Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 2447

Brief Description: Addressing emergency health care services balanced billing.

Sponsors: Representatives Cody, Robinson, Tharinger, Van De Wege, Jinkins and Johnson; by request of Insurance Commissioner.

Brief Summary of Bill

- Prohibits enrollees from incurring out-of-pocket expenses for emergency services rendered by non-participating providers that exceed the amounts that would be incurred for services rendered by participating providers.
- Requires binding arbitration for a non-participating provider and a carrier if they are unable to agree on a reimbursement amount for emergency services.

Hearing Date: 1/20/16

Staff: Jim Morishima (786-7191).

Background:

Balance Billing.

Generally speaking, when an enrollee receives covered health services from a participating (in-network) provider, he or she is held harmless for the difference between what the health carrier pays the provider and what the provider normally charges for the services. However, if the person receives services from a non-participating (out-of-network) 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

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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. The difference between cost-sharing amounts for participating and non-participating providers may not exceed $50. Differential cost-sharing may not be applied for utilization of 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), 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 carrier 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. A carrier 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 Bill:

When an enrollee utilizes a participating health care facility, a participating provider is unavailable, and services are provided by a provider who provides emergency services to an enrollee in a participating facility, the carrier must ensure that the enrollee incurs no greater out-of-pocket costs than he or she would have incurred with a participating provider. If the enrollee agrees to assign the benefits he or she receives for services to the non-participating provider:

- the carrier must provide the non-participating provider with a written explanation of benefits within 30 days;
- the carrier must pay any reimbursement directly to the non-participating provider; and
- the non-participating provider may not bill the enrollee, except for applicable deductibles, copayments, or coinsurance.

The non-participating provider may bill the carrier directly and the carrier may either pay the full billed charges or attempt to negotiate a different amount. If attempts at negotiation are unsuccessful within 30 days of receipt of the explanation of benefits, the carrier or provider may initiate binding arbitration by filing a request with the Insurance Commissioner (Commissioner). The parties must inform each other of their final offers prior to arbitration.

The Commissioner must publish a list of approved arbitrators. The arbitrators must be trained by the American Arbitration Association or the American Health Lawyers Association. If both parties do not agree to an arbitrator, the Commissioner must provide the parties with a list of five arbitrators. Both parties must then eliminate two arbitrators and the remaining arbitrator will conduct the arbitration. The final decision must be rendered within 45 days and is binding on both parties. The arbitrator's expenses and fees, along with other expenses other than attorneys' fees, must be paid as provided in the decision.

The provider may bill an enrollee for services rendered if:

- the enrollee refuses to assign benefits to the non-participating provider; or

- the enrollee, after being fully informed in writing that the provider is a non-participating provider, willfully chooses to access a non-participating provider for services that are available through a participating provider (in which case contractual requirements for non-participating providers apply).

Appropriation: None.

Fiscal Note: Available.

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