OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Balance Billing Protection Act arbitration proceedings

Annual report

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Balance Billing Protection Act background

The Washington state Legislature passed the Balance Billing Protection Act (BBPA) (Chapter 427, Laws of 2019) to protect consumers from balance billing, also called surprise billing. Balance billing is when a patient receives out-of-network emergency medical services and out-of-network surgical or ancillary services (such as lab testing, radiology and anesthesia services) at an in-network hospital or outpatient surgical facility. The BBPA went into effect on Jan. 1, 2020.

For services subject to the BBPA, when an out-of-network health care provider or health care facility (hereinafter called "provider") submits a claim to a health insurance carrier, the allowed amount paid to that provider must be a commercially reasonable amount. It also must be based on payments for the same or similar services provided in a similar geographic area (RCW 48.49.030(2)). The BBPA includes a process for out-of-network providers to dispute an initial payment from a carrier. If, after a 30-day period of informal negotiation, the carrier and provider cannot resolve the dispute, the provider or carrier can initiate arbitration proceedings. The BBPA specifies timelines for each of the steps in the dispute resolution and arbitration process. (RCW48.49.030 and RCW 48.49.040).

The BBPA is structured to allow providers to address multiple claims in a single arbitration proceeding. These "bundled" claims must:

- Involve identical carrier or facility parties.
- Involve claims with the same or related billing codes.
- Occur within a period of two months of one another.

Under the law (RCW 48.49.040), once an arbitrator is chosen, each party must submit its written materials to the arbitrator within 30 days. The arbitrator's decision is made based upon the written materials submitted by the parties. Within 30 days of receiving the parties' submissions, the arbitrator must issue a written decision requiring payment of the final offer amount of either the party that initiated the arbitration or the party that responded to the arbitration (i.e., the final offer amount of the carrier or the provider) and notify the parties of their decision. The arbitrator must provide the decision and information required for this report to the Office of the Insurance Commissioner (OIC).

This report addresses arbitration proceedings that occurred during calendar year 2021. On March 31, 2022, the governor signed E2SHB 1688 (Chap. 263, Laws of 2022). This new law amends several of the BBPA arbitration provisions, which are described here.

The BBPA directed the OIC to contract with the Office of Financial Management to develop the All Payer Claims Database (APCD). This database provides information on amounts that carriers paid to providers for services protected from balance billing under the BBPA. It is a source of objective information for providers and carriers to use during negotiation and helps arbitrators evaluate final offers made by the parties.

RCW 48.49.050 requires the insurance commissioner to submit an annual report to the Legislature through 2022.[1] The report must summarize information from the arbitrators' decisions and provide the following information for each dispute resolved through arbitration:

- The name of the carrier.
- The name of the health care provider.
- The health care provider's employer or the business entity in which the provider has an ownership interest.
- The health care facility where the services were provided.
- The type of health care services at issue.

[1] E2SHB 1688 amends RCW 48.49.050 such that the reporting obligation expires on Jan. 1, 2023.

Implementation of the arbitration provisions under the Balance Billing Protection Act

The OIC adopted rules to implement the BBPA in November 2019 (Chapter 284-43B WAC) and amended those rules in November 2020 in response to the initial implementation experience. The OIC consulted extensively with interested organizations and parties regarding rulemaking and additional implementation activities, including minimum qualifications for arbitrators and other aspects of the arbitration process.

In addition, the OIC developed a BBPA section on its website that makes the information about the BBPA easily accessible to consumers, providers, carriers, and self-funded group health plans that have elected to extend the protections of the BBPA to their plan members.

The arbitration pages on the OIC's website include an online application for individuals and entities to apply to serve as arbitrators and a list of approved arbitrators and arbitration entities. As of May 2022, there are 31 individual arbitrators and five arbitration entities approved as BBPA arbitrators.

The BBPA arbitration webpage section also includes links to required forms for submitting a request to initiate arbitration and for arbitrators to submit to the OIC along with their decisions. Both forms were adopted during rulemaking in 2020. The webpage section includes a link to the surprise billing dataset, drawn from the APCD, as well as extensive explanatory information and instructions on how to use the database.

The BBPA webpage section includes the online form for self-funded group health plans that elect to participate in the BBPA , as well as an updated list of the participating plans. To date, approximately 380 self-funded group health plans have elected to offer BBPA protections to their enrollees.

