OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Balance billing protection act impact analysis

Biennial report to the Legislature

Dec. 15, 2024

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www.insurance.wa.gov

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Purpose & background

In 2019, Washington state enacted the Balance Billing Protection Act (BBPA), which took effect on Jan. 1, 2020. The BBPA is intended to protect consumers from balance or "surprise" billing. It's specifically for out-of-network facility or provider charges billed to patients for emergency services and for certain non-emergency services that patients receive at in-network hospitals or ambulatory surgical facilities. Since its enactment, the Legislature expanded the scope of the BBPA twice. In 2022, the Legislature expanded coverage of balance billing protections for emergency services to include behavioral health crisis services, to align with state and federal behavioral health parity laws. In 2024, the Legislature added ground ambulance balance billing protections to the BBPA, effective Jan. 1, 2025.

E2SHB 1688 (2022) directs the Office of the Insurance Commissioner (OIC) to evaluate any impact that the BBPA has had on nonparticipating (also known as out-of-network) provider claims and amounts paid to health care facilities and providers for services subject to the BBPA's protections under commercial health plans, as follows:

> "Until December 31, 2030, the office of the insurance commissioner shall contract with the state agency responsible for administration of the database or other organizations biennially beginning in 2022, for an analysis of commercial health plan claims data to assess any impact that chapter 48.49 RCW or P.L. 116-260 have had or may have had on payments to participating and nonparticipating providers and facilities and on the volume and percentage of claims that are provided by participating compared to nonparticipating providers. To the extent that data related to self-funded group health plans is available within funds appropriated for this purpose, the analysis may include such data. The first analysis shall compare 2019 claims data to the most recent full year's claims data. The analysis must be published on the website of the office of the insurance commissioner, with the first analysis published on or before December 15, 2022."

The OIC contracted with ONPOINT Health Data to conduct this analysis. ONPOINT Health Data serves as the contracted data management and analytics vendor for the Washington State All-Payer Health Care Claims Database (WA-APCD). As part of this evaluation, ONPOINT's work included an analysis to help the OIC understand trends in:

- Utilization of participating and nonparticipating health care facilities and providers of services protected from balance billing under the BBPA.
- The amounts carriers paid to participating and nonparticipating health care facilities and providers for services protected from balance billing under the BBPA.

This analysis provides data on the trends between calendar year 2019 and calendar year 2023 for the items noted above. Given that other unknown variables may have influenced these trends, the OIC cannot definitively conclude that changes described in this analysis were a direct result of the BBPA's enactment.

In 2022, the Washington state Legislature enacted E2SHB 1688 (Chapter 263, Laws of 2022). This new law went into effect on March 31, 2022, and expanded the scope of services protected from balance billing to align with those protected under the federal No Surprises Act. The 2022 report addressed only services that were subject to balance billing protections under the original BBPA.

In 2024, the Washington state Legislature enacted SSB 5986 (Chapter 218, Laws of 2024). This law will take effect Jan. 1, 2025, and includes ground ambulance services in the BBPA. This report addresses services that were subject to the original BBPA and those included in E2SHB 1688.

Methods (prepared by ONPOINT Health Data)

The ONPOINT analysis focused on changes in the following two key areas related to services provided by participating and nonparticipating health care facilities and providers:

> (1) The volume of participating and nonparticipating claims for services subject to protection from balance billing under the BBPA.
>
> (2) The allowed amounts paid for services subject to protection from balance billing under the BBPA.

Specifically, the research sought to identify any changes in the distribution of participating and nonparticipating provider claims volume and allowed amounts paid by service category (e.g., surgical, emergency professional, hospitalist, emergency department), OIC rating area, county and Current Procedural Terminology (CPT) code. Additionally, ONPOINT examined whether there were differences in those metrics between services subject to the BBPA compared to services outside of BBPA protections.

The data source for this report is the WA-APCD. The database contains administrative claims data submitted by Washington state health plans, including data from commercial, Medicaid and Medicare sources. Self-funded group health plans are not required to submit claims data to the WA-APCD, other than claims for the PEBB/SEBB Uniform Medical Plan. The WA-APCD includes enrollment and claims (i.e., medical, pharmacy and dental) data, and provides information on services provided, provider locations, diagnoses, procedures, charges, paid amounts and more.

This analysis includes claims from commercial payers for calendar years (CYs) 2019, 2021, and 2023. Medicaid and Medicare data were not included. To assess changes in service volumes and payments following adoption of the BBPA, ONPOINT compared CY2019 data (pre-BBPA) to CY2021 and CY2023 data (post-BBPA).

A detailed explanation of ONPOINT's data methods can be found in Appendix A.

Figure 1. Map of the OIC rating areas

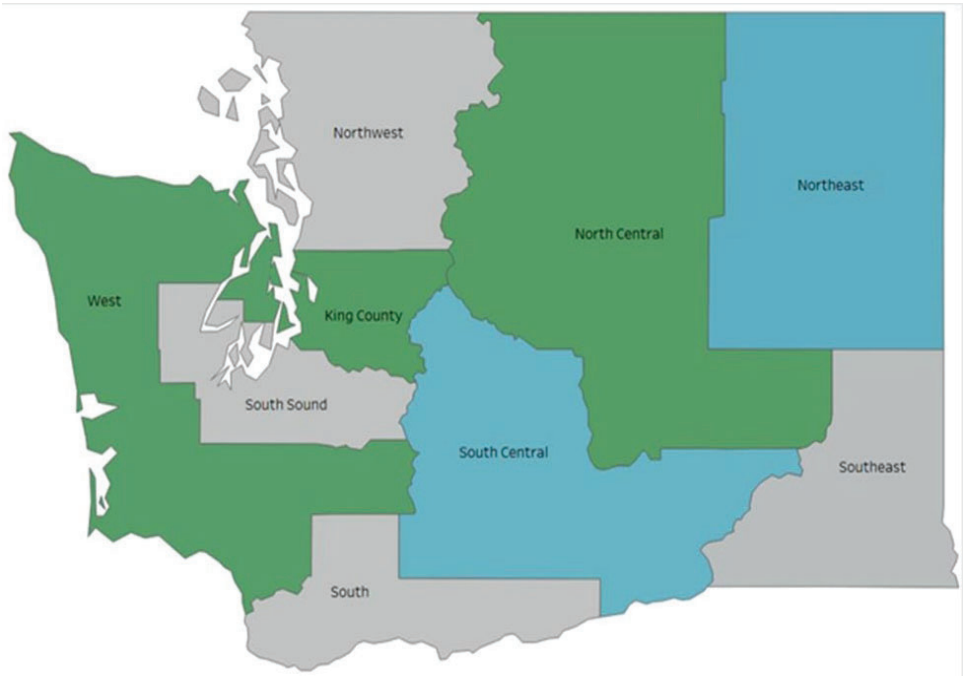


Table 1. The OIC rating areas & Washington counties

OIC rating area	Counties
Area 1: King County	King
Area 2: West	Clallam, Cowlitz, Grays Harbor, Jefferson, Kitsap, Lewis, Pacific, Wahkiakum
Area 3: South	Clark, Klickitat, Skamania
Area 4: Northeast	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
Area 5: South Sound	Mason, Pierce, Thurston
Area 6: South Central	Benton, Franklin, Kittitas, Yakima
Area 7: North Central	Adams, Chelan, Douglas, Grant, Okanogan
Area 8: Northwest	Island, San Juan, Skagit, Snohomish, Whatcom
Area 9: Southeast	Asotin, Columbia, Garfield, Walla Walla, Whitman

Glossary

- Allowed amount: Sum of total payments made by the member and health plan.
- BBPA: Balance Billing Protection Act, codified in RCW48.49.
- BB: Services subject to protection from balance billing under the BBPA.
- BB facility: Claims for services performed at an emergency facility or radiology facility in a hospital or ambulatory surgical facility.
- BB professional services: Services provided by health care professionals providing services subject to balance billing protections, e.g., radiology, anesthesiology, lab/pathology, hospitalist, surgical, emergency physician.

- HASC: Denotes claims with a place of service of either a hospital or ambulatory surgical facility.
- "Hospitalist:" A physician who often earns a residency in internal medicine and is certified in hospital medicine. Practice is confined to a hospital setting.
- Non-BB professional HASC: Non-balance billing professional services performed at a hospital or ambulatory surgical center.
- Non-BB professional any: Non-balance billing professional services performed in any setting.

Lab/pathology services

When analyzing claims data for lab and pathology services, ONPOINT found the median allowed amount for 2019 nonparticipating provider claims was $7, as compared to $35 in 2021. In contrast, median allowed amounts were in the $55 - $65 range for participating provider services in all three years. The distribution of the data was examined.

In 2019, for nonparticipating provider services, there was a higher number of claims with $6-$7 amounts. For example, the 5th, 10th and 25th percentiles for 2019 nonparticipating provider services were all $6. The distribution suggests higher volume of $6 and $7 claims for 2019 out-of-network services than any other groupings. Therefore, due to the high volume of $6 and $7 claims compared to other groupings, the 2019 nonparticipating provider grouping has a much lower median allowed amount than other groupings. In addition, the number of nonparticipating provider claims for these services dropped from 15,208 in CY 2019 to 1,089 in CY 2021. Given this atypical difference in both changes in the number of nonparticipating provider claims and changes to allowed amounts, in several places throughout the report, aggregate figures exclude lab/pathology claims.

Claims volume/participating provider – nonparticipation provider utilization

Exhibits 1 through 15 illustrate findings related to changes in the volume of claims paid to participating and nonparticipating providers from 2019 - 2023. In the aggregate, a greater share of claims was paid to participating providers over the four-year period. However, there was variability in the change by geographic region and by provider specialty and facility type, especially when broken out by geographic region.

