Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1117

Brief Description: Addressing health care services balance billing.

Sponsors: Representatives Cody, Caldier, Jinkins, Harris, McBride, Kilduff and Tharinger; by request of Insurance Commissioner.

Brief Summary of Bill

- Modifies requirements related to coverage of emergency services provided at an out-of-network emergency department.
- Requires health care facilities in a health carrier's network to provide either in-network treatment options or a disclosure related to provider networks.
- Regulates the practice of balance billing by out-of-network providers in emergency departments and in-network facilities.
- Requires binding arbitration of balance billing disputes between health carriers and out-of-network providers.

Hearing Date: 1/18/17

Staff: Alexa Silver (786-7190).

Background:

Balance Billing.
When a covered person receives covered health services from an in-network health care 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. If the person receives services from an out-of-network provider, however, the provider may bill the person for this difference. This practice is known as "balance billing."

Emergency Services Under Federal Law.

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.

Under the Emergency Medical Treatment and Active Labor Act, a hospital must screen, evaluate, and provide treatment necessary to stabilize any patient who comes to the emergency department with an emergency medical condition. Under the Patient Protection and Affordable Care Act (ACA), 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. "Emergency services" and "emergency medical condition" are defined the same as in state law.

The rules implementing the ACA 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: (1) the amount negotiated with in-network providers for the emergency services; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payment for out-of-network services; or (3) the Medicare amount. An out-of-network provider may "balance bill" the patient for the balance between the provider's billed charges and the amount the provider was paid by the carrier.

Emergency Services Under State Law.
Under state law, a health carrier must cover "emergency services" provided at an out-of-network emergency department if the services were necessary to screen and stabilize a covered person and a prudent layperson would reasonably have believed that use of an in-network 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 an out-of-network emergency department if a prudent layperson acting reasonably would have believed that an emergency medical condition existed and that use of an in-network 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 or reduce payment after the services have been provided unless the approval was based on the provider's material misrepresentation about the covered person's health condition.

Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles. A health carrier may impose reasonable differential cost-sharing arrangements for in-network and out-of-network emergency services, but the difference may not exceed $50. Differential cost-sharing may not be applied when the carrier requires pre-authorization for post-evaluation and post-stabilization emergency services if: the covered person was unable to go to an in-network 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 would have reasonably believed that the person would be unable to go to an in-network hospital in a timely fashion without serious impairment to the person's health.

"Emergency services" are defined as a medical screening examination within the capability of a hospital emergency department, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, and further medical examination and treatment to the extent they are within the capabilities of the staff and facilities at the hospital, as required to stabilize the patient. "Emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such

that a prudent layperson could reasonably expect the absence of immediate medical attention to result in a condition placing the person's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part.

Consumer Protection Act.
The Consumer Protection Act (CPA) prohibits unfair or deceptive trade practices. A private person or the Attorney General may bring a civil action to enforce the provisions of the CPA. A person or entity found to have violated the CPA is subject to treble damages and attorney's fees.

Summary of Bill:

Emergency Services.
A carrier must cover emergency services provided by an out-of-network emergency department regardless of whether a prudent layperson would have reasonably believed that using an in-network emergency department would result in a delay that would worsen the emergency or whether federal, state, or local law requires the use of a specific provider or facility. A carrier may only retract authorization or reduce payment for coverage of previously authorized emergency services if the provider's material misrepresentation was made with the patient's knowledge and consent. Coverage of emergency services may be subject to applicable in-network copayments, coinsurance, and deductibles, and provisions related to differential cost-sharing for emergency services are removed.

The definition of "emergency medical condition" includes behavioral health conditions, as well as conditions that manifest themselves by symptoms of emotional distress.

In-Network Health Care Facilities.
Carriers must include in their agreements with health care facilities a requirement that the facility provide in-network options for all health care services provided at the facility. If the facility is unable to make in-network options available, the carrier must require the facility to provide the following disclosure on its website:

- the names and websites of the carriers with which the facility contracts as a network provider;
- a statement that: (1) services may be provided in the facility by in-network providers, as well as out-of-network providers who may bill the covered person separately if no in-network provider is available when the services are scheduled or provided; and (2) prospective covered persons should contact the provider who will provide services in the facility to determine the carriers for which the provider is in-network; and
- the names, addresses, and phone numbers of providers with which the facility contracts to provide services, and instructions on how to contact the providers to determine the carriers for which they are in-network.

The definition of "health care facility" is modified to mean any institution, place, building, or agency where health care services are provided. It includes hospitals, ambulatory surgical centers, clinics, outpatient surgery or care centers, laboratories or diagnostic centers, and specialized care centers, such as birthing centers and psychiatric care centers. The definition of "health care provider" is modified to mean any health professional, health care facility, or other institution, organization, or person that furnishes any health care services to a covered person.

Balance Billing.
"Balance billing" is defined as charging a covered person for health care services when the balance of the provider's fee is not fully reimbursed by the carrier, exclusive of permitted cost-sharing. Consumers are protected against balance billing when: (1) emergency health care services are provided to a covered person; or (2) health care services are provided to a covered person at an in-network facility by an out-of-network provider when no in-network provider is available. The provisions related to balance billing must be liberally construed to ensure that consumers are not billed out-of-network charges.

