SENATE BILL REPORT
E2SHB 1688

As Reported by Senate Committee On:
Health & Long Term Care, February 23, 2022

Title: An act relating to 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.

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).

Brief History: Passed House: 2/11/22, 67-30.
Committee Activity: Health & Long Term Care: 2/21/22, 2/23/22 [DP-WM, DNP, w/oRec].

Brief Summary of Bill

- Expands the services covered by the balance billing prohibitions to include post-stabilization services and air ambulance services in alignment with federal law.
- Expands the definition of emergency services to include post-stabilization services and emergency services provided by behavioral health emergency services providers.
- Modifies the dispute resolution process for carriers, health care providers, and facilities for bills covered by the balance billing prohibitions.

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.

- Requires the Insurance Commissioner to submit a report and any recommendations on how balance billing for ground ambulance services can be prevented and if ground ambulance services should be subject to the balance billing prohibitions.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass and be referred to Committee on Ways & Means.
Signed by Senators Cleveland, Chair; Frockt, Vice Chair; Muzzall, Ranking Member; Conway, Holy, Keiser, Randall, Robinson and Van De Wege.

Minority Report: Do not pass.
Signed by Senator Rivers.

Minority Report: That it be referred without recommendation.
Signed by Senators Padden and Sefzik.

Staff: Greg Attanasio (786-7410)

Background: Balance Billing Protection Act. 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 involve surgical or ancillary services and are provided by an out-of-network provider.

The balance billing provisions apply to health carriers regulated under the insurance laws and health plans offered to public employees and their dependents, but do not apply to Medicaid. A self-funded group health plan may elect to participate in the prohibition on balance billing.

If an enrollee receives health care services for which balance billing is prohibited, the enrollee satisfies the obligation 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. 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.

The carrier must make payments for health care services covered by the balance billing prohibition 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. If the provider or facility disputes the carrier's payment, 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.

Either party can start the arbitration process by sending a notice to the Insurance Commissioner's (Commissioner) office. That notice also must be sent to the party not initiating arbitration. The parties then choose an arbitrator from a list of approved arbitrators or entities providing arbitration services. If they cannot agree on one, the list will be narrowed to five. If the parties still cannot agree, one will be assigned from the narrowed list.

Each party must provide a written submission in support of the party's position on the payment amount, including evidence and methodology for asserting the amount is commercially reasonable. The arbitrator will determine the final payment amount the insurer or provider must accept by choosing one of the parties' best final offer.

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 website.

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.

All-Payer Claims Database Data Set. The Office of the Insurance Commissioner (OIC) must contract with the agency responsible for administration of the All-Payer Claims Database (APCD) and the lead organization, 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 must be composed of commercial health plans 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.

Federal No Surprises Act. In 2020, Congress passed the federal No Surprises Act (NSA), which establishes federal protections against balance billing for emergency services and certain other services provided at in-network facilities beginning January 1, 2022. The NSA balance billing protections 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.

Covered non-emergency services include treatment, equipment and devices, telemedicine services, imaging and lab services, and preoperative and postoperative services, regardless of whether those services are provided within the facility itself.

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

The NSA provides limited exceptions to the balance billing protections if a patient gives prior written consent to waive their rights and be billed more by out-of-network providers for certain non-emergency services.

The federal government has exclusive enforcement responsibility for federally regulated private health plans and states will lead enforcement for state-regulated plans. States have a primary role in enforcing NSA rules against health providers, with federal enforcement as back up.

Health plans and providers can negotiate privately over the amount to be paid for the

surprise bill, and if they can not agree, either party can ask for an Independent Dispute Resolution (IDR) process to decide the payment amount. The federal IDR process will be conducted by certified entities chosen by the Department of Health and Human Services. The plan and provider will each submit their best offer for the out-of-network payment amount for a claim. The IDR entity will begin with the presumption the median rate plans pay in-network providers in that geographic area, also known as the qualifying payment amount, is the correct amount but can consider other factors, including patient acuity, the level of training and expertise of the treating provider, the market shares of both parties, and past good faith efforts of both parties to reach a network agreement. The IDR entity then chooses the offer it determines to be most appropriate, which becomes the out-of-network payment for that bill.

Summary of Bill: Balance Billing Protections. 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.

The definition of emergency services is expanded 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, including 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.

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 contracted with a behavioral health administrative services organization (BHASO) to provide crisis response services in the BHASO's area.