Exhibit 1 Increase in claims 2019 to 2023

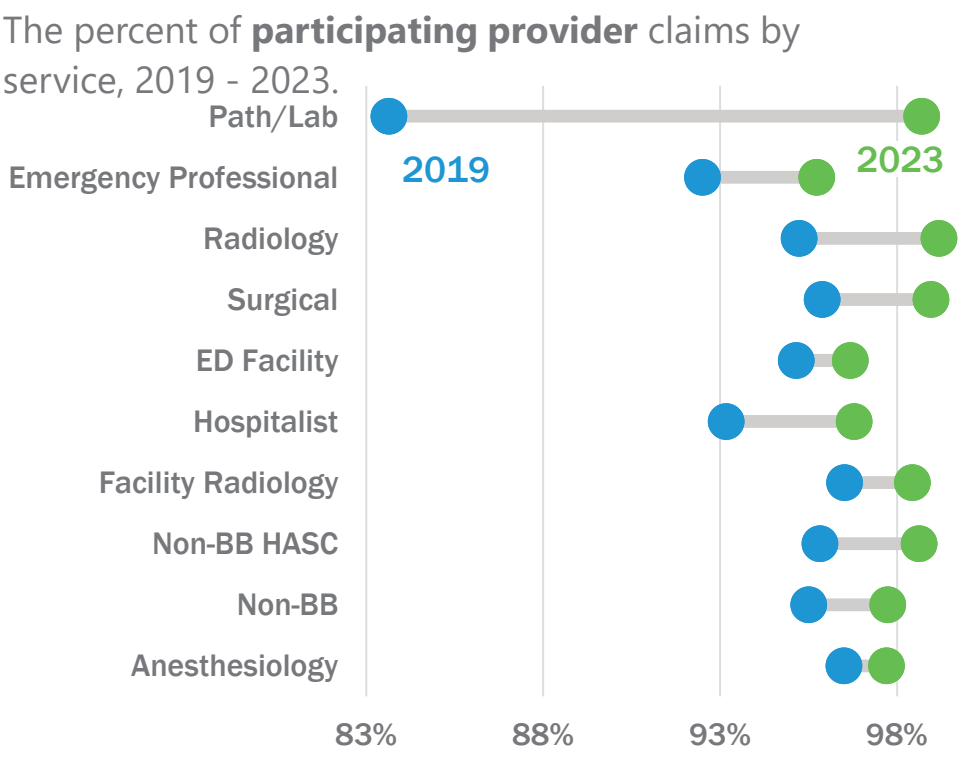
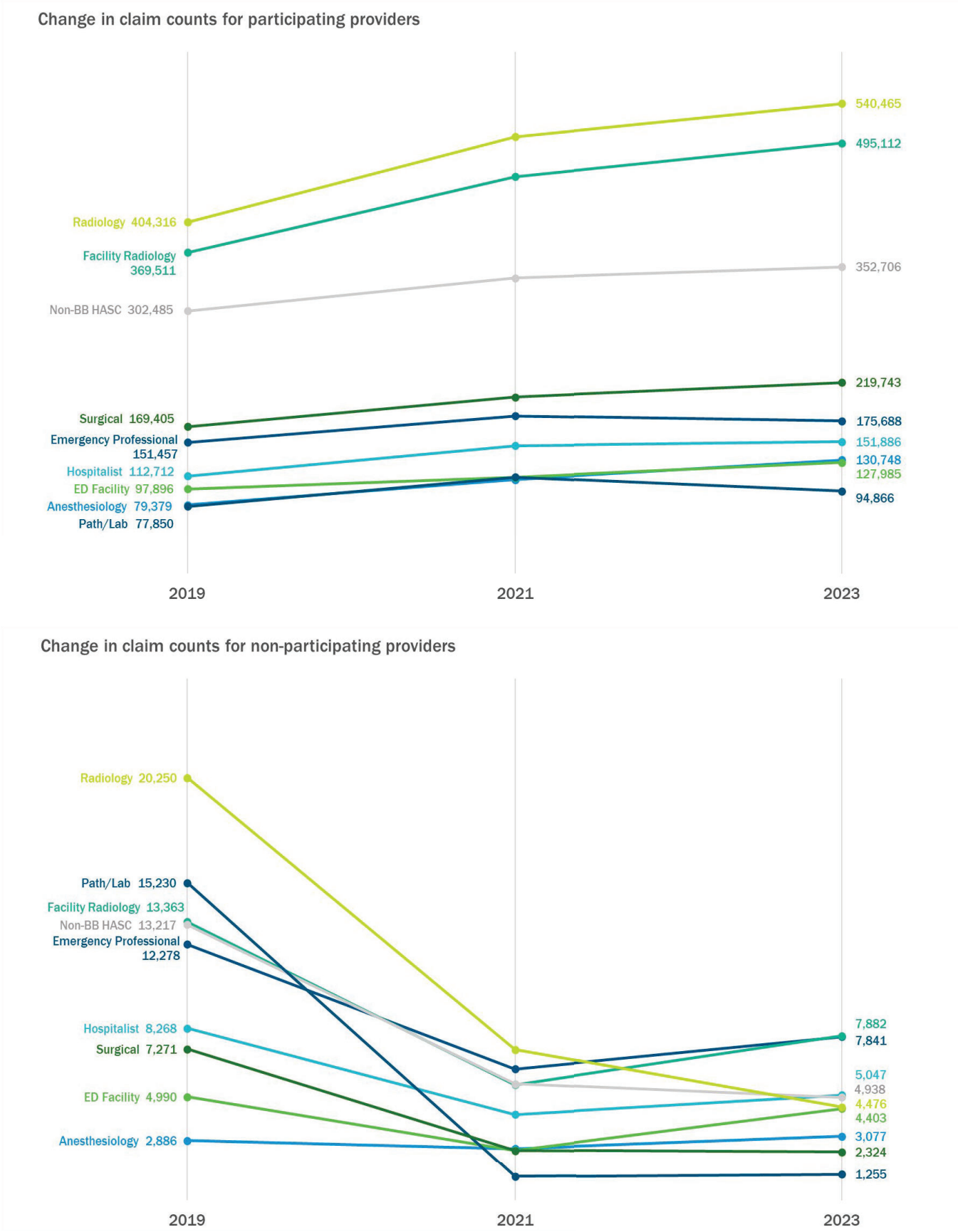


Exhibit 2 Change in claims volume 2019 to 2023



Across categories, generally we see patterns of increasing participating provider claims and decreasing nonparticipating provider claims

Exhibit 3 Percent change in claim volume 2019 to 2023

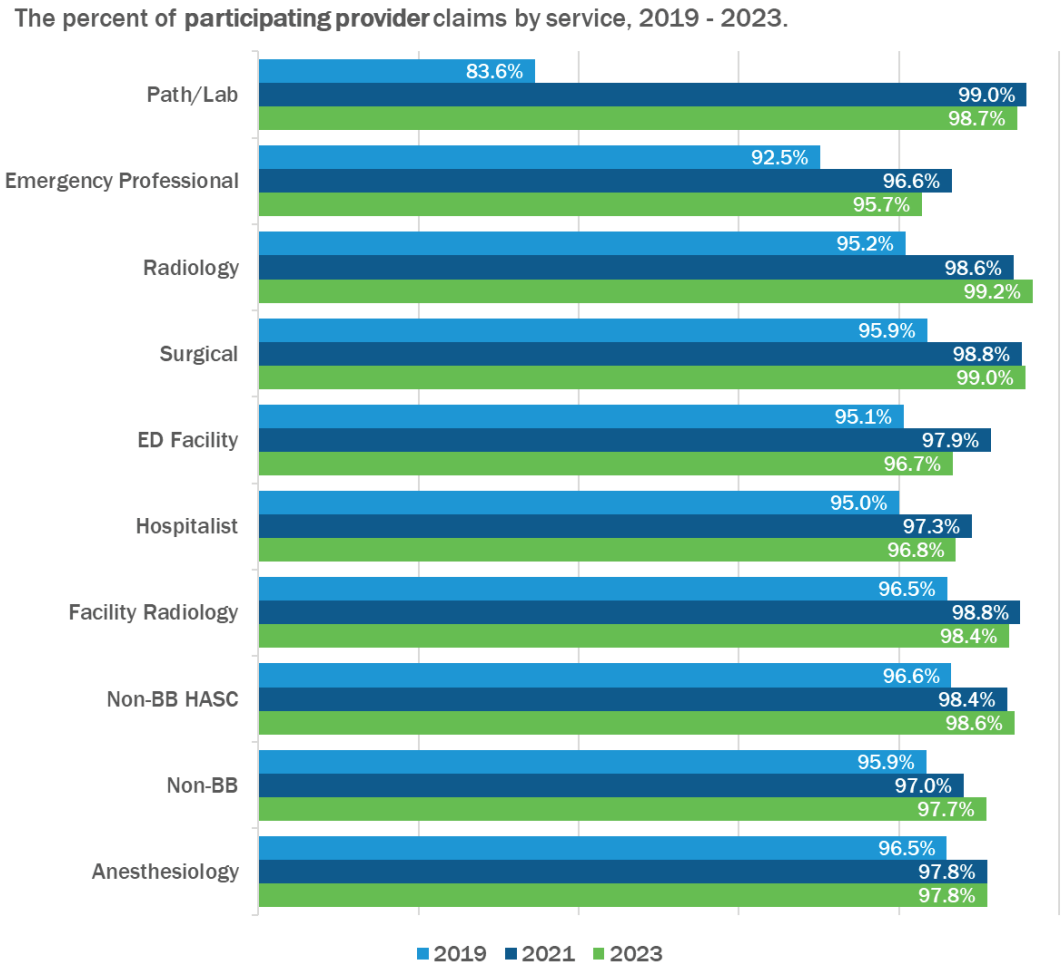
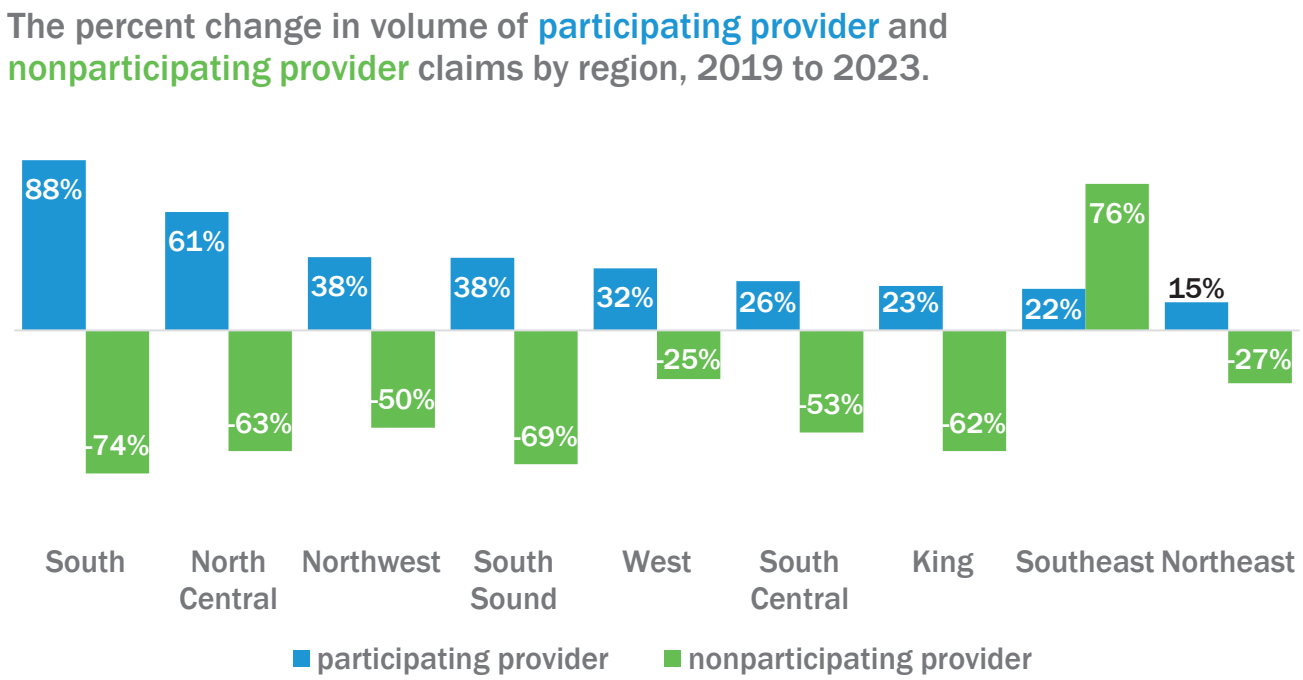


Exhibit 3 shows the percent of participating provider claims by service category. For half of services, participating provider utilization stayed the same or increased from 2019 to 2023. There was little change between 2021 and 2023. While the changes were small, services that saw a decrease in the proportion of participating provider claims were facility-based services, i.e. emergency physicians, hospitalists, emergency departments and facility-based radiology services.

Exhibit 4 The percent change in claims volume by region



All regions saw an increase in participating provider claims from 2019 to 2023 (and all but one region saw a corresponding decrease in nonparticipating provider claims).

