



Surprise Billing – Chap. 263, Laws of 2022 – Behavioral Health Community

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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 – Applies to...

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

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.

Coverage of Emergency Services

RCW 48.43.005 defines an emergency medical condition to include “a medical, mental health or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress...”, according to a prudent layperson standard, which is consistent with CMS’s interpretation of the federal Emergency Medical Treatment and Active Labor Act (EMTALA) law.

See 86 Fed. Reg. at p. 36,879 (July 13, 2021)

BH Emergency Services Providers

Section 2 amends RCW 48.43.005 to include “behavioral health emergency services providers” as providers of emergency services covered by the act. “Behavioral health emergency services providers” include:

- A crisis stabilization unit as defined in RCW 71.05.020.
- An evaluation and treatment licensed or certified as such by DOH.
- An agency certified by DOH under chapter 71.24 RCW to provide outpatient crisis services.
- A triage facility as defined in RCW 71.05.020.
- An agency certified by DOH under chapter 71.24 RCW to provide medically managed or medically monitored withdrawal management services.
- A mobile rapid response crisis team as defined in RCW 71.24.025 that is contracted with a BHASO to provide crisis response services in the behavioral health administrative services organization's service area.

See Sec. 2(48) for additional detail regarding these settings.

What are “emergency services”?

Health plans must cover “emergency services” provided to a consumer in an out-of-network (nonparticipating) hospital emergency department or by a behavioral health emergency services provider. The health insurer cannot require prior authorization for the emergency services.

Applies to health plans/carriers regulated by OIC.

RCW 48.43.093, as amended by section 3 of E2SHB 1688.

What are “emergency services”?

Emergency services include the following services provided by a behavioral health emergency services provider:

- Screening: A screening examination that is within the capability of a behavioral health emergency services provider including ancillary services routinely available to the behavioral health emergency services provider to evaluate that emergency medical condition.
- Stabilization: Examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health emergency services provider to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in § 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)).

What are “emergency services”? (con’t)

- Post-stabilization care: Covered behavioral health services provided by staff or facilities of a behavioral health emergency services provider after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished.
- Post-stabilization services relate to mental health or substance use disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Balance Billing Provisions

Balance billing prohibitions apply to....

Service	Facility	Providers
Emergency services, including post-stabilization services	In-network or out-of-network (OON): <ul style="list-style-type: none"> • Hospital • Behavioral health emergency services provider* 	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 prohibitions apply to...

Because behavioral health emergency services providers are integrated into the definition of “emergency services” under state law, they cannot balance bill consumers enrolled in:

- Fully insured individual and group health plans.
- Washington state public employee and school employee health benefit plans.
- Self-funded group health plans that have opted into the BBPA.

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.

Consumer Notice & Transparency

Sec. 13, amending RCW 48.49.060, Sec. 14, amending RCW 48.49.070 & Sec. 15, amending RCW 48.49.080:

OIC must develop a template for a notice of consumer rights that applies to both the BBPA and the NSA. [Notice](#) posted on OIC website.

- OIC determines through rulemaking when and how the notice must be provided to consumers.

Consumer Notice of BB Protections

	Providers and Facilities	Carriers
When consumer schedules non-emergency services (BBPA)		
Within 72 hours of a consumer receiving <u>emergency services</u> (BBPA)		
When provider/facility requests payment from a consumer, and if payment is not requested, on the date a claim is submitted for payment (NSA)		
When a carrier authorizes non-emergency services for a consumer (BBPA)		
On a consumer's Explanation of Benefits, i.e. whether service is protected from balance billing (BBPA & NSA)		

Transparency

Providers, including behavioral health emergency services providers must post on their website, if one is available (if not, when requested by a consumer):

- List of the carrier health plan networks they participate in;
- Notice of consumer balance billing consumer rights.

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
<p>Sec. 9, new section added to Chap. 48.49 RCW</p> <p>BBPA: “Commercially reasonable amount”</p>	<p>Sec. 9, new section added to Chap. 48.49 RCW</p> <p>Transition to NSA provisions</p>

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
<p>Sec. 11, amending RCW 48.49.040:</p> <p>If nonparticipating provider and carrier cannot agree on a commercially reasonable payment, BBPA arbitration for <u>all disputes, other than air ambulance</u>.</p> <p>Air ambulance payment disputes use the NSA IDR system.</p> <p>Arbitrations under section 18 use the BBPA arbitration system.</p>	<p>Sec. 11, amending RCW 48.49.040:</p> <p>If nonparticipating provider and carrier cannot agree on a payment amount, use NSA “independent dispute resolution” (IDR) system.</p> <p><u>Except</u>, BBPA arbitration system is used for:</p> <ul style="list-style-type: none">• 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

BBPA OON Provider Payment & Dispute Resolution

The out-of-network (nonparticipating) provider is paid a “commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area.”

