SENATE BILL REPORT
SB 5031

As of February 4, 2019

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

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

Sponsors: Senators Rolfes, Kuderer, Randall, Mullet, Van De Wege, Liias, Conway, Darneille, Frockt, Hasegawa, Wellman, Wilson, C., Keiser and Saldaña; by request of Insurance Commissioner.

Brief History:
Committee Activity: Health & Long Term Care: 2/04/19.

Brief Summary of 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 of balance billing disputes.
- Requires health care facilities, providers, and carriers to provide patients with information about network status and consumer rights.
- 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.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

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,

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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 (EMTALA), 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 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 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 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.

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 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 enrollee satisfies their obligation to pay for health care services if they pay the in-network cost-sharing amount specified in the enrollee's health plan contract;
- the enrollee's obligation must be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area, and out-of-network providers and facilities may not balance bill or otherwise attempt to collect any greater amount from the enrollee; and
- carriers must treat any cost-sharing amounts paid by the enrollee for an out-of-network provider or facility's services in the same manner as cost-sharing for in-network services, and must apply any cost-sharing amounts paid toward the enrollee's maximum out-of-pocket payment obligation.

If the enrollee pays an out-of-network provider or facility an amount that exceeds the required in-network cost-sharing amount, the provider or facility must refund any amount in excess of the in-network cost-sharing amount to the enrollee within 30 business days—interest must be paid to the enrollee at a rate of 12 percent beginning on the 31st business day.

Payments by the Carrier. If a covered person receives health care services for which balance billing is prohibited, the allowed amount paid to the out-of-network provider must be limited

to a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. The carrier must offer to pay the provider or facility a commercially reasonable amount within 30 days of receiving a claim from the out-of-network provider or facility. Carrier payments must be made directly to a provider or facility, and not to the enrollee.

The provider or facility then has 30 days to notify the carrier if the provider or facility wishes to dispute the carrier's payment. If a provider or facility disputes the carrier's initial offer, the carrier and provider or facility have 30 days from the initial offer to negotiate in good faith. If the carrier and provider or facility do not agree to a commercially reasonable payment amount within 30 days, the dispute must be resolved through arbitration.

Providers, hospitals, and ambulatory surgical facilities may not require a patient to sign or execute any document that would attempt to avoid, waive, or alter the statutory payment methodology of services for which balance billing is prohibited.

Arbitration. If good faith negotiation between a carrier and a provider or facility fails, a carrier, provider, or facility may initiate arbitration to determine a commercially reasonable payment amount. Arbitration must be initiated in writing to the insurance commissioner (commissioner) and the non-initiating party no later than ten calendar days following completion of the good faith negotiation period, stating the initiating party's final offer. The non-initiating party has 30 days following receipt of the notification to provide its final offer back to the initiating party. The parties are free to reach an agreement on reimbursement during this time.

Multiple claims may be addressed in a single arbitration if the claims:
- involve identical carrier and provider or facility parties;
- involve claims with the same or related current procedural terminology codes relevant to the the particular procedure; and
- occur within three months of one another.

Within seven days of receiving notification from the initiating party, the commissioner must provide the parties with a list of approved 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 the parties a list of five arbitrators;
- each party may then veto two of the five named arbitrators, and if only one arbitrator remains, that person is chosen as arbitrator; and
- if more than one arbitrator remains, the commissioner must choose the arbitrator from the remainder.

This process must be completed within 20 days of the parties' receiving the list of arbitrators from the commissioner.

Each party must make written submissions to the arbitrator within 30 days of its selection, stating the party's position. The initiating party must include in its submission, the evidence and methodology for asserting its proposed amount and whether or not it is commercially reasonable. The arbitrator must issue a written decision requiring payment of the final offer

amount from one of the parties within thirty days of the parties' submissions. Arbitrators, in reviewing the submissions of the parties and making decisions on the payment amount, must consider:

- the evidence and methodology submitted by the parties;
- the median in-network and out-of-network allowed amounts and the median billed charge amount for the service at issue in the geographic region, as reported in a dataset prepared by the Washington State All Payer Claims Database (APCD);
- the established rate that Medicare would pay for the same service or procedure on a fee-for-service-basis in the same or similar geographic region; and
- patient characteristics, the circumstances, and the complexity of the case.

If a party fails to make a timely submission without good cause, the party will be considered in default. Arbitrators must require defaulting parties to pay the final offer amount submitted by the parties not in default. Defaulting parties may be required to pay expenses incurred by the parties not in default, including reasonable attorneys' fees.

Expenses incurred during arbitration, including attorneys' fees, must be divided equally among the parties to the arbitration. The enrollee is not liable for any costs of arbitration, and may not be required to participate in arbitration.

The parties must enter a non-disclosure agreement to protect any personal health or fee information provided during arbitration.

Through 2023, the commissioner must prepare an annual report summarizing the dispute resolution information provided by arbitrators, and must post the report on the commissioner's website and submit it to the legislature.