Exhibit 5 Participating provider claims by region

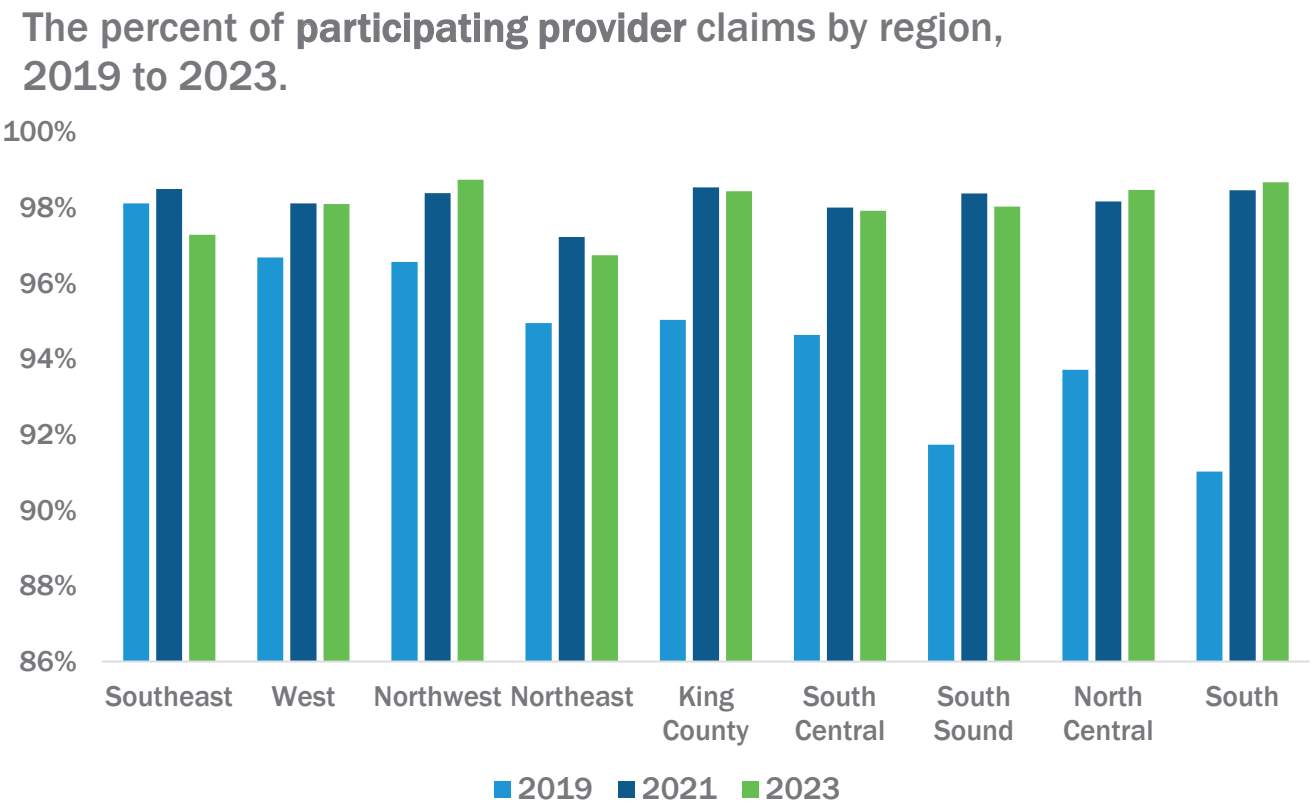


Exhibit 5 shows the variation in the percent of participating provider claims by region between 2019 and 2023. While some regions show a slight decrease between 2021 and 2023, there is very little change between 2021 and 2023.

Appendix B includes the changes in participating and nonparticipating provider claims volume, by provider specialty and for hospital emergency department and radiology facility claims, by geographic region. For each provider type, most geographic regions generally showed an increase in participating provider claims. For each provider type with nonparticipating provider claims there were one or two outlier geographic regions that did not show a significant trend in decreasing nonparticipating provider claims. This variability could be impacted by multiple factors such as provider supply, consolidation of providers, and the number of claims submitted for each year.

Exhibits 6 and 7 below show the procedure codes with the largest change in volume from 2019 to 2023 by both nonparticipating and participating providers. Emergency department critical care visits saw the largest decrease in the number of nonparticipating claims and the largest increase in participating provider claims.

Exhibit 6 Procedure codes with the largest change in volume by nonparticipating providers, 2019-2023.

Category	Procedure Code	Code Description	Claim Count 2019	Claim County 2021	Claim Count 2023
Emergency	99285	Emergency Department Visit High MDM	3,628	1,745	1,905
Path/Lab	85025	Blood County Complete Auto&Auto Difrntl WBC	1,534	37	29
Radiology	71046	Radiologic Exam Chest 2 Views	1,636	325	188
Radiology	71045	Radiologic Exam Chest Single View	1,442	812	333
Emergency	99283	Emergency Department Visit Low MDM	1,508	799	432
Path/Lab	80053	Comprehensive Metabolic Panel	1,068	41	54
Radiology	77067	Screening Mammography Bi 2-View Breast Inc Cad	1,358	461	362
Hospitalist	99233	Sbsq Hospital Ip/Obs Care High HDM 50 Minutes	2,260	1,249	1,294
Hospitalist	99232	Sbsq Hospital Ip/Obs Care Mod MDM 35 Minutes	2,450	1,111	1,502
Radiology	74177	Ct Abdomen & Pelvis W/Contrast Material	931	356	189
Radiology	77063	Screening Digital Breast Tomosynthesis Bl	1,079	440	339
Facility Radiology	71046	Radiologic Exam Chest 2 Views	1,195	295	543
Emergency	99285	Emergency Department Visit Moderate MDM	2,727	1,291	2,490
Emergency	93010	Ecg Routine Ecg W/Least 12 Lds I&R Only	2,430	1,674	1,803

Exhibit 7 Procedure codes with the largest change in volume by participating providers, 2019-2023.

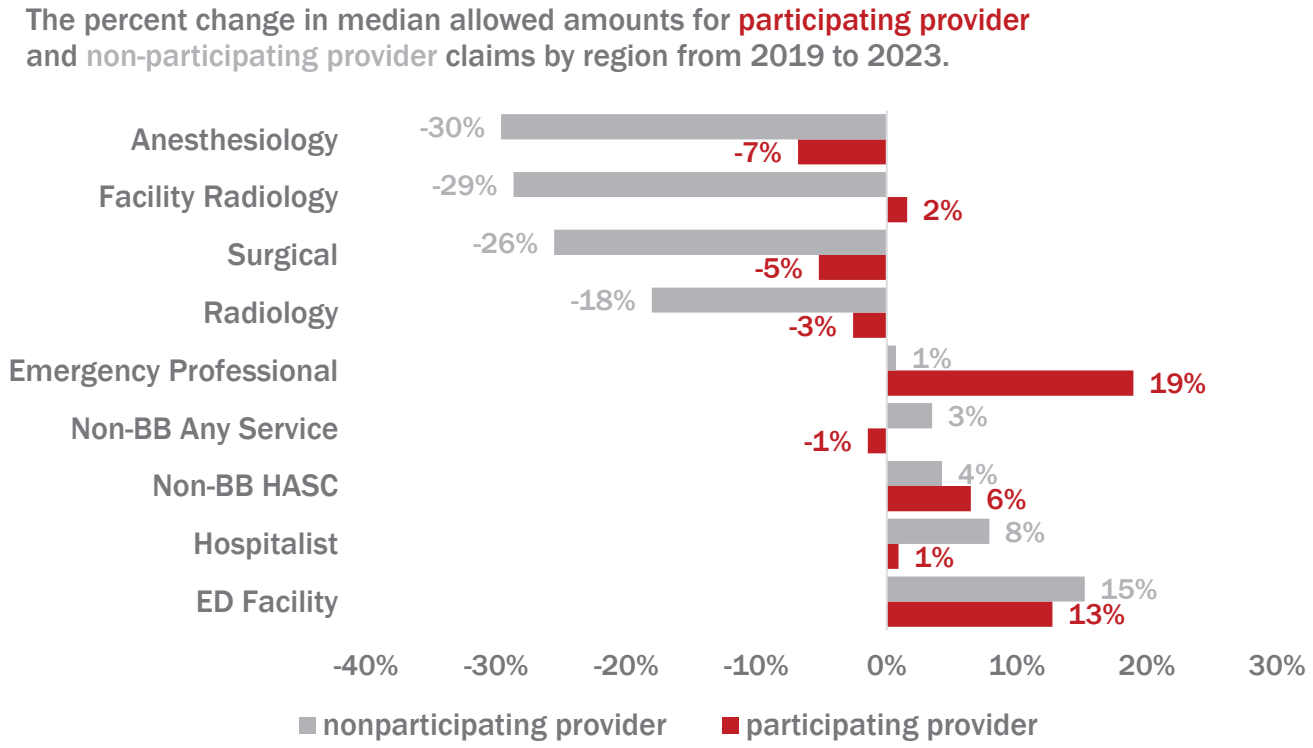
Category	Procedure Code	Code Description	Claim Count 2019	Claim County 2021	Claim Count 2023
Emergency	99284	Emergency Department Visit Moderate MDM	34,166	37,971	52,825
Radiology	77063	Screening Digital Breast Tomosynthesis Bl	25,795	38,707	43,267
Anesthesiology	00812	Anesthesia Lower Intst Endoscopic Px Scr Colsc	9,136	15,238	24,321
Facility Radiology	77063	Screening Digital Breast Tomosynthesis Bl	29,483	40,004	43,570
Radiology	71045	Radiologic Exam Chest Single View	22,741	41,267	36,680
Hospitalist	99232	Sbsq Hospital Ip/Obs Care Mod MDM 35 Minutes	32,520	41,605	45,481
Radiology	77067	Screening Mammography Bi 2-View Breast Inc Cad	32,372	40,469	43,961
ED Facility	96374	Ther Proph/Dx Njx Iv Push Single/1St Sbst/Drug	20,940	26,556	31,190
Radiology	74177	Ct Abdomen & Pelvis W/Contrast Material	16,655	22,172	26,435
Surgical	45385	Colsc Flx W/Rmvl Of Tumor Polyp Lesion Snare Tq	11,066	15,071	20,665
Hospitalist	99233	Sbsq Hospital Ip/Obs Care High MDM 50 Minutes	27,636	40,942	36,629
Hospitalist	99223	1St Hospital Ip/Obs Care High MDM 75 Minutes	10,751	13,501	18,225
ED Facility	96375	Therapeutic Injection Iv Push Each New Drug	15,379	18,688	22,148
Facility Radiology	77067	Screening Mammography Bi 2-View Breast Inc Cad	39,832	45,003	46,530

Changes in median allowed amounts

Exhibits 8 through 22 illustrate findings related to changes in allowed amounts paid to participating and nonparticipating providers and facilities from 2019 and 2023. The amounts in these exhibits have been adjusted for inflation using the CPI-Urban medical care component for the Seattle/Tacoma/Bellevue area from 2019-2020, 2020-2021, 2021-2022, and 2022-2023. Thus, any increases in allowed amounts are in excess of inflation adjustments.

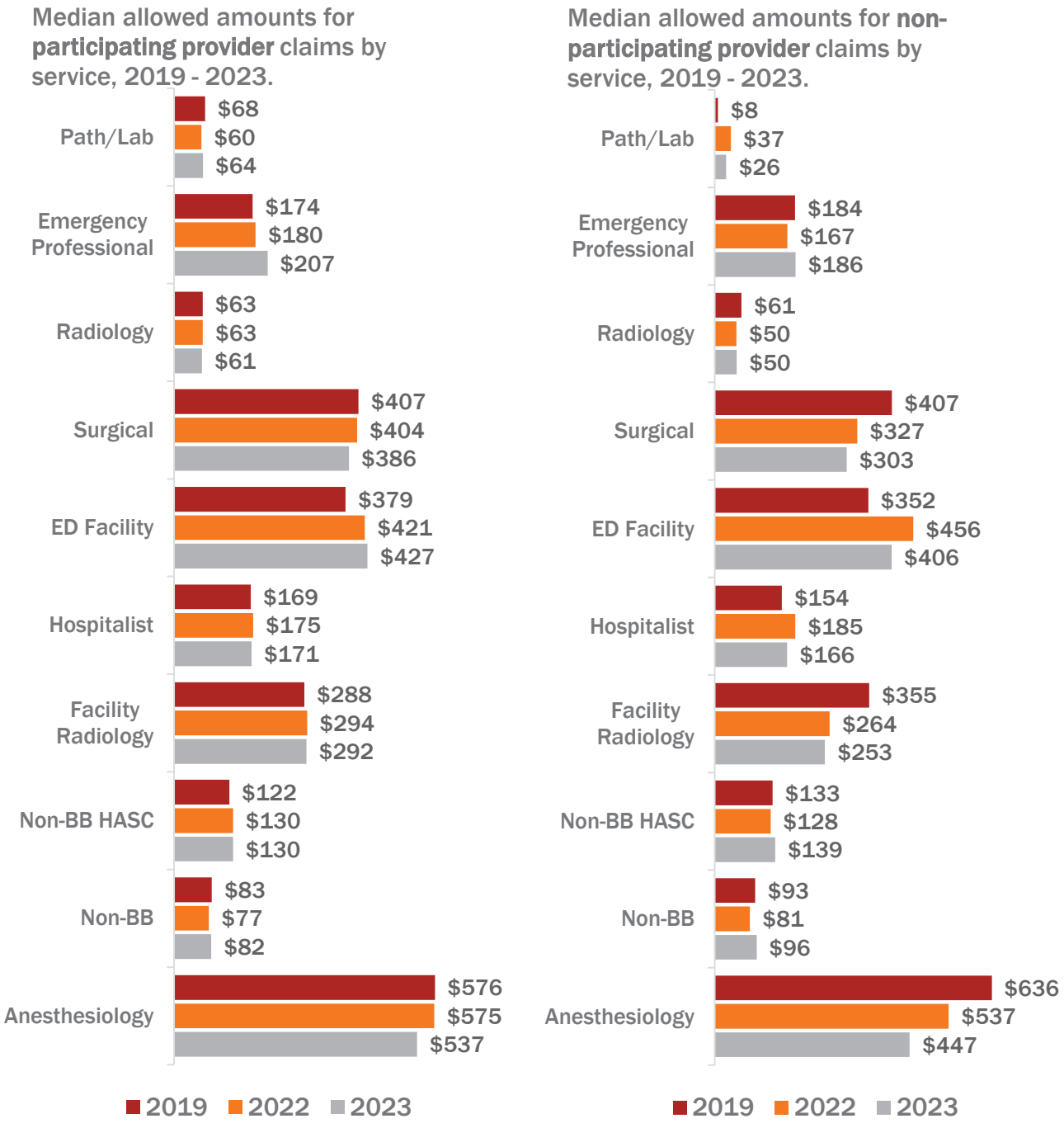
Over the four-year period, among the services subject to balance billing protection, participating emergency department facility and participating emergency physician allowed amounts increased significantly more than other services. However, there are notable differences across regions and across provider types by region.

