Balance Billing Protection Act

Use of Washington State’s APCD to support implementation

August 2020
BBPA Application

BBPA applies to:

• All fully insured health plans sold in Washington State (as defined in RCW 48.43.005)
• Washington State employee health plans (PEBB)
• New Washington State school employee health plans (SEBB)
• Self-funded group health plans that “opt-in” to the balance billing prohibition, arbitration, and consumer protections

Provider can check whether consumer’s plan is covered via HIPAA Standard 271 (Health Care Eligibility Benefit Inquiry and Response)
A self-funded group health plan can elect to participate in two parts of the act:

1. The surprise billing prohibition and related consumer protections
2. The out-of-network provider payment and dispute resolution process

Web-based process: To opt-in, the self-funded group health plan:
- Makes this decision on an annual basis (annual or “evergreen”)
- Attest to the plan’s participation and willingness to be bound by the law

More than 200 plans have opted-in to date. List is on OIC website: https://www.insurance.wa.gov/how-self-funded-group-health-plans-can-protect-their-enrollees-surprise-billing
Scope of Balance Billing Protection

As of January 1, 2020, surprise/balance billing is prohibited for:

• Emergency services

• Non-emergency surgical or ancillary services provided by an out-of-network (OON) provider at an in-network hospital or ambulatory surgical center. Surgical or ancillary services include surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.
Consumer Protections

When surprise billing is *not* allowed, the *following protections also apply*:

- Insurers must pay OON providers and facilities directly
- Consumer cost-sharing based on “median in-network contracted rate for the same or similar service in the same or similar geographic area”
- Explanation of benefits must show how much is the patient’s responsibility
- Any amount that the patient pays must be applied to their deductible and out-of-pocket limit
Consumer Protections

• A provider must refund, within 30 business days, any amount that the patient overpaid an out-of-network provider

• No provider, hospital, or outpatient surgical facility can ask a patient to limit or give up these rights
Consumer Protections

How will consumers be informed of their rights under the BBPA?

  – Has been translated into multiple languages

• Notice from provider/facility when a procedure is scheduled

• Explanation of Benefits notes whether claim is subject to BBPA protection (effective July 1, 2020)
Out-of-Network Provider Payment

The OON provider will be paid a “commercially reasonable amount based on payments for the same or similar services provided in the same or a similar geographic area”

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

- OIC provides parties with list of arbitrators / arbitration entities
- Providers can “bundle” same or similar claims that occurred within two months of each other if same insurer and same provider
- Arbitrator chooses one party’s “best and final offer”; parties split the cost of arbitration; each pays its own attorney’s fees
<table>
<thead>
<tr>
<th>Days</th>
<th>Event</th>
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<tbody>
<tr>
<td>0 Days</td>
<td><strong>Day 0:</strong> Out-of-network provider submits claim to carrier/payer.</td>
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<tr>
<td>30 Days</td>
<td><strong>Day 30:</strong> Carrier/Payer sends claim payment to out-of-network provider.</td>
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<tr>
<td>30 Days</td>
<td><strong>Day 60:</strong> 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.</td>
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<tr>
<td>10 Days</td>
<td><strong>Day 70:</strong> Carrier, provider, or facility can initiate arbitration by sending notice to OIC and non-initiating party. That notice must include their “final offer.”</td>
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<tr>
<td>20/30 Days</td>
<td><strong>Day 90:</strong> Arbitrator is chosen by parties; if they can’t agree, one is chosen by OIC. <strong>Day 100:</strong> Non-initiating party must provide final offer.</td>
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<tr>
<td>30/20 Days</td>
<td><strong>Day 120:</strong> Parties must make written submissions to the arbitrator.</td>
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<tr>
<td>30 Days</td>
<td><strong>Day 150:</strong> Arbitrator must issue a written decision.</td>
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</tbody>
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APCD Data Set

- Parties and arbitrators will have access to a data set from the state’s all-payer claims database (WA-APCD)
- Data set serves as a source of neutral, credible information on payment for services subject to the BBPA
- Developed through a partnership between OFM (then WA-APCD lead agency), Onpoint, and OIC, with close involvement of health insurers and health care providers/facilities
APCD Data Set

• Based on 2018 commercial fee-for-service health insurance claims
• Provides median in-network, median out-of-network, and median billed charges
• Updated annually based on the Medical Consumer Price Index (CPI)
Data Set Key Components

• Most recent and available full calendar year of data (2018)
• Commercial fee-for-service data (excludes Medicaid, Medicare, and managed care data)
• Median in-network and out-of-network allowed amounts, and median billed charges for the following:
  – Emergency services
  – Non-emergency services provided at an in-network hospital or in-network ambulatory surgical facility if the services
    a) Involve surgical or ancillary services and
    b) Are provided by out-of-network providers
Calculating Data Set Values

- Included claims processed as primary
- Excluded denied and orphaned claims
- Billed charge amount (when charge >0)
- Total paid (allowed) amount (when allowed >0)
  - Sum of paid, copay, coinsurance, and deductible amounts
Calculating Data Set Values – Geographic Areas

• Median allowed amounts for procedures were calculated at two levels:
  – OIC Geographic Rating Region
  – Statewide
• Service was assigned to geography based on the ZIP code of the rendering provider for the service
• Out-of-state services or unknown provider ZIP codes were excluded
Calculating Data Set Values – Geographic Areas

Geographic Rating Regions
Calculating Data Set Values – Modifiers

• Current Procedural Terminology (CPT) modifiers serve multiple purposes
  – Add detail (e.g., indicating left or right side in bilateral procedures)
  – Determine pricing (e.g., indicating whether the bill is for an assistant surgeon)

• Calculations removed records with modifiers affecting pricing
  – AS, FX, FY, SA, UE, 22, 23, 25, 47, 50–56, 62, 66, 73, 78, 80–82, SG

• Values were calculated for claims for three modifier groups:
  1. 26: Professional component of a procedure such as for radiology claims
  2. TC: Technical component of a procedure such as for radiology claims
  3. Other: Records with modifiers not impacting pricing or no modifier
Calculating Data Set Values – ED Services

ED professional services

- Identified using Onpoint Health Data’s service flag indicating the record was an ED service. The flag evaluates services using:
  - Place of Service codes
  - Procedure codes
  - Revenue codes
ED facility services

• Paid in a variety of ways – Ambulatory Payment Classifications (APCs), percent of charges, case rates / set rates, etc.
• Applied APC grouper to WA APCD study data
• Calculated median allowed amount by APC stratified by geography (statewide and OIC rating region)
• Created a ratio of the median value by APC grouper to Medicare by APC (statewide) and overall (regions)
Calculating Data Set Values – Non-Emergency Services

Identifying claims for non-emergency services

• Restricted to claims where:
  – Type of Setting is inpatient or outpatient OR
  – Place of Service is inpatient hospital, outpatient hospital, or ambulatory surgical center

• CPT groupings
  – Surgery (10004–69990)
  – Hospitalists (99217–99226 and 99231–99239, excluding 99237)
  – Laboratory & Pathology (80047–89398)
  – Radiology (70010–79999)
  – Anesthesiology (00100–01999)*
Specifications in Development

Anesthesiology services

• Methodology provides a conversion factor by geographic area
• Requires base units, quantity, and physical status units
• Quantity for these services was not sufficient in APCD
  – The WA-APCD Data Submission Guide was updated (effective 1/1/2020) to provide more detailed instructions for the values reported using the Quantity field
Resources

- Table summarizing BBPA: https://www.insurance.wa.gov/sites/default/files/documents/Chart%20of%202019%20surprise%20billing%20law.pdf
Questions?

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Connect with the OIC!
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