FINAL BILL REPORT
E2SHB 1688

C 263 L 22
Synopsis as Enacted

Brief Description: Protecting consumers from charges for out-of-network health care services, by aligning state law and the federal no surprises act and addressing coverage of treatment for emergency conditions.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Cody, Schmick, Leavitt, Ryu, Graham, Taylor, Berry, Paul, Wicks, Springer, Sells, Bateman, Valdez, Davis, Eslick, Goodman, Klicker, Macri, Ramos, Simmons, Wylie, Callan, Sullivan, Chopp, Slatter, Tharinger, Thai, Pollet, Riccelli, Ormsby, Caldier, Kloba and Frame; by request of Insurance Commissioner).

House Committee on Health Care & Wellness
House Committee on Appropriations
Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means

Background:

Emergency Services under State Law.
Health carriers must cover emergency services, including services provided at out-of-network facilities, up until the point of stabilization and without prior authorization if a layperson acting reasonably would have believed that an emergency medical condition existed. 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.

If a carrier requires pre-authorization for post-evaluation or post-stabilization services, the carrier must provide access to an authorized representative at all times to facilitate review. For these services to be covered, the provider or facility must make a documented good faith effort to contact the carrier within 30 minutes of stabilization.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

"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, as required to stabilize the patient. "Emergency medical condition" is defined as a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including severe pain or emotional distress, such that a prudent layperson could reasonably expect the absence of immediate attention to result in a condition: placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Balance Billing Protection Act.

Prohibition on Balance Billing.

In 2019 the Legislature enacted the Balance Billing Protection Act, which prohibited balance billing for emergency services and certain non-emergency services. An out-of-network provider or facility is prohibited from balance billing an enrollee for:

- emergency services provided to an enrollee; or
- non-emergency health care services provided to an enrollee 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.

For these purposes, a "balance bill" is a bill sent to an enrollee by an out-of-network provider or facility for health care services provided to the enrollee 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 and health plans offered to public employees and their dependents, but do not apply to Medicaid. A self-funded group health plan may elect to participate in the prohibition on balance billing.

Payments by the Enrollee.

If an enrollee receives health care services for which balance billing is prohibited:

- the enrollee satisfies the obligation to pay if he or she pays the in-network cost-sharing amount specified in the enrollee's group health plan contract, which must be determined using the carrier's median in-network contracted rate for the same or similar service in a similar geographic region;
- a carrier, out-of-network provider, or out-of-network facility, or agent, trustee, or assignee must ensure the enrollee incurs no greater cost than the determined in-network cost-sharing amount and may not balance bill or otherwise attempt to collect from the enrollee more than the determined amount; and
- the carrier must treat any cost-sharing amounts paid in the same manner as cost-sharing for in-network services.

A provider, hospital, or ambulatory surgical center may not require a patient to sign any document that would attempt to waive or alter any of the provisions related to payment of a balance bill.

Payments by Carriers.
The carrier must make payments for health care services covered by the balance billing prohibitions directly to the provider or facility. The amount paid to an out-of-network provider for services covered by the balance billing prohibitions must be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. Within 30 days of receipt of a claim from an out-of-network provider or facility, the carrier must offer to pay the provider or facility a commercially reasonable rate. If a provider or facility disputes the carrier's payment, the provider or facility must notify the carrier within 30 days of payment or payment notification from the carrier. If the provider or facility disputes the carrier's offer, the carrier and provider or facility have 30 days from the initial offer to negotiate in good faith. If the parties do not agree to a payment amount within the 30 days and the parties choose to pursue further action to resolve the dispute, it must be resolved through arbitration.

Arbitration.
To initiate arbitration, the carrier, provider, or facility must provide written notice to the Insurance Commissioner (Commissioner) and the non-initiating party no later than 10 days following the 30-day good faith negotiation period. Within 30 days of receiving the notice, the non-initiating party must provide its final offer. The parties may reach an agreement on reimbursement before the arbitration proceeding.

Within seven days of receiving the notice from the initiating party, the Commissioner must provide the parties with a list of approved arbitrators. If the parties do not agree on an arbitrator from that list, the parties must notify the Commissioner who must provide the parties with a list of five arbitrators and each party may veto two arbitrators. If more than one arbitrator remains, the Commissioner must choose from the remaining arbitrators on the list. This selection process must be completed within 20 days.