Exhibit 8 Percent change in median allowed amounts



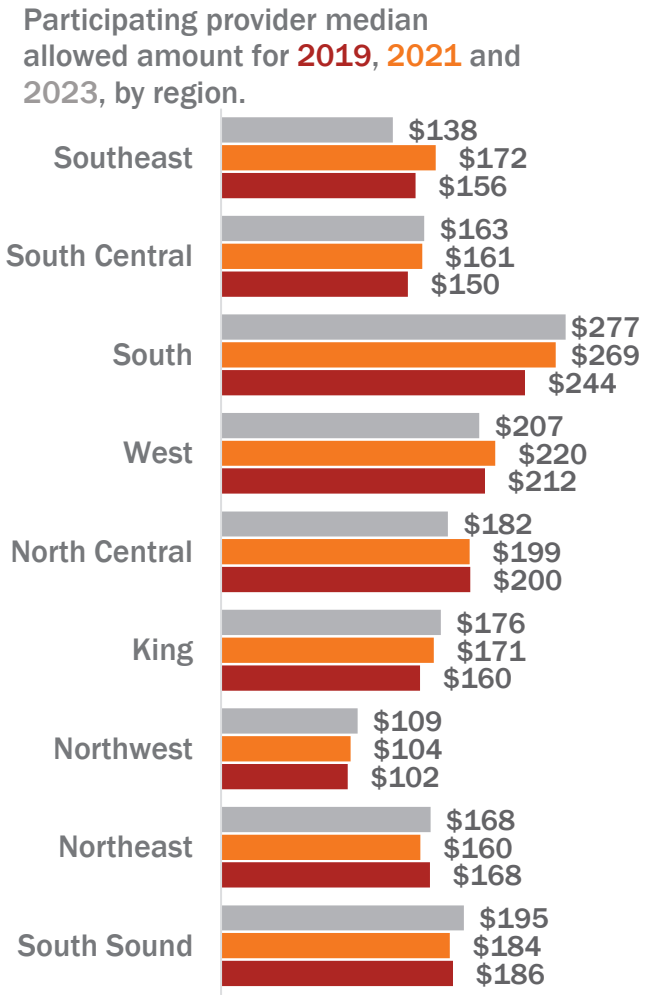
The median allowed amount for services subject to balance billing protections provided by nonparticipating providers decreased from 2019 to 2023 for anesthesiology, facility radiology, surgical and radiology claims. For participating provider claims, emergency physician professional saw the largest increase in median allowed amounts, followed by ED Facilities.

Exhibit 9 Median allowed amounts by service for both participating and nonparticipating provider claims, 2019-2023



Exhibits 10 to 18 show the percentage change in median allowed amounts paid to participating and nonparticipating providers, by provider specialty, hospital emergency department facility and radiology facility, by geographic region.

Exhibit 10 Median allowed amounts by region for participating and non-participating providers.



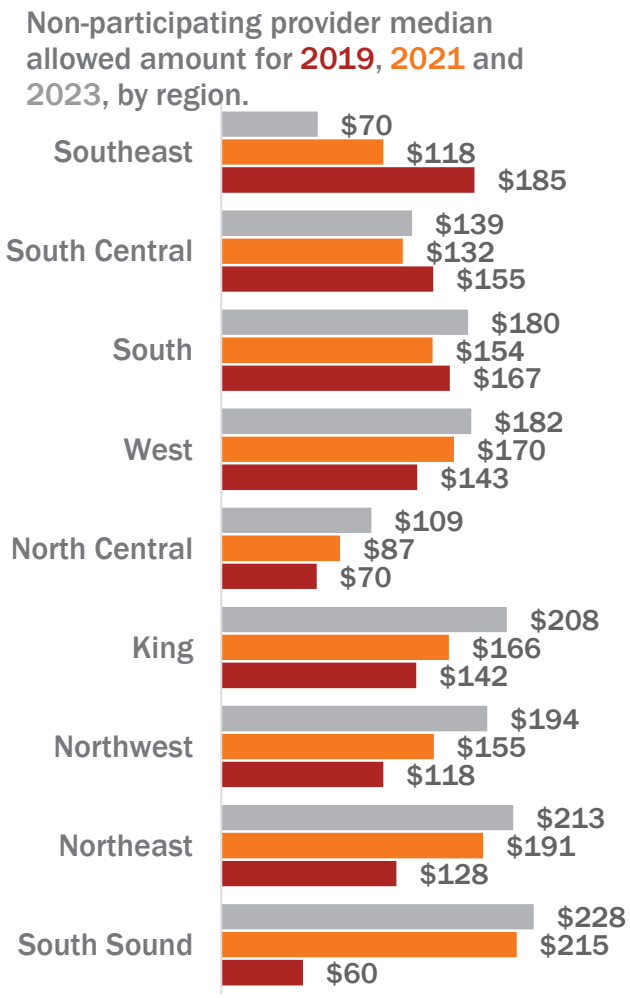
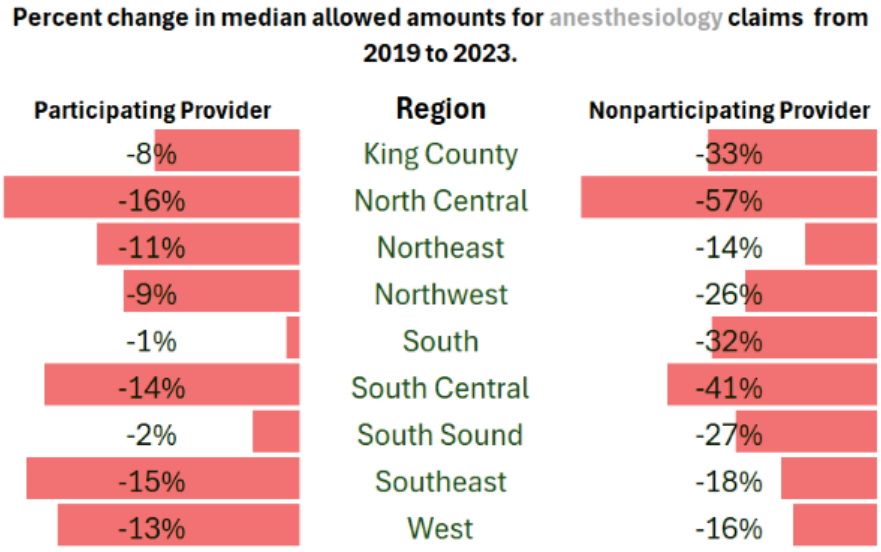
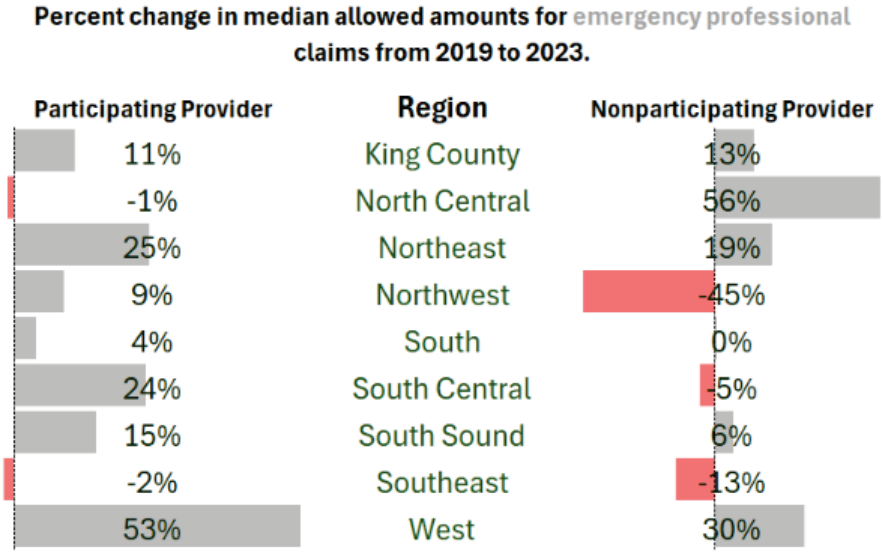


Exhibit 11 Percent change in median allowed amounts for anesthesiolgy claims



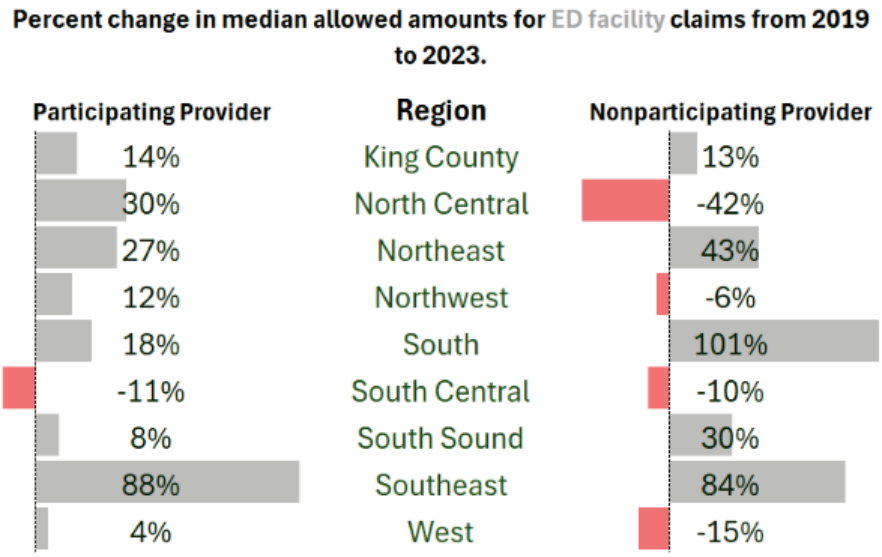
Across regions, anesthesiology services showed a decline in median allowed amounts for both participating and nonparticipating provider services.

