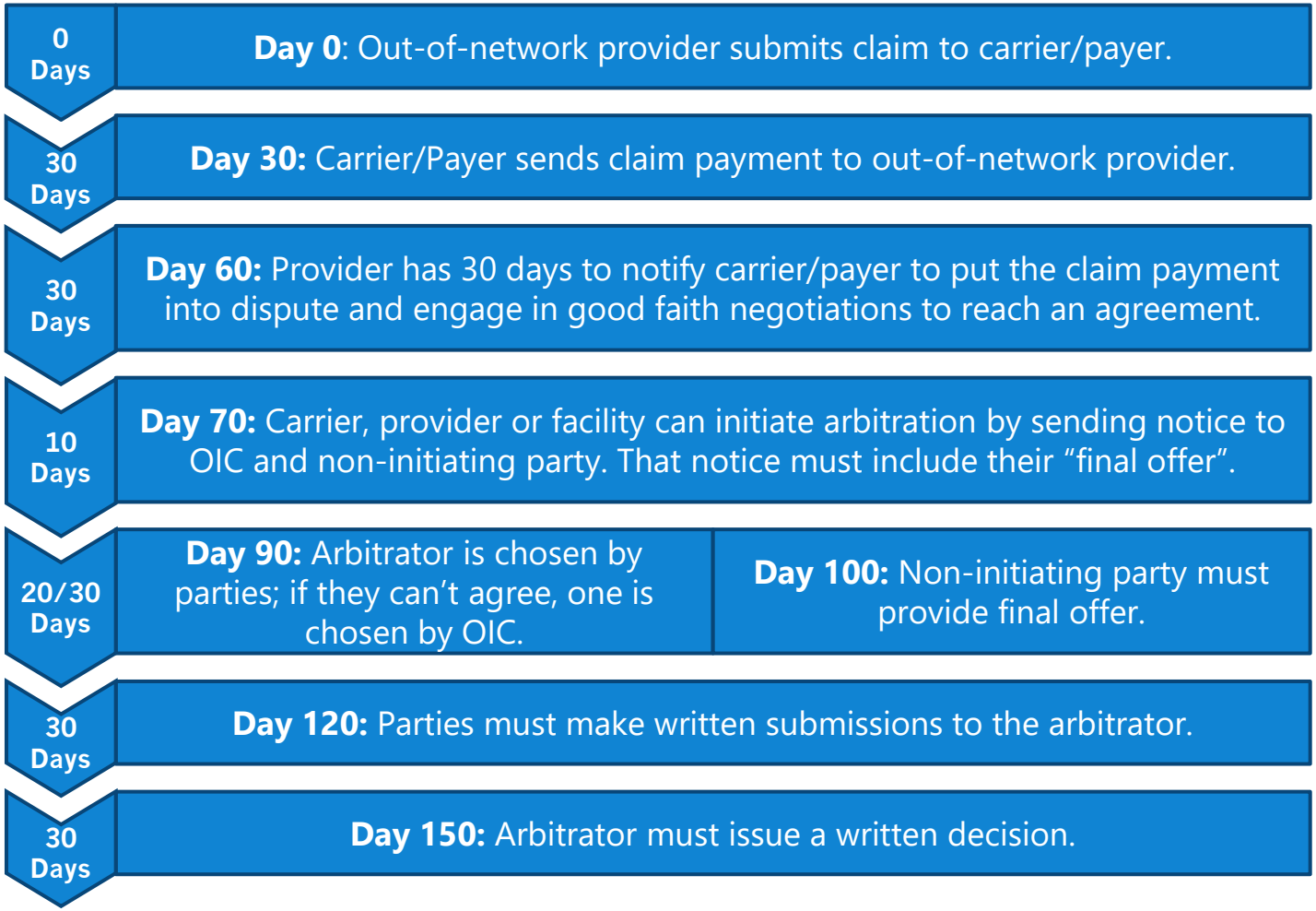
- For services subject to the balance billing prohibition, a carrier cannot treat their payment of out-of-network providers or facilities under the BBPA or NSA to satisfy OIC's network access standards, unless expressly authorized by OIC under Section 18.
- For services subject to balance billing prohibition, 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.

