SENATE BILL REPORT
2ESHB 2114

As Reported by Senate Committee On:
Health & Long Term Care, February 22, 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: Passed House: 3/06/17, 81-17; 5/25/17, 61-33; 2/13/18, 72-26.
Committee Activity: Health & Long Term Care: 2/20/18, 2/22/18 [DPA-WM, DNP, w/ oRec].

Brief Summary of Amended 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; authorizes arbitration and mediation of balance billing disputes.
- Requires health care facilities, providers, and carriers to provide patients with information about network status.
- Requires the insurance commissioner (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.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Cleveland, Chair; Kuderer, Vice Chair; Rivers, Ranking Member; Conway, Keiser, Mullet and Van De Wege.

Minority Report: Do not pass.
Signed by Senators Becker and Fain.

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.

Minority Report: That it be referred without recommendation.
Signed by Senator Bailey.

Staff: Evan Klein (786-7483)

Background: Balance Billing. When a covered person receives covered health services from an in-network health care provider, the covered person 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 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.

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 and emergency medical condition are defined the same as in federal law.

Summary of Amended 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 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. 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 because an in-network provider was unavailable or the need for the service was unforeseen and arose at the time they were rendered.

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:

1. 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. The carrier must adjudicate the claim using an allowed amount that is the greater of:
    a. the median allowed amount paid to in-network providers as determined by referencing the All Payer Claims Database (APCD);

b. the median amount paid to out-of-network providers as determined by referencing the APCD; or
c. 175 percent of the amount that would be paid under Medicare.

2. A carrier, out-of-network provider, or out-of-network facility, or agent, trustee, or assignee:
   a. must ensure the covered person incurs no greater cost than he or she would have incurred if the services had been provided in-network;
   b. 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;
   c. 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
   d. may not use wage garnishments or liens on a primary residence to collect unpaid bills.
3. 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.
4. 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 un-refunded payment at a 12 percent rate.

Payments by Carriers. The 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, for a similar geographic area, 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, for a similar geographic area, 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.

For calculating both in and out-of-network median amounts, the health carrier must use the greater of the median amount calculated using annually updated APCD data or the median amount calculated using the 2019 APCD data set, inflated annually by a health care inflation factor set by the Commissioner. Out-of-network provider payments are subject to prompt claim payment standards adopted by the Commissioner.

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 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.

The arbitrator may consider information that a party believes is justified or other factors the arbitrator requests to make a decision regarding the appropriate amount to be paid to the out-of-network provider or facility. 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 (OIC's) website, and submit it to the Legislature by July 1.

Facility Network Status. A hospital or ambulatory surgical facility must disclose that nonemployed providers may not be in the same health plan provider network as the facility. Facilities must also provide carriers it contracts with, with a list of nonemployed providers under contract with the facility to provide surgical or ancillary services, within 30 days before signing a contract with a carrier. The facility must notify a carrier within 30 days of a provider's removal from or addition to the list.

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 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 non-employed 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; and upon request, information on a provider's network status, and 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, the Commissioner 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 reasonably 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 non-employed provider groups that provide services at the facility.

EFFECT OF HEALTH & LONG TERM CARE COMMITTEE AMENDMENT(S):

- Adds a requirement is added that an out-of-network provider payment is subject to prompt claim payment standards adopted by the Commissioner.
- Modifies the payment formula used when a carrier adjudicates a claim to note that the median in-network and out-of-network allowed amounts are based on data from a similar geographic area.
- Adds language, so that in determining median allowed amounts for both in and out-of-network calculations, median allowed amount is the greater of the amount in the most recently updated APCD data set or the amount in the 2019 APCD data set, inflated annually by a health care inflation factor set by the insurance commissioner.
- Removes the requirement that an in-person meeting be part of the informal settlement process.
- Removes the requirement that a facility post on its web site the health plan networks that its nonemployed contracted provider groups participate in.
- Adds a requirement that the facility disclose that nonemployed providers may not be in the same health plan provider network as the facility.
- Requires the facility to provide carriers it contracts with, with a list of nonemployed providers under contract with the facility to provide surgical or ancillary services, within 30 days before signing a contract with a carrier.
- Requires that the facility must notify the carrier within 30 days of a provider's removal from or addition to the list.
- Clarifies that the OIC may report a potential violation to the DOH or disciplinary authorities, who then determine whether to investigate and to take any currently allowable informal or formal disciplinary action.
- Clarifies that the APCD data set will be updated annually.

Appropriation: None.

Fiscal Note: Requested on February 15, 2018.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill takes effect on January 1, 2019.

Staff Summary of Public Testimony on Second Engrossed Substitute House Bill: *The committee recommended a different version of the bill than what was heard.* PRO: The only people that will inevitably benefit from this bill are consumers. To ensure one group does not get a benefit over another, there needs to be balance. We do not want to say you do not get balance billed just because you decide to go out-of-network. This bill is about when the consumer does not have any choices in the matter. The major difference from last year, is that the updated bill contains the element of access to the APCD. The APCD will be able to come up with data and examples about the impact of this bill on consumers. The amounts

paid in-network versus out-of-network are not uniform, but it is important to have that data. This is a consumer protection bill that will ensure a health crisis does not turn into a financial crisis for many Washington families. Many families have trouble paying medical debt, and much of that debt is due to balance billing. There are 21 other states with balance billing protections.

CON: Balance billing is an extremely important issue. The hope is to protect patients while treating physicians fairly. The network adequacy provision, the dispute resolution provisions, and the claims dispute bundling element are all positive elements of the bill. However, the reimbursement mechanism creates a lot of uncertainty for physicians. This bill might remove natural incentives for carriers to contract with physicians and will have the unintended consequence of obstructing patients' access to care. There is already a shortage of ER doctors nationwide, and barriers to contracting will further deteriorate patient access. There are better options to fix balance billing. Getting rid of balance billing, while a benefit to the consumer, is also a benefit to the insurance carriers. Hospitals' goal is to provide quality care to patients, and this legislation makes that goal more difficult to achieve. A lot of these balance billing problems are caused by network adequacy issues. This is a fundamental change in how the state pays for healthcare and will result in narrower health networks.

Carriers are opposed to balance billing and are committed to establishing networks that provide sufficient care to consumers. In order to have competitive rates, the rates need to be negotiated with providers. Prohibiting balance billing is the right step forward, but this bill has many provisions that are unworkable. The bill does not provide a good incentive for providers to come to the table to contract, yet some in-network providers have agreed to rates below 175 percent of Medicare. This means that some providers will leave networks. Moreover, the rates required to be paid to out-of-network providers in the bill will increase premiums. Health plans are presented with staffing by a hospital, and the plans therefore cannot choose who to contract with in many cases already.

Persons Testifying: PRO: Representative Eileen Cody, Prime Sponsor; Lonnie Johns-Brown, Office of the Insurance Commissioner; Jane Beyer, Office of the Insurance Commissioner; Jennifer Muhm, Washington State Nurses Association.

CON: Sean Graham, Washington State Medical Association; Dr. Erik Penner, WA-ACEP; Chris Bandoli, Washington State Hospital Association; Roman Daniels-Brown, Washington State Medical Association, US Anesthesia Partners; Dr. James Burkman, Washington State Society of Anesthesiologists, US Anesthesia Partners; Kate White-Tudor, Washington State Society of Pathologists; Meg Jones, Association of Washington Healthcare Plans; Mel Sorensen, America's Health Insurance Plans; Zach Snyder, Regence; Len Sorrin, Premera Blue Cross.

Persons Signed In To Testify But Not Testifying: No one.