Exhibit 12 Percent change in median allowed amounts for emergency professional claims



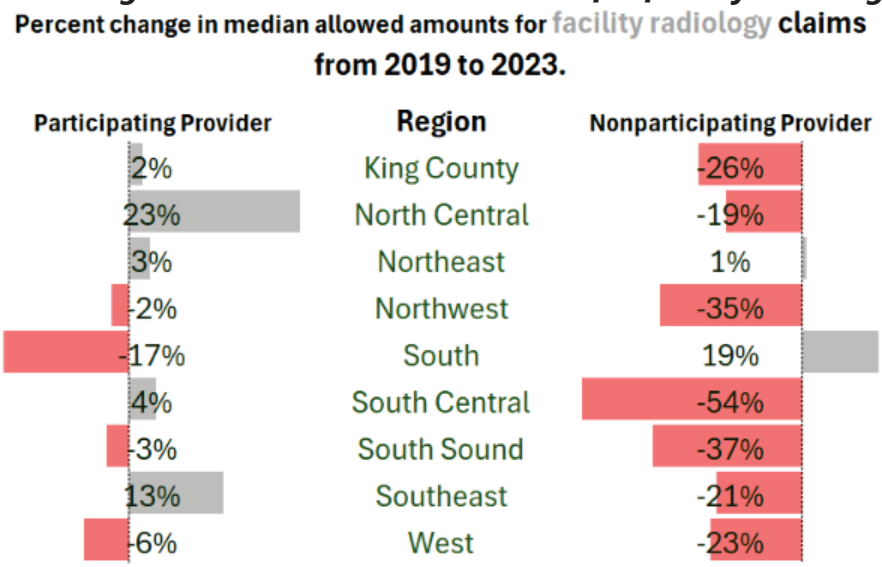
For emergency professional, participating provider median allowed amounts increased across all regions except two, North Central and Southeast. For nonparticipating emergency physician services, nonparticipating services showed both increases and decreases, with an increase of 56% in the North Central region and a decline of 45% in the Northwest region.

Exhibit 13 Percent change in median allowed amounts for ED facility claims



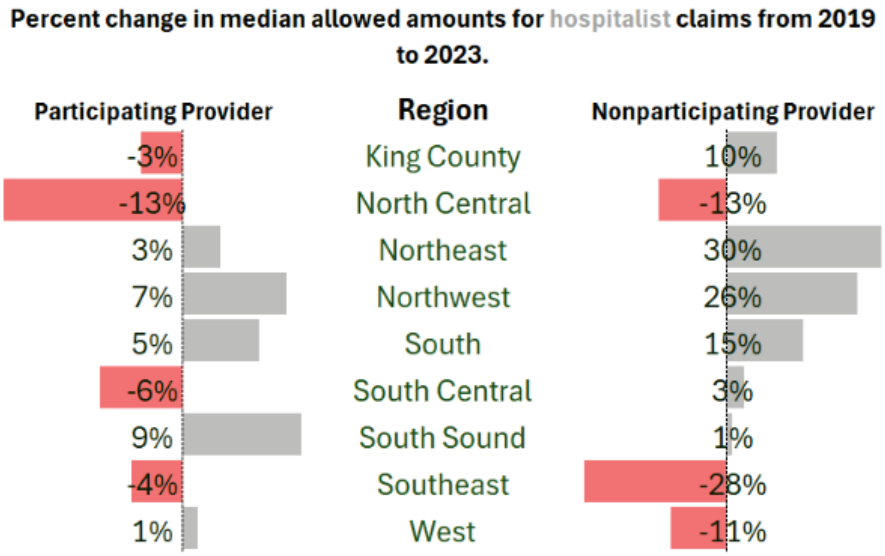
For ED facility services, all counties except South Central showed an increase in participating facility median allowed amounts.

Exhibit 14 Percent change in median allowed amounts for facility radiology claims



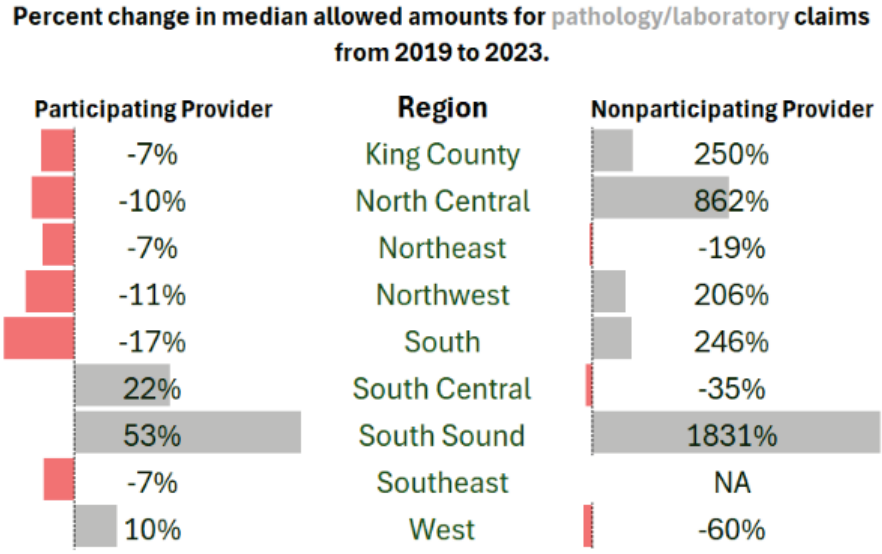
North Central saw the largest change in medial allowed amounts for radiology facility services. Nonparticipating facility allowed amounts decreased for all regions other than Northeast and South.

Exhibit 15 Percent change in median allowed amounts for hospitalist claims



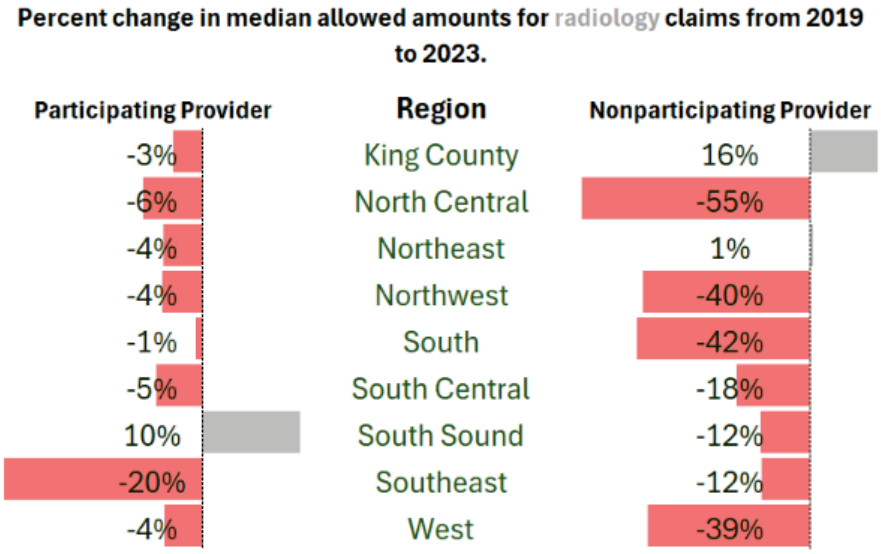
For hospitalist services, three out of nine regions showed a decline in nonparticipating provider median allowed amounts.

Exhibit 16 Percent change in median allowed amounts for pathology/laboratory claims



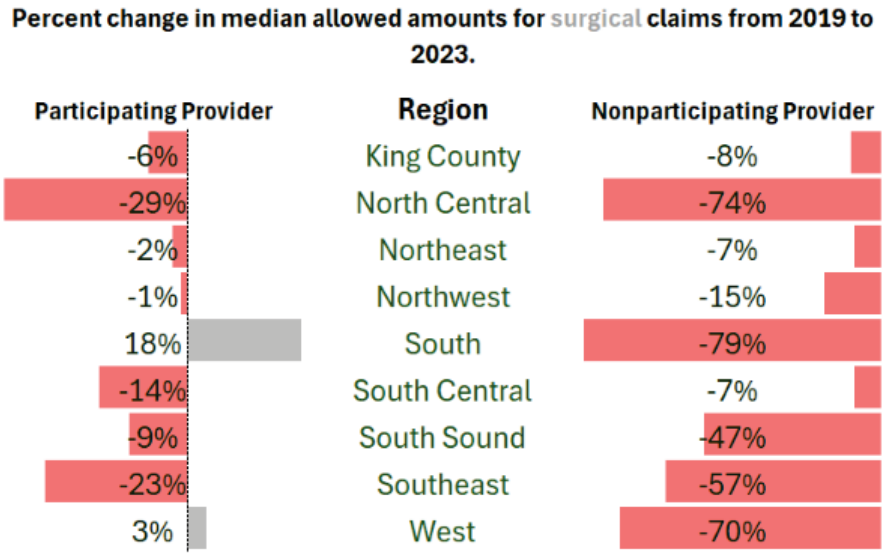
There is substantial variability in trends in allowed amounts for pathology/lab services for the reasons noted on page six of this report.

Exhibit 17 Percent change in median allowed amounts for radiology claims



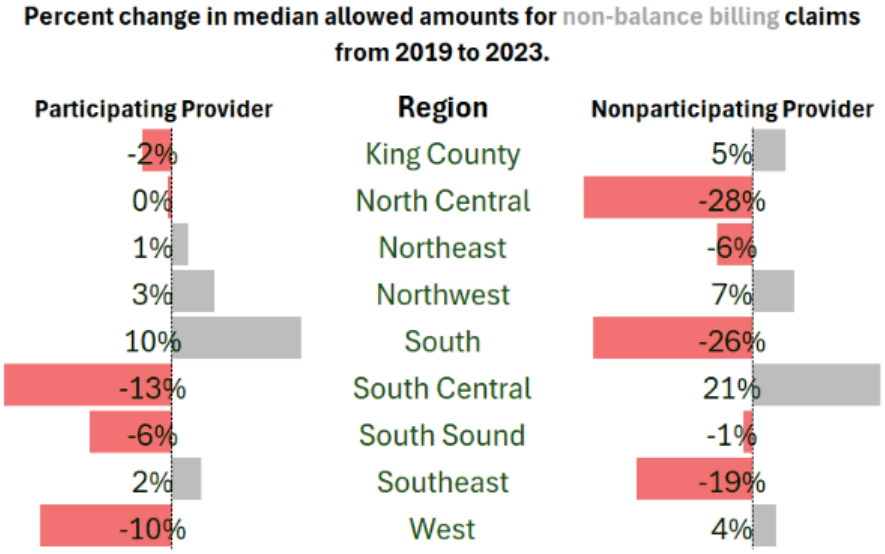
Professional radiology services saw declines in most regions for both participating and nonparticipating provider median allowed amounts in 2023 from 2019.

Exhibit 18 Percent change in median allowed amounts for surgical claims



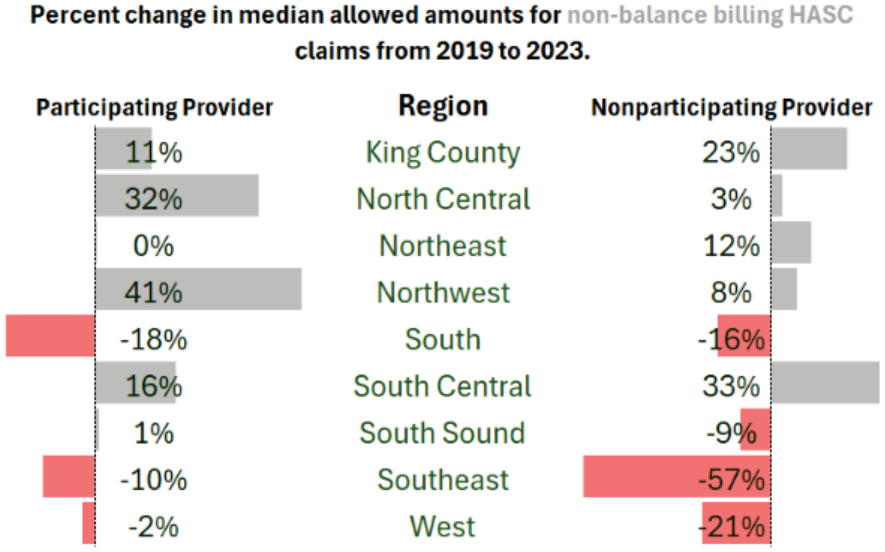
Similar to the professional radiology trends, professional surgical results showed large declines in participating and nonparticipating provider median allowed amounts.

Exhibit 19 Percent change in median allowed amounts for non-balance billing claims



For services <u>not</u> subject to balance billing protections provided in any setting, five regions showed unchanged or decreased participating provider median allowed amounts. Five regions showed a decline in nonparticipating provider median allowed amounts.

Exhibit 20 Percent change in median allowed amounts for non-balance billing HASC claims



For services not subject to balance billing protections performed at hospitals and ambulatory surgical centers, six out of nine regions showed either no change or an increase in median allowed amounts paid to participating providers from 2019 to 2023. There was considerable variability in the percent change in median allowed amount between regions for nonparticipating provider services. For example,

the South Central region showed an increase of 33%, while the Southeast region showed a decline of 57% in nonparticipating provider median allowed amounts.