The carrier, the out-of-network provider, a person acting on behalf of the carrier or provider, and the carrier or provider's assignees of debt must ensure that a covered person incurs no greater cost-sharing that he or she would have incurred with an in-network provider when: (1) the covered person uses emergency health care services provided by an out-of-network provider; or (2) the covered person uses or arranges for care at an in-network facility, and either the facility did not provide the required disclosure regarding contracts with carriers and providers, or the facility gave the disclosure but no in-network provider was available when the services were scheduled or provided.

Cost-sharing amounts: Before billing a covered person, an out-of-network provider must request from a carrier a written explanation of benefits specifying the applicable in-network cost-sharing amounts owed by the covered person. The carrier must provide the explanation of benefits within 60 days. To determine the in-network cost-sharing amount for an out-of-network provider's services, the carrier must substitute for its contract rate 125 percent of the amount Medicare would reimburse for similar services or another method established by the Insurance Commissioner (Commissioner) in rule. If there is more than one level of cost-sharing, the amount most beneficial to the covered person must be used. Neither the out-of-network provider nor a health care facility may hold the covered person financially responsible for an amount in excess of the in-network cost-sharing amounts. No provider, agent, trustee, or assignee may bring suit against a covered person to collect an amount owed in excess of the cost-sharing amount detailed by the carrier.

If a covered person receives either emergency health care services provided by an out-of-network provider or health care services provided by an out-of-network provider at an in-network facility when no in-network provider is available:

- any cost-sharing paid by the covered person for those services counts toward the plan's limit on in-network maximum out-of-pocket expenses;
- cost-sharing arising from those services must be counted toward any cost-sharing in the same manner as cost-sharing for in-network services; and
- cost-sharing paid by the covered person satisfies the obligation to pay for the health care services.

Collections: An out-of-network provider may not attempt to collect an amount greater than the covered person's in-network cost-sharing amount, as provided in the explanation of benefits or under the health plan, whichever is less. Neither an out-of-network provider nor a person acting on his or her behalf may report adverse information to a consumer credit reporting agency or bring suit against a covered person until 150 days after the initial billing. An out-of-network provider may not use wage garnishments or liens on a primary residence to collect unpaid bills. The carrier or provider must refund the covered person within 30 days for any amount paid in

excess of the in-network cost-sharing amount; after 30 days, interest accrues at a rate of 12 percent.

Payments by carriers to out-of-network providers: For emergency health care services provided by an out-of-network provider, the carrier must pay the provider the amount billed if the amount is $300 or less. If the amount billed is more than $300, the carrier must pay the provider the greater of: (1) the average contracted rate; (2) 125 percent of the amount Medicare would reimburse on a fee-for-service basis for the same or similar services in the general geographic region; or (3) $300. For non-emergency health care services provided by an out-of-network provider at an in-network facility when either the facility failed to give the required notice or the facility gave the notice but no in-network provider was available, the carrier must pay the provider the greater of: (1) the average contracted rate; or (2) 125 percent of the amount Medicare would reimburse on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. By January 1, 2019, the Commissioner must specify a methodology for the "average contracted rate" based on data submitted by carriers.

The carrier's payment must be made within the time limits for payment of in-network claims. A provider may seek additional payment from the carrier using the dispute resolution process.

Dispute resolution process: If payment to the provider does not resolve the payment dispute within 30 days of receipt of the carrier's written explanation of benefits, the carrier or provider may initiate binding arbitration to determine payment for services provided on a per-bill basis. Arbitration is initiated by filing a request with the Commissioner within 90 days of receipt of the carrier's written explanation of benefits. The party requesting arbitration must notify the other party and state its final offer before the process begins. The non-requesting party must inform the requesting party of its final offer before materials are submitted to the arbitrator.

The Commissioner must provide a list of approved arbitration entities or arbitrators, who must be trained by the American Arbitration Association or the American Health Lawyers Association. If the parties do not agree on an arbitrator from the list, the Commissioner provides a list of five arbitrators. Each party may veto two of the five arbitrators, and if more than one arbitrator remains, the Commissioner chooses the arbitrator. This process must be completed within 20 days.

Within 30 days of requesting arbitration, each party must make its written submissions to the arbitrator, and the arbitrator must provide a written decision within 30 days of receiving the submissions. The covered person may not be required to appear as a witness. The arbitrator may consolidate multiple disputes in a single proceeding if the parties are identical and consolidation would not violate other requirements. In determining the amount the carrier must pay the provider, the arbitrator must select the payment amount from either the carrier or the provider. The decision is final and binding on both parties and must provide for payment of the arbitrator's expenses and fees. The covered person is not liable for any arbitration costs.

Enforcement and rulemaking: The Commissioner may issue a cease and desist order, levy a fine of up to $1000 per violation, and take additional action as permitted under the insurance laws. Violation of the balance billing law is also an unfair or deceptive act under the Consumer Protection Act.

The Commissioner may adopt rules, including rules related to:

- arbitration and dispute resolution;
- establishing different cost-sharing amounts to be paid by the covered person; and
- payment by the carrier to the provider based on the all-payer claims database once it has collected 80 percent of the commercial market data, or other method established by the Commissioner.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect on January 1, 2018.