If the provider and carrier cannot agree on this amount, after a 30-day informal negotiation period, they can proceed to arbitration:

- Initiation of arbitration notice to OIC
- OIC provides parties with list of arbitrators/arbitration entities
- Providers can “bundle” claims with same procedural code that occur within 1 month of each other, if same carrier and same provider
- Each party presents evidence/methodology to support their position
- Parties can “settle” any time prior to arbitrator issues their decision
- Arbitrator chooses one party’s “best final offer”. Decision is final and binding.
- Parties split the cost of arbitration, each pays its own attorney’s fees

See Appendix for more detail on arbitration process

APCD Data set

To inform negotiations and arbitration, providers, carriers and arbitrators have access to a [data set](#) from the state's All Payer Claims Database:

- Provides median in-network, median out-of-network and median billed charges.
- Updated annually based on medical CPI to avoid rate changes due to impact of the Act.
- Will be revised in 2022 to add expanded scope of services protected from balance billing 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.

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 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.

Other No Surprises Act/CAA Protections

Good Faith Estimate

§2799B-6 of PHS Act – Uninsured and self-pay individuals

- All providers and facilities that schedule items or services for an uninsured or self-pay individual (i.e. individual will not be submitting a claim for the service) or receive a request for a Good Faith Estimate (GFE) from an uninsured (or self-pay) individual must provide a GFE. No specific specialties, facility types, or sites of service are exempt from this requirement.
- Patient-provider dispute resolution (PPDR) process: the uninsured (or self-pay) individual can use if the actual billed charges exceed the GFE by at least \$400.
- [CMS FAQs on Good Faith Estimates](#)
- [CMS FAQs on Good Faith Estimates – Part 2](#)

Advanced Explanation of Benefits

§2799B-6 of PHS Act – Insured individuals who intend to submit a claim for coverage:

- Providers and facilities to provide GFE to insured individuals.
- GFE transferred to carrier to prepare Advanced Explanation of Benefits (AEOB) to consumers.
- Federal agencies intend to undertake notice and comment rulemaking, including establishing appropriate data transfer standards.
- Until that time, the Departments (and OIC) will defer enforcement of the requirement that plans and issuers must provide an AEOB.
- [FAQs about ACA and CAA Implementation Part 49](#)
- [OIC TAA](#)

Continuity of Care

§§2799A-3 and 2799B-8 of the PHS Act:

- When a carrier/in-network provider contract is terminated for some or all services:
 - Carrier must notify “continuing care patients” of their right to receive transitional care from the provider for up to 90 days with same terms as if the provider were still in-network.
 - Provider must accept payment from the health plan as payment in full and adhere to all health plan policies and quality standards during transitional care period.
- Federal rulemaking pending, but until fully implemented, federal agencies expect carriers and providers to implement using a good faith, reasonable interpretation of the statute.

Enforcement

Enforcement – Carriers

Section 5 (Chap. 48.43 RCW) & Section 19 (Chap. 48.49 RCW):

OIC has authority to enforce provisions of the Consolidated Appropriations Act of 2021, including the NSA, and implementing federal regulations that are applicable to or regulate the conduct of carriers issuing health plans or grandfathered health plans to residents of Washington state on or after January 1, 2022.

Enforcement – Providers and Facilities

A “pattern of unresolved violations” of the BBPA consumer protection provisions constitutes “unprofessional conduct” under the state’s provider Uniform Disciplinary Act and is a basis for discipline under hospital, ASF and laboratory licensing statutes.

OIC will first give provider/facility opportunity to cure violations.

If OIC determines a pattern of unresolved violations has occurred, can refer the provider/facility to DOH/disciplinary authority for further action.

Enforcement – Department of Health

Providers

Balance Billing Protection Act

- DOH receives referrals from OIC for violations of RCW 48.49.020 and 48.49.030
- DOH investigates referrals from OIC
- If DOH finds that evidence supports a violation, DOH will proceed with enforcement under RCW 18.130.180(21)

No Surprises Act

- DOH will enforce No Surprises Act provisions related to providers
- NSA provisions applicable to providers include:
 - §2799B-1
 - §2799B-2
 - §2799B-3
 - §2799B-6
 - §2799B-7
 - §2799B-8
 - §2799B-9

Enforcement – Department of Health

Facilities

Balance Billing Protection Act

- DOH receives referrals from OIC for violations of RCW 48.49.020 and 48.49.030
- DOH investigates referrals from OIC
- If DOH finds that evidence supports a violation, DOH will proceed with enforcement under
 - RCW 70.230.210 - Ambulatory Surgical Facilities
 - RCW 70.41.510 - Hospitals
 - RCW 70.42.162 - Medical Test Sites
 - RCW 71.24.618 - Behavioral Health Agency

No Surprises Act

- Centers for Medicare and Medicaid Services will be responsible for enforcement of No Surprises Act provisions applicable to facilities and air ambulance providers