The two tables below show the medial allowed amounts for the top 10 procedure codes with the most claims in 2023.

Exhibit 21 Participating provider median allowed amounts for the most common procedure codes, 2019-2023

Category	Procedure Code	Code Description	Median Allowed Amount			Change
			2019	2021	2023	
Emergency	99284	Emergency Department Visit Moderate MDM	$236	$246	$245	
Facility Radiology	77067	Screening Mammography Bi 2-View Breast Inc Cad	$191	$185	$171	
Hospitalist	99232	Sbsq Hospital Ip/Obs Care Mod MDM 35 Minutes	$133	$134	$127	
Radiology	77067	Screening Mammography Bi 2-View Breast Inc Cad	$73	$71	$67	
Emergency	99285	Emergency Department Visit High MDM	$366	$363	$344	
Facility Radiology	77063	Screening Digital Breast Tomosynthesis Bl	$43	$43	$41	
Radiology	77063	Screening Digital Breast Tomosynthesis Bl	$59	$58	$54	
Path/Lab	88305	Level Iv Surg Pathology Gross&Microscopic Exam	$70	$69	$65	
Radiology	71045	Radiologic Exam Chest Single View	$18	$18	$17	
Hospitalist	99233	Sbsq Hospital Ip/Obs Care High MDM 50 Minutes	$187	$191	$185	

Exhibit 22 Non-Participating Provider Median Allowed Amounts for the Most Common Procedure Codes, 2019-2023

Category	Procedure Code	Code Description	Median Allowed Amount 2019	2021	2023	Change
Emergency	99284	Emergency Department Visit Moderate MDM	$239	$222	$226	
Emergency	99285	Emergency Department Visit High MDM	$409	$334	$333	
Emergency	93010	Ecg Routine Ecg W/Least 12 Lds I&R Only	$13	$16	$16	
Hospitalist	99232	Sbsq Hospital Ip/Obs Care Mod MDM 35 Minutes	$114	$137	$131	
Hospitalist	99233	Sbsq Hospital Ip/Obs Care High MDM 50 Minutes	$160	$186	$190	
ED Facility	96374	Ther Proph/Dx Njx Iv Push Single/1St Sbst/Drug	$340	$545	$453	
ED Facility	96375	Therapeutic Injection Iv Push Each New Drug	$141	$148	$135	
ED Facility	99283	Emergency Department Visit Low MDM	$662	$636	$535	
Anesthesiology	00812	Anesthesia Lower Intst Endoscopic Px Scr Colsc	$451	$407	$343	
Hospitalist	99223	1St Hospital Ip/Obs Care High MDM 75 Minutes	$311	$373	$332	

Discussion

As noted in the purpose and background section of this report, other unknown variables may have influenced the trends found in the claims data. The variability in trends among provider specialty types and across geographic regions may be impacted by provider supply and concentration. In addition, given the substantial decrease in the number of claims from nonparticipating providers, median allowed amounts for nonparticipating providers can be impacted more significantly than those for participating provider claims. This was most evident with respect to lab/pathology claims, as described above. The OIC cannot definitively conclude that changes described in this analysis were a direct result of the BBPA's enactment.

The BBPA directs[1] the OIC to produce an update to this report in 2026 and biennially until 2030. Given the enactment of E2SHB 1688 (Chapter 263, Laws of 2022), this report encompasses a broader range of services that are subject to balance billing protections than the 2022 report. For the report due to the

[1] RCW 43.371.100 (3) Until December 31, 2030, the office of the insurance commissioner shall contract with the state agency responsible for administration of the database or other organizations biennially beginning in 2022, for an analysis of commercial health plan claims data to assess any impact that chapter **48.49** RCW or P.L. 116-260 have had or may have had on payments to participating and nonparticipating providers and facilities and on the volume and percentage of claims that are provided by participating compared to nonparticipating providers. To the extent that data related to self-funded group health plans is available within funds appropriated for this purpose, the analysis may include such data. The first analysis shall compare 2019 claims data to the most recent full year's claims data. The analysis must be published on the website of the office of the insurance commissioner, with the first analysis published on or before December 15, 2022.

legislature in 2026, ground ambulance services will also be included in services that are subject to balance billing protections.

Changes in claim counts

Between 2019 and 2021 there were more significant changes in the participating and nonparticipating claim counts. Between 2021 and 2023, the changes were less significant. Overall, the number of participating providers claim counts increased from 2019 to 2021 and again from 2021 to 2023 for most provider and facility types. A notable exception being pathology and laboratory services which saw a decline in claim counts between 2021 and 2023. An explanation for this is examined on page six of this report and in Appendix A.

Nonparticipating provider claims saw corresponding decreases from 2019 to 2021, however between 2021 and 2023 most provider and facility types saw approximately the same or a slight increase in the number of claims submitted. The exception being radiology services which continued to show a corresponding decrease in nonparticipating provider claim submission.

Changes in median allowed amounts

The changes in median allowed amounts showed considerably more variation across regions and provider types. Some participating provider types showed consistent increases in their allowed amounts from 2019 to 2023, such as participating emergency providers and emergency department facilities. Others showed overall decreases between their 2019 and 2023 amounts, such as nonparticipating surgical, facility radiology and anesthesiologists. A possible cause of this, might be the impacts on provider reimbursement from the Covid-19 pandemic. Given the variability across all regions and all provider and facility types it is not possible to conclude the impacts of the BBPA on median allowed amounts.

Conclusion

In conclusion, we see a shift in volume from nonparticipating to participating providers for services subject to balance billing protections and a decline in utilization of nonparticipating provider and facility services. There was considerable variability in changes in the median allowed amount for participating and nonparticipating provider and facility services, with the largest declines in nonparticipating provider services. Additionally, in-network median allowed amounts generally increased across both participating and nonparticipating services by category.

Appendix A

Methods (prepared by ONPOINT Health Data)

The ONPOINT analysis focused on changes in the following two key areas related to services provided by participating and nonparticipating health care facilities and providers:

> (1) The volume of participating and nonparticipating claims for services subject to protection from balance billing under the BBPA.
>
> (2) The allowed amounts paid for services subject to protection from balance billing under the BBPA.

Specifically, the research sought to identify any changes in the distribution of participating and nonparticipating provider claims volume and allowed amounts paid by service category (e.g., surgical, emergency professional, hospitalist, emergency department), OIC rating area, county and Current Procedural Terminology (CPT) code. Additionally, ONPOINT examined whether there were differences in those metrics between services subject to the BBPA compared to services outside of BBPA protections.

Data source

The data source for this report is the Washington State All Payer Claims Database (WA-APCD). The database contains administrative claims data submitted by Washington state health plans, including data from commercial, Medicaid and Medicare sources. Self-funded group health plans are not required to submit claims data to the WA-APCD, other than claims for the PEBB/SEBB Uniform Medical Plan. The WA-APCD includes enrollment and claims (i.e., medical, pharmacy, and dental) data, and provides information on services provided, provider locations, diagnoses, procedures, charges, paid amounts, and more.

This analysis includes claims from commercial payers for calendar years (CYs) 2019, 2021 and 2023. Medicaid and Medicare data were not included. To assess changes in service volumes and payments following adoption of the BBPA, ONPOINT compared CY2019 data (pre-BBPA) to CY2021 and 2023 data (post-BBPA).

Population: Identifying services from claims data

As an initial step in this study, ONPOINT identified claims for both services subject to protection from balance billing and services outside of BPPA protections (i.e., referred to as "non-balance billing" services). ONPOINT identified an initial pool of claims for inclusion in the study with a reported first service date in the 2019, 2021 or 2023 calendar year (i.e., Jan. 1 – Dec. 31)[1]. Additionally, only claims processed as primary were included. Denied and orphaned claims were excluded. The analysis was limited to commercial claims in the WA-APCD with a reported payment arrangement indicator that identified a fee-for-service or Diagnosis-Related Group (DRG) basis for the charges. The WA-APDC does not include non-claims payments, such as quality bonuses or capitated payments to providers. Charge and paid amounts were restricted to only positive amounts (i.e., negative and zero charge/paid amounts were removed).

The allowed amount field was calculated by summing the amount paid to the facility or provider by the carrier and any applicable enrollee copay, coinsurance or deductible amounts. Allowed amounts were adjusted for inflation using the Consumer Price Index (CPI) – CPI-Urban medical care component for the Seattle/Tacoma/Bellevue area from 2019-2020, 2020-2021, 2021-2022 and 2022-2023. The CPI is established by the U.S. Department of Labor, Bureau of Labor Statistics.

Unique, blinded provider numbers were created to allow data to be presented at the provider level without revealing providers' National Provider Identifiers (NPIs) or other potentially identifiable information. Rendering provider ZIP codes were used to identify a county and the OIC rating area for each provider. The OIC rating areas are presented in Figure 1. The list of rating areas and counties is provided below in Table 1.

Figure 1. Map of the OIC rating areas

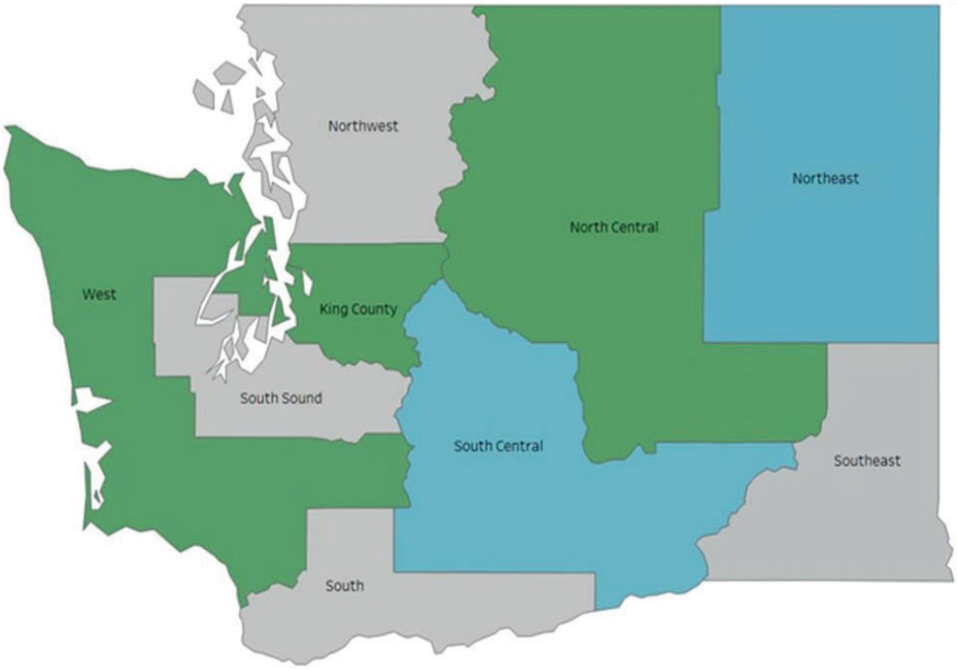


Table 1. The OIC rating areas & Washington counties

OIC rating area	Counties
Area 1: King County	King
Area 2: West	Clallam, Cowlitz, Grays Harbor, Jefferson, Kitsap, Lewis, Pacific, Wahkiakum
Area 3: South	Clark, Klickitat, Skamania
Area 4: Northeast	Ferry, Lincoln, Pend Oreille, Spokane, Stevens
Area 5: South Sound	Mason, Pierce, Thurston
Area 6: South Central	Benton, Franklin, Kittitas, Yakima
Area 7: North Central	Adams, Chelan, Douglas, Grant, Okanogan
Area 8: Northwest	Island, San Juan, Skagit, Snohomish, Whatcom
Area 9: Southeast	Asotin, Columbia, Garfield, Walla Walla, Whitman

To identify services subject to protection from balance billing, ONPOINT used the same definitions as provided in the BBPA, which are listed below by service type.