BBPA Dispute Resolution/Arbitration Process


0 Days
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30 Days
Day 30: Carrier/Payer sends claim payment to out-of-network provider.
30 Days
Day 60: Provider has 30 days to notify carrier/payer to put the claim payment into dispute and engage in good faith negotiations to reach an agreement.
10 Days
Day 70: Carrier, provider or facility can initiate arbitration by sending notice to OIC and non-initiating party. That notice must include their "final offer".
20/30 Days
Day 90: Arbitrator is chosen by parties; if they can't agree, one is chosen by OIC.
Day 100: Non-initiating party must provide final offer.
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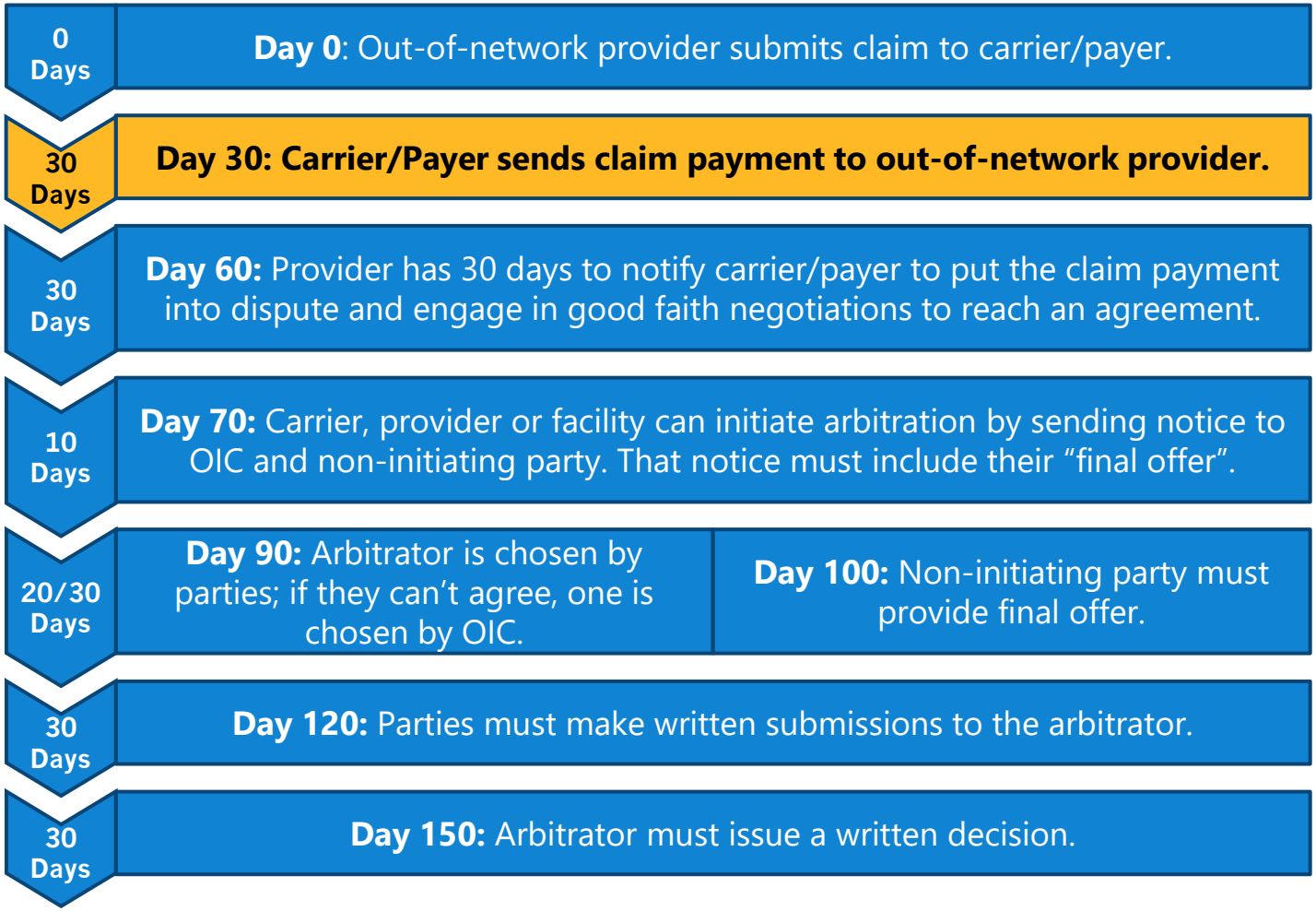
Day 120: Parties must make written submissions to the arbitrator.
30 Days
Day 150: Arbitrator must issue a written decision.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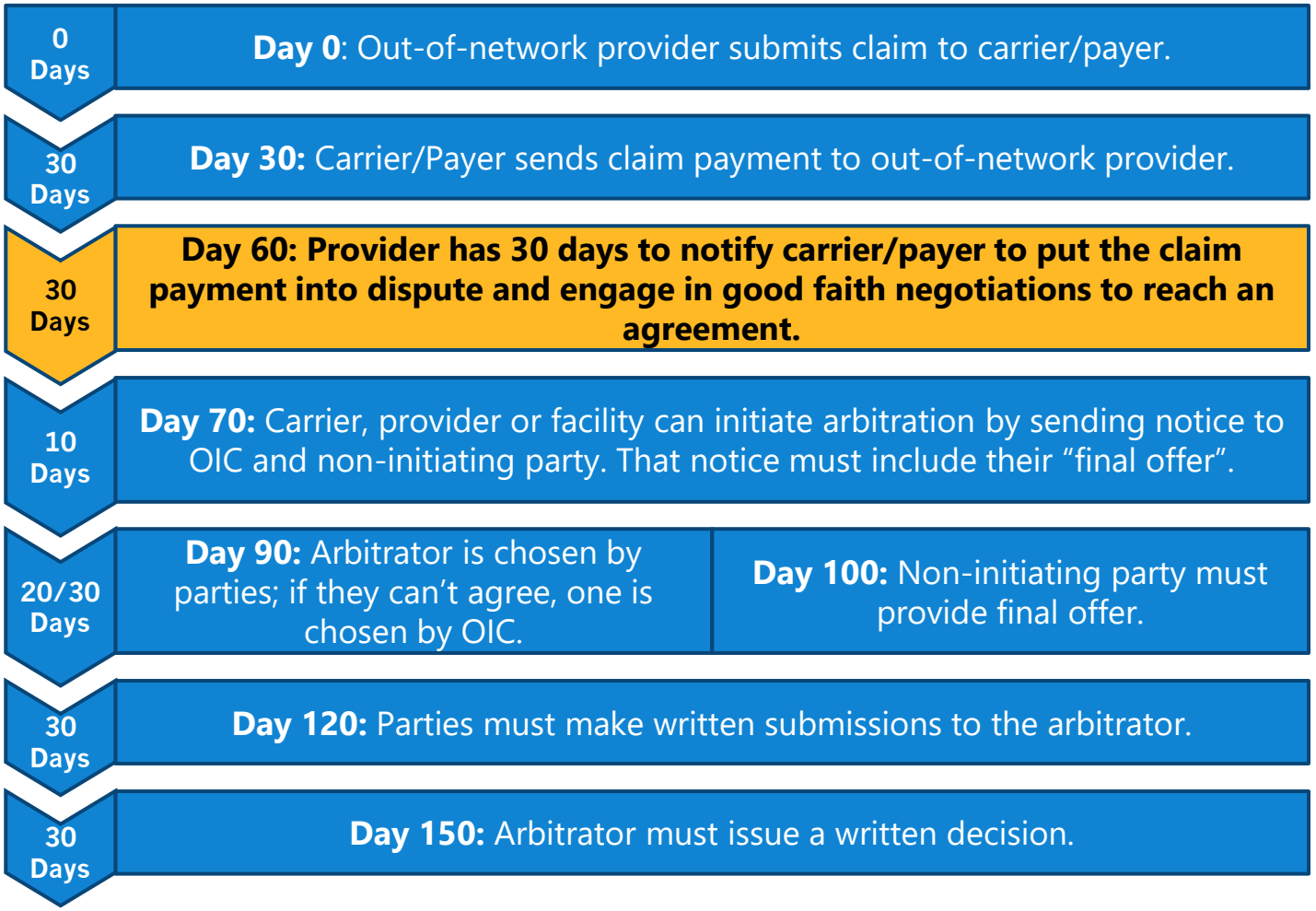
Carrier payment to OON provider