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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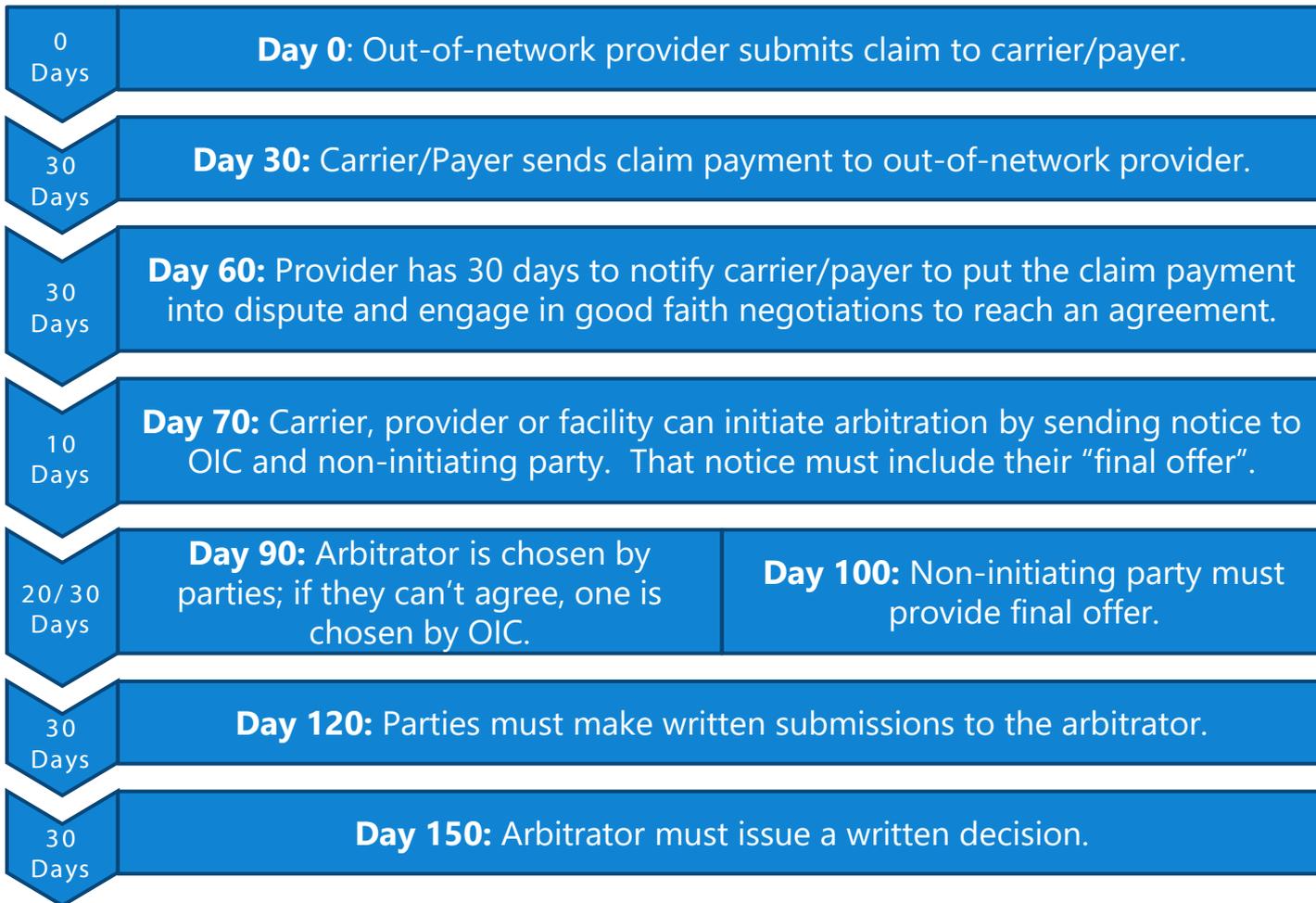
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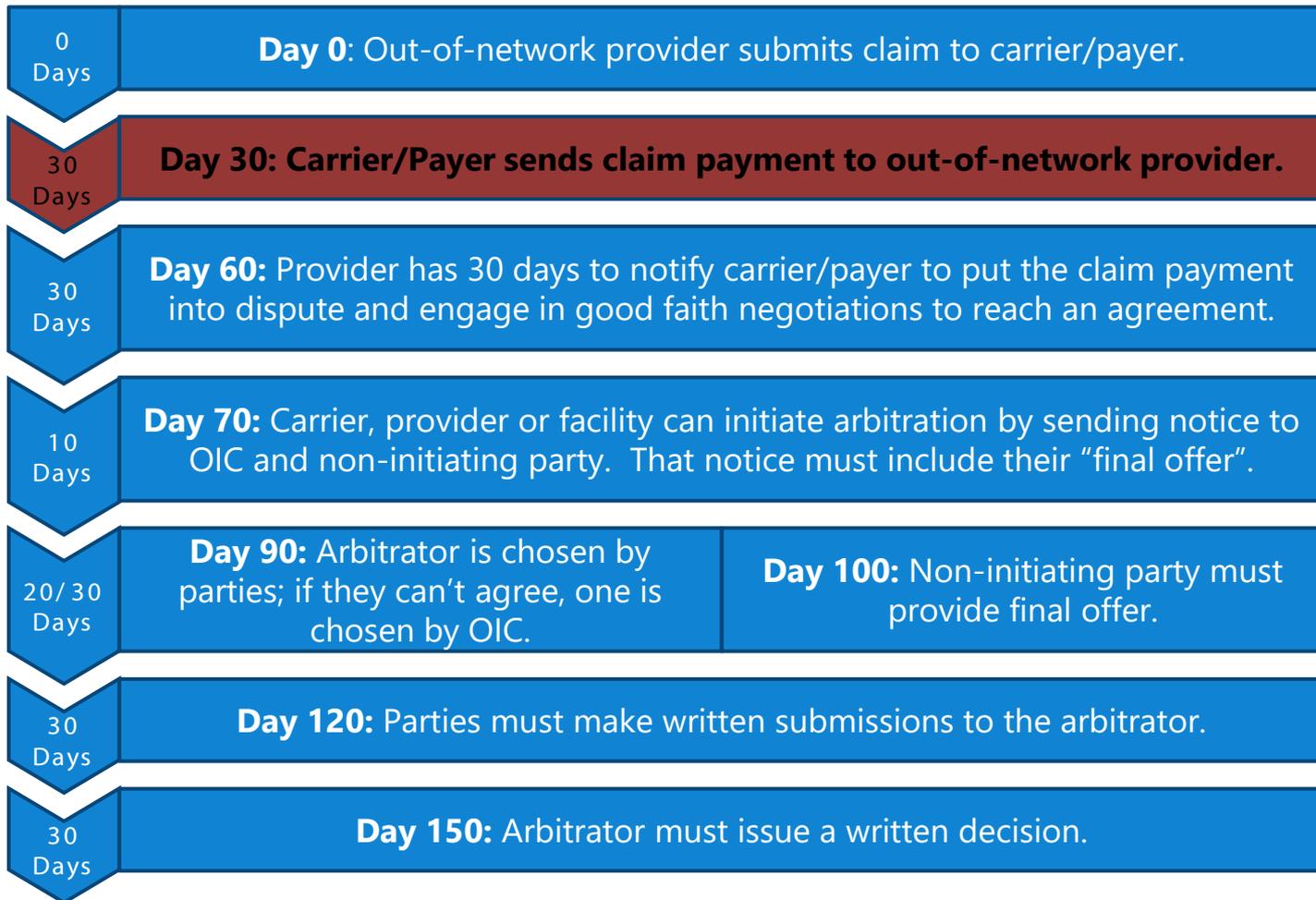
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- OIC Surprise Billing website: <https://www.insurance.wa.gov/surprise-medical-billing>
- Facebook: <https://www.facebook.com/WSOIC>
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- www.insurance.wa.gov