Each party must provide a written submission in support of the party's position within 30 days of the arbitrator's selection. The initiating party's submission must include the evidence and methodology for asserting that the amount proposed to be paid is or is not commercially reasonable. A party that fails to make a timely submission without good cause is considered in default and must pay the final offer amount submitted by the party not in default.

Within 30 days of receipt of the parties' submissions, the arbitrator must issue a written decision requiring payment of the final offer amount of one of the parties and notify the parties and Commissioner of the decision. The arbitrator must consider: the evidence and methodology submitted by the parties; and patient characteristics and the circumstances and

complexity of the case. The arbitrator may consider other information that a party believes relevant to the other factors, other factors the arbitrator requests, and information provided by the parties relevant to an arbitrator's request, including the All-Payer Claims Database (APCD) data set.

Arbitration fees, not including attorney's fees, must be equally divided among the parties. Multiple claims may be addressed in a single arbitration if the claims: (1) involve the same parties; (2) involve claims with the same or related current procedural terminology codes relevant to a particular procedure; and (3) occurred within two months of each other.

The Commissioner must prepare an annual report summarizing the dispute resolution information provided by arbitrators to the Commissioner.

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. Health carriers, health providers, and health facilities must post the notice on their respective websites.

A hospital or ambulatory surgical facility must post on its website a list of the carrier health plan provider networks with which the facility is an in-network provider. A health care provider's website must list the carrier health plan provider networks with which the provider contracts. An in-network provider must submit accurate information to a carrier regarding network status in a timely manner.

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 an enrollee 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 whether there are in-network providers available to provide surgical or ancillary services at the specified in-network facility; 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, the Commissioner may submit information to the Department of Health (DOH) or the appropriate disciplining authority for action. If a provider or facility has engaged in a pattern of unresolved violations relating to balance billing, the DOH or appropriate disciplining authority may levy a fine or cost recovery upon the health care provider or facility or take other action as permitted under the authority of the DOH or disciplining authority. A pattern of violations of the balance billing provisions constitutes

unprofessional conduct under the Uniform Disciplinary Act.

It is an unfair or deceptive practice for a health carrier to initiate arbitration with such frequency as to indicate a general business practice. A health carrier violating the balance billing provisions is subject to fines and other remedies imposed by the Commissioner. Violations of the balance billing provisions subjects a provider or facility to a fine of up to $1,000 per violation.

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.

Federal No Surprises Act.
In 2020 Congress passed the federal No Surprises Act (NSA), which establishes federal prohibitions against balance billing for emergency services and certain other services provided at in-network facilities beginning January 1, 2022. The NSA was passed as part of the 2021 Consolidated Appropriations Act and amended the Public Health Service Act. The NSA balance billing prohibitions apply to:

- emergency services, including services provided in hospital emergency departments, freestanding emergency departments, urgent care settings that are licensed to provide emergency care, and air ambulance transportation;
- post-stabilization services provided in a hospital following an emergency visit; and
- non-emergency services provided at certain in-network facilities.

Enrollee cost sharing is limited to the amounts the enrollee would have paid if the services were furnished by a participating provider. Providers are prohibited from billing patients more than the patient's applicable in-network cost-sharing amount for services covered by the NSA.

The NSA provides some exceptions to the balance billing prohibitions if the enrollee consents to receive the services from a nonparticipating provider under certain circumstances if notice and written consent are provided. This waiver is not permitted for the following services: emergency services; unforeseen urgent medical needs arising when non-emergent care is provided; ancillary services, including anesthesiology, pathology, radiology, and neonatology; services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services including radiology and lab services; and items and services provided by an out-of-network provider if there is not another in-network provider who can provide that service in that facility.

The NSA requires an independent dispute resolution (IDR) process to be established through rule and creates a certification process for IDR entities.

Air Ambulance Regulation.
The DOH is responsible for licensing emergency medical services agencies and services, including air ambulance services.

The Airline Deregulation Act of 1978 prohibits states from regulating the price, route, or service of an air carrier, including air carriers that provide air ambulance services. The Federal Aviation Administration Reauthorization Act of 2018 established an advisory committee to review options to improve the disclosure of charges and fees for air medical services, better inform consumers of insurance options for such services, and protect consumers from balance billing.

