HOUSE BILL REPORT
HB 1561

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to payment for critical services rendered by out-of-network providers in in-network hospitals.

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

Sponsors: Representatives Cody, Jinkins and Kenney.

Brief History:
Committee Activity:
Health Care & Wellness: 2/14/11, 2/17/11 [DPS].

Brief Summary of Substitute Bill

- Requires hospitals, insurance carriers, and providers to provide patients with information about balance billing.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 6 members: Representatives Cody, Chair; Jinkins, Vice Chair; Clibborn, Green, Moeller and Van De Wege.

Minority Report: Do not pass. Signed by 5 members: Representatives Schmick, Ranking Minority Member; Hinkle, Assistant Ranking Minority Member; Bailey, Harris and Kelley.

Staff: Jim Morishima (786-7191).

Background:

Balance Billing.

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

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the organization pays the provider and what the provider normally charges for the services. However, if the person receives services from a nonparticipating 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 have believed that an emergency medical condition existed. If the emergency services were provided in a nonparticipating 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 nonparticipating 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 nonparticipating providers. However, the difference between cost-sharing amounts for participating and nonparticipating providers may not exceed $50. Differential cost-sharing may not be applied when a covered person utilizes a nonparticipating 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, 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 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 Substitute Bill:

A hospital must post in its emergency department reception area a sign indicating whether the providers in the emergency department are nonparticipating providers with any of the health carriers with whom the hospital participates. The hospital is not required to post the sign if the providers in the emergency department participate with all of the health carriers with whom the hospital participates. The hospital must also provide the information to the patients when obtaining informed consent for emergency services, unless to do so would endanger the life or health of the patient. A hospital that fails to comply with these notice requirements must promptly reimburse the patient for any balance bill.

In any explanation of benefits sent to a covered person, the health carrier must inform the patient whether any emergency services were provided by nonparticipating providers. The health carrier must also inform the person that he or she may be subject to balance billing,

that the balance bill is often subject to negotiation, and that the person may wish to contact the provider about the bill. A health carrier that fails to comply with these notice requirements must promptly reimburse the patient for any balance bill.

A nonparticipating provider that balance bills a patient must notify the person in writing that the amount in the bill is not necessarily reflective of the provider's actual costs and may be subject to negotiation. The provider must also notify the patient that he or she may not be responsible for paying the balance bill if the hospital or health carrier fails to comply with applicable notice requirements. A nonparticipating provider who fails to meet these notice requirements must refund any amounts collected from the patient and is guilty of unprofessional conduct under the Uniform Disciplinary Act.

Substitute Bill Compared to Original Bill:

The substitute bill eliminates all of the provisions of the underlying bill (banning balance billing, providing a minimum payment methodology for critical services, and requiring direct payment for critical services.

The substitute bill requires hospitals to post a list of nonparticipating providers in its waiting area and to provide patients with the information when obtaining informed consent (unless to do so would endanger the patient). A hospital that does not comply with this requirement must reimburse the patient for any balance bill.

The substitute bill requires a carrier, in any explanation of benefits, to inform the covered person: (a) whether emergency services were provided by a nonparticipating provider, (b) that the person may be subject to a balance bill, and (c) that the amount on the balance bill is often subject to negotiation and that the covered person may therefore wish to contact the provider about the bill. A carrier that does not comply with this requirement must reimburse the patient for any balance bill.

The substitute bill requires a nonparticipating provider who balance bills a patient to inform the person in writing that that: (a) the amount in the bill may not be reflective of the provider's actual costs and may be subject to negotiation, and (b) the covered person may not be responsible to pay the bill if the hospital or carrier violates the act. A nonparticipating provider who violates this requirement must reimburse the patient for any payment he or she receives. Failure to provide this refund constitutes unprofessional conduct under the Uniform Disciplinary Act.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) This bill will help control costs for patients and will help prevent sticker shock when patients receive balance bills. Emergency departments are an area of particular concern with respect to building a sustainable system for insured patients. The amount that emergency department providers are reimbursed is significantly higher than the Medicare amount. The amount between what the insurers pay the providers and what is billed is significant. In an emergency, hospitals are required to treat patients and insurers are required to pay for the services. The law is, however, silent on how much should be paid. There has been upward pressure on these prices and the rules implementing federal health care reform set a reasonable level. However, federal health care reform allows providers to balance bill patients. This bill will create incentives for physicians to contract with health insurers. Balance billing is a dispute between the insurer and the provider, but the patient gets unfairly caught in the middle. Patients assume that if they visit an emergency department in a participating hospital that they will be fully covered by insurance, but this is not always the case. Patients in this situation should be held harmless. This bill is a fair compromise between the interests of insurers, the interests of providers, and the interests of patients.

(Opposed) Balance billing does not impact many patients. Emergency departments are the safety net; they serve anyone who walks in the door without regard to insurance. By taking away a provider's ability to balance bill, this bill turns the payment standards in federal health care reform into de facto price controls. This will result in risk being transferred to providers and patients and will cause providers to withdraw from practice. Taking away balance billing will negatively affect a provider's ability to negotiate with a health insurer. The bill will also negatively affect the state's ability to attract providers from other states, which is vital since Washington does not train any emergency department physicians in-state. Balance billing is permissible under federal law, but this bill makes the practice unprofessional conduct under state law. Current law already protects patients from balance billing by limiting their responsibility for emergency department visits to a $50 cost sharing differential. The current law requires the insurance company to pay the remainder of the billed charges. However, the Insurance Commissioner is not enforcing the current law as written. There is a pending lawsuit to require the Insurance Commissioner to enforce the current law as written and the Legislature should wait until a ruling is issued in that case before taking action.

Persons Testifying: (In support) Representative Cody, prime sponsor; Bill Akers, Premera BlueCross; Joe Gifford, Regence BlueShield; Joe King, Group Health; Dave Knutson, United Healthcare; Ingrid McDonald, Association for the Advancement of Retired Persons; and Daniel Gross, Northwest Health Law Advocacy.

(Opposed) Dr. Dean Martz and Tim Layton, Washington State Medical Association; Dr. John Milne, Washington Chapter American College of Emergency Physicians; Dr. Gary Twiggs, Pediatrix Medical Group; Steve Marshall, Washington Chapter of the American College of Emergency Physicians; and Dr. Erik Penner.

Persons Signed In To Testify But Not Testifying: None.