Payments by an 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 provisions protecting enrollees from balance bills. 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. The balance billing prohibitions and provisions protecting enrollees from balance bills are applied to behavioral health emergency services providers for emergency services provided to enrollees.

If an enrollee receives emergency services from a behavioral health emergency services provider, the enrollee satisfies the obligation if they pay 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. The carrier must treat any cost-sharing amounts paid by the enrollee for a nonparticipating behavioral health emergency services provider's services in the same manner as cost-sharing for in-network services.

Payments by Carriers. Until July 1, 2023, or a later date determined by the Commissioner, the allowed amount paid to a non-participating provider for health care services subject to the balance billing prohibitions, except air ambulance providers, must be a commercially reasonable amount based on the same or similar service provided in a similar geographic region. The allowed amount paid to a nonparticipating behavioral health emergency services provider for behavioral health emergency services 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 process as applicable.

Dispute Resolution. 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 independent dispute resolution 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 arbitration initiation notice 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; and
- 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.

Beginning July 1, 2023, or a later date determined by the Commissioner, services subject to the balance billing prohibitions, except air ambulance and emergency services provided by behavioral health emergency services providers, if the process is not available for these services, are subject to the payment standards and independent dispute resolution process established under the NSA and its implementing regulations. If a certified IDR entity determines 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.

Air ambulance services are subject to the independent dispute resolution process established in the NSA and implementing federal regulations in effect on the effective date of this act.

Consumer Notification. 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 chapter, the NSA, and its implementing federal regulations.

Enforcement. The Commissioner is authorized to enforce the provisions of the NSA and implementing federal regulations 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. 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 of emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist and diagnostic services, including radiology and laboratory services, 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). A number of the Commissioner's administrative rules related to AADRs are codified and require a carrier in order to submit an AADR, to:

- ensure that enrollees will not bear any greater cost of receiving services under the alternate access delivery request 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; and
- demonstrate there is not an available provider or facility with which the carrier can contract to meet the commissioner's provider network standards.

A carrier may not treat its payment of non-participating providers or facilities under the balance billing chapter or the NSA as a means to satisfy network access standards, unless approved by the Commissioner. The Commissioner may approve and determine the associated process for a carrier to use the offer of payment and the state's arbitration process to determine the amount that will be paid to providers or facilities for services referenced in an AADR, provided that the process adopted by the Commissioner requires carriers to provide documentation of good faith efforts to contract for the delivery of services.

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 OIC must contract with the agency responsible for administration of the APCD or other organizations biennially beginning in 2022, for an analysis of commercial health plan claims data to assess the impact of the balance billing provisions or the NSA have had or may have had on payments to participating and non-participating providers and facilities and on the utilization of out-of-network services. 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.

Ground Ambulance. On or before October 1, 2023, the Commissioner, in collaboration with the Health Care Authority and Department of Health, must submit 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 restrictions.

Review by an Independent Review Organization. An enrollee is permitted to 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 chapter, and the NSA and its implementing federal regulations.

Rulemaking. 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 bill.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 14, 2022.

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

Effective Date: The bill contains an emergency clause and takes effect immediately.

Staff Summary of Public Testimony: PRO: The bill expands critical protections against balance billing including behavioral health crisis care. Expanding protections is crucial to protect patients and drive down costs. The bill retains aspects of current law that work well and clarifies how state and federal law work together and fill in the existing gaps.

CON: The bill should require carriers to contract with a full scope of providers. This bill currently creates a disincentive for carriers to contract with providers by allowing AADRs to use the dispute resolution process to determine payment.

OTHER: The current language regarding network adequacy surrenders too much authority to OIC. The bill should allow carriers to use dispute resolution process to settle alternate access delivery request payment disputes. Hospitals should be given more time to notify carriers when treating out-of-network patients for emergency care.

Persons Testifying: PRO: Jane Beyer, Office of the Insurance Commissioner; Sam Hatzenbeler, Economic Opportunity Institute; Emily Brice, Northwest Health Law Advocates; Sara Kofman, Leukemia & Lymphoma Society and Patient Coalition of Washington; JOANNA GRIST, AARP.

CON: Sean Graham, WA State Medical Association (WSMA).

OTHER: Gary Strannigan, Premera Blue Cross; Andrew Busz, Washington State Hospital Association; Chris Bandoli, Association of WA Healthcare Plans; Kelsey Beck, Kaiser Permanente; Kate White Tudor, Washington State Society of Pathologists, College of American Pathologists, Rayus Radiology.

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