Comparison of the No Surprises Act (P.L. 116-260) with State laws in Washington and Vermont
Prepared by the Vermont Department of Financial Regulation
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Issue	Federal No Surprises Act (H.R. 133, Public Law 116-260)[1]	Washington State Law [including BBPA (Chap. 427, Laws of 2019/ Chap. 48.49 RCW)]	Vermont State Law [including H-2009-03, Title 8 Chapter 107]
Applicability	• Fully insured health plans, including grandfathered plans • Self-funded group health plans (including state and local government self-funded plans) • Federal Employee Health Benefit Program	• Fully insured health plans • PEBB/SEBB • Self-funded group health plans that elect to participate in BBPA (approximately 335 as of January 1, 2021)	• Fully insured health plans • State and local government self-funded plans (non-ERISA)
Effective date of protections	• January 1, 2022	• January 1, 2020	• January 24, 2017 (H-2009-03 Amended Effective)
CONSUMER BALANCE BILLING PROTECTIONS			
Settings and services covered – <u>emergency and post-stabilization</u>	• Emergency medical services provided in an emergency facility (hospital or independent freestanding facility), whether in-network or OON, including emergency services by an OON provider at an in-network facility.	• Emergency services provided in a hospital (includes freestanding emergency facilities) or ambulatory surgical facility (ASF), whether in-network or out-of-network (OON), including emergency services by an OON provider at an in-network facility.	• Emergency services provided in a hospital or other medically appropriate setting necessary to evaluate, stabilize and provide medically

[1] Thanks to the Georgetown University Center for Health Insurance Reform for their review of this document. Their summary of the No Surprises Act can be found at https://www.commonwealthfund.org/sites/default/files/2021-01/Surprise_Billing_Law_Summary_v2_UPDATED_01-19-2021.pdf

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	• Post-stabilization services as part of outpatient observation or an inpatient or outpatient stay during a visit if the items and services would otherwise be covered under the plan if furnished by a participating provider or facility, unless certain conditions with respect to the participant, beneficiary or enrollee exist: ○ The individual is stable and the provider or facility determines that the individual is able to travel using nonmedical transportation or non-emergency medical transportation; ○ The provider furnishing the additional items and services satisfies the	• Does not protect consumers from balance billing for OON services provided post-stabilization in an OON hospital or ASF. • Protects consumers from balance billing for post-stabilization services provided by OON providers at an in-network facility, as non-emergency services (see below) • Specific timelines apply for facility notification of carrier for authorization of post-stabilization services, and requires carrier to arrange for an alternative plan of treatment if the carrier and out-of-network hospital cannot agree on post-stabilization care. RCW 48.49.020 & RCW 48.43.093	necessary emergency transport for a member. (2.4)

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	notice and consent criteria; ○ The individual is in a condition to receive the information and to provide informed consent (in accordance with State law) and such other conditions as specified by the Secretary, such as conditions relating to coordinating care transitions to participating providers and facilities; and ○ The enrollee is given a compliant notice and provides written consent to bear responsibility for OON amounts. §2799A-1(a) of the PHS Act		
Coverage of emergency services by health plans	• If a health plan provides or covers any benefits with respect to emergency services in a	• Carriers must cover "emergency services" (as defined in RCW 48.43.005) necessary to	• A managed care organization shall not require prior

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	hospital emergency department or an independent freestanding emergency department, it must cover those emergency services: o Without the need for any prior authorization determination, o Whether the provider or facility is or is not participating and, o If OON, covers those services without imposing any prior authorization requirement or any limitation on coverage that is more restrictive than the requirements or limitations applicable to emergency services received from in-network providers and facilities.	screen and stabilize an enrollee. • Carriers cannot require prior authorization for services provided prior to the point of stabilization, and must cover emergency services provided by out-of-network providers. • Coverage of emergency services can be subject to in-network cost-sharing. RCW 48.49.093	authorization of emergency services or the use of contracted providers. Coverage for the member shall be consistent with the terms and conditions for coverage of services obtained from a contracted provider within the service area whether or not the emergency services were obtained from contracted providers within or outside of the health benefit plan's service area. There shall be no additional liability to the member. (2.4) • Coverage of emergency services shall be subject to