All-Payer Claims Database Data Set.
The Office of the Insurance Commissioner must contract with the agency responsible for administration of the APCD, who in collaboration with health carriers, health care providers, hospitals, and ambulatory surgical facilities centers, must establish a data set and business process to provide carriers, providers, facilities, and arbitrators to assist in determining commercially reasonable payment. The data used to calculate the median in-network and out-of-network allowed amounts and the median billed charge amounts by geographic area, for the same or similar service, must be drawn from commercial health plan claims and exclude Medicare and Medicaid claims. The data must be reviewed by an advisory committee that includes representatives of health carriers, health care providers, hospitals, and ambulatory surgical facilities for validation before use. The data set must be based upon the most recently available full calendar year of claims data. The data set for each subsequent year must be adjusted by applying the consumer price index-medical component established by the United States Department of Labor to the previous year's data set.

Alternate Access Delivery Request.
A health carrier may propose an alternate access delivery system in several circumstances, including when the carrier is unable to contract with sufficient providers or facilities to meet network adequacy standards or when a provider or facility type becomes unavailable after the health carrier's network is approved. An alternate access delivery system must provide access to medically necessary care on a reasonable basis without detriment to an enrollee's health at no greater cost to the enrollee. The health carrier must show evidence of good faith efforts to contract with providers or facilities before the Commissioner may approve an alternate access delivery system.

Review by Independent Review Organization.
An enrollee in a health plan may seek review by a certified independent review organization (IRO) if: (1) a carrier denies, modifies, reduces, or terminates coverage of, or payment for, a health care service; and (2) the enrollee has exhausted the carrier's grievance process or the carrier has exceeded timelines for grievances without good cause and without reaching a decision.

Summary:

Emergency Services.
The definition of emergency services is expanded beyond medical screening, examination, and treatment within a hospital to include:

- medical screening, examination, and treatment provided within the capabilities of a behavioral health emergency services provider; and
- post-stabilization services in hospitals and behavioral health emergency services providers, which are the covered services provided by staff or facilities of a hospital or behavioral health emergency services provider after the enrollee is stabilized as part of outpatient observation or an inpatient or outpatient stay following screening and stabilization services.

A health carrier must cover emergency services, including post-stabilization services, provided to a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. A health carrier must cover emergency services provided at a non-participating behavioral health emergency services provider in addition to a hospital emergency department and may not require prior authorization. A health carrier must cover emergency services without limiting what constitutes an emergency medical condition solely on the basis of diagnosis codes. Any determination of whether the prudent layperson standard has been met must be based on all pertinent documentation and be focused on the presenting symptoms and not solely on the final diagnosis. Requirements that a facility make a documented good faith effort to notify the covered person's health carrier within 30 minutes of stabilization and that the carrier make an authorized representative available at all times are removed, however, a carrier is permitted to require notice within 48 hours of stabilization or by the end of the business day following the day of stabilization, whichever is later, if an authorized representative is available seven days a week.

For these purposes, a "behavioral health emergency services provider" means emergency services provided in the following settings: a crisis stabilization unit, an evaluation and treatment facility, an agency certified to provide outpatient crisis services, a triage facility, an agency certified to provide medically managed or monitored withdrawal management services, and a mobile rapid response crisis team that is contracted with a behavioral health administrative services organization (BHASO) to provide crisis response services in the BHASO's area.

Balance Billing.
Balance Billing Prohibitions.
A non-participating provider or facility may not balance bill an enrollee for:

- emergency services provided to an enrollee;
- non-emergency health care services performed by a non-participating provider at certain participating facilities; or
- air ambulance services.

Behavioral health emergency services providers may not balance bill enrollees for emergency services.

"Non-emergency health care services performed by non-participating providers at certain participating facilities" are the covered items or services other than emergency services with respect to a visit at a participating facility as provided in the No Surprises Act (NSA). For these purposes, "visit" includes items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and other items or services determined by the Secretary of Health and Human Services (HHS). A "participating health care facility" is a hospital, hospital outpatient department, critical access hospital, ambulatory surgical center, or any other facility specified by the Secretary of HHS that has a direct or indirect contractual relationship with a plan or carrier to provide items or services.

Payments by the Enrollee.
A health care provider, health care facility, or air ambulance service may not request or require a patient at any time, for any procedure, service, or supply, to sign or otherwise execute any document that would attempt to avoid, waive, or alter the balance billing provisions. If an enrollee pays a non-participating provider, facility, or air ambulance service more than the in-network cost-sharing amount determined under the NSA and the implementing regulations, the provider must refund the excess amount within 30 days.