Emergency professional

Emergency department (ED) professional services were identified using ONPOINT's ED flag, which identifies any procedure that occurred in the ED based on the presence of any of the following codes in the claims:

- Place of service code: 23
- Procedure codes: 99281–99288
- Revenue codes: 0450–0459, 0981

Emergency department – facility

Emergency department facility claims were identified based on the following criteria:

- Claim type code: 2
- Revenue codes: 0450–0452, 0459

Surgical & ancillary services

Surgical and ancillary services were restricted to claims for services that met both of the following conditions:

- Place of service: 21–24
- Type of setting: 1, 7, 8, 14

Five categories of surgical and ancillary services were identified using the following CPT codes:

- Anesthesiology: 00100–01999
- Hospitalists: 99217–99226, 99231, 99232, 99234–99236, 99238, 99239
- Lab and pathology: 80047–89398
- Radiology: 70010–79999
- Surgery: 10004–69990

Procedure modifier codes

Procedure modifier codes serve multiple purposes. In some cases, they may simply be informative (e.g., indicating the patient's left or right side), while in other cases, they may affect pricing (e.g., flagging whether a surgeon or their assistant performed the service).

To get the best estimate of what the procedure typically would cost without such adjustments, procedure modifier codes that affect pricing were removed from all calculations. This list of procedure modifier codes included the following: AS, FX, FY, SA, SG, UE, 22, 23, 25, 47, 50– 56, 62, 66, 73, 78, 80–82.

"Non-balance billing" services

Because services protected from balance billing occur in hospitals or ambulatory surgical facilities under the BBPA, only professional services are applicable for comparing services subject to BBPA protections to those services that are not. To identify the comparison group for professional non-balance billing services, ONPOINT selected professional claims and CPT codes that were not included in any of the balance billing categories.

Evaluating impact

To evaluate the impact of BBPA on participating and nonparticipating provider utilization and allowed amounts, ONPOINT summarized key metrics, including count of claims, median allowed amount and the sum of allowed amount by specific strata. These strata included network indicator, service category (e.g., radiology, ED facility), county, the OIC rating area and CPT code. Each metric was calculated separately for each grouping (e.g., the median of allowed amount was calculated by network indicator for the network indicator grouping).

To evaluate participating and nonparticipating provider utilization, ONPOINT calculated the percent of claims that were submitted by participating and nonparticipating providers for CY2019, CY2021 and CY2023 separately.

To evaluate payments, ONPOINT calculated the median allowed amount by year and given strata. Additionally, ONPOINT calculated the ratio of allowed amount for participating provider to nonparticipating provider claims in each year. For example, they compared the median allowed amount for participating provider services in 2019 to the median allowed amount for nonparticipating provider services in 2019. A ratio higher than 1.0 indicates higher payments for participating provider services compared to nonparticipating provider services.

To inform aggregate reporting, ONPOINT also calculated metrics such as median allowed amount and the ratio of participating provider to nonparticipating provider services for the following totals shown here:

Balance billing:

- All services
- All services- ED facility excluded

Non-balance billing:

- All services (any setting)
- Hospital ambulatory surgical center services only

Glossary

- Allowed amount: Sum of total payments made by the member and health plan.
- BBPA: Balance Billing Protection Act, codified in RCW 48.49.
- BB: Services subject to protection from balance billing under the BBPA.
- BB facility: Claims for services performed at an emergency facility or radiology facility in a hospital or ambulatory surgical facility.
- BB professional services: Services provided by health care professionals providing services subject to balance billing protections, e.g., radiology, anesthesiology, lab/pathology, hospitalist, surgical, emergency physician.
- HASC: Denotes claims with a place of service of either a hospital or ambulatory surgical facility.
- "Hospitalist:"": A physician who often earns a residency in internal medicine and is certified in hospital medicine. Practice is confined to a hospital setting.
- Non-BB professional HASC: Non-balance billing professional services performed at a hospital or ambulatory surgical center.
- Non-BB professional any: Non-balance billing professional services performed in any setting.

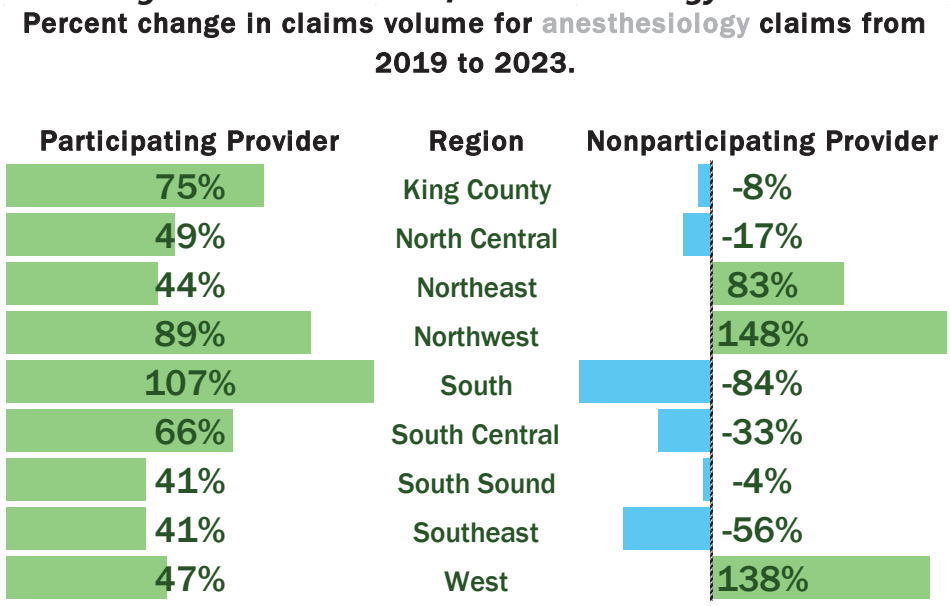
Lab/pathology services

When analyzing claims data for lab and pathology services, ONPOINT found the median allowed amount for 2019 nonparticipating provider claims was $7, as compared to $35 in 2021. In contrast, median allowed amounts were in the $55 - $65 range for participating provider services in all three years. The distribution of the data was examined.

In 2019, for nonparticipating provider services, there was a higher number of claims with $6-$7 amounts. For example, the 5th, 10th and 25th percentiles for 2019 nonparticipating provider services were all $6. The distribution suggests higher volume of $6 and $7 claims for 2019 out-of-network services than any other groupings. Therefore, due to the high volume of $6 and $7 claims compared to other groupings, the 2019 nonparticipating provider grouping has a much lower median allowed amount than other groupings. In addition, the number of nonparticipating provider claims for these services dropped from 15,208 in CY 2019 to 1,089 in CY 2021. Given this atypical difference in both changes in the number of nonparticipating provider claims and changes to allowed amounts, in several places throughout the report, aggregate figures exclude lab/pathology claims.

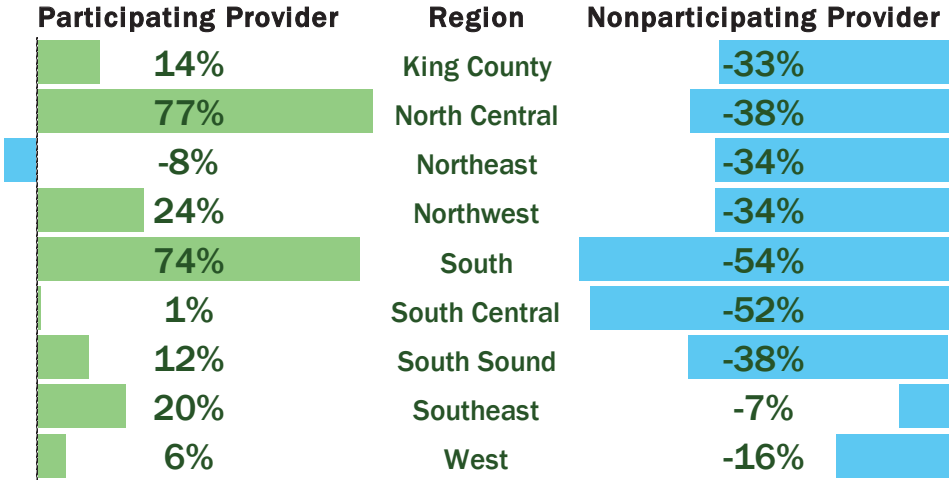
Appendix B

Exhibit 6 Percent change in claims volume for anesthesiology claims



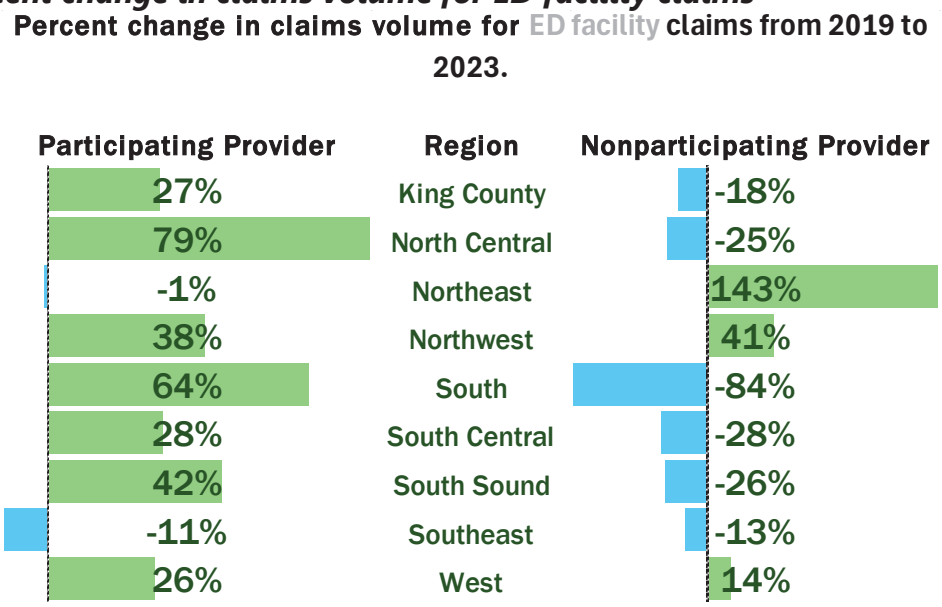
All regions showed an increase in participating provider anesthesiology claims volume from 2019 to 2023. Most regions show a slight decline in nonparticipating provider use except Northeast, Northwest and West regions.

Exhibit 7 Percent change in claims volume for emergency professional claims



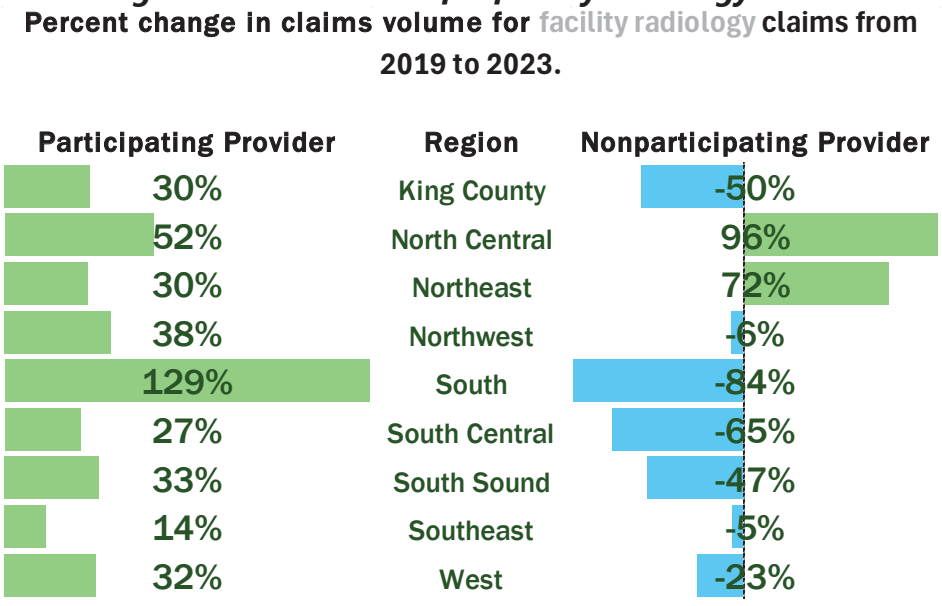
All regions except Northeast showed an increase in participating provider claims for Emergency Professional services. Similarly, all regions showed a decline in nonparticipating provider use. The regions with larger declines in nonparticipating provider use and the largest increases in participating provider use are: North Central and South**.**