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	§2799A-1(a) of the PHS Act		applicable copayments, coinsurance, and deductibles.
Settings and services covered – <u>non-emergency</u>	• Prohibits balance billing for nonemergency services furnished by OON providers for a visit by an enrollee at participating health care facilities <u>unless required notice and consent have been met.</u> • A health care facility includes a hospital, hospital outpatient department, critical access hospital, ambulatory surgical center or <u>any other facility, specified by the Secretary</u> that provides items or services for which coverage is provided under the health plan. • Qualified items and services furnished to an individual during a visit to a health care facility include: equipment and devices, telemedicine services, laboratory services, preoperative and postoperative services, and such other	• Surgical and ancillary services provided by an OON provider at an in-network hospital or ASF are subject to the BBPA. • Includes: surgery, anesthesiology, radiology, pathology, laboratory and hospitalist services. • There are no exceptions to the balance billing prohibition.	• Nothing in this section shall be construed to prohibit a managed care organization from holding members financially responsible pursuant to the terms of the insurance policy or certificate if they obtain services that do not meet the definition of "emergency services" set forth in this rule. (2.4)

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	items and services as the Secretary may specify regardless of whether or not the provider furnishing the items or services is at the facility. (§2799A-1(b)(2) of PHS Act). • Exception to allow balance billing if the enrollee receiving non-emergency services (<u>other than ancillary services</u>) from an OON provider consents to receive those services from that provider. Applies if: ○ Enrollee is given a compliant notice by the OON provider not later than 72 hours prior to the date of the delivery of the items or services (or if the notice and consent is given on the date of the appointment if the enrollee		

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	makes an appointment within 72 hours of the furnishing of the items or services); ○ Enrollee provides written consent to bear responsibility for OON amounts, then OON cost sharing (including any balance bills) will apply with respect to the enrollee and their health plan. The NSA law details the content of the required notice and the consent form. • No exception to balance billing protections for "ancillary services": items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology,		

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	assistant surgeons, hospitalists, intensivists and other services, including advanced diagnostic services, added by the Secretary in rule. Does not include primary surgeons. • The notice and consent exception does not apply if the furnished service results from unforeseen, urgent medical needs arising at the time of the service. §2799B-2(c) of the PHS Act		
Air ambulance services	• Prohibits balance billing by air ambulance providers; provider can only bill the in-network cost-sharing amount. • Cost sharing for air ambulance services provided by an OON provider same as in-network cost-sharing, any cost-sharing amounts must be counted toward the plan's in-network	• States preempted by federal law from regulation of air ambulance services. • Not addressed in BBPA.	• Emergency services provided in a hospital or other medically appropriate setting necessary to evaluate, stabilize and provide medically necessary emergency

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	deductible and in-network out-of-pocket maximum amount for the plan year. (§105 of the bill) • Requires cost and utilization reporting by air ambulance providers and health plans, and issuance of report (§106 of the bill) • Establishes Advisory Committee on Air Ambulance Quality and Patient Safety. §2799A-2 of the PHS Act, §§105 & 106 of the NSA		transport for a member. (2.4) • A managed care organization shall not require prior authorization of such services or the use of contracted providers.
Ground ambulance services	• Establishes an advisory committee to review options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for those services, and protect consumers from balance billing. • Agencies must develop recommendations	• Not addressed in BBPA.	• Emergency services provided in a hospital or other medically appropriate setting necessary to evaluate, stabilize and provide medically necessary emergency

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	addressing, at a minimum: (1) options, best practices, and identified standards to prevent instances of balance billing; (2) steps that can be taken by states; and (3) legislative options for Congress to prevent balance billing. • Advisory Committee report and recommendations to federal agencies and Congressional committees not later than 180 days after the date of its first meeting §106(g) of the NSA		transport for a member. (2.4) • A managed care organization shall not require prior authorization of such services or the use of contracted providers.
Reliance on provider directory	• In-network cost-sharing applies to an OON provider service if the enrollee demonstrates that they relied on the health plan's provider directory and that information turned out to be incorrect. §2799A-5(b) of the PHSA Act	• No comparable provision in Washington state law.	• 6.4 Provider Directory – not comparable
Consumer cost-sharing for services	• Patients are held harmless from surprise	• Patients are held harmless from surprise	• Patients are held harmless

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protected from balance billing	medical bills within the scope of the NSA. • Patients are only required to pay the in-network cost-sharing (i.e., co-payment, coinsurance and deductibles) amount for out-of-network care within the scope of the NSA. • Enrollee cost sharing will be calculated as if the contracted rate for the services, if furnished by an in-network provider (or facility, in the case of emergency services) is equal to the recognized amount. The recognized amount is defined as the amount defined under State law, where applicable; or the qualifying payment amount, which is generally the median contracted rate. • Patients' in-network cost-sharing payments for out-of-network	medical bills within the scope of the BBPA. • Patients are only required to pay the in-network cost-sharing (i.e., co-payment, coinsurance and deductibles) amount for OON care within the scope of the BBPA. • Enrollee cost-sharing is calculated based upon the carrier's median contracted rated for the same or similar service in the same geographic area. • Patients' in-network cost-sharing payments for out-of-network surprise bills within the scope of the BBPA are attributed to a patient's in-network deductible and out-of-pocket maximum. • Consumers cannot be asked to waive their	from surprise medical bills within the scope of H-2009-03. 5.1 (K) – network adequacy and 2.4 – emergency services

