SENATE BILL REPORT
ESHB 2114

As Reported by Senate Committee On:
Health Care, March 28, 2017

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

Brief Description: Addressing protecting consumers from charges for out-of-network health services.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Cody and Pollet; by request of Insurance Commissioner).

Brief History: Passed House: 3/06/17, 81-17.
Committee Activity: Health Care: 3/28/17, 3/28/17 [DP-WM, w/oRec].

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 and mediation of balance billing disputes.
- Requires health care facilities, providers, and carriers to provide patients with information about network status.
- Requires carriers to treat hospitals and ambulatory surgical facilities as out-of-network if a certain percentage of providers who provide surgical or ancillary services do not contract with the same carrier.

SENATE COMMITTEE ON HEALTH CARE

Majority Report: Do pass and be referred to Committee on Ways & Means.
Signed by Senators Rivers, Chair; Cleveland, Ranking Minority Member; Kuderer, Assistant Ranking Minority Member; Bailey, Conway, Keiser, Miloscia, Mullet and Walsh.

Minority Report: That it be referred without recommendation.
Signed by Senators Becker, Vice Chair; Fain and O'Ban.

Staff: Mich'l Needham (786-7442)

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

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, 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, 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 and emergency medical condition are defined the same as in state law.

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 that 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 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.

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 that 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 because an in-network provider was unavailable or the need for the service was unforeseen and arose at the time they were rendered.

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 that consumers are not billed out-of-network charges.

Payments by the Covered Person. Before billing a covered person for in-network cost-sharing, an out-of-network provider or facility must request from a carrier a written explanation of benefits specifying the applicable in-network cost-sharing amounts owed by the covered person. The carrier must provide the explanation of benefits within 60 days. A carrier must calculate the in-network cost-sharing amount using the carrier's median contracted rate for similar services in the geographic area where the services were provided. If there is more than one level of cost-sharing, the amount most beneficial to the covered person must be used.

If a covered person receives health care services for which balance billing is prohibited:

- the covered person satisfies their obligation to pay for the services if the covered person pays the in-network cost-sharing amount;
- a carrier, out-of-network provider, or out-of-network facility, or agent, trustee, or assignee:

        - must ensure the covered person incurs no greater cost than the covered person would have incurred if the services had been provided in-network;
        - may not balance bill or otherwise attempt to collect from the covered person more than the in-network cost-sharing amount;
        - may not report adverse information to a credit reporting agency or bring suit against a covered person until 150 days after the initial billing; and
        - may not use wage garnishments or liens on a primary residence to collect unpaid bills;
    - the carrier must treat any prior cost-sharing amounts paid in the same manner as cost-sharing for in-network services and must apply paid cost-sharing amounts toward the limit on in-network out-of-pocket maximum expenses; and
    - if the covered person pays an amount in excess of the in-network cost-sharing amount, the provider, facility, or carrier must refund the excess within 30 days. After 30 days, interest is owed on the un-refunded payment at a rate of 12 percent.

Payments by Carriers. Upon receipt of a bill for services for which balance billing is prohibited, a carrier must make payment directly to the provider or facility. If the billed amount is less than $300, the carrier must pay the full billed amount. If the billed amount is more than $300, the parties may agree to resolve the dispute using arbitration if the amount in dispute is $2,000 or more, or using mediation. If the amount in dispute is less than $2,000, mediation expenses must be divided equally among the carrier, provider, and facility. The Uniform Mediation Act applies.

Dispute Resolution. A carrier, out-of-network provider, or out-of-network facility may initiate arbitration by filing a request with the Insurance Commissioner (Commissioner) within 90 days of receipt of the explanation of benefits. Each proceeding may not involve more than one episode of care or more than one provider or facility, and the arbitrator may not consolidate multiple disputes. The party requesting arbitration must notify the other party and state its final offer, and the non-requesting party must provide its final offer to the requesting party within 30 days. The Commissioner must provide the parties with a list of approved arbitration entities or 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 provides a list of five arbitrators. Each party may veto two arbitrators, and if more than one remains, the Commissioner chooses the arbitrator. This process must be completed within 20 days.

Within 30 days of requesting arbitration, each party must make its written submissions to the arbitrator. Within 30 days of receiving the submissions, the arbitrator must provide a written decision to the parties requiring payment of one of the final offer amounts, notify the parties, and provide information regarding the decision to the Commissioner. In making a decision regarding the appropriate amount to be paid to the out-of-network provider or facility, the arbitrator must consider the following factors:

- whether there is a gross disparity between the amount at issue and amounts paid to the provider or facility for the same services by other carriers for which the provider or facility is out-of-network, and amounts paid by the carrier to reimburse similarly qualified out-of-network providers or facilities for the same services in the same region;
- the circumstances and complexity of the case; and

- patient characteristics.

