Balance Billing Protection Act Overview

The Balance Billing Protection Act protects consumers from getting a balance bill from an out-of-network facility or physician for emergency services or for a scheduled procedure they receive at an in-network hospital or ambulatory surgical facility. The effective date of the law is January 1, 2020.

The law only applies to services provided to patients insured by a fully-insured, state regulated health plan, as plans organized under the federal ERISA statute may not be regulated by state authorities. This is a critical distinction as ERISA plans, commonly used by very large employers, typically account for about 60% of the commercially insured market.

If a consumer is treated by an out-of-network physician or facility for services covered by the new law, the physician or facility will submit the claim to the consumer’s insurer. They will be paid a “commercially reasonable amount” based on payments for the same or similar services in a similar geographic area. Payment must be sent directly to the physician, rather than to the patient. Patients may only be held responsible for co-pays and deductibles as they would if the service were provided in-network. The “commercially reasonable amount” is not defined in statute and is left up to carriers to determine. It is expected that these amounts will likely be substantially below the typical in-network rates.

There are new requirements for physician groups in the Act. If your group has a web site, that website must list the plans for which your group is in-network, and this list must be maintained and accurate. Additionally, your group must provide patients with a standardized form advising them of their rights under the Act and when they may or may not be responsible for a balance bill.

If the physician feels the payment provided by an insurer for an out-of-network service was not commercially reasonable, then a 30-day period of negotiation must follow. If no agreement is reached, then the dispute may be settled through arbitration. Either party can start the arbitration process by sending notice to the Office of the Insurance Commissioner. The parties then choose an arbitrator. If they cannot agree on one, one will be assigned. Importantly, the arbitration process may include multiple similar claims bundled together, provided the services were delivered within a 2-month time frame.

Both parties will submit their “final offer” as well as supporting information and data to the arbitrator. The arbitrator will determine the final payment amount the insurer or physician must accept, choosing one party’s offer without modification, which is called “baseball style” arbitration. Under the Act, a Surprise Billing Data Set has been developed using data from the Washington All Payer Claims Database. The dataset includes payment data to assist carriers, facilities, physicians and arbitrators as an independent source of claims payment information.
A review of the Surprise Billing Data Set, unfortunately, shows a discrepancy between the claims data and the state of the commercial market in Washington. Using a percentage of Medicare as a reference point, the Data Set shows median allowed in-network rates of about 175% of Medicare, and median allowed out of network rates of about 140% of Medicare, for the most commonly provided ED services. Those familiar with the contracting market will affirm that these are significantly lower than the typical contracted rates for commercial payers. The data collected in the APCD only includes claims from state-regulated plans. It is possible that the exclusion of ERISA plans has skewed the data downwards; such plans may not be compelled to submit data to the APCD.

The lower-than-expected rates in the Surprise Billing Data Set have the potential to exert downwards pressure on arbitration outcomes. However, the law does not require the Data Set to be controlling, and when physicians enter arbitration, it may be emphasized that these rates are lower than typical contracted rates, with appropriate supporting information. WA-ACEP is developing a data set from the FAIR Health database, which more accurately reflects the state of the market. This will be made available to WA-ACEP members should the need for arbitration arise.

It is quite likely that the first few “test cases” in arbitration will be very influential in setting precedents relating to how the process will affect reimbursement for emergency care in the future. It is therefore critically important that the initial arbitration experience be at the least neutral if not favorable to emergency physicians. The Chapter is invested in providing support, whether data and analytics, logistic, or legal, to the groups that are the first to engage this process. If your group is considering entering the arbitration process, please reach out to Chapter leadership in advance so we can support you.

If a consumer insured by an ERISA health plan is treated by an out-of-network physician or facility, then the law does not apply, and the consumer may still receive a balance bill. Under the law, however, ERISA carriers may “opt in” to the law’s provisions, in which case balance billing is not permitted and the arbitration process would be utilized. Insurance carriers are required to notify physicians whether they are subject to, or have opted into, the law. This notification will be performed via a standardized electronic data exchange commonly used by insurance carriers. As of this writing, over 60 ERISA plans have opted into the law.

It is premature to predict the effect the law will have on the contracting market. While there are provisions which are adverse to physicians’ interests, there has been positive experience with the arbitration process in other states. WA-ACEP leadership is very aware of this issue and the impact it may have on the practice of emergency medicine in this state. If your group is impacted by this law, and we can be of assistance, we urge you to contact us so we can help your practice ensure that you are paid fairly for the critical work that you do.