Appendix

BBPA Dispute Resolution/Arbitration Process





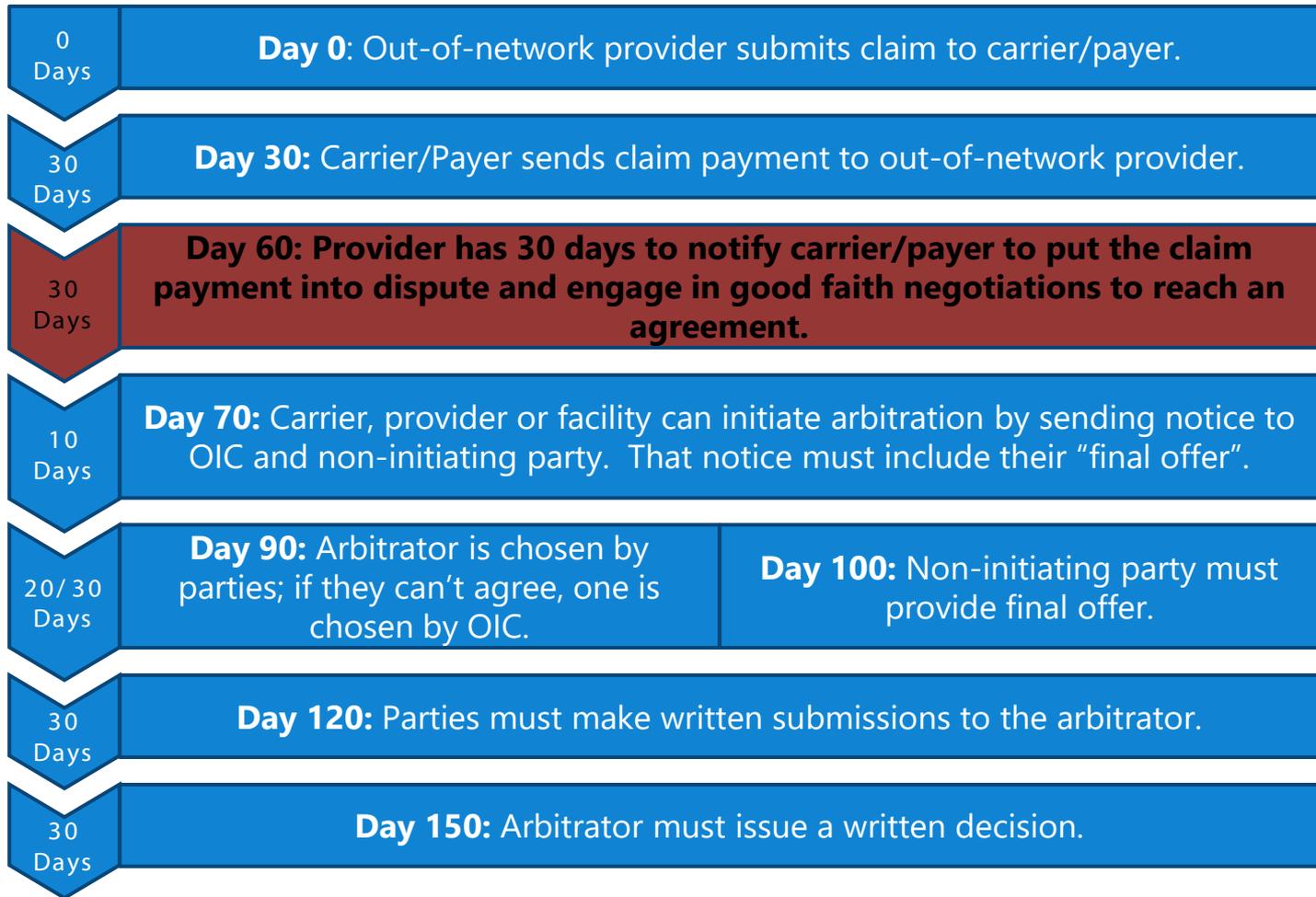
Carrier payment to OON provider

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)