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	surprise bills within the scope of the NSA are attributed to a patient's in-network deductible and out-of-pocket maximum. • These protections do <u>not</u> apply where a consumer has consented to use of an OON provider, per the requirements above. §2799A-1(b)(1) of the PHS Act	rights under the BBPA. No provision for consumer consent to being balance billed for OON services that are subject to the BBPA. RCW 48.49.030(1)	
Refunds to enrollees	• If the enrollee pays the OON provider or facility an amount that exceeds the applicable in-network cost-sharing amount, the provider or facility must refund any amount in excess of the in-network cost-sharing amount to the enrollee, plus interest at a rate determined by the Secretary. • A provider can require in the terms of a contract or contract termination with a health plan that the	• If the enrollee pays the OON provider or facility an amount that exceeds the applicable in-network cost-sharing amount, the provider or facility must refund any amount in excess of the in-network cost-sharing amount to the enrollee within 30 business days of receipt. Interest must be paid to the enrollee for any unrefunded payments at a rate of 12% beginning on the first calendar day after the 30 business days.	• No comparable statute.

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	plan remove, at the time of contract termination, the provider from the directory or that the plan bear the financial responsibility for providing inaccurate network status information to an enrollee. §2799B-9 of the PHS Act	RCW 48.49.030(1)	
Standard for, and timing of, payment of the OON provider	• No standard for OON provider payment. ○ **NOTE**: For States with laws in place to determine the amount an insurer must pay an OON provider, whether through a payment standard or a state-run dispute resolution program, the Act provides for deference to State rules on establishing payment amounts for	• Payment standard is "commercially reasonable amount" • Carrier pays OON provider within 30 days of provider submitting claim that complies with requirements of WAC 48.43B.030(1) • Payment sent directly to provider in the amount by which the rate determined through negotiation or arbitration exceeds the patient's applicable in-network cost-sharing amount.	• No later than 30 days from receipt of the claim, pay or deny. 18 V.S.A. 9418 (b) • Interest will accrue at 12% per annum. 18 V.S.A. 9418 (e)

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	those plans and services the State regulates. • Health plan pays initial amount or sends notice of denial of payment to OON provider within 30 days or provider submitting a claim. • Within 30 days of an IDR determination or successful negotiation, health plan must directly pay the OON provider the amount by which the OON rate, as determined in independent dispute resolution (IDR) or negotiation, exceeds the patient's applicable in-network cost-sharing amount §2799A-1(c) of the PHS Act	RCW 48.49.030(2)	

OUT-OF-NETWORK PROVIDER PAYMENT AND DISPUTE RESOLUTION

- ***<u>NOTE</u>: For States with laws in place to determine the amount an insurer must pay an OON provider, whether through a payment standard or a state-run dispute resolution program, the Act provides for deference to State***

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rules on establishing payment amounts for those plans and services the State regulates.			
Putting claim in dispute and informal negotiation	Either party can open a 30 day negotiation period, which begins on the date the OON provider or facility receives a response from the plan regarding the payment to determine a payment amount (including any cost sharing) that is agreed to by the parties.. §2799A-1(c) of the PHS Act	Either party can open a 30 day period to put claim into dispute and negotiate OON provider payment rate, which begins on the date the OON provider or facility receives payment or payment notification from the carrier. RCW 48.49.030(2)	
Claim "bundling" or "batching"	• Multiple claims may be "batched" in a single IDR if the claims at issue: ○ Were provided by the same provider or facility; ○ Involve the same health plan; ○ Involve items and services related to the treatment of a similar condition, and ○ Occur within a period of 30 days of one another.	• Multiple claims may be "bundled" in a single arbitration proceeding if the claims at issue: ○ Involve identical carrier and provider group or facility parties; ○ Involve claims with the same or related CPT codes relevant to the particular procedure, and ○ Occur within a period of 2 months on one another. RCW 48.49.040(1)	•