Exhibit 8 Percent change in claims volume for ED facility claims



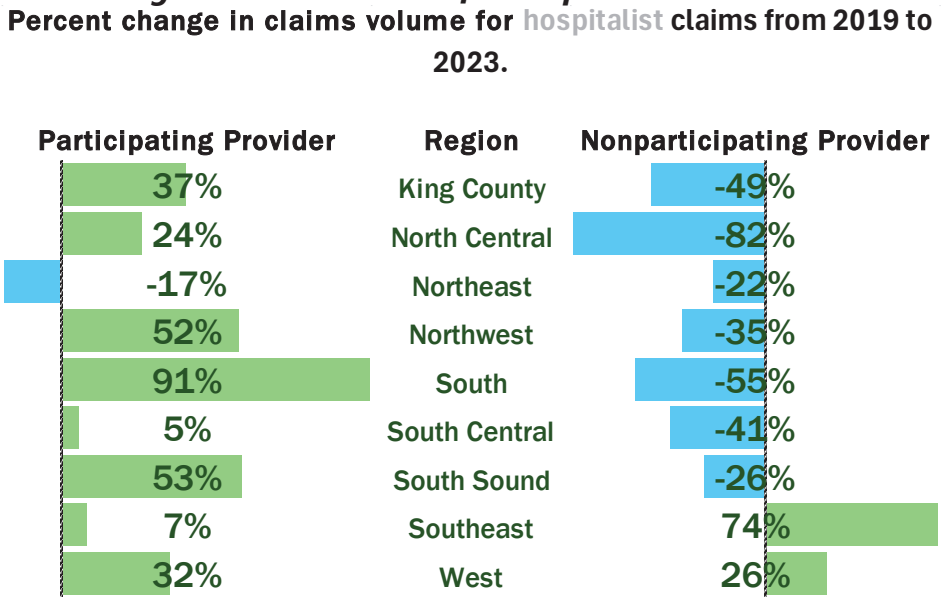
All but two regions, Northeast and Southeast, showed an increase in participating ED facility claims. Similarly, all but three regions showed a decline in nonparticipating facility use (Northeast, Northwest and West).

Exhibit 9 Percent change in claims volume for facility radiology claims



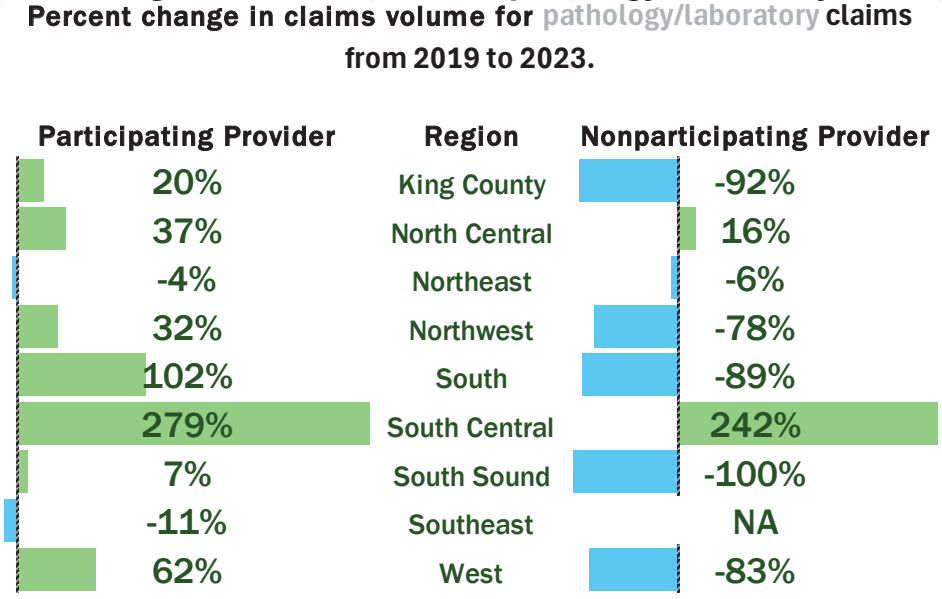
All regions showed an increase in participating facility claims for radiology services at facilities. All regions except North Central and Northeast showed a decline in nonparticipating facility use for the same services.

Exhibit 10 Percent change in claims volume for hospitalist claims



For hospitalist services, most regions saw an increase in participating provider claims, and a corresponding decrease in nonparticipating provider claims.

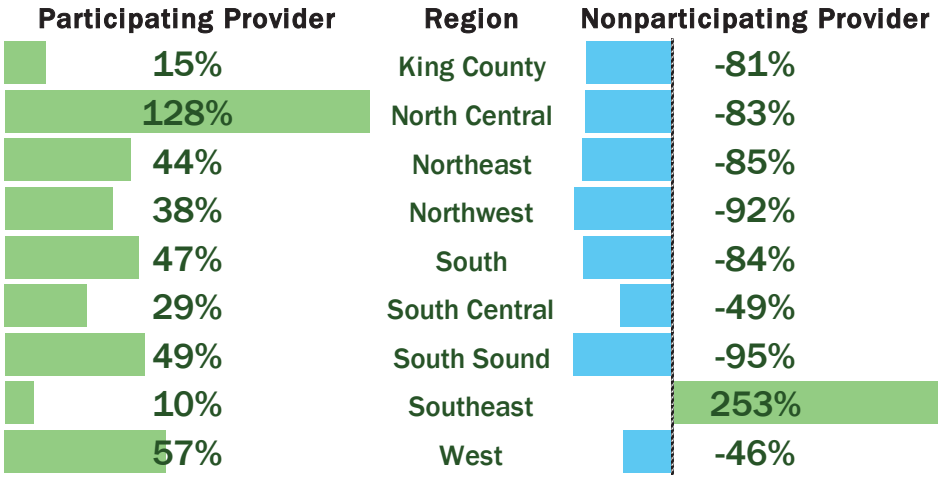
Exhibit 11 Percent change in claims volume for pathology/laboratory claims



In general, participating provider claims for pathology/lab services increased while nonparticipating provider claims volume declined. As noted on page nine and 10 of this report, pathology and laboratory claims experienced a large shift in both the number of claims and the median allowed amount for services. This is reflected in Exhibit 11.

Exhibit 12 Percent change in claims volume for radiology claims

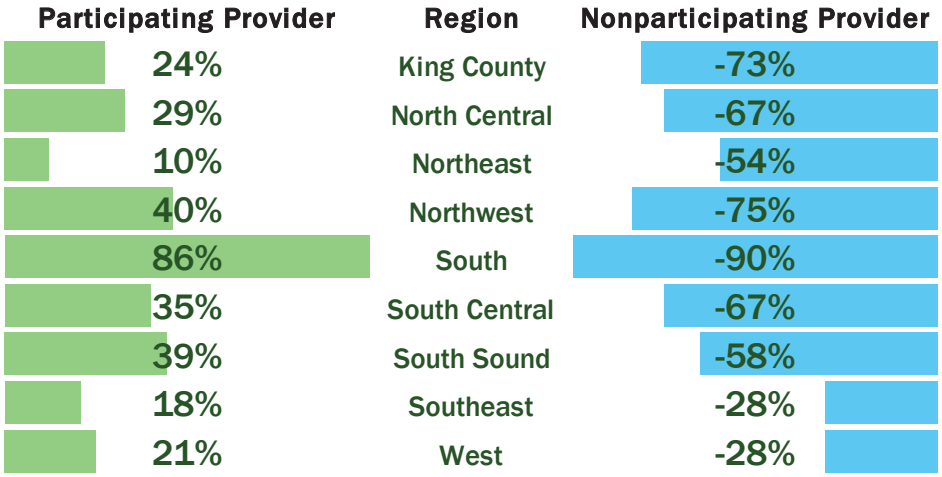
Percent change in claims volume for radiology claims from 2019 to 2023.



All regions showed an increase in participating provider professional radiology claims volume. All regions except for Southeast showed a decline in nonparticipating provider professional radiology claims.

Exhibit 13 Percent change in claims volume for surgical claims

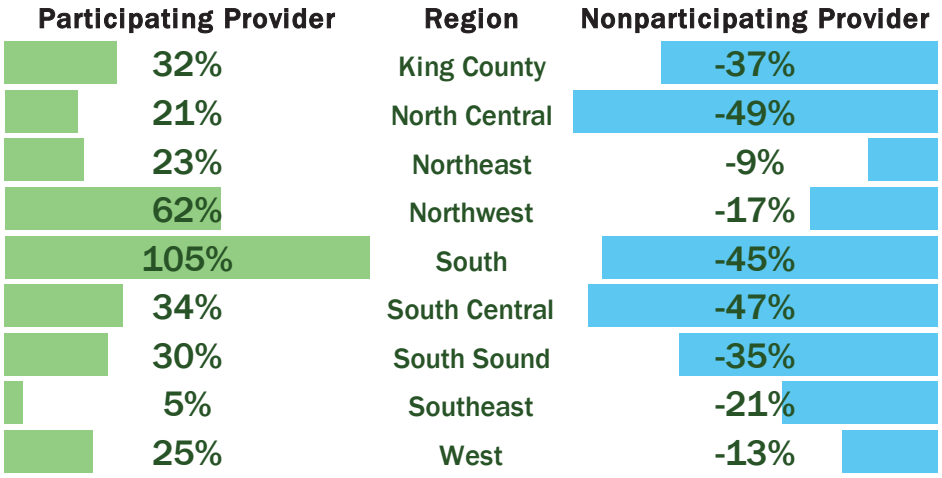
Percent change in claims volume for surgical claims from 2019 to 2023.



Across all regions, surgical procedures showed an increase in participating provider claims volume coupled with a decline in nonparticipating provider claims volume.

Exhibit 14 Percent change in claims volume for non-balance billing claims

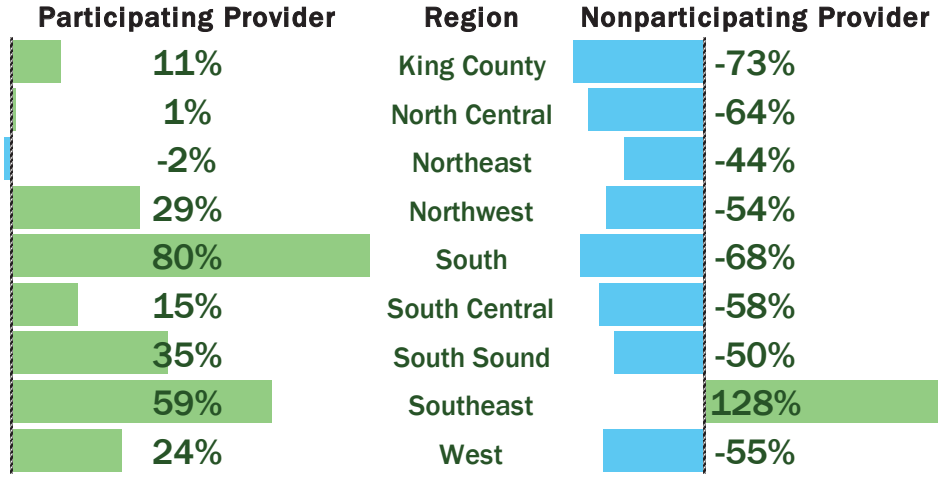
Percent change in claims volume for non-balance billing claims from 2019 to 2023.



Across all regions there was a total decline in nonparticipating services performed by health professionals in any setting for services not subject to balance billing protections, with increases in all regions for participating provider claims volume from 2019 to 2023. Because these are services not subject to balance billing protections, these declines would have been associated with other dynamics.

Exhibit 15 Percent change in claims volume for non-balance billing HASC claims

Percent change in claims volume for non-balance billing HASC claims from 2019 to 2023.



This exhibit shows changes in claims volume for professional services provided in hospitals and ambulatory surgical facilities that were not subject to balance billing protections. Across all regions except for Southeast, there was a decline in nonparticipating provider services. Participating provider claims increased for all regions except for Northeast.