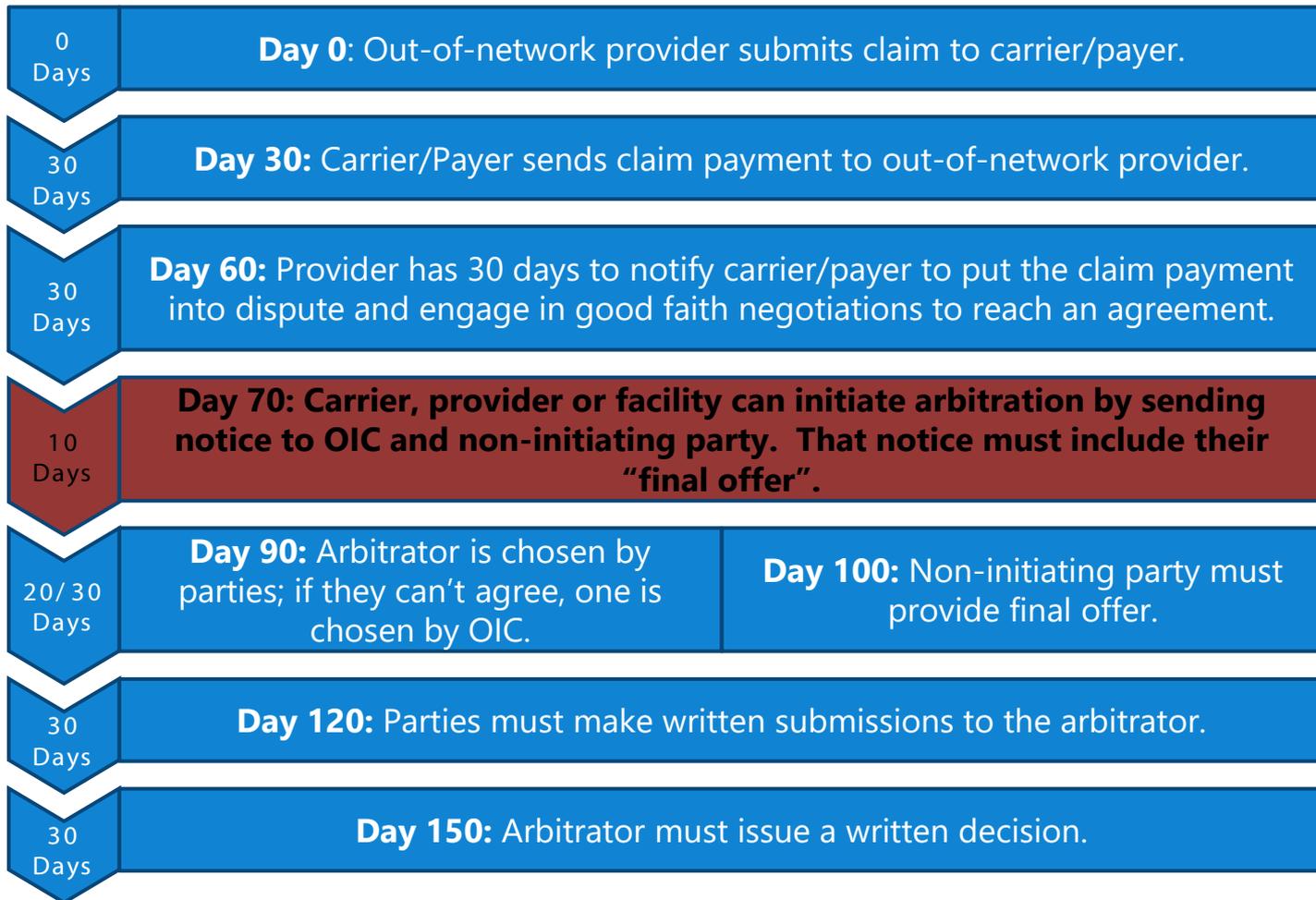


Claim in dispute/ good faith negotiations

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)