Application to Self-Funded Group Health Plans. Self-funded group health plans may elect to be subject to the prohibition on balance billing, the balance billing payment methodologies for enrollees and carriers, the dispute resolution processes for disputing payment of a commercially reasonable amount, and the arbitration processes for determining a commercially reasonable payment amount. To elect to participate in these provisions, a self-funded group health plan must annually provide notice to the commissioner.

Transparency. The commissioner, in consultation with carriers, providers, and facilities, must develop a standard template notice of consumer rights, as outlined in the bill.

Hospitals and ambulatory surgical facilities must post on their websites, if one is available, a list of the carrier health plan provider networks with which the hospital is an in-network provider, and the notice of consumer rights. If the facility does not operate a website, the facility must provide consumers with this information upon oral or written request. At least 30 days prior to executing a contract with a carrier, a hospital or ambulatory surgical facility must provide the carrier with a list of non-employed providers or provider groups contracted to provide surgical or ancillary services at the facility. The facility must also notify the carrier of any removals or additions to this non-employed list within 30 days.

A health care provider must post on their website, if one is available, a list of the carrier health plan provider networks with which the provider contracts and the notice of consumer

rights. If the provider does not maintain a website, the information must be provided to consumers upon oral or written request. An in-network provider must submit accurate information to a carrier regarding the provider's network status.

A carrier must update its website and provider directory no later than 30 days after the addition or termination of a facility or provider, and must provide an enrollee with:

- a clear description of the health plan's out-of-network benefits;
- the notice of consumer rights;
- notification that if the enrollee receives services from an out-of-network provider or facility for which balance billing is not prohibited, the enrollee will have financial responsibility in excess of the health plan's applicable cost-sharing amounts;
- information on how to use a carrier's member transparency tools;
- upon request, information on whether a provider is in- or out-of-network; and
- upon request, an estimated range of out-of-pocket costs for an out-of-network benefit.

Enforcement. If the commissioner has cause to believe any provider, hospital, or ambulatory surgical facility, has engaged in a pattern of unresolved violations, the commissioner may submit information to the Department of Health (DOH) or the appropriate disciplining authority. The commissioner may first allow the party to cure the alleged violations or explain why the actions in question did not violate provisions of this act.

If a provider, hospital, or ambulatory surgical facility has engaged in a pattern of violations, DOH or the appropriate disciplining authority may levy a fine. If a carrier has engaged in a pattern of unresolved violations, the commissioner may levy a fine.

It is an unfair or deceptive practice for a carrier to initiate arbitration with such frequency as to indicate a general business practice.

Network Adequacy. The commissioner, in determining the adequacy of a carrier's proposed or ongoing provider network, must consider whether the carrier's proposed or in-effect provider network includes a sufficient number of contracted providers of emergency, surgical, or ancillary services at or for the carrier's contracted in-network hospitals or ambulatory surgical facilities to reasonably ensure enrollees have in-network access to covered benefits delivered at that facility.

APCD Dataset. The Office of Financial Management must establish a data set and business process to provide carriers, providers, hospitals, ambulatory surgical facilities, and arbitrators with prevailing payment and billed charge amounts for the services for which balance billing is prohibited. The dataset must include commercial health plan claims, and must exclude Medicare and Medicaid claims, and claims paid for on other than a fee-for-service basis. The dataset must be available beginning November 1, 2019. The 2019 dataset must be based on the most recently available full calendar year of claims, and subsequent years must be adjusted by applying the consumer price index-medical component established by the United States Department of Labor.

Appropriation: None.

Fiscal Note: Available.

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

Effective Date: The bill contains several effective dates. Please refer to the bill.

Staff Summary of Public Testimony: PRO: Mrs. Hansen received about $110,000 in medical bills, $96,000 of which was related to balance billing, related to procedures that her son received in Portland. In order to stay in network, Mrs. Hansen would have had to take her son almost two hours north. Mrs. Hansen was balance billed for ambulance services, gastroenterologists, cardiologists, and for radiology consulting services. Everyone associated with the stay was out-of-network. This issue leaves border counties in very tough situations. Nurses want to see the patient taken out of the middle of the balance billing issue. The two primary themes of this bill are, take the patient out of the middle, and provide a balanced approach to solving the issue.

OTHER: This bill is closer than ever to a resolution on balance billing that takes patients out of the middle. This bill contains important elements, like being able to bundle claims and network adequacy protections. This bill does not include provisions that effect the issue that ERISA plans are not covered. There are concerns that this bill contains provisions that would undermine incentives for providers to enter into contract with carriers. This bill needs to encourage providers to join a carrier's network. Allowing for bundling claims under arbitration creates an incentive for providers to stop negotiating in good faith, which is an issue. These bills are closer than ever, and the framework on SB 5031 is the appropriate framework to move forward with.

Persons Testifying: PRO: Amy Brackenbury, Washington State Nurses Association; Jane Beyer, Office of the Insurance Commissioner; Mrs. Hansen, citizen.

OTHER: Sean Graham, Washington State Medical Association; Chris Bandoli, Washington State Hospital Association; Meg Jones, Association of Washington Healthcare Plans; Zach Snyder, Regence; Len Sorrin, Premera.

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