Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 2779

Brief Description: Concerning emergency services provided by nonparticipating providers in hospitals.

Sponsors: Representative Cody.

Brief Summary of Bill

- Prohibits "balance billing" for health carriers, public employee health plans, and Medicaid managed care programs.
- Changes the definition of "emergency services" for purposes of the state insurance law.

Hearing Date: 1/21/10

Staff: Jim Morishima (786-7191).

Background:

I. Balance Billing.

Most insured people obtain their insurance from managed care organizations such as preferred provider organizations and health maintenance organizations. Generally speaking, when an insured person receives covered health services from a provider participating in the organization, he or she is "held harmless" for the difference between what the organization pays the provider and what the provider normally charges for the services. However, if the person receives services from a non-participating provider, the provider may bill the person for this difference. This practice is known as "balance billing."

Medicaid recipients are, generally speaking, protected from balance billing. For example, a Medicaid managed care entity may pay emergency service providers who do not have a Medicaid managed care contract no more than would be paid under the state's fee for service

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Medicaid program. Federal law defines "emergency services" as services that are needed to evaluate or stabilize an emergency medical condition.

II. Emergency Services.

A health carrier must cover "emergency services" necessary to screen and stabilize a covered person without prior authorization if a prudent layperson would reasonably have believed that an emergency medical condition existed. If the emergency services were provided in a non-participating hospital, the health carrier must cover emergency services necessary to screen and stabilize a covered person if a prudent layperson would reasonably have believed that use of a participating 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 a non-participating hospital if a prudent layperson acting reasonably would have believed that an emergency medical condition existed and that use of a participating hospital would result in a delay that would worsen the emergency.

If an authorized representative of the health carrier authorizes coverage for emergency services, the carrier may not retract the authorization after the services have been provided or reduce payment for services provided in reliance on the approval. The carrier may retract the authorization or reduce payment, however, if the approval was based on a material misrepresentation about the covered person's health condition made by the provider.

Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles. A health carrier may also impose reasonable differential cost-sharing arrangements for emergency services rendered by non-participating providers. However, the difference between cost-sharing amounts for participating and non-participating providers may not exceed $50. Differential cost-sharing may not be applied when a covered person utilizes a non-participating hospital emergency department when the carrier requires pre-authorization for post-evaluation and post-stabilization emergency services if:

- the covered person was unable to go to a participating hospital in a timely fashion without serious impairment to the person's health due to circumstances beyond the person's control; or
- a prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that the person would be unable to go to a participating hospital in a timely fashion without serious impairment to the person's health.

"Emergency services" are defined as otherwise covered health services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

Summary of Bill:

I. Balance Billing.

A. Health Carriers.

Beginning January 1, 2011, the amount a health carrier pays for emergency services rendered by a non-participating provider in a participating hospital must be the greater of:

- the rate the carrier would pay in the same geographic area for the same covered service to a similarly-licensed participating provider. The rate paid to the provider must be the net of applicable cost-sharing payable by the covered person; or
- one hundred forty percent of the rate paid by Medicaid for a similarly-licensed provider.

The carrier must disclose to the provider, upon request, the applicable payment rate. The payment amount, plus any applicable cost-sharing on behalf of the covered person, constitutes payment in full for the services rendered by the provider. Any attempt by the provider to balance bill the covered person constitutes unprofessional conduct under the Uniform Disciplinary Act.

B. Public Employee Health Plans.

Beginning January 1, 2011, the amount a public employee health plan pays for emergency services rendered by a non-participating provider in a participating hospital must be the greater of:

- the rate the plan would pay in the same geographic area for the same covered service to a similarly-licensed participating provider. The rate paid to the provider must be the net of applicable cost-sharing payable by the covered person; or
- one hundred forty percent of the rate paid by Medicaid for a similarly-licensed provider.

The plan must disclose to the provider, upon request, the applicable payment rate. The payment amount, plus any applicable cost-sharing on behalf of the covered person, constitutes payment in full for the services rendered by the provider. Any attempt by the provider to balance bill the covered person constitutes unprofessional conduct under the Uniform Disciplinary Act.

C. Medicaid Managed Care Programs.

Beginning January 1, 2011, the amount a Medicaid managed care system pays for emergency services rendered by a non-participating provider in a participating hospital must be no greater than the medical assistance rate paid by the Department of Social and Health Services to providers for comparable services rendered to clients in the fee for service delivery system.

The managed care system must disclose to the provider, upon request, the applicable payment rate. The payment amount constitutes payment in full for the services rendered by the provider. Any attempt by the provider to balance bill the covered person constitutes unprofessional conduct under the Uniform Disciplinary Act.

II. Emergency Services.

The definition of "emergency services" for health carriers is expanded to include otherwise covered health services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital (as opposed to a hospital emergency department). The same definition is made applicable to the balance billing provisions applicable to public employee health plans and Medicaid managed care programs.

Provisions relating to differential cost-sharing by health carriers are eliminated.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.