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	§2799A-1(c)(3) of the PHS Act		
Dispute resolution entities	• HHS certifies "independent dispute resolution" (IDR) entities. • The tri-agencies (DOL/HHS/Treasury) must establish the IDR process, certify IDR entities, set fees, and specify criteria for the scope of claims that can be considered together as part of a single determination. §2799A-1(c)(4) of the PHS Act	• BBPA sets minimum standards for arbitrator qualification. Private arbitrators submit application to OIC, which posts list of approved arbitrators on OIC BBPA website. RCW 48.49.040	•
Dispute resolution timelines	• Parties may submit dispute to IDR process within 4 days of the end of the negotiation period. • Parties choose IDR entity; Secretary chooses if parties cannot agree. • Parties submit their offers and materials to arbitrator within 10 days of the date of	• Provider, facility or carrier can initiate arbitration by filing notice with OIC within 10 days of end of period of good faith negotiation. Notice includes the initiating party's "final offer" • Parties choose arbitrator, or OIC chooses if parties cannot agree. • Parties submit their materials to arbitrator	•

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	selection of the IDR entity. • IDR chooses one of the parties' offers within 30 days of selection of the IDR entity. • Payment to the OON provider not later than 30 days after IDR decision. • **NOTE**: If a state has its own payment standard and/or IDR process in place, that process can continue to apply for services covered by state-regulated health plans. §2799A-1(c)(4)	within 30 days of appointment. • Arbitrator's decision issued within 30 days of parties' submission of written materials to the arbitrator. • If dispute is settled prior to arbitration, parties must notify OIC of settlement. Arbitrator decision must be sent to OIC. RCW 48.49.040; WAC 284-43B-035	
Factors considered by decision maker	• The NSA calls for the arbitrator to consider: ○ Offers submitted by the parties; ○ Median contracted rate for the service at issue in the same geographic region;	• Arbitrator must consider: ○ Evidence and methodology submitted by the parties to assert that their final offer amount is reasonable; and	•

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	○ The provider's level of training and experience; ○ Quality and patient outcome; ○ The market share of the provider or payer; ○ The acuity of the patient's condition and complexity of services provided; ○ Teaching status and case mix; ○ Good faith efforts to join the payer's network in the past; and ○ Prior contracted rates during the previous 4 years. • The arbitrator is barred from considering the provider's billed charge, "usual and customary charges" or the rates paid under government	○ Patient characteristics and the circumstances and complexity of the case, including time and place of service and whether the service was delivered at a level I or level II trauma center or a rural facility, that are not already reflected in the provider's billing code for the service. • Arbitrator may consider other information that a party believes is relevant to the factors above or other factors the arbitrator requests and information provided by the parties that is relevant to such request, including the Washington state all-payer claims database data set developed under RCW **43.371.100**. RCW 48.49.040	

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	programs such as Medicare or Medicaid. • Additional federal rulemaking may offer guidance for arbitrators on how to interpret the arbitration factors. §2799A-1(c)(5) of the PHS Act		
Arbitrator decision	• "Baseball style arbitration": arbitrator must choose either the amount sought by the provider or the amount offered by the payer. • The arbitrator's decision is binding on the parties, and the losing party must pay the costs of the arbitration. • There is also a separate annual administrative fee charged to all parties for use of the IDR system. §2799A-1(c)(5)	• "Baseball style arbitration": arbitrator must choose either the amount sought by the provider or the amount offered by the carrier. • The parties to an arbitration must execute a nondisclosure agreement. • Chap. 7.04A RCW (Uniform Arbitration Act) applies to BBPA arbitration. If that chapter conflicts with the BBPA, the BBPA provisions govern. RCW 48.49.040; WAC 284-43B-035	•

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Costs of arbitration	• Non-prevailing party must pay all fees charged by the IDR entity. If the parties reach a settlement prior to IDR, costs are divided equally, unless the parties agree otherwise. §2799A-1(c)(5) of the PHS Act	• Parties split the cost of arbitration, and each party pays their own attorney's fees. If one party fails to make timely submissions to arbitrator, arbitrator can order the defaulting party to pay full cost of arbitration and pay the non-defaulting party's final offer amount. RCW 48.49.040(3)	•
Reporting on dispute resolution proceedings	• Quarterly reporting beginning in CY 2022, number of IDR notifications; size of provider practices and facilities submitting IDR notifications; number of IDR payment determinations made; information with respect to which a determination was made; number of times the IDR decision or settlement agreement exceeded the median contracted amount, specified by item and service; cost to HHS for IDR process; total amount of IDR fees paid; and total amount	• For period of 2020 to 2024, OIC issues annual report on arbitration proceedings. Report to include at a minimum: summary information related to the matters decided through arbitration, as well as 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	•

