Washington State Medical Association
Physician Driven, Patient Focused

May 31, 2022

Honorable Mike Kreidler
Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504

Commissioner Kreidler,

On behalf of the Washington State Medical Association, representing more than 12,000 physicians and physician assistants across the state, as well as the undersigned organizations, thank you for the opportunity to provide comment on the CR-101 for R 2022-02, implementing House Bill 1688 from the 2022 legislative session.

Consistent with comments we have provided on previous rulemakings related to balance billing, our primary request is the exercise of discretion in determining which areas of the state's balance billing law should be modified or developed via rule. The BBPA in its current form represents years of painstaking negotiation – we'd hope the next iteration of this work will aim to maintain a balance in policy that seeks to drive insurance carriers and providers towards voluntarily contracting, as most have and currently do.

In line with that principle, our comment will focus on suggestions for the new arbitration provisions of the law under Section 18 of HB 1688 related to alternate access delivery requests.

- **AADR reimbursement**
  - Throughout the discussions on HB 1688 during the 2022 legislative session, it was repeatedly noted by the OIC that a carrier would generally be required to reimburse a provider party to an AADR at the provider's billed charges. This tracks with WAC 284-170-210, but the law does not explicitly require carriers to reimburse at billed charges, instead directing that AADRs "may result" in payment at billed charges. Carriers reimbursing providers at billed charges for three months was critical to the negotiations on Section 18 of HB 1688. The rule should specify that for those AADRs that include services covered by the BBPA, carriers are explicitly required to reimburse at billed charges for the three month period that precedes the ability to petition for arbitration to establish a commercially reasonable payment rate for the duration of the AADR. Further, the OIC should verify that the carrier has been reimbursing the provider as directed before they are eligible to initiate arbitration.
- **Duration of AADRs**
  - Another element of the negotiations on HB 1688 was the duration of AADRs, and it was repeatedly noted by the OIC that an AADR may be in place for up to one year. This policy was critical to the physician community's moving away from opposition to the bill

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as passed into law. The maximum duration of AADRs should be formalized in statute as lasting no longer than one year, after which point the carrier would have to submit a new request, consistent with the terms of Section 18 of HB 1688.

- **AADR arbitration**
  - Creating an allowance for carriers to utilize the arbitration process under the BBPA to establish reimbursement rates for an AADR represents a significant deviation from the status quo, under which providers would generally expect to be paid billed charges. The result of arbitration will almost necessarily reduce reimbursement to providers. Prospective arbitration will likely be more complex and higher stakes than the retroactive manner in which arbitration has been used to date. For these reasons, arbitration processes undertaken pursuant to an AADR should include the following provisions:
    - A single instance of arbitration should be used to establish the amount that will be paid to providers or facilities for the duration of the AADR (i.e., up to nine months, following the three-month period where claims would be paid at billed charges and concluding with the duration of the AADR at no longer than one year). Establishing rates in a single instance of arbitration is necessary to avoid the cost and administrative burden that multiple instances of arbitration would represent.
    - Parties should be required to submit factual statements under oath to support their arguments in arbitration. Depending on the parties and services at question in arbitration, an arbitrator's decision could have significant financial impact. All parties should have confidence in the arbitrator's decision, which would be promoted by ensuring that neither side is relying on unverified information.
    - There should be a higher standard in place for arbitrators to be eligible to participate in arbitration pursuant to an AADR. These will be complex, multi-variate decisions. In addition to the standards for arbitrators outlined in RCW 48.49.040, the individuals making determinations in instances of arbitration pursuant to an AADR should have specific experience in provider contract negotiations.
    - Previously contracted rates between the two parties should be required to be taken into consideration. An essential data point for an arbitrator to consider is whether the two parties to arbitration have contracted in the past, and if so, what rates were established under the contract as those rates were considered by the carrier to be patently reasonable at that time. While parties to arbitration are able to submit information they deem relevant to the arbitrator, prior contracting history between the two parties is crucial data that an arbitrator should be required to take into consideration.
    - Information from reputable claims databases that include self-insured claims should be required to be taken into consideration. The claims dataset established pursuant to RCW 43.371.100 was created via a thoughtful process but the data is limited by the exclusion of claims from self-insured health plans that make up the majority of the state's commercial health plan enrollment as carriers have opted not to submit these claims. This yields a dataset with a skewed perspective on the market that likely undervalues physician reimbursement. Examples of reputable claims databases that should be required to be considered are those that are not owned or affiliated with insurance carriers, health care providers or trade associations in the field of insurance, health benefits or providers of health care.
  - **Good faith negotiation standard**
    - Section 18 of HB 1688 requires that insurance carriers that are requesting to amend an AADR to allow for arbitration demonstrate "substantial evidence of good faith efforts" to contract. An opportunity should be provided for the health

care provider or facility party to the AADR to verify the information provided by the insurance carrier is accurate prior to the request for arbitration being granted.

- **Cost of arbitration**
  - Section 11 of HB 1688 directs that the OIC will establish allowable arbitrator fee ranges. This issue is currently being considered by federal regulators implementing the No Surprises Act. We recommend mirroring recent guidance from the Centers for Medicare & Medicaid Services which establishes reasonable arbitrator fees at $200-500 per instance of arbitration, or $268-670 if arbitration involves bundled claims.

Thank you for your consideration. We look forward to continuing to work together on the implementation of the law. Please feel free to let us know if you have questions or if there is additional information that we can provide.

Sincerely,

Sean Graham
Director of Government Affairs
Washington State Medical Association

Washington Chapter – American College of Emergency Physicians
Washington State Society of Anesthesiologists
Washington State Society of Pathologists
Washington State Society of Radiologists
Emergency Department Practice Management Association
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