The claim submitted by the out-of-network provider or facility to the carrier must include the following information:

- Patient name;
- Patient date of birth;
- Provider name;
- Provider location;
- Place of service;
- Provider federal tax identification number;
- CMS INPI and ONPI, if applicable;
- Date of service;
- Procedure code; and
- Diagnosis code.

Carrier must offer to pay commercially reasonable amount within 30 days of receipt of claim from OON provider.

(Sec. 9; WAC 284-43B-030)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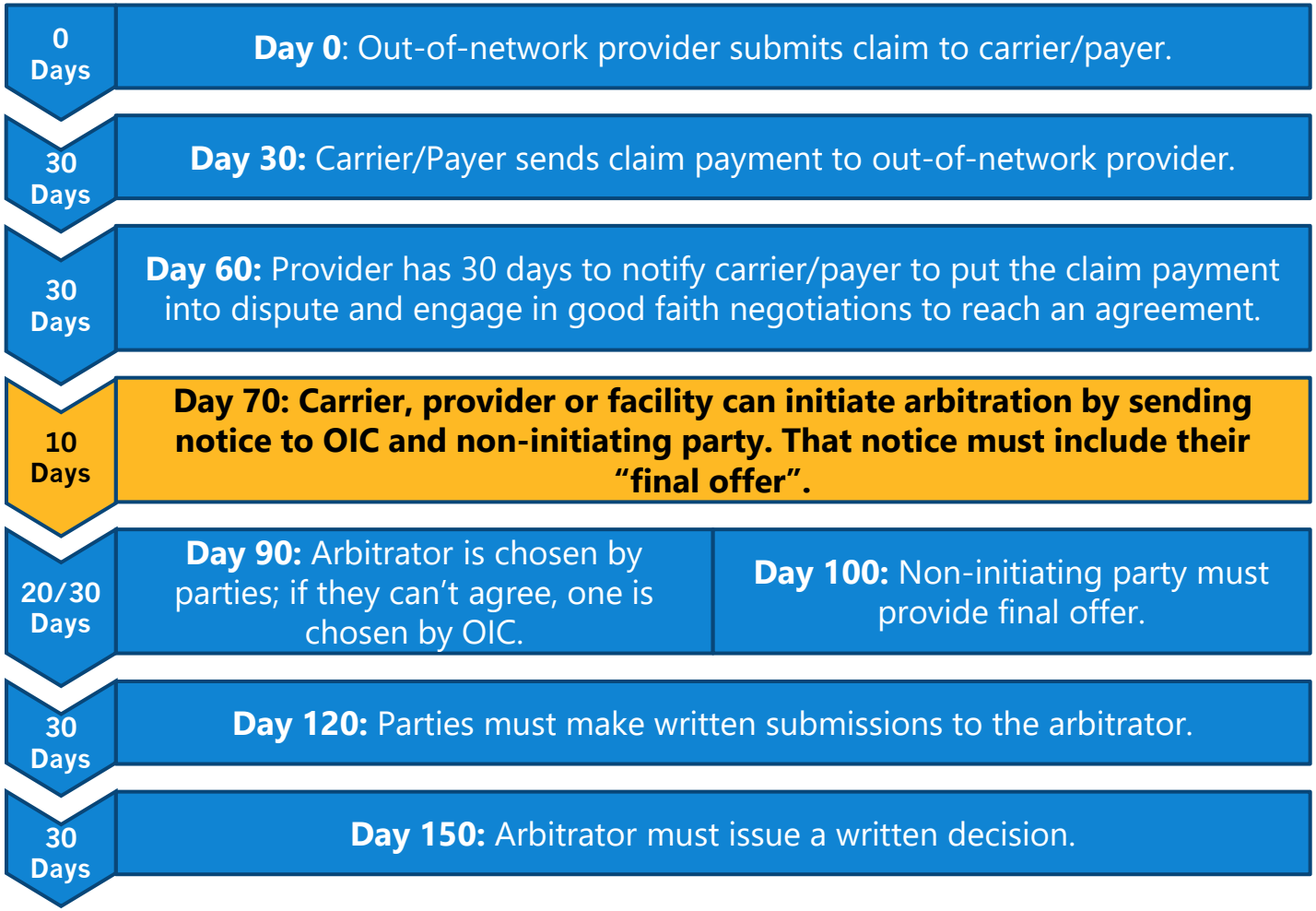
30 Days
Day 150: Arbitrator must issue a written decision.

Claim in dispute/ good faith negotiations

- From the date provider receives "offer to pay" from carrier, there is a single 30 day period for:
  - Provider to put a claim "into dispute", and;
  - Engage in good faith negotiation to reach agreement on a commercially reasonable amount.

(Sec. 9; WAC 284-43B-030)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30 Days
Day 150: Arbitrator must issue a written decision.

Initiating Arbitration

- To initiate arbitration, written notification must be provided to OIC and the non-initiating party no later than ten calendar days following completion of the period of good faith negotiation.
- Arbitration Initiation Request Form [AIRF]: required format in rule.
- Untimely arbitration initiation request will be rejected by OIC. Filing another request involving the same claims is permanently foreclosed

RCW 48.49.040; WAC 284-43B-030

Initiating Arbitration – Bundled Claims

All the claims at issue must:

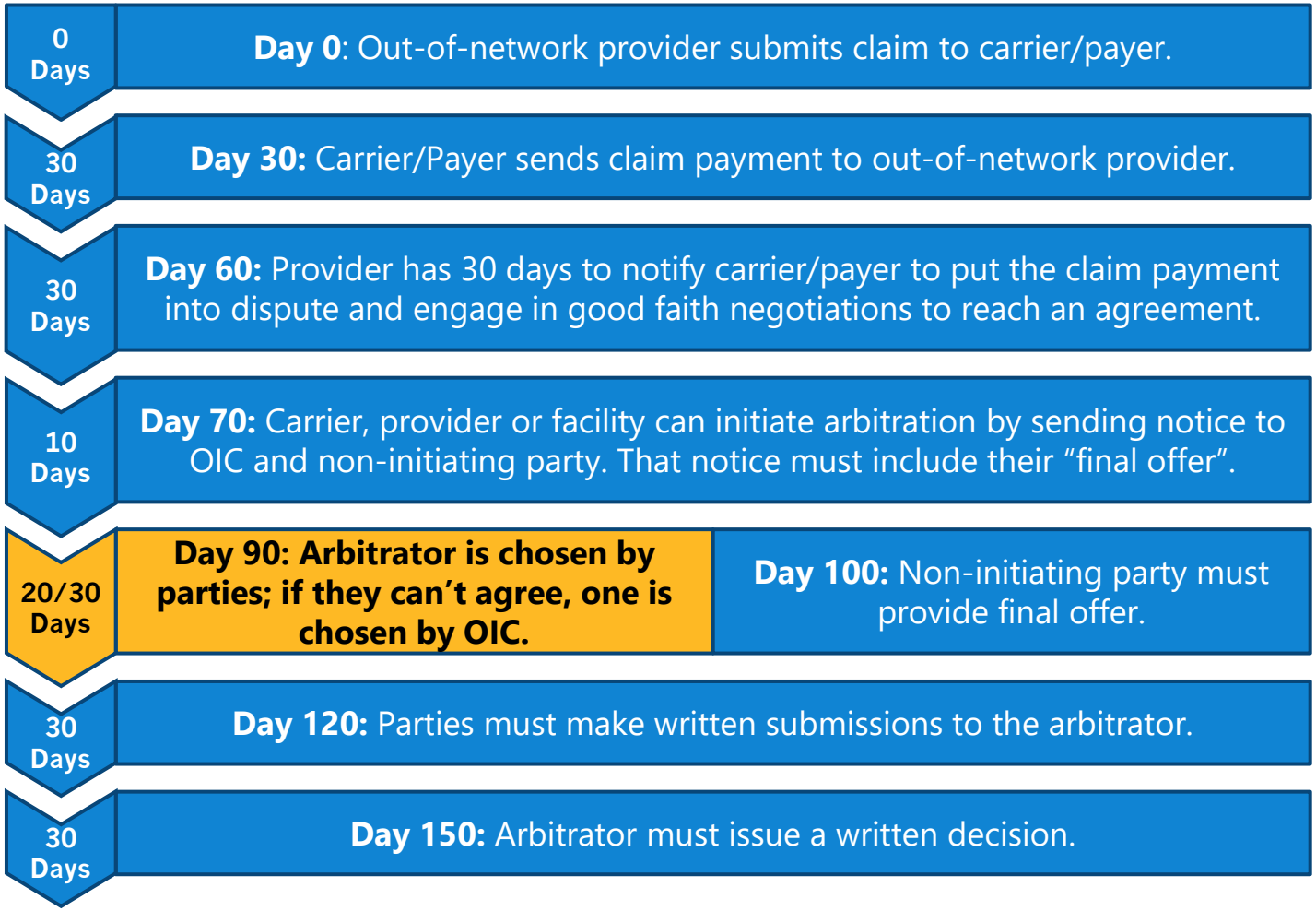
- The claims must involve identical carrier and provider, provider group, facility, or behavioral health emergency services provider parties. Sec. 11(4)(a).
- The bundled claims must have the same procedural code, or a comparable code under a difference procedural code system. Sec. 114(b).
- Bundled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

For bundled claims, the 10-day period to initiate arbitration starts at the end of the 30-day period for the most recent of the bundled claims.

Any list of bundled claims should include, for each claim:

- Date offer to pay received by the provider.
- Date of completion of 30 day period of good faith negotiation
- Initiating party's final offer.