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	of compensation paid to IDR entities. • For each dispute reported, must include a description of the services; geographical area where the service was provided; each party's final offer amount, expressed as a percentage of the median in-network rate; category or specialty of the provider or facility; identity of the health plan and provider or facility; length of time taken to make each determination; the compensation paid to the IDR entity; and any other information specified by HHS. • Separate but similar reporting for air ambulance services. §2799A-2(b)(7) of the PHS Act	provided; and the type of health care services at issue. RCW 48.49.050	
TRANSPARENCY			
Providers and facilities:	Each provider and facility is required to make publicly	• OIC must develop a standard template	• Title 18, Chapter 42, Bill of Rights

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Consumer notice of rights	available and, if applicable, post on its public website and provide to individuals who are enrollees of a health plan a one-page notice (either postal or electronic, as specified by the person) in clear and understandable language containing information: (1) on requirements and prohibitions on balance billing in certain circumstances (specified by the Act); (2) if required under State law, any other requirements on the provider or facility regarding the amounts it may charge an enrollee with respect to an item or service to which the provider or facility may balance bill if it is nonparticipating with the health plan; and (3) Information on contacting appropriate State and federal agencies in the case that an individual believes that the provider or facility has violated the Act's balance billing prohibitions. §2799B-3 of the PHS Act	consumer notice. (NOTE: The current OIC notice includes most components of the NSA notice) • OIC consumer notice must be provided to consumers as follows: ○ Posted on provider & facility websites ○ Providers must include the notice in any communication to a patient related to scheduling of nonemergency surgical or ancillary services at a facility. ○ Facilities providing emergency medical services must provide or mail the notice to a patient within seventy-two hours following a patient's receipt of emergency medical services. ○ Carriers, providers and	for Hospital Patients and Patients Access to Information. • The patient has the right to receive an itemized, detailed, and understandable explanation of charges regardless of the source of payment and to be provided with information about financial assistance and billing and collections practices.

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		facilities must provide notice upon consumer request WAC 284-43B-050	
Health plans: Transparency & consumer notice	Health Plan Website. Each health plan is required to make publicly available, post on its website, and include on each explanation of benefits for an item or service with respect to which the No Surprises Act's balance billing prohibitions apply: (1) information in plain language on: (a) the prohibitions on balance billing; (b) if provided for under applicable State law, any other requirements regarding the amounts the providers and facilities may charge an enrollee if the provider or facility does not have a contractual relationship under the health plan after receiving payment from the health plan and any applicable cost-sharing payment; and (c) the Act's protections against surprise billing with respect to the furnishing of emergency and non-emergency services; and	• Notice of consumer rights: Carriers must: ○ Post the OIC BBPA consumer notice on their website (see above for info included in OIC notice) ○ Include the notice the OIC BBPA consumer notice in their communication to an enrollee, in electronic or other format, that authorizes nonemergency surgical or ancillary services at an in-network facility. • Explanation of benefits: Carriers must use standard language to indicate on an enrollee's Explanation of Benefits whether the claim was	•

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	(2) information on contacting appropriate State and federal agencies in the case that an individual believes that the provider or facility has violated any related requirement. §2799A-5(c) of the PHS Act A health plan will also be required to include, in clear writing, on the physical or electronic plan or insurance identification card issued to enrollees: (i) any deductible applicable to the health plan; (ii) any out-of-pocket maximums; and (iii) a telephone number and website through which the individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with the health plan. §2799A-1(e) of the PHS Act	processed subject to Washington state's balance billing protection act. • Provider eligibility verification: Carriers must include information in the HIPAA standard 271 transaction as to whether a patient's health plan is subject to the BBPA, either as fully-insured or via SFGHP opt-in. WAC 284-43B-040, -050 No comparable requirement related to information on enrollee's plan or insurance identification card.	
Information provided to consumers by providers or facilities in	Beginning January 1, 2022, in the case of an individual who schedules an item or service, the provider and facility must	No comparable provision in Washington (pending DOH review)	The patient has the right to receive an itemized, detailed, and understandable

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advance of receipt of services	provide information to the individual: (1) inquire if the individual is enrolled in a health plan or a federal health care program; and (2) provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for the item or, with the expected billing and diagnostic codes for the item or service to the individual or their health plan. The notice must be provided: at least 3 business days before the date the item or service is to be furnished; not later than 1 business day after scheduling (or, in the case of an item or service scheduled at least 10 business days before the date of the service or item (or if requested by the individual), not later than 3 business days after the date of such scheduling or such request). §2799B-6 of the PHS Act		explanation of charges regardless of the source of payment and to be provided with information about financial assistance and billing and collections practices.
Information provided to consumers by health plans/carriers in advance of	<u>Advanced Explanation of Benefits</u>. Each health plan that has received a notification from a provider or facility of a scheduled item or service for an individual is required to provide to that	No comparable provision in Washington state	

