Washington State Hospital Association

August 6, 2020

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

Re: WSHA Comments on Balance Billing Protection Act Stakeholder Draft WSR 20-12-083

Dear Commissioner Kreidler,

On behalf of our 108 hospital and health system members, the Washington State Hospital Association (WSHA) values the opportunity to comment on additional rulemaking implementing HB1065, the Balance Billing Protection Act (BBPA). We appreciate the Commissioner's efforts to implement legislation that provides protection for patients in a way that is workable for all stakeholders including carriers, hospitals and providers and minimizes unintended impacts to the insurance market. We appreciate the rulemaking that has already been done and the efforts of OIC staff to provide information regarding the BBPA requirements and dispute resolution process to both carriers and providers. We agree that further rulemaking will help clarify responsibilities of the parties and better refine the processes. For the most part, we support the stakeholder draft changes. Below are our comments on specific provisions in the stakeholder draft and questions raised at the August 5 stakeholder Zoom meeting.

Provision of Notice of Consumer Rights Following Emergency Services. The stakeholder draft includes a provision requiring facilities that provide emergency services to provide the patient with the notice of consumer rights within 48 hours of provision of an emergency service. This is a new requirement that is not in the BBPA as codified in RCW 48.49.070-.080 and we request that it be withdrawn. We appreciate that the draft rule allows that the notice be provided electronically via email or text with either the notice language or link to the notice, though not all patients will have an email address or cell number to receive electronic notice. In such cases the notice will need to be sent via regular mail to the patient's billing address. We believe the forty-eight-hour requirement will be difficult to meet, particularly for emergency services provided near or during the weekend. We believe the time period for this notice can be extended and still be received by the patient in advance of a potential balance billing from the hospital or an out of network provider of the emergency care since in most cases, a hospital or provider will not receive a response from a carrier or ERISA group in less than 30 days from the date of service. We request that if the notification requirement is added that the time period be extended to 30 days following the provision of the emergency service.

Extension of negotiation period. We support a mechanism where the parties can by mutual agreement continue negotiations to avoid arbitration. In our previous comments we suggested

that the good faith informal negotiation period be extended beyond 30 calendar days upon written mutual agreement of the parties, allowing the parties to pursue arbitration later if the negotiations are unsuccessful. It appears the stakeholder draft language allows the parties to delay their written submissions following initiation of the arbitration process if they stipulate that they plan to complete settlement negotiations prior to making submissions to the arbitrator. Please provide more clarity regarding how this stipulation would be communicated to the commissioner and how the commissioner would ensure it is by mutual agreement of the parties.

Use of standardized form for arbitration. WSHA supports use of a standardized form to ensure all necessary particulars of the dispute are communicated to arbitrators in a standard way. We believe this will enhance the efficiency of the process for both carriers and providers. We request that the form retain the ability for the provider or carrier to include any additional information they believe relevant to the determination.

Criteria for bundling for arbitration. The stakeholder draft retains the original bill language concerning aggregation of claims in involving the same carrier and provider entities arbitration. WSHA supports the decision to retain the original language, but we are concerned there may be attempts to narrow its application. WSHA believes it is in the public's best interest if the provisions allowing bundling of similar claims for arbitration are construed liberally. Payment disputes are rarely regarding a single claim. They are generally a result of disagreement regarding the rate the carrier is paying for all services of the provider for all patients insured by the carrier. Few claims will by themselves justify the cost of arbitration for a provider. The ability of a provider to aggregate smaller claims from a high-volume carrier is necessary for arbitration to be financially available for providers. We also think aggregation of claims will encourage permanent agreements between carriers and providers across a broader set of services. We recognize that to facilitate this, there are a few terms that require clarification.

(i) **Involve identical carrier and provider or facility parties.** Most providers contract with carriers as a group rather than as individual providers. We believe "provider or facility party" should be the provider's group if that is the entity level that they would normally contract with carriers. Likewise, carriers usually contract with emergency department (ED) physicians, anesthesiologists, radiologists, and other hospital-based providers at the group level rather than at the individual provider level.

(ii) **Involve claims with the same or related current procedural terminology codes relevant to a particular procedure.** WSHA recommends that this provision be construed liberally to ensure provider access to the arbitration process and maximize the potential of negotiated agreements. We recommend "same or related" be applied to services within the specialty of the provider or the provider's group if it is a single specialty or group of related specialties. For example, an anesthesiologist or anesthesiology group should be able to aggregate all anesthesia services with the

single payor within the two-month period. Carriers do not negotiate payment for individual services, they apply a payment rate (conversion factor) to all services of the provider.

Use of remark code and 835 transaction. WHSA supports the requirement that carriers indicate payment is made subject to and in accordance with the BBPA through the use of remark code and 835 transaction. This will be a helpful source of information for facilities and providers to identify services subject to the BBPA and avoid inadvertent balance billing. We recognize this will create some programming for the carriers but believe that if they choose to pay an amount to an out of network provider other than what has been negotiated it is reasonable that they provide this information on the remittance.

Information to be included in Commissioner's annual report on dispute resolution information regarding arbitration over commercially reasonable payment amounts. We suggest that the report include the information required under RCW 48.49.050 include and also indicate:

- If the arbitration was settled by the parties prior to the arbitration decision,
- If the arbitration decision was in favor of the carrier
- If the arbitration decision was in favor of the facility/provider

We recommend that the information **does not** include the specific offer amount that was selected by the arbitrator as this would nullify the intent of the non-disclosure agreement.

Self-funded group health opt in. We appreciate the clarification that in the stakeholder draft that election by a self-funded health plan operated by an out of state employer only applies to enrollees of that group that are Washington state residents. We also appreciate the clarification that election by a self-funded in-state employer also applies to out of state residents that receive care from Washington state employers. We believe this the correct interpretation and application of the BBPA but will be more challenging for hospitals and providers to administer. Because the BBPA applies differently to enrollees of in-state and out of state self-funded employer groups, is crucial that providers are able to determine whether the electing self-funded group in sponsored by an in-state or out of state employer. We request that the OIC's listing of participating self-funded groups be modified and expanded to include additional information, including whether the group is operated by an in-state or out of state employer, the primary physical employer site, and the number of enrollees in the group. This will help facilities and providers better identify patients that are subject to the BBPA. We also request that the carriers' and groups' 271 and 835 transaction standards accurate reflect the enrollees BBPA status based on residence.

Thank you again for the opportunity to comment. If you have questions, please contact Andrew Busz, WSHA Policy Director, Finance at (206) 216-2533 or andrewb@wsha.org.

Andrew Busz
Policy Director, Finance
Washington State Hospital Association