(RCW 48.49.040 as amended by E2SHB 1688; WAC 284-43B-030)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10 Days
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20/30 Days
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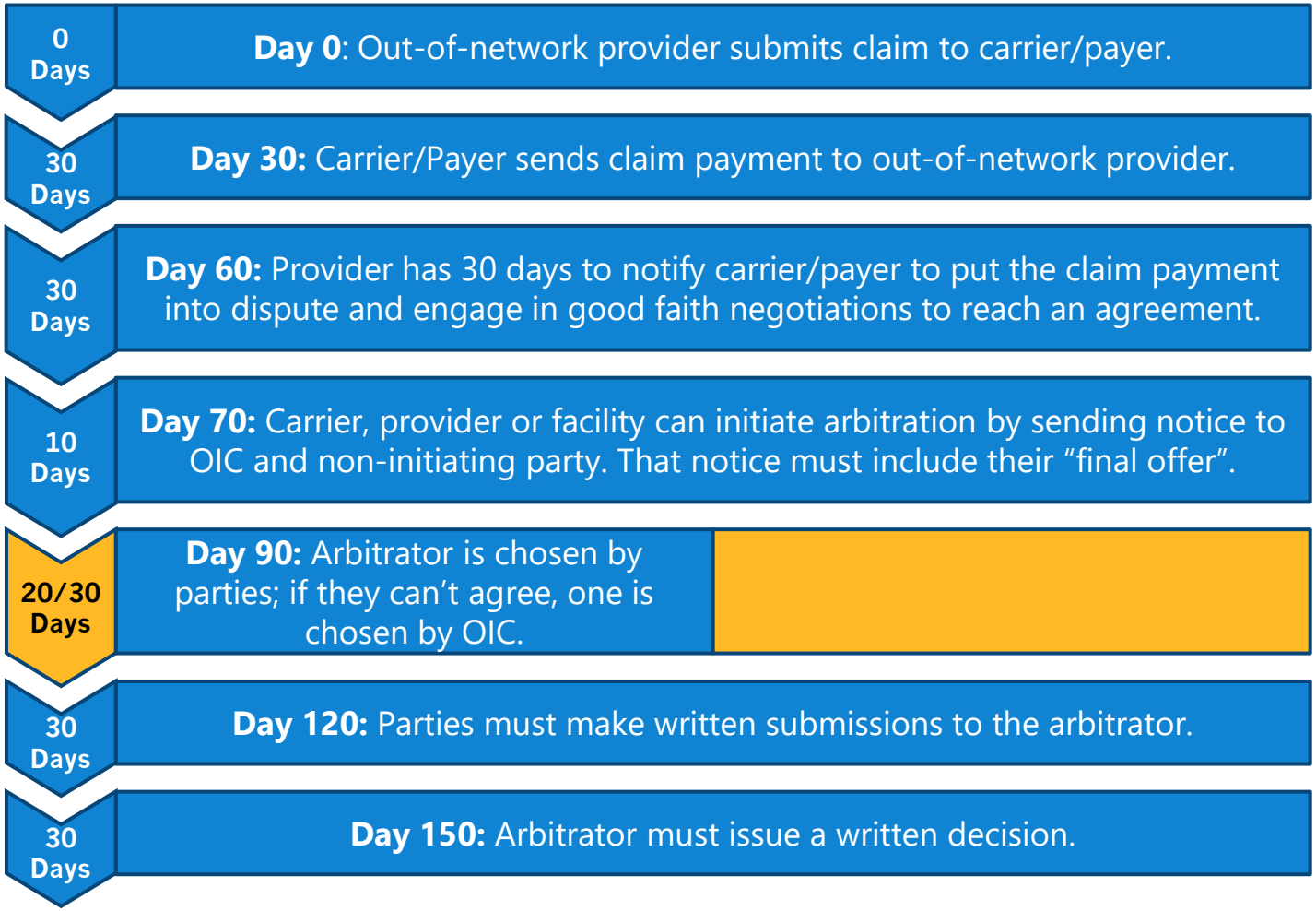
Day 100: Non-initiating party must provide final offer.
30 Days
Day 120: Parties must make written submissions to the arbitrator.
30 Days
Day 150: Arbitrator must issue a written decision.

Choosing the Arbitrator

Total time for choice of arbitrator: 20 days

- Within 7 calendar days of receipt of AIRF, OIC provides parties the list of approved arbitrators
- If parties can't agree on arbitrator, OIC sends list of five arbitrators within five calendar days of receipt of this notice.
- Each party can veto up to 2 names/entities:
  - If one remains, that is the arbitrator.
  - If more than one remains, OIC chooses.
- Failure of non-initiating party to respond without good cause to AIRF: initiating party chooses the arbitrator.