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receipt of services	individual within the time frames below (through mail or electronic means, as requested by the individual) a notification in clear and understandable language that includes: (1) Whether or not the provider or facility is in-network and, if so, the contracted rate or coverage; if the provider is OON, then a description of how the individual may obtain information on in-network providers and facilities. (2) The good faith estimate included in the notification received from the provider or facility based on such codes. (3) A good faith estimate of the amount the plan is responsible for and the amount of any enrollee cost sharing. (4) A good faith estimate of the amount that the enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan (as of the date of such notification). (5) If the item or service is subject to a medical management technique for coverage, a disclaimer that		

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	the coverage is subject to that technique. (6) A disclaimer that the information provided in the notification is only an estimate. (7) Any other information or disclaimer the plan determines appropriate consistent with the NSA. Time frames. The notice must be provided not later than 1 business day after the provider or facility gives notice to the health plan or, if the item or service was scheduled in time, then at least 10 business days before the item or service is to be furnished. If the notification was made pursuant to an enrollee request, then the time is 3 business days after the date on which the plan receives the notification. §2799A-1(f) of the PHS Act		
Patient-Provider Dispute Resolution Process	The Act requires the Secretary, not later than January 1, 2022, to establish a patient-provider dispute resolution process. Under this process, an uninsured individual who received a good faith advance estimate from a provider or facility of their expected charges and	No comparable provision in BBPA	No comparable provision.

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	who then receives a bill from that provider of facility for charges that are substantially in excess of the estimate, to seek a determination from a selected dispute resolution entity for the charges to be paid by the individual.		
Provider directories	• Information from providers to health plans: Beginning not later than January 1, 2022, each provider and facility is required to have a business processes to ensure the timely provision of provider directory information to a health plan to support the NSA provider directory requirements, including any material changes to the provider directory information; and at any other time (including at the request of the health plan) determined appropriate by the provider, facility, or the Secretary. §2799B-9 of the PHS Act	• Information from some providers to health plans: Hospitals and ambulatory surgical facilities: Not less than thirty days prior to executing a contract with a carrier, a hospital or ambulatory surgical facility must provide the carrier with a list of the non-employed providers or provider groups contracted to provide surgical or ancillary services at the hospital or ambulatory surgical facility. The hospital or ambulatory surgical facility must notify the carrier within thirty days of a removal from or addition to the non-employed provider list. A hospital or ambulatory surgical facility also must provide an updated list	• Reg H-2009-03 Section 6.4 sets out requirements of Managed Health Organizations with respect to the management of provider directories.

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	• Requirements on health plans Each health plan must establish: (i) a verification process; (ii) a response protocol; and (iii) a provider database and include in any directory (other than the database) specified provider directory information. The health plan—not less frequently than once every 90 days—must verify and update the provider directory information in a database. It must establish a procedure for the removal from the database of a provider or facility if the plan has been unable to verify the information during a period specified by the health plan. The database must be updated within 2 business days of the health plan receiving information that a provider or facility has changed its network status.	of these providers within fourteen calendar days of a request for an updated list by a carrier. RCW 48.49.070 • Carriers must maintain online and printed provider directories. Printed and online provider directories must be updated for accuracy at least monthly. • Each provider directory must include clear instructions about how a consumer or an enrollee can report inaccurate information in the provider directory to the carrier. ○ Carriers must have an easily available method for providers to report changes to their provider directory information. • Carriers must investigate reported inaccuracies from providers and	

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	§2799B-9 of the PHS Act Response protocol. In the case of an enrollee who requests information through a telephone call, electronic web-based means, or email on whether a provider or facility has a contractual relationship, the health plan must have a protocol that responds to the individual as soon as practicable and in no case later than 1 business day after the call or email is received, through a written electronic or paper (as requested by the individual) communication. This communication must be retained in the individual's file for at least 2 years thereafter. A health plan must maintain on its public website a list of each provider and facility with which it has a direct or indirect contractual relationship and provider directory information with respect to each such provider and facility. The information must be accurate as of the date of the provider directory	consumers, and if verified, correct inaccuracies as part of the carrier's monthly updates. • Carriers must establish processes and procedures to confirm the accuracy of provider directory information, including processes and procedures to ensure that changes are made when inaccuracies are verified. • Printed and online provider directories must include the following information for each provider: (a) The provider's location and telephone number; (b) The specialty area or areas for which the provider is licensed to practice and included in the network; (c) Any in-network institutional affiliation of the	