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

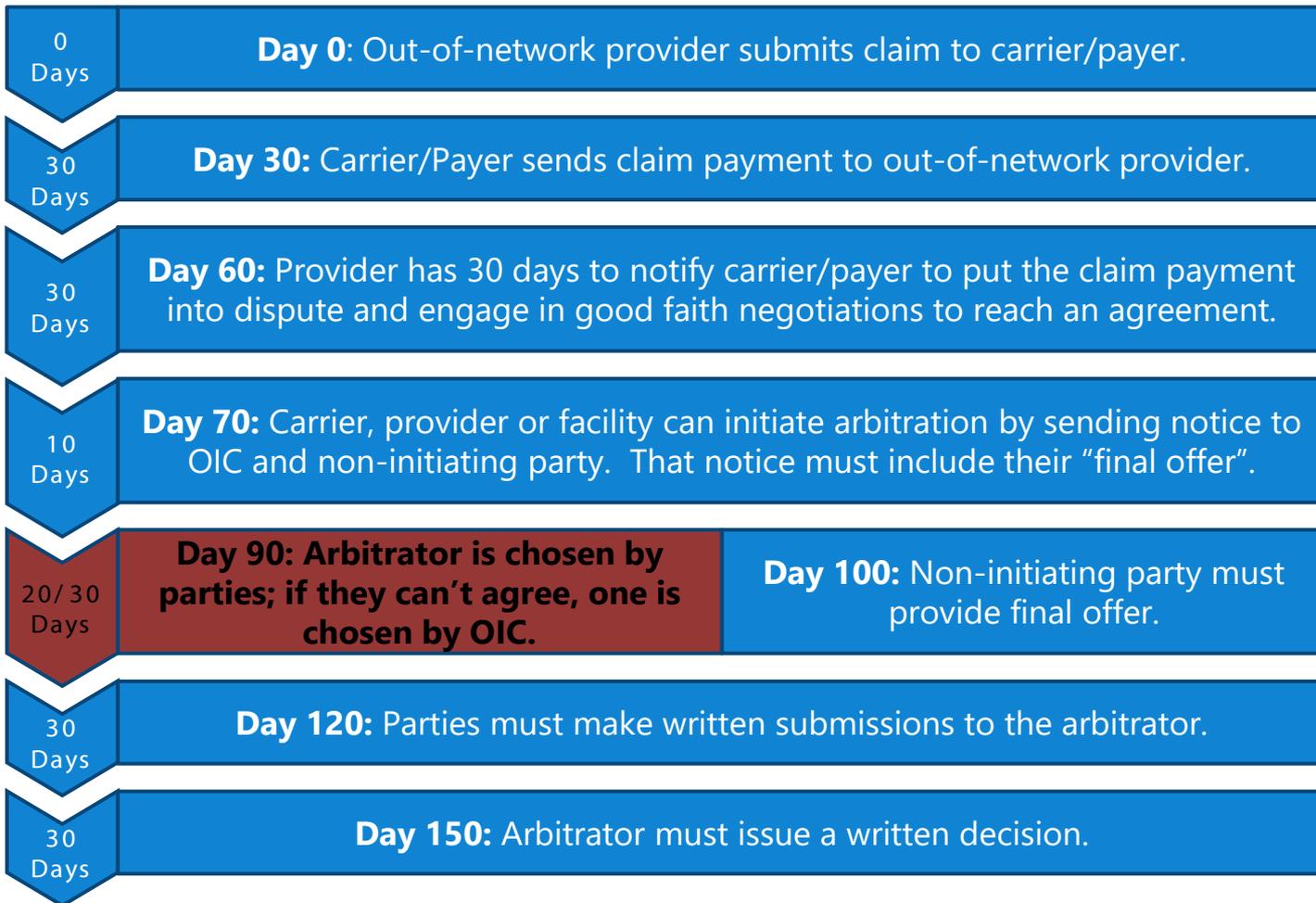
All of the claims at issue must:

- 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 ten day period to initiate arbitration is measured from 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)

