HOUSE BILL REPORT
2ESHB 2114

As Passed House:
February 13, 2018

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

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

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Cody and Pollet; by request of Insurance Commissioner).

Brief History:
Committee Activity:
Health Care & Wellness: 2/17/17 [DPS];
Appropriations: 2/23/17, 2/24/17 [DPS(HCW)].
Floor Activity:
Passed House: 3/6/17, 81-17.
Second Special Session
Floor Activity:
Passed House: 5/25/17, 61-33.
Floor Activity:
Passed House: 2/13/18, 72-26.

Brief Summary of Second Engrossed 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 facilities, and authorizes arbitration of balance billing disputes.
- Requires health care facilities, providers, and carriers to provide patients with information about network status.
- Requires the Insurance Commissioner to take into account the accessibility of in-network providers in in-network facilities when determining the adequacy of a health carrier's provider networks.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

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.

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: Jim Morishima (786-7191).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill by Committee on Health Care & Wellness be substituted therefor and the substitute bill do pass. Signed by 23 members: Representatives Ormsby, Chair; Robinson, Vice Chair; Bergquist, Caldier, Cody, Fitzgibbon, Haler, Hansen, Harris, Hudgins, Jinkins, Kagi, Lytton, Nealey, Pettigrew, Pollet, Sawyer, Schmick, Senn, Springer, Stanford, Sullivan and Tharinger.

Minority Report: Do not pass. Signed by 8 members: Representatives Chandler, Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Buys, Manweller, Taylor, Vick, Volz and Wilcox.

Minority Report: Without recommendation. Signed by 1 member: Representative Stokesbary, Assistant Ranking Minority Member.

Staff: David Pringle (786-7310).

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.
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 Second Engrossed 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.
An out-of-network provider or facility may not balance bill a covered person for:

- emergency 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 surgical or ancillary services; and (2) are provided by an out-of-network provider.

"Balance bill" is defined as a carrier bill sent to a covered person by an out-of-network provider or facility for health care services provided to the person after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing. "Surgical or ancillary" services are defined as surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

The balance billing provisions apply to health carriers regulated under the insurance laws and health plans offered to public employees and their dependents, but do not apply to Medicaid. The provisions must be liberally construed to ensure that consumers are not billed out-of-network charges.

Payments by the Covered Person.
If a covered person receives health care services for which balance billing is prohibited:

- The covered person satisfies his or her obligation to pay for the services if he or she pays the in-network cost-sharing amount. The health carrier must calculate the in-network cost-sharing amount for the out-of-network provider or facility's services using the amount at which the claim was adjudicated.
- A carrier, out-of-network provider, or out-of-network facility, or agent, trustee, or assignee:
    - must ensure the covered person incurs no greater cost than he or she would have incurred if the services had been provided in-network;
    - may not balance bill or otherwise attempt to collect from the covered person more than the in-network cost-sharing amount, but may continue to collect a past-due balance for the cost-sharing amount plus interest;
    - may not report adverse information to a credit reporting agency or bring suit against a covered person until 150 days after the initial billing; and
    - may not use wage garnishments or liens on a primary residence to collect unpaid bills.
- The carrier must treat any prior cost-sharing amounts paid in the same manner as cost-sharing for in-network services and must apply paid cost-sharing amounts toward the limit on in-network out-of-pocket maximum expenses.
- If the covered person pays an amount in excess of the in-network cost-sharing amount, the provider, facility, 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.

Payments by Carriers.
The All Payer Claims Database (APCD) must establish a data set and business process to provide information on prevailing payment and billed charge amounts. The data and business process must be available beginning January 1, 2019.

Upon receipt of a bill for services for which balance billing is prohibited, a carrier must make payment directly to the provider or facility. The health carrier must adjudicate the claim using an allowed amount that is the greater of the following three amounts:

- the median allowed amount paid to in-network providers for the service as determined by reference to the data set prepared by the APCD, including any applicable enrollee in-network cost-sharing requirement;

- the median amount paid to out-of-network providers for the service as determined by reference to the data set prepared by the APCD, including any applicable enrollee in-network cost-sharing requirement; or
- 175 percent of the amount that would be paid under Medicare, including any applicable enrollee in-network cost-sharing.

Dispute Resolution.
In the event of a dispute between a carrier and an out-of-network provider or facility, arbitration may be initiated only after an informal settlement process. The informal process must be initiated no later than 30 days after receipt of payment or payment notification from the carrier. A party may not refuse to participate in a teleconference or in-person meeting, if requested.

If the informal process is ineffective, a carrier, out-of-network provider, or out-of-network facility may initiate arbitration by filing notification with the Insurance Commissioner (Commissioner) no later than 60 days after the informal settlement communication. The notification must state the initiating party's final offer. The non-initiating party must provide its final offer no later than 30 days after receipt of the notification. The parties may reach an agreement during the time before the arbitration proceeding. Multiple claims may be addressed in a single arbitration if the claims involve identical parties, involve claims with the same or related current procedural terminology codes, and occur within six months of each other.

