HOUSE BILL REPORT
HB 2447

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to emergency health care services balanced billing.

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 History:
Committee Activity:
Health Care & Wellness: 1/20/16, 2/2/16 [DPS].

Brief Summary of Substitute Bill

- Requires the Insurance Commissioner to convene a work group to study balance billing.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 13 members: Representatives Cody, Chair; Riccelli, Vice Chair; Harris, Assistant Ranking Minority Member; Caldier, Clibborn, Jinkins, Johnson, Moeller, Robinson, Rodne, Short, Tharinger and Van De Wege.

Minority Report: Do not pass. Signed by 2 members: Representatives Schmick, Ranking Minority Member; DeBolt.

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

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carrier pays the provider and what the provider normally charges for the services. However, if the person receives services from a nonparticipating (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 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. The difference between cost-sharing amounts for participating and nonparticipating providers may not exceed $50. Differential cost-sharing may not be applied for utilization of 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 (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 Substitute Bill:

The Insurance Commissioner (Commissioner) must convene a work group to study ways to eliminate balance billing for health services. The study must, at a minimum, include findings and recommendations on:

- the scope of the balance billing issue, including an estimate of the number of affected consumers, the average billed charges, and the average amount paid by consumers;
- the impact of narrow impacts on the frequency of balance billing;
- ways to eliminate balance billing for health services;
- whether a prohibition on balance billing for emergency services should extend outside of the emergency department; and
- payment methodologies for paying nonparticipating providers, including payment methodologies required by federal law, direct payments to nonparticipating providers, and payment dispute resolution. When making recommendations on payment

methodologies, the work group must consider the effects of each recommendation on payment rates for participating providers, the ability of issuers to maintain adequate networks, and overall costs to consumers, issuers, providers, and hospitals.

The work group must, at a minimum, consist of representatives from providers of health services, issuers, hospitals, and consumers. The Commissioner must convene the first meeting of the work group by July 1, 2016. The Commissioner must report the recommendations of the work group to the Legislature by December 1, 2016.

Substitute Bill Compared to Original Bill:

The substitute:

- removes the provisions of the bill that:
  - prohibited enrollees from incurring out-of-pocket expenses for emergency services rendered by nonparticipating providers that exceed the amounts that would be incurred for services rendered by participating providers; and
  - required binding arbitration for a nonparticipating provider and a carrier if they are unable to agree on a reimbursement amount for emergency services;
- requires the Office of the Insurance Commissioner (OIC) to convene a stakeholder work group to study balance billing;
- requires the study to include findings and recommendations on:
  - the scope of the balance billing issue;
  - the impact of narrow networks on balance billing;
  - ways to eliminate balance billing;
  - whether a prohibition on balance billing for emergency services should apply outside of the emergency department; and
  - payment methodologies for nonparticipating providers;
- requires the OIC to convene the first meeting of the work group no later than July 1, 2016; and
- requires the OIC to report to the Legislature by December 1, 2016.

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 is not a new issue. Balance billing is plaguing consumers. Most patients believe all providers in an in-network facility are also in-network, but this is not the case. Patients go to the emergency room in an in-network hospital and pay all applicable cost sharing. Then they receive another, surprise bill. Most consumers do not have the resources to pay these bills. Often the providers are willing to reduce the charges, but this can be a burdensome process. There is no limit on how high a balance bill can be. The number of

people reporting balance billing is only the tip of the iceberg. Narrow networks will only cause this problem to grow. People trying to do the right thing should not be placed in the middle of a dispute between issuers and providers. This bill will get the consumer out of the middle and establishes a way to moderate disputes between providers and issuers.

(Opposed) This is a difficult issue. There is a lack of data on this issue and the prevalence of this problem is unknown. Balance billing is infrequent and the amount of the bills is usually moderate. Providers often work with patients to reduce balance bills. This needs to be a more comprehensive conversation.

Emergency room physicians are the safety net and have to treat everyone. It is hard to recruit and retain emergency room physicians. Hospitals often subsidize emergency providers because insurance reimbursement is inadequate. Emergency room physicians have participated in state programs to reduce unnecessary emergency room usage, which has saved the state money. These physicians are able to do this because balance billing put pressure on issuers to contract with these providers. This is an access to care issue.

Most providers are in-network already. The binding arbitration provisions in this bill will result in increasing the number of out-of-network providers because they affect contracting incentives. This bill will allow issuers to set the rates. Binding arbitration will be ineffective and will favor issuers. In other states, payments were reduced and wait times and mortality increased.

Participating provider contracts are a great benefit to consumers, giving them certainty that the issuer will pay the cost of care without balance bills from the participating providers. Sometimes providers do not sign, but the answer is not binding arbitration. Binding arbitration will drive up costs as arbitrators split the baby, which gives providers the incentive not to sign contracts. This will undermine an issuer's ability to maintain adequate networks of providers.

Patients who receive surprise bills are sympathetic, but this bill will not fix the problem. It will make the problem worse. Issuers are heavily regulated—they are already required to pay in-network rates for emergencies and more federal regulations are on the way. A more global solution to the problem should be sought with which both issuers and providers can get onboard.

Persons Testifying: (In support) Representative Cody, prime sponsor; Janet Varon, Northwest Health Law Advocates; and Julie Blake.

(Opposed) Sean Graham, Washington Medical Association; Liam Yore, American College of Emergency Physicians; Erik Penner, Olympia Medical Services; John Gallagher, Sunnyside Community Hospital and Clinics; Chris Bandoli, Regence Blue Shield; Len Sorrin, Premera Blue Cross; Sydney Smith Zvara, Association of Washington Health Plans; and Mel Sorensen, America's Health Insurance Plans.

Persons Signed In To Testify But Not Testifying: None.