The covered person may not be required to appear as a witness. Expenses must be paid by the party whose final offer was rejected by the arbitrator. The covered person is not liable for any arbitration costs. The parties must enter into a nondisclosure agreement to protect personal health information and fee information. Arbitrations are governed by the Uniform Arbitration Act, except in cases of conflict with the bill.

Annually until January 1, 2023, the Commissioner must prepare a report summarizing dispute resolution information, post the report on the Commissioner's website, and submit it to the Legislature by July 1st.

Facilities' Network Status. A non-employed provider group providing surgical or ancillary services must notify a hospital or ambulatory surgical facility of the carriers with which it contracts and whether the contract will be terminated. Hospitals and ambulatory surgical facilities must notify the carriers with which they contract of the network status of their contracted provider groups on a quarterly basis. The notice must include, for each type of surgical or ancillary service, whether at least 75 percent of the providers providing the service were in-network during the previous three months. If the 75 percent threshold is not met, the carrier must treat the facility as out-of-network for nonemergency services and notify 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 not be balance billed. A hospital or ambulatory surgical facility must post on its website the carriers with which it contracts and whether each non-employed provider group providing surgical or ancillary services contracts with the same carriers. When a patient is scheduled for nonemergency health care services, a hospital or ambulatory surgical facility must provide one of the following notices at least ten days before the service:

1. If the facility is in-network, the notice must: (1) advise the patient that the patient may request only in-network providers; (2) disclose the names and network status of providers who will provide surgical or ancillary services; (3) advise the patient of their rights under the bill using the standard template language; and (4) provide an estimated range of the cost.
2. If the facility is out-of-network, the notice must: (1) advise the patient that the facility is out-of-network and that the patient may choose an in-network facility; (2) advise the patient regarding out-of-network financial responsibility; (3) provide an estimated range of the cost of services; and (4) inform the patient that the patient may qualify for a discount.

If the facility's network status changes after providing its notice, the facility must promptly notify the patient.

A health care provider's website must list the carriers with which the provider contracts. An in-network provider must submit accurate information to a carrier regarding network status in a timely manner, consistent with the contract between the carrier and the provider. When a patient is scheduled for nonemergency health care services at an out-of-network hospital or ambulatory surgical facility, an out-of-network provider must provide a notice at least ten

days before the service: (1) disclosing that the provider is out-of-network; (2) advising the patient that they patient may seek alternatives; (3) advising the patient about out-of-network financial responsibility; and (4) providing an estimated range of the cost of services.

A carrier must update its website and provider directory within 30 days of an addition or termination of a facility or provider, as long as the carrier had notice. A carrier must provide a covered person with: (1) a clear description of the plan's out-of-network benefits; (2) notice of rights under the bill using the standard template language; (3) notification regarding out-of-network financial responsibility; (4) information on how to use the carrier's transparency tools; (5) upon request, information on a provider's network status; and (6) upon request, an estimated range of out-of-pocket costs.

Enforcement and Rulemaking. The Commissioner may adopt rules, including rules related to the dispute resolution process, and may issue a cease and desist order, levy a fine of up to $1,000 per violation, and take additional action as permitted under the insurance laws. The Commissioner's enforcement authority extends to any person, including a health care provider, hospital, or ambulatory surgical facility.

Appropriation: None.

Fiscal Note: Available.

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

Effective Date: The bill takes effect on January 1, 2018.

Staff Summary of Public Testimony: PRO: I started work on this topic years ago and in the meantime the problem has spread. We worked through the interim and are still working toward a solution that makes each side equally comfortable and gets the patient out of the middle. This bill touches every health care provider. My experience seeking emergency care at my in-network facility revealed that none of the providers in the emergency department were contracted providers. During treatment of my wife, they brought forms for me to sign indicating they were not contracted providers but in the middle of the emergency treatment; there were no options other than signing the forms and receiving a balance bill. We need to represent the consumer's interests and get them out of the middle of these contract disputes. Consumers need protection from surprise billing. The New England Journal of Medicine article indicate one of four consumers may face a surprise bill. These surprise bills create real hardship. There is a tension between providers and carriers and we need to get consumers out of