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 must provide a list of five arbitrators. Each party may veto two arbitrators, and if more than one remains, the Commissioner must choose 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. A party that fails to make timely written submissions without good cause is considered to be in default and must pay the final offer amount submitted by the other party. The arbitrator may require the party in default to pay the other party's reasonable attorneys' fees.

In making a decision regarding the appropriate amount to be paid to the out-of-network provider or facility, the arbitrator may consider information that a party believes is justified or other factors the arbitrator requests. The arbitrator must also consider the following factors:
- the median amounts paid to in-network and out-of-network providers and facilities for the service as determined by reference to the APCD data set;
- the median billed charge amount for the service as reported in the APCD data set;
- the circumstances and complexity of the case, including the time and place of service and whether the service was delivered at a level I or II trauma center or a rural facility;
- patient characteristics; and
- the level of training, education, and experience of the provider.

The covered person may not be required to appear as a witness. Expenses must be paid by the party whose final offer was rejected by the arbitrator. 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. Arbitrations are governed by the Uniform Arbitration Act, except in cases of conflict with the arbitration provisions related to balance billing.

Within 30 days of receiving the submissions, the arbitrator must provide a written decision to the parties requiring payment of one of the final offer amounts, notify the parties, and provide information regarding the decision to the Commissioner.

Annually until January 1, 2023, the Commissioner must prepare a report summarizing dispute resolution information, post the report on the Office of the Insurance Commissioner's website, and submit it to the Legislature by July 1.

Facility Network Status.
A nonemployed provider group providing surgical or ancillary services must notify a hospital or ambulatory surgical facility of the carriers with which it contracts and whether the contract will be terminated. The notice must be provided as soon as practicable, but no later than 45 days prior to termination of the contract.

Notification Requirements.
The Commissioner, in consultation with stakeholders, must develop standard template language for notifying consumers of the circumstances under which they may or may not be balance billed. The template must include contact information for the Office of the Insurance Commissioner (OIC) so that consumers may contact the OIC if they believe they have been improperly balance billed. The OIC must determine by rule when and in what format health carriers, health providers, and health facilities must provide consumers with the notice.

A hospital or ambulatory surgical facility must post on its website the carriers with which it contracts and whether each nonemployed provider group providing surgical or ancillary services contracts with the same carriers. A health care provider's website must list the carriers with which the provider contracts. An in-network provider must submit accurate information to a carrier regarding network status in a timely manner, consistent with the contract between the carrier and the provider.

A carrier must update its website and provider directory within 30 days of an addition or termination of a facility or provider. A carrier must provide a covered person with: a clear description of the plan's out-of-network benefits; notice of rights regarding balance billing using the standard template; notification regarding out-of-network financial responsibility; information on how to use the carrier's transparency tools; upon request, information on a provider's network status; and upon request, an estimated range of out-of-pocket costs.

Enforcement and Rulemaking.
If the Commissioner has reason to believe any person or facility is violating provisions relating to balance billing, he or she may submit information to the Department of Health (DOH) or the appropriate disciplining authority for action. Violations of the provisions

relating to balance billing subjects a provider or facility to a fine of up to $1,000 per violation. Upon completion of its review of any potential violation, the DOH or the disciplining authority must notify the Commissioner of the results of the review. Violations of the balance billing provisions also constitute unprofessional conduct under the Uniform Disciplinary Act. A health carrier violating the balance billing provisions is subject to fines and other remedies imposed by the Commissioner.

The Commissioner may adopt rules to implement the balance billing provisions, including rules governing the dispute resolution process.

Network Adequacy.
When determining the adequacy of a health carrier's provider network, the Commissioner must consider whether the carrier's network includes a sufficient number of contracted providers practicing at the same facilities with which the carrier has contracted for the network to reasonable ensure enrollees have in-network access for covered benefits delivered at the facilities. A hospital or ambulatory surgical facility must provide the health carrier with information about the network status of nonemployed provider groups that provide services at the facility.

Appropriation: None.

Fiscal Note: Available.

Effective Date: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 1 through 21 and 23, relating to coverage for emergency services and balance billing, which take effect January 1, 2019.

Staff Summary of Public Testimony (Health Care & Wellness):

(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 creates 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.

Staff Summary of Public Testimony (Appropriations):

(In support) Costs to the Office of the Insurance Commissioner are related to rulemaking and reporting. Consumers need to understand what the costs might be for elective surgery, and they need to be protected in emergency situations. Consumers need protection from currently permitted balanced billing practices. The Washington Medical Association is committed to continuing to work on this issue.

(Opposed) The Association of Washington Health Plans are opposed to this bill as it passed out of the Health Care Committee. A solution to the balance billing problem needs to be found that doesn't just kick all disputes over billing into arbitration.

(Other) This bill needs more work in order to reach a solution to the very complex problem of balance billing.

Persons Testifying (Health Care & Wellness): (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 Testifying (Appropriations): (In support) Lonnie Johns-Brown, Office of the Insurance Commissioner.

(Opposed) Dave Knutson, Association of Washington Healthcare Plans.

(Other) Sean Graham, Washington State Medical Association; and Lisa Thatcher, Washington State Hospital Association.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.