SENATE BILL REPORT
SB 5618

As of January 19, 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: Senators Cleveland, Muzzall, Das, Dhingra, Hasegawa, Hunt, Kuderer, Robinson, Rolfes, Stanford, Wilson, C. and Nobles; by request of Insurance Commissioner.

Brief History:
Committee Activity: Health & Long Term Care: 1/21/22.

Brief Summary of Bill

- Expands the scope of services protected from balance billing to include services provided following an emergency once a patient has been stabilized, a broader set of non-emergency services provided at in-network hospitals or facilities, and air ambulance services.
- Adds behavioral health emergency services as emergency services providers.
- Retains the state dispute resolution process until January 1, 2023, or a later date determined by the Insurance Commissioner, and thereafter, aligns the process with the federal system for independent dispute resolution.
- Requires the Insurance Commissioner to submit 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.

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.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

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.

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.

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 January 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 January 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

January 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 January 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 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 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. When determining the adequacy of a health carrier's provider network or the ongoing adequacy of an in-force provider network, the 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.

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: Requested on January 11, 2022.

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

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