If an enrollee receives emergency services from a behavioral health emergency services provider:

- the enrollee satisfies the obligation to pay if he or she pays the in-network cost-sharing amount specified in the enrollee's group health plan contract, which must be determined using the median contracted rate as calculated using the methodology described in federal rules implementing the NSA;
- a carrier, non-participating behavioral health emergency services provider, or agent, trustee, or assignee must ensure the enrollee incurs no greater cost than the median contracted rate and may not balance bill or otherwise attempt to collect from the enrollee more than the determined amount; and
- the carrier must treat any cost-sharing amounts paid by the enrollee for a non-participating behavioral health emergency services provider's services in the same manner as cost-sharing for in-network services.

Payments by Carriers.
Payment for services covered by the balance billing prohibitions, except for emergency services provided by behavioral health emergency services providers, is subject to the federal NSA and the implementing regulations. However, until July 1, 2023, or a later date determined by the Insurance Commissioner (Commissioner), the allowed amount paid to a non-participating provider for health care services subject to the balance billing prohibitions, except air ambulance and emergency services provided by behavioral health

emergency services providers, must be a commercially reasonable amount based on the same or similar service provided in a similar geographic region. Claims must be paid to the provider within 30 days. If the provider disputes the carrier's offer, the parties have 30 days to negotiate in good faith and if the parties fail to agree to a commercially reasonable amount, the dispute must be resolved under the state's arbitration process or federal independent dispute resolution (IDR) process as applicable. These payment provisions apply to emergency services provided to behavioral health emergency services providers and continue to apply after July 1, 2023.

Carriers must make available through a means generally used by a provider or facility to verify enrollee eligibility, whether the enrollee's health plan is subject to the requirements of the Balance Billing Protection Act or the NSA.

Dispute Resolution under the State Arbitration Process.
Until July 1, 2023, or a later date determined by the Commissioner, the state's arbitration process applies to non-participating provider or facility payments and disputes between carriers and facilities and providers for services subject to the balance billing prohibitions except air ambulance services. If the federal IDR process is not available to the state for disputes regarding behavioral health emergency services providers, the state's arbitration process will continue to apply beyond July 1, 2023.

The state's arbitration process is modified to include the following:

- If the parties agree on an out-of-network rate after providing notice of arbitration initiation to the Commissioner, but before the arbitrator has made a decision, the amount agreed to will be treated as the out-of-network rate for the service and the initiating party must provide notice to the Commissioner and arbitrator within three business days of the agreement.
- Each party, rather than only the initiating party, must include with their written submission to the arbitrator their evidence and methodology for asserting the proposed amount is or is not commercially reasonable.
- The arbitrator's decision must include an explanation of the elements of the parties' submissions the arbitrator relied on to make their decision and why those factors were relevant.
- The Commissioner is authorized to establish allowable arbitrator fee ranges or a fee schedule.
- The decision of the arbitrator is final, binding on the parties, and not subject to judicial review.

Multiple claims may be addressed in a single arbitration if the claims:

- involve identical carriers and provider parties;
- involve claims with the same procedural code or comparable code under a different procedural code system; and
- occur within the same 30-business day period.

Dispute Resolution under the Federal Process.
Beginning July 1, 2023, or a later date determined by the Commissioner, services subject to the balance billing prohibitions, except air ambulance, and if the process is not available for such services, emergency services provided by behavioral health emergency services providers, are subject to the IDR process established under the NSA and its implementing regulations in effect on July 1, 2023, or a later date determined by the Commissioner. If a certified IDR entity determines that the federal process does not apply to a dispute, a party may initiate arbitration under the state's arbitration process:

- without completing good faith negotiation as required by the state's balance billing requirements if the federal open negotiation period was completed; and
- by providing notice to the Commissioner and non-initiating party within 10 days following the notice from the certified IDR entity.

Air ambulance services are only subject to the federal independent dispute resolution process.

Notification Requirements.
The standard template language the Commissioner must develop to notify consumers of their rights is modified so that template language must notify customers of their rights under the Balancing Billing Protection Act, and the NSA and its implementing federal regulations. The requirements for hospitals and ambulatory surgical facilities to posts notices and lists of their carrier health plan networks on the facility's website are applied to behavioral health emergency services providers.

Enforcement.
The Commissioner is authorized to enforce the provisions of the NSA and implementing federal regulations that are applicable to or regulate the conduct of carriers issuing health plans or grandfathered health plans to residents in Washington beginning January 1, 2022. The Commissioner may also impose a civil penalty not to exceed $100 for each day for each individual for failure to comply with the NSA provisions.

The enforcement provisions that apply to health care providers and facilities are applied to behavioral health emergency services providers.