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	publication and indicate that the individual should consult the database to obtain the most current information. The information must include the name, address, specialty, and telephone number of each provider or facility with which the health plan has a contractual relationship for furnishing items and services under the specific health plan. §2799A-5(a)of the PHS Act These provisions <u>do not</u> preempt any provision of State law relating to provider directories. § 2799A-5(a)(7), 2799B-9 of the PHS Act	provider, such as hospitals where the provider has admitting privileges or provider groups with which a provider is a member; (d) Whether the provider may be accessed without referral; (e) Any languages, other than English, spoken by the provider; (f) If a provider offers mental health or substance use disorder treatment services, identify in the directory that the provider is contracted to deliver mental health or substance use disorder treatment services. • A carrier must include in its printed and online	

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	Price comparison tool. A health plan must offer price comparison guidance by telephone and make available on its website a price comparison tool that (to the extent practicable) allows an enrollee, for the plan year, geographic region, and its participating providers, to compare the amount of cost sharing that the enrollee would be responsible for paying with respect to the furnishing of a specific item or service by any such provider. §2799A-4 of the PHS Act	provider directories a notation of any primary care, chiropractor, women's health care provider, mental health provider, substance use disorder provider, or pediatric provider whose practice is closed to new patients; information about any available telemedicine services and how to access those services; information about any available interpreter services, communication and language assistance services, and accessibility of the physical facility; and information about the network status of emergency providers as required by WAC 284-170-370. WAC 284-170-260. Additional requirements for carrier web pages and directories specific to behavioral health services. WAC 284-170-285	

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		<u>Price and quality information.</u> Carriers must have a transparency tool that, at a minimum: • Displays costs for common treatments in the inpatient, outpatient, diagnostic tests and online visits categories; • For integrated delivery systems, data on total cost of care, • Includes a method for members to provide rating or feedback on their experience with a provider, that other enrollees can review • Allows members to access the estimated cost of the treatment as described above on a portable electronic device • Displays the estimated cost of the treatment, or total cost of care episode, and the estimated out of pocket costs of the treatment for the member and the application of personalized benefits,	

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		such as deductibles and cost-sharing, • Displays provider quality information when available, • Includes information to allow a provider and hospital search of in-network providers and hospitals with provider information, including specialties, distance from patient, provider contact information, provider's education, board certification and other credentials, where to find information on malpractice history and disciplinary actions, affiliated hospitals and clinics, and directions to the provider office or hospital, and • Provides enrollees with performance information required by §2717 of PPACA and any applicable regulations or guidance. RCW 48.43.007	

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Continuity of care requirements on health plans and issuers	• Continuity of care when contract terminations affect provider network status. If an individual is a "continuing care patient" with an in-network provider or facility, and the provider contract with the plan is terminated or the health plan contract is terminated, the health plan must notify the enrollee that they have a right to continued transitional care; provide the enrollee with the opportunity to notify the health plan of their need for transitional care, and continue benefits for the course of treatment with their provider for 90 days, or when the person is no longer a continuing care patient with the provider, whichever is earlier. • Continuing care patient. Such patient is an individual who, with respect to a provider or facility, is (i) undergoing	Provider contracting standards: When a carrier terminates a provider contract, whether for cause or without cause, the carrier must make a good faith effort to ensure written notice of a termination is provided at least thirty days prior to the effective date of the termination or immediately for a termination for cause that results in less than thirty days' notice to a provider or carrier to all enrollees who are patients seen: (a) On a regular basis by a specialist; (b) By a provider for whom they have a standing referral; or (c) By a primary care provider. WAC 284-170-421 (10)	Reg H-2009-3 Section 5.1(H) provides "The managed care organization shall establish policies and procedures to ensure the orderly transfer of those members whose providers' contracts with the health benefit plan have expired or been terminated, with or without cause, to other contracted providers. In so doing, each managed care organization shall permit certain members receiving an ongoing course of treatment to continue to use providers whose contracts have been terminated without cause, or whose contracts have not been renewed without cause, so long as those providers agree to abide by the health benefit plan's payment rates, quality-of-care standards and protocols, and to provide the necessary clinical information to the managed care organization, as follows: 1. Members with life-threatening, disabling or degenerative conditions shall be allowed to continue to see their providers for sixty (60) days from the date of termination or non-renewal or until accepted by a contracted provider, whichever is shorter; and 2. Women in their

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	a treatment for a "serious and complex condition" from that provider or facility; (ii) is undergoing a course of institutional or inpatient care from it; (iii) is scheduled to undergo non-elective surgery from the provider, including postoperative care; (iv) is pregnant and undergoing a course of treatment for the pregnancy; or (v) is or was determined to be terminally ill (as determined under the Medicare hospice benefit and is receiving treatment for such illness. • A "serious and complex condition" is defined, in the case of an acute illness, as a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or, in the case of a chronic illness or condition, a condition that is life		second or third trimester of pregnancy shall be allowed to continue to obtain care from their previous provider until the completion of postpartum care."