2021 arbitration report

This report summarizes information from the arbitrators' decisions, and provides the following information for each dispute resolved through arbitration in calendar year 2021:

- The name of the carrier.
- The name of the health care provider.
- The health care provider's employer or the business entity in which the provider has an ownership interest.
- The health care facility where the services were provided.
- The type of health care services at issue.

The BBPA law includes specific timelines that a provider or carrier must meet to initiate arbitration. The OIC reviews each request to determine whether the statutory timelines have been met.

Claims for self-funded group health plans that did not elect to participate in the BBPA are not subject to arbitration under the act. Any questions about the inclusion of such claims in an arbitration request would have been resolved either through discussion between the parties or arbitration. These claims are included in the count in the table below.

Throughout 2020 and 2021, the OIC responded to inquiries from provider groups, provider practice management and carriers about the arbitration process.

The OIC received substantially fewer arbitration cases in 2021 than in 2020. In summary, a total of 11 Arbitration Initiation Request Forms (AIRFs) were submitted to the OIC in 2021. Of these, two were rejected by the OIC due to noncompliance with timelines established in the BBPA and its implementing rules. To date, nine cases have resulted in an arbitration decision.

Disposition (2021)	Number of AIRFs	Total claims at issue
Rejected	2	506
Settled/Withdrawn	0	0
Arbitrator decision	9	698
Pending resolution or unknown	0	0
Total	**11**	**1204**

The 2021 experience contrasts with 2020, when the OIC received substantially more AIRFs. The OIC received 71 AIRFs in 2020. Of these, 19 were rejected by the OIC due to noncompliance with timelines established in the BBPA and its implementing rules. Eighteen of the requests were withdrawn or settled by the parties prior to proceeding to arbitration and 29 cases to date have resulted in an arbitration decision.

Disposition (2020)	Number of AIRFs	Total claims at issue
Rejected	19	263
Settled/Withdrawn	18	335
Arbitrator decision	29	221
Pending resolution or unknown	5	58
Total	**71**	**877**

Like 2020, most providers initiating arbitration used the bundled claims option in RCW 48.49.040. Of the nine arbitration initiation requests that were accepted, six included multiple or "bundled" claims. The services in dispute were emergency and anesthesiology.

Attachment A provides greater detail about the disputes that proceeded to arbitration in 2021. In these proceedings, the arbitrator decided in favor of the carrier in six cases and in favor of the provider in two cases. One of the bundled claims cases resulted in some claims being decided in favor of the carrier and the remainder in favor of the provider.

Attachment A

Attachment to the Balance Billing Protection Act Arbitration Proceedings Annual Report for calendar year 2021.

AIRF #	Carrier	Provider	Provider employer/business entity	Facility(ies) where services provided	Type of health care services	Number of claims	Prevailing party
21A-0001	United Health Care (UHC)	Not reported	South Sound Anesthesia Associates, PLLC	Not reported	Anesthesiology	6	Provider
21A-0002	Kaiser Fdn. Health Plan of WA (KPWA)	Not reported	Olympia Emergency Services, PLLC (OES)	Providence St. Peter Hospital, Olympia	Emergency	187	Provider: 98 claims KP: 64 claims
21A-0003	KPWA	Not reported	OES	Providence St. Peter Hospital, Olympia	Emergency	171	Carrier
21A-0004	KPWA	Not reported	OES	Providence St. Peter Hospital, Olympia	Emergency	172	Carrier
21A-0005	UHC	Not reported	Anesthesia Associates, PS Spokane, WA	Deaconess Medical Center Valley Hospital, Spokane	Anesthesiology	8	Provider
21A-0006	KPWA	Not reported	OES	Providence Health & Services, Olympia	Emergency	151	Carrier
21A-0007	UHC	Dennis W. Miller, M.D.	Northwest Emergency Physicians --TeamHealth	Cascade Valley Hospital, Arlington	Emergency	1	Carrier, by default
21A-0008	UHC	Jason Oost, M.D.	Northwest Emergency Physicians -- TeamHealth	St. Joseph Washington Hospital, Bellingham	Emergency	1	Carrier, by default
21A-0009	UHC	Dustin Shawcross, M.D.	Northwest Emergency Physicians -- TeamHealth	St. Anthony Hospital, Gig Harbor	Emergency	1	Carrier