Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1561

Brief Description: Requiring payment for critical services rendered by out-of-network providers in in-network hospitals.

Sponsors: Representatives Cody, Jinkins and Kenney.

Brief Summary of Bill

- Bans balance billing for critical services.
- Imposes a minimum payment methodology for critical services provided by out-of-network providers.
- Requires out-of-network providers to be reimbursed directly for critical services.

Hearing Date: 2/14/11

Staff: Jim Morishima (786-7191).

Background:

Balance Billing.

Most insured people obtain their insurance from managed care organizations such as preferred provider organizations and health maintenance organizations. Generally speaking, when an insured person receives covered health services from a provider participating in the organization, he or she is "held harmless" for the difference between what the organization pays the provider and what the provider normally charges for the services. However, if the person receives services from a non-participating provider, the provider may bill the person for this difference. This practice is informally known as "balance billing."

Emergency Services Under State Law.

Under state law, a health carrier must cover "emergency services" necessary to screen and stabilize a covered person without prior authorization if a prudent layperson would reasonably

---

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

have believed that an emergency medical condition existed. If the emergency services were provided in a non-participating hospital, the health carrier must cover emergency services necessary to screen and stabilize a covered person if a prudent layperson would reasonably have believed that use of a participating hospital would result in a delay that would worsen the emergency or if use of a specific hospital is required by federal, state, or local law. Likewise, a health carrier may not require prior authorization of emergency services in a non-participating hospital if a prudent layperson acting reasonably would have believed that an emergency medical condition existed and that use of a participating hospital would result in a delay that would worsen the emergency.

If an authorized representative of the health carrier authorizes coverage for emergency services, the carrier may not retract the authorization after the services have been provided or reduce payment for services provided in reliance on the approval. The carrier may retract the authorization or reduce payment, however, if the approval was based on a material misrepresentation about the covered person's health condition made by the provider.

Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles. A health carrier may also impose reasonable differential cost-sharing arrangements for emergency services rendered by non-participating providers. However, the difference between cost-sharing amounts for participating and non-participating providers may not exceed $50. Differential cost-sharing may not be applied when a covered person utilizes a non-participating hospital emergency department when the carrier requires pre-authorization for post-evaluation and post-stabilization emergency services if:

- the covered person was unable to go to a participating hospital in a timely fashion without serious impairment to the person's health due to circumstances beyond the person's control; or
- a prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that the person would be unable to go to a participating hospital in a timely fashion without serious impairment to the person's health.

"Emergency services" are defined as otherwise covered health services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

Emergency Services Under Federal Law.

Under the Emergency Medical Treatment and Active Labor Act (EMTALA), which was passed by Congress in 1986, a hospital may not turn away a patient who comes to the emergency department with an emergency medical condition. The hospital must screen and evaluate the patient and provide treatment necessary to stabilize him or her.

Under the federal Patient Protection and Affordable Care Act (PPACA), a health insurer that offers coverage for services in an emergency department must cover emergency services without prior authorization, without regard to whether the provider is in-network or out-of-network, and with no differential copayments or coinsurance for out-of-network services. The services must be provided without regard to any other term or condition of coverage other than applicable cost sharing, federally authorized affiliation or waiting periods, or federally authorized exclusion or coordination of benefits.

The administrative rules implementing the PPACA clarify that enrollees remain subject to applicable cost-sharing amounts, but may not be charged a different cost-sharing rate for out-of-network services. The rules also provide a payment methodology for emergency services provided by out-of-network providers. An insurer is in compliance with the rules if it pays the greater of the three following amounts adjusted for applicable in-network cost sharing:

- the amount negotiated with in-network providers for the emergency services (if there is more than one amount, the median of those amounts);
- the amount for the emergency service calculated using the same method the plan generally uses to determine payment for out-of-network services; or
- the Medicare amount.

Any cost sharing other than a copayments or coinsurance may be imposed for emergency services provided out-of-network if the cost sharing generally applies to out-of-network benefits. A deductible may be imposed with respect to out-of network emergency services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, the out-of-pocket maximum must apply to out-of-network emergency services.

An out-of-network provider who receives payment from an insurer based on the payment methodology may bill the patient for the balance between the provider's billed charges and the amount the provider was paid by the insurer; i.e., the provider may "balance bill" the patient.

Summary of Bill:

For covered "critical services" rendered to a covered person in an in-network hospital, a health carrier or a health benefit plan offered to public employees must pay the claim at the rate provided in federal law; i.e., the greater of the amount negotiated with in-network providers for the emergency services (if there is more than one amount, the median of those amounts); the amount for the emergency service calculated using the same method the plan generally uses to determine payment for out-of-network services; or the Medicare amount. Employer-sponsored, self funded health plans (and third party administrators of these plans) are encouraged, but not required, to follow this payment methodology as well. The Insurance Commissioner may, by rule, change the amount that must be paid based on changes to the federal law.

"Critical services" are defined as:

- services provided in the emergency department; and
- services provided outside the emergency department that are necessary to stabilize the patient.

Health carriers, health benefit plans offered to public employees, and employer-sponsored, self-funded health plans must pay out-of-network providers directly for critical services.

The amount paid to the out-of-network provider for the critical services, plus any applicable cost sharing, constitute payment in full for the critical services. The person who received the critical services is not liable for any excess amounts; i.e., the provider may not "balance bill" the person. Any attempt to balance bill the patient constitutes unprofessional conduct under the Uniform Disciplinary Act.

Appropriation: None.

Fiscal Note: Requested on February 10, 2011.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.