HOUSE BILL REPORT
HB 2114

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to protecting consumers from charges for out-of-network health services.

Brief Description: Protecting consumers from charges for out-of-network health services.

Sponsors: Representatives Cody and Pollet; by request of Insurance Commissioner.

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

Brief Summary of Substitute Bill

- Modifies requirements related to coverage of emergency services provided at an out-of-network emergency department.
- Regulates the practice of balance billing by out-of-network providers, and authorizes binding arbitration of balance billing disputes between health carriers and out-of-network providers.
- Requires health care facilities, health care providers, and health carriers to provide patients with information about network status.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 17 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Harris, Jinkins, MacEwen, Maycumber, Riccelli, Robinson, Rodne, Slatter, Stonier and Tharinger.

Staff: Alexa Silver (786-7190).

Background:

Balance Billing.

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.

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.
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 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. 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 the prudent layperson standard is met. If the 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. Except under certain circumstances, a carrier may impose reasonable differential cost-sharing arrangements for in-network and out-of-network emergency services.

"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.

Summary of Substitute 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 mental health and substance use disorder conditions, as well as conditions that manifest themselves by symptoms of emotional distress.

Prohibition on 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. Balance billing is prohibited for:

- emergency health care services provided to a covered person; and
- nonemergency health care services provided to a covered person at an in-network hospital or ambulatory surgical facility if the services: (1) involve an invasive medical procedure; (2) involve surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services; and (3) are provided by an out-of-network provider without the person's consent, or because an in-network provider was unavailable or the need for the service was unforeseen and arose at the time they were rendered.

When a covered person receives such services, 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 the covered person incurs no greater cost-sharing that he or she would have incurred with an in-network provider. The balance billing provisions apply to health carriers regulated under the insurance laws and health plans offered to public employees and their dependents and must be liberally construed to ensure that consumers are not billed out-of-network charges.

Payments by the Covered Person.
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. A carrier must calculate the in-network cost-sharing amount using the carrier's average contracted rate for similar services in the geographic area where the services were provided. If there is more than one level of cost-sharing, the amount most beneficial to the covered person must be used. An out-of-network provider or facility, or an agent, trustee, or assignee of a provider or facility, may not hold the covered person financially responsible for, or bring suit against the covered person to collect, an amount in excess of the in-network cost-sharing amounts.

If a covered person receives health care services for which balance billing is prohibited: the carrier must apply any cost-sharing paid by the covered person toward the in-network out-of-pocket maximum; the carrier must treat any prior cost-sharing amounts paid in the same manner as cost-sharing for in-network services; the covered person satisfies the obligation to pay for the services if he or she pays the amount specified in the explanation of benefits; the out-of-network provider may not collect an amount greater than the in-network cost-sharing amount from the covered person; and if the covered person pays an amount in excess of the in-network cost-sharing amount, the provider or carrier must refund the excess within 30 days. After 30 days, interest is owed on the unrefunded payment at a rate of 12 percent. 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.

Dispute Resolution.

If a carrier's payment to an out-of-network provider does not resolve a payment dispute, either party may initiate binding arbitration by filing a request with the Insurance Commissioner (Commissioner) within 90 days of receipt of the explanation of benefits. The party requesting arbitration must notify the other party and state its final offer, and the non-requesting party must provide its final offer to the requesting party. The Commissioner must provide the parties with 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, the Commissioner provides a list of five arbitrators. Each party may veto two arbitrators, and if more than one 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. Within 30 days of receiving the submissions, the arbitrator must provide a written decision to the parties and provide information regarding the decision to the Commissioner. In making a decision regarding the appropriate amount to be paid to the out-of-network provider, the arbitrator must consider the following factors:

- whether there is a gross disparity between the fee at issue and fees paid to the provider for the same services by other carriers for which the provider is out-of-network, and fees paid by the carrier to reimburse similarly qualified out-of-network providers for the same services in the same region;
- the provider's training, education, and experience;
- the circumstances and complexity of the case;
- patient characteristics; and
- whether the provider or carrier has a disproportionate pattern of initiating or being a respondent in dispute resolution proceedings.

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. The decision is final and binding on both parties. Expenses must be divided equally, but the Commissioner may adopt rules modifying the division of expenses if the Commissioner finds a pattern of disproportionate involvement in dispute resolution. The covered person is not liable for any arbitration costs.

The parties must enter into a nondisclosure agreement to protect personal health information and fee information.

The Commissioner must prepare a report summarizing dispute resolution information, post the report on the Office of the Insurance Commissioner website and submit it to the Legislature annually by July 1.

Notification Requirements.
A health care facility must post on its website: the carriers with which it contracts; a list of providers providing surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services; and a notice that patients should contact their carrier about providers' network status. A health care provider's website must list the carriers with which the provider contracts. A carrier must update its website and provider directory within 20 days of an addition or termination of a facility or provider, as long as the carrier had notice.

When a patient or covered person is scheduled for nonemergency services involving an invasive medical procedure, facilities, providers, and carriers must provide notice containing specified information to the patient or covered person. The notice must be provided the earlier of 10 days before the service will be provided or two days after the service is scheduled. The provider must notify the patient if the provider is out-of-network and provide additional specified information. The facility's notice must inform patients if not all scheduled providers for the above services are employees or participating providers and provide contact information for scheduled providers. If the facility is out-of-network, the notice must include additional information, such as an estimated range of the cost of services. If the facility's network status changes after providing its notice, it must promptly notify the patient. Upon request, the facility must make a good faith effort to schedule in-network providers.

The carrier's notice must include, among other things, information about out-of-network benefits and, upon contacting the carrier directly, an estimated range of the out-of-pocket costs. When a covered person receives preauthorization for nonemergency services involving an invasive medical procedure scheduled at an in-network facility, the carrier must provide the person with the names of in-network providers for surgery, anesthesiology, pathology, radiology, laboratory, and hospitalist services.