RCW 48.49.040; WAC 284-43B-030)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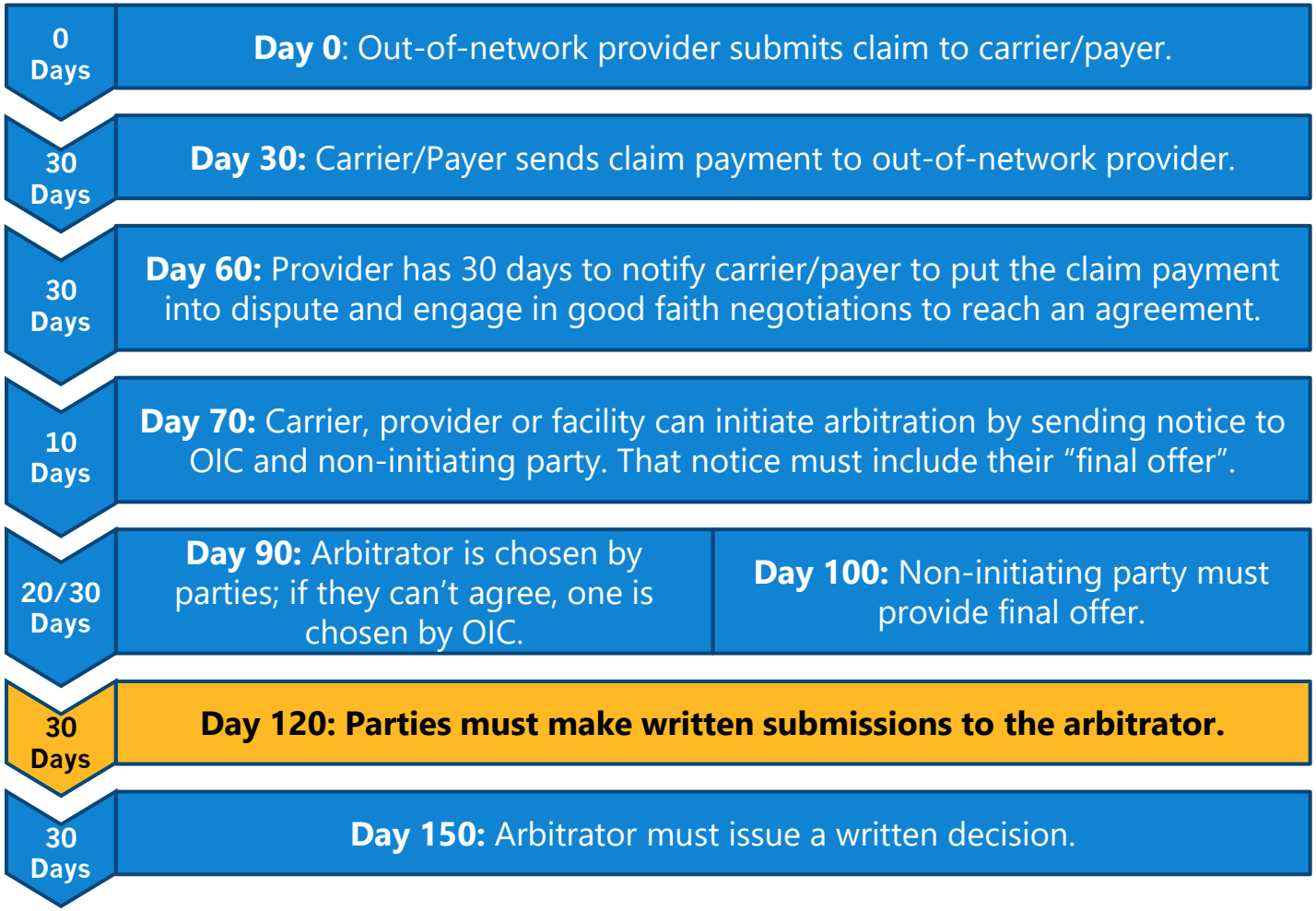
30 Days
Day 120: Parties must make written submissions to the arbitrator.
30 Days
Day 150: Arbitrator must issue a written decision.

Arbitration

- Both parties must execute a nondisclosure agreement when arbitration initiated.
- No later than 30 calendar days following receipt of AIRF, the non-initiating party must provide its final offer to the initiating party.
- The parties may reach an agreement on payment prior to the arbitrator's final decision. 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.
- The parties may also request additional time to complete settlement negotiations prior to making written submissions to the arbitrator.

(RCW 48.49.040, as amended by E2SHB 1688; WAC 284-43B-035)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Day 150: Arbitrator must issue a written decision.

Arbitration proceeding

Written submissions to the arbitrator are due no later than 30 calendar days after the final selection of the arbitrator. Each party's submission must include evidence and methodology for asserting the amount is commercially reasonable.

- Parties that fail to make timely submissions without good cause shall be considered in default. They must pay final offer amount submitted by other party. They can be ordered to pay arbitration/arbitrator costs.

Arbitrator must consider:

- Evidence and methodology submitted by parties to support their final offer.
- Patient characteristics and complexity of case.

Arbitrator may consider:

- Surprise billing data set.
- Additional information submitted by parties.

RWC 48.43.040, as amended by E2SHB 1688

Arbitration proceeding

- Arbitration expenses, including the arbitrator's expenses and fees, but not including attorneys' fees, are divided equally among the parties.
- The Commissioner has authority to establish arbitrator fee ranges or schedules by rule. ESHB 1688/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. ESHB 1688/Sec. 11(9).
- Washington state's Uniform Arbitration Act (Chapter 7.04A RCW) applies to BBPA arbitrations. In the event of a conflict between BBPA and Chapter 7.04A, BBPA governs.