Network Adequacy and Alternate Access Delivery Requests.
When determining the adequacy of a health carrier's provider network, the Commissioner must review the carrier's network to determine whether the 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.

When determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, the Commissioner may allow a carrier to submit an alternate access delivery request (AADR). In order to submit an AADR, a carrier must:

- ensure that enrollees will not bear any greater cost of receiving services under the AADR than if the provider or facility was contracted with the carrier or make other arrangements acceptable to the Commissioner;
- provide substantial evidence of good faith efforts on its part to contract with providers or facilities;
- demonstrate that there is not an available provider or facility with which the carrier can contract to meet the network access standards; and
- notify out-of-network providers and facilities that deliver services referenced in the AADR within five days of submitting the AADR to the Commissioner.

A carrier may not treat payment of non-participating providers or facilities for services for which balance billing is prohibited as a means to satisfy network access standards, unless the following conditions are met:

- if a carrier is unable to obtain to contract with a provider or facility delivering services addressed in an AADR, the carrier may ask the Commissioner to amend the AADR if the request occurs at least three months after the effective date of the AADR and the carrier demonstrates substantial evidence of good faith efforts to contract during that three-month time period;
- if the carrier has demonstrated substantial evidence of good faith efforts to contract, the Commissioner must allow a carrier to use the modified state's dispute resolution process described below to determine the amount that will be paid to providers or facilities for services referenced in the AADR; and
- once the carrier notifies a provider or facility of the AADR request, a carrier is not responsible for reimbursing a provider's or facility's charges in excess of the amount charged by the provider or facility for the same or similar service at the time the notification was provided.

For dispute resolution proceedings initiated for services referenced in an AADR, the following modifications are made to the state's balance billing arbitration process:

- the issue before the arbitrator is the commercially reasonable payment for services addressed in the AADR rather than the commercially reasonable rate for single or multiple claims;
- the arbitrator must issue a decision related to whether the payment for the applicable services should be made at the final offer amount of the carrier or the provider or facility;
- the arbitrator's decision is final and binding on the parties for services rendered to the enrollees from the effective date of the amended AADR to either the expiration date of the AADR or once a provider contract and provider compensation agreement are executed between the parties, whichever occurs first; and
- from the effective date of the amended AADR to the issuance of the arbitrator's decision, the allowed amount to be paid to providers or facilities for services addressed in the AADR must be a commercially reasonable amount.

Beginning January 1, 2023, when determining the adequacy of a proposed provider network

or the ongoing adequacy of an in-force provider network, the Commissioner must require the carrier include a sufficient number of contracted behavioral health emergency services providers.

All-Payer Claims Database Data Set.
Until December 31, 2030, the Office of the Insurance Commissioner (OIC) must contract with the agency responsible for administration of the All-Payer Claims Database or other organizations biennially beginning in 2022, for an analysis of commercial health plan claims data to assess the impact of the Balance Billing Protection Act or the NSA have had or may have had on payments to participating and non-participating providers and facilities and on the volume and percentage of claims that are provided by participating compared to non-participating providers. The analysis may include self-funded group data to the extent available within appropriated funds and the analysis must be published on the OIC website. The first analysis must compare 2019 claims data to the most recent full year's claims data.

Ground Ambulance.
On or before October 1, 2023, the Commissioner, in collaboration with the Health Care Authority and Department of Health, must submit a report and any recommendations to the appropriate legislative committees detailing how balance billing for ground ambulance services can be prevented and if ground ambulance services should be subject to the balance billing prohibitions.

Review by an Independent Review Organization.
An enrollee may seek review by a certified independent review organization of a health carrier's adverse determinations made under the balance billing prohibitions, the enrollee's obligations to pay under the Balance Billing Protection Act, and the NSA and its implementing federal regulations.

Miscellaneous.
References to "out-of-network" are changed to "non-participating." References to "surgical and ancillary services" are replaced with "emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist, and diagnostic services, including radiology and laboratory services." The stated intent of the balancing billing act is to align Washington state law with the federal balance billing prohibitions and transparency protections of the NSA and its implementing federal regulations while maintaining provisions of the balancing billing chapter that provide greater protection from consumers.

The Commissioner is authorized to adopt rules or incorporate by reference without material change federal regulations adopted on or after the effective date of the Act.

If any provision of the Act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

Votes on Final Passage:

House	67	30	
Senate	49	0	(Senate amended)
House	88	10	(House concurred)

Effective: March 31, 2022