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	threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time. §2799A-3 and §2730(b)(2) of the PHS Act		
Continuity of care requirements on providers and facilities	• For a continuing care patient, the provider or facility must accept payment from the plan and any applicable cost sharing from the individual as payment in full, and continue to adhere to all policies, procedures, and quality standards imposed by the plan in the same manner as if termination had not occurred. §2799B-8 of the PHS Act	No comparable provision in Washington state law	Reg H-2009-3 Section 5.1(H) provides "The managed care organization shall establish policies and procedures to ensure the orderly transfer of those members whose providers' contracts with the health benefit plan have expired or been terminated, with or without cause, to other contracted providers. In so doing, each managed care organization shall permit certain members receiving an ongoing course of treatment to continue to use providers whose contracts have been terminated without cause, or whose contracts have not been renewed without cause, so long as those providers agree to abide by the health benefit plan's payment rates, quality-of-care standards and protocols, and to

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			provide the necessary clinical information to the managed care organization, as follows: 1. Members with life-threatening, disabling or degenerative conditions shall be allowed to continue to see their providers for sixty (60) days from the date of termination or non-renewal or until accepted by a contracted provider, whichever is shorter; and 2. Women in their second or third trimester of pregnancy shall be allowed to continue to obtain care from their previous provider until the completion of postpartum care."
Enforcement	States are relied on to enforce the NSA's balance billing prohibition, payment rules, IDR process, provider directory and other information, and transparency requirements on State-regulated health insurance issuers of group and individual health insurance coverage. State-regulated plans include state and local governmental plans. The HHS Secretary can impose a civil monetary penalty not to exceed $10,000 per violation. This authority is limited to	OIC can refer potential violations of balance billing prohibition to: • Health professions regulatory authorities, including the Washington Medical Commission and the Nursing Care Quality Assurance Commission • DOH for violations by facilities. OIC enforces carrier obligations under the BBPA. RCW 48.49.100	Reg H-2009-03 Section 1.10 provides that DFR may enforce the regulation pursuant to its powers under Title 8 and chapter 221 of Title 18 of the Vermont Statutes Annotated.

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	enforcement of provisions where a State has failed to enforce the Act's requirements. DOL enforces as related to actions by self-funded group health plans.		
Interaction with state law related to "Part D"/ carrier requirements and "Part E"/provider requirements	The NSA amends section 2724 of the PHS Act (42 USC §300gg-23 – the ACA preemption/state flexibility provision) to add a reference to Part D of the NSA. It preserves State flexibility to be more protective of consumers except to the extent that such standard or requirement prevents the application of the NSA. The NSA does not affect or modify the provisions of section 514 of ERISA with respect to group health plans (i.e., federal preemption of State laws relating to employee benefits plans). The NSA uses almost the same preemption/state flexibility language as the ACA standard with respect to the provider/facility requirements of the NSA §2799B-4 of the PHS Act	N/A	

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All Payer Claims Databases	The Act requires the Secretary to make one-time grants to eligible States to: (1) establish a State All Payer Claims Database (APCD) and (2) to improve an existing State APCD. The state APCD may include medical claims, pharmacy claims, dental claims and eligibility and provider files, which are collected from private and public payers. HHS may prioritize applications from States whose application demonstrates a willingness to work with other States to establish a single application for access to data by authorized users across multiple States, and a willingness to implement the reporting format for self-insured group health plans. DOL will establish a standardized format for reporting by self-insured group health plans to State APCDs. Appropriates $50 million for each of fiscal years 2022 and 2023 and $25 million for fiscal year 2024. Grants will be awarded for a period of three years and in an amount of $2.5 million of which $1		VT's APCD is established by 18 VSA Section 9410 and maintained by the Green Mtn Care Board.

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	million is made available to the State for each of the first two years of the grant period and $500,000 be made available to the State for the third year of the grant period. §320B of the PHS Act (§115 of the NSA)		