IF IDR determines no jurisdiction ……

If a federal arbitrator determines that the federal IDR system does not apply to all or part of a dispute, the parties can initiate BBPA arbitration:

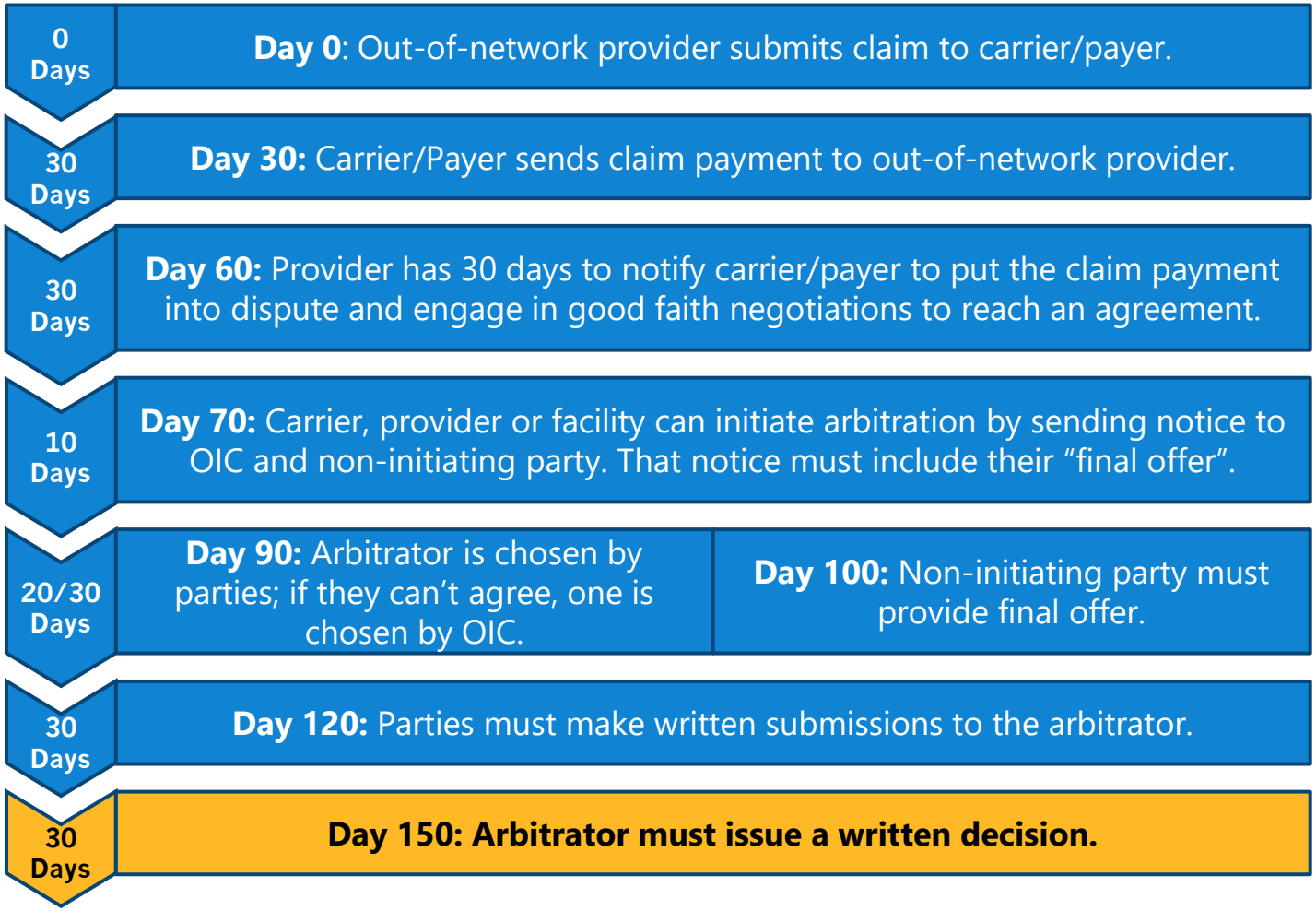
- Without completing good faith negotiation under RCW 48.49.040, if the federal IDR period of good faith negotiation was completed; and
- By providing notification to OIC and the noninitiating party no later than ten (10) calendar days following the date the parties receive notice from the IDR that the dispute is not subject to the NSA IDR process

RCW 48.49.040 as amended by E2SHB 1688

APCD Surprise Billing Data set

Parties and arbitrators have access to a data set from the state's All Payer Claims Database.

- Data set based on 2018 commercial fee-for-service health insurance claims and inflated annually by CPI-medical.
- Provides median in-network, median out-of-network and median billed charges for services subject to the BBPA.
- Data set will be revised in 2022 to reflect broader scope of services protected from balance billing under RCW 48.49.020, as amended by E2SHB 1688.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Day 150: Arbitrator must issue a written decision.

Arbitration

Within 30 days of receipt of submissions, arbitrator issues a written decision requiring payment of final offer amount of one of the parties.

- Arbitrator's decision must include explanation of the elements of the parties' submissions relied upon to make their decision and why those elements were relevant to the decision.

Arbitrator provides decision and the following information to OIC:

- Name of the carrier;
- Name of the health care provider;
- Health care provider's employer or associated business entity;
- Health care facility where the services were provided; and
- Type of health care services at issue.

Arbitrator reporting form is in rule.

RCW 48.49.040, as amended by E2SHB 1688

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.

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?

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