Enforcement and Rulemaking.
The Commissioner may adopt rules (including rules related to the dispute resolution process) and may issue a cease and desist order, levy a fine of up to $1,000 per violation, and take additional action as permitted under the insurance laws. If the Commissioner determines that a covered person reasonably relied on an inaccurate provider directory to access certain services, the health plan must cover those services.

Substitute Bill Compared to Original Bill:

The substitute bill:
- limits the nonemergency services for which balance billing is prohibited;
- requires carriers to calculate cost-sharing using the average contracted rate, rather than 125 percent of the amount Medicare would reimburse;

- removes provisions establishing the rates for payment to out-of-network providers;
- removes the requirement that the arbitrator choose between the parties' final offers, provides factors for the arbitrator to consider, requires the fees to be divided equally (unless the Commissioner adopts a rule), requires the parties to sign a nondisclosure agreement, and requires the Commissioner to prepare an annual report;
- adds notification requirements for facilities, providers, and carriers; and
- applies the balance billing provisions to health plans offered to public employees and their dependents.

Appropriation: None.

Fiscal Note: Requested on February 20, 2017.

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

Staff Summary of Public Testimony:

(In support—from testimony on HB 1117, which is identical to HB 2114 except for the title, on January 18, 2017) The goal of the bill is to get the patient out of the dispute between the provider and the carrier. A significant number of people experience surprise bills and medical debt. The Office of the Insurance Commissioner received 260 complaints about the issue, but that does not represent the full scope of the problem. It is especially problematic in emergency departments, laboratories, and for outpatient surgery. If either the provider or the carrier is dissatisfied, they have the opportunity to use binding arbitration.

Patients have been surprised about their financial responsibility for services from in-network providers at out-of-network facilities. They are expected to research every single provider and facility. Patients who are in shock from a serious diagnosis are too stressed to do that research. Even if they check the provider and facility's network status, they may receive a bill from another provider, like an anesthesiologist. A patient can't check on a provider's network status when he or she is unconscious. Narrow networks have made it more complicated to inform consumers about provider networks. Patients may not have computer access and may need language access. In a fair, free market economy, a consumer would be informed of the cost before receiving services and be able to make informed economic decisions. That information is missing in the health care industry. Group Health helps covered persons determine their costs up-front.

(Opposed—from testimony on HB 1117, which is identical to HB 2114 except for the title, on January 18, 2017) Very few patients experience balance billing, but the bill would impact the broader market. Providers want to protect patients from balance billing. Providers offer discounts for in-network care and get paid higher out-of-network rates for fewer patients. Patients are best served by in-network providers, but it is difficult to contract with carriers. The incentives to contract are critical. If the bill allow carriers to pay out-of-network providers less, it create a perverse incentive for carriers to terminate provider contracts. The rates in the bill are arbitrary and lower than market rates. The bill tilts the playing field to insurers. This bill threatens emergency room care and the safety net by significantly

reducing payments to doctors. It will lead to more consolidation. The medical community proposed a solution based on the New York model. The solution should be data-driven.

To solve balance billing, narrow networks must be addressed. Hospital-based physicians should be part of network adequacy. Carriers should only call a hospital in-network if it contracts with hospital-based physicians. The hospital's role in providing transparency is unclear, because the hospital does not know all providers' network status. Patients using ambulatory surgical facilities for elective surgeries have time to look at providers' network status.

The bill has technical flaws and grants the Insurance Commissioner broad rulemaking authority.

(Other—from testimony on HB 1117, which is identical to HB 2114 except for the title, on January 18, 2017) The reimbursement policies should incentivize contracting and good networks. The entire system should not be disrupted by treating a minority of providers differently. Tying reimbursement to charges incentivizes increasing reimbursement. In Alaska, the FairHealth standard has driven rates up. The reimbursement rate for emergency care should be the same as for qualified health plans under the Affordable Care Act. The $300 threshold for emergency care will create a disincentive for contracting and drive up costs. Arbitration would not be needed if the bill sets a fair reimbursement rate.

There are some technical issues with the bill, but the concept is supported. High performing networks are compliant with the rules. Participating provider agreements have hold harmless requirements, which offer consumer protection. There should be transparency about out-of-network providers at in-network facilities. Carriers are not set up to monitor compliance.

Persons Testifying: (In support) Mike Kreidler, Office of the Insurance Commissioner; Diane Zipperman; Debra Schmitz; Jeff Keenan; Diana Stadden, The Arc of Washington; Demas Nesterenko, Service Employees International Union 775; Melissa Johnson, Washington State Nurses Association; Jo Rodman, League of Women's Voters; Bob Cooper, National Association of Social Workers; David Roth, Northwest Health Law Associates; William Daley, Washington Community Action Network; and Catherine Wiess, Washington State Labor Council.

(Opposed) Nathan Schlicher and Sean Graham, Washington State Medical Association; Dominique Coco, Washington State Society of Pathologists; Christopher Crancer, Center for Diagnostic Imaging; Dave Kimberling, Washington Managed Imaging Radiology; Chris Bandoli, Washington State Hospital Association; Liam Yore, American College of Emergency Physicians; Emily Studebaker, Washington Ambulatory Surgery Center Association; and Mack Hinson, MEDNAX and Pediatrix Medical Group.

(Other) David Knutson, Association of Washington Healthcare Plans; Beth Johnson, Premera Blue Cross; Andrea Tull, Coordinated Care; Scott Plack, Group Health Cooperative; Mel Sorenson, America's Health Insurance Plans; and Zach Snyder, Regence BlueShield.

Persons Signed In To Testify But Not Testifying: None.