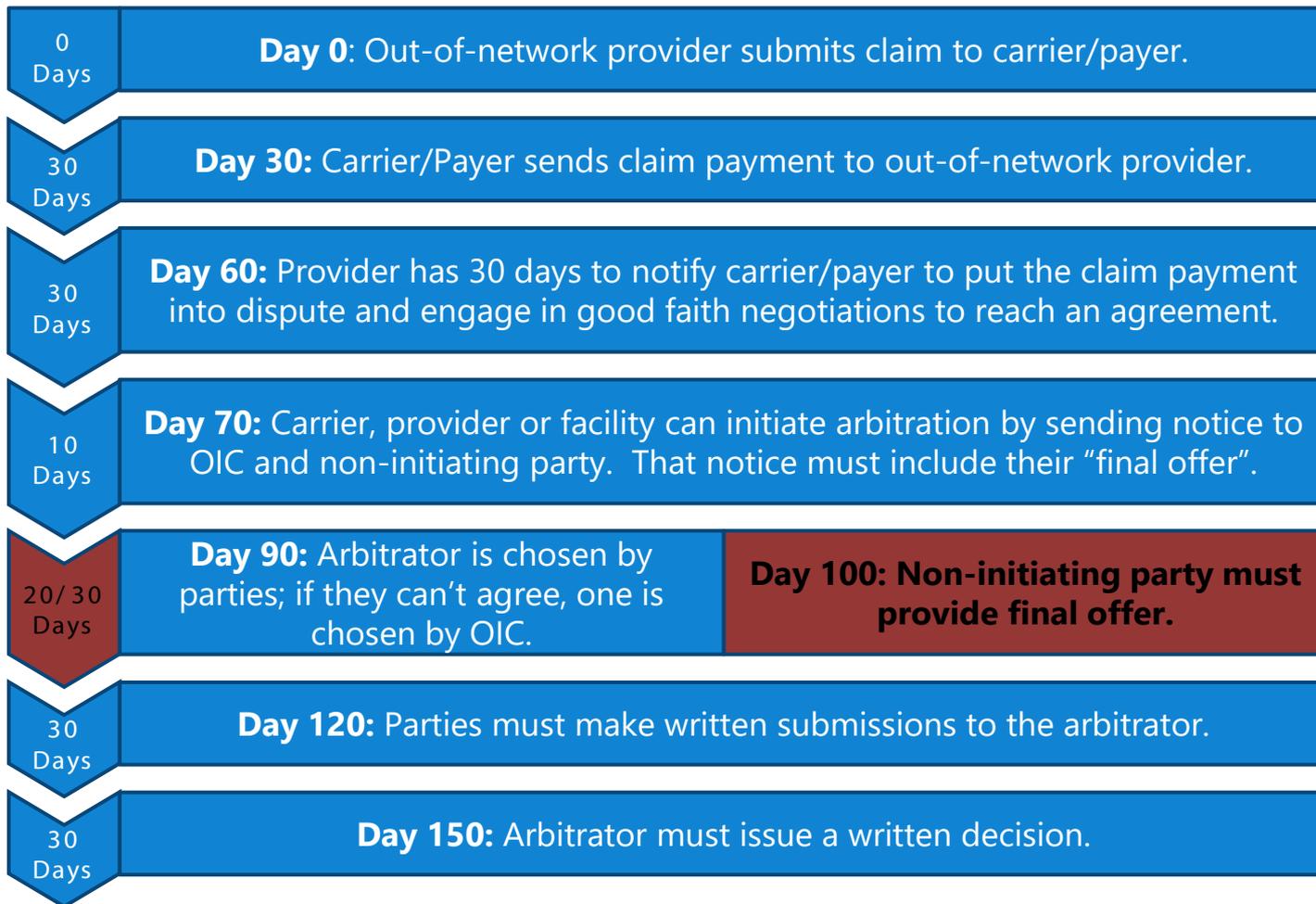


Choosing the Arbitrator

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.

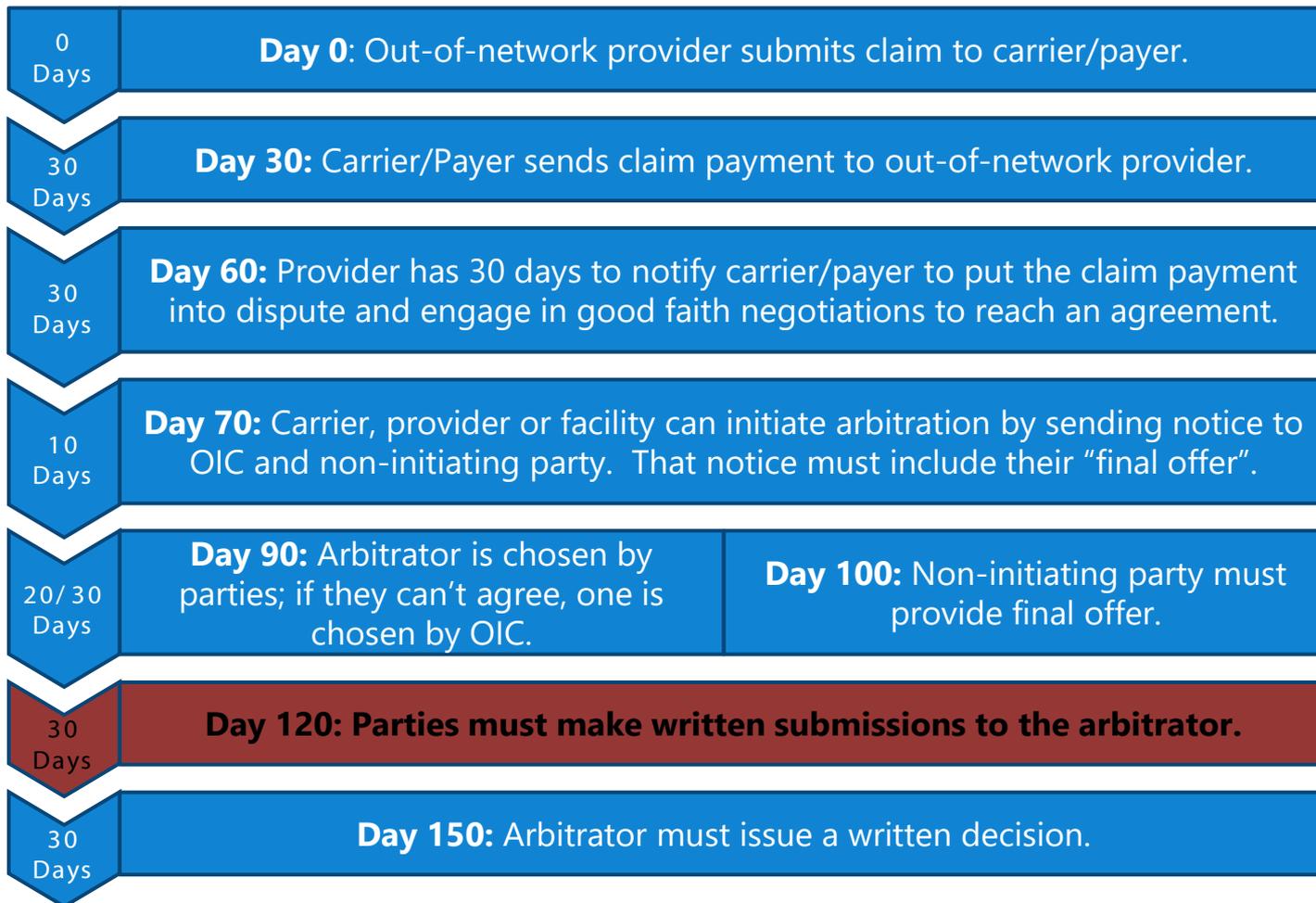
RCW 48.49.040; WAC 284-43B-030)



Arbitration

- Both parties must execute a nondisclosure agreement when arbitration initiated.
- No later than thirty 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)



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:

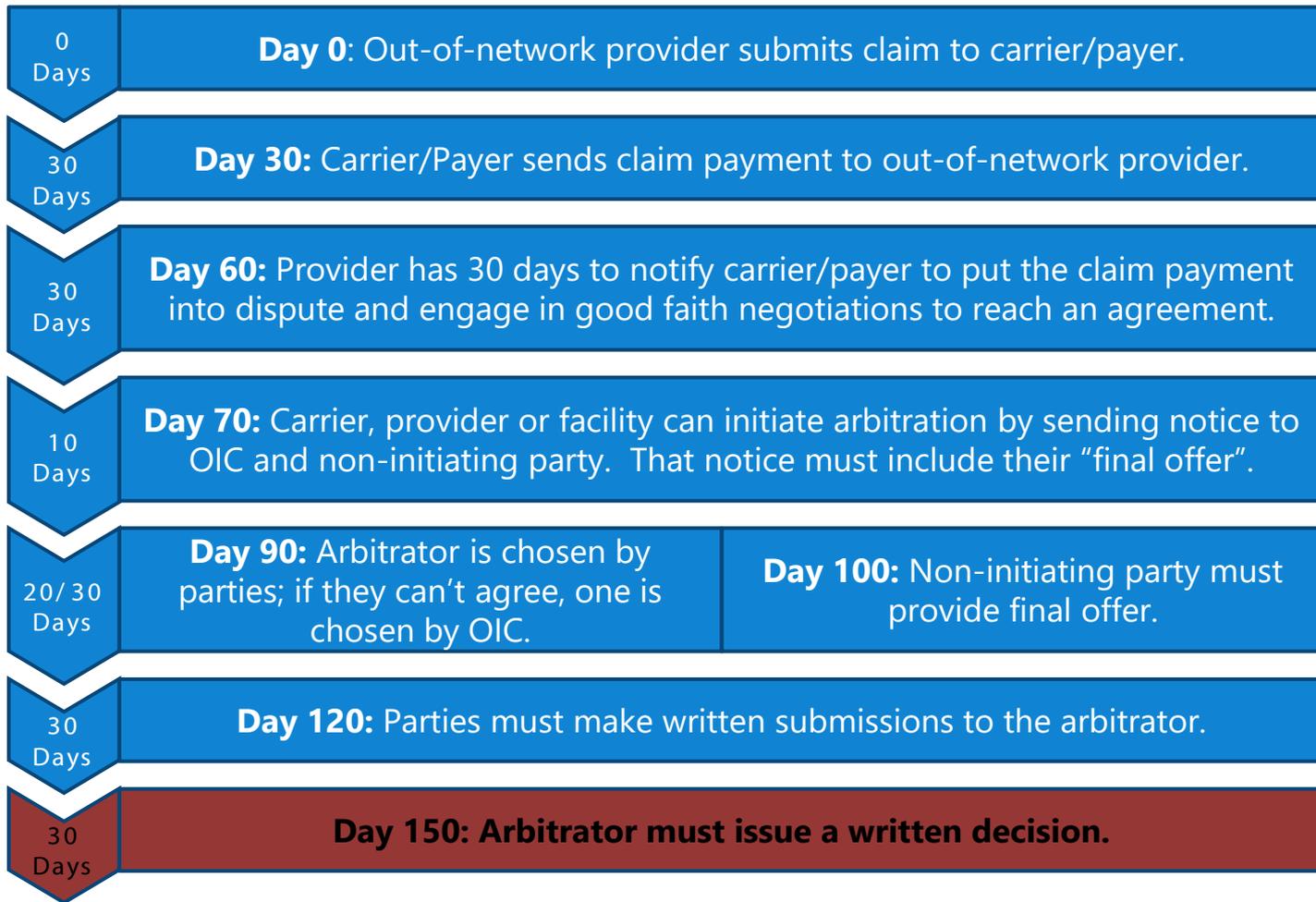
- Without completing good faith negotiation under RCW 48.49.040, if the federal IDR period of good faith negotiation was completed; and
- By providing notification to OIC and the noninitiating party no later than ten (10) calendar days following the date the parties receive notice from the IDR that the 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



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.
- Type of health care services at issue.

Arbitrator reporting form is in rule.

RCW 48.49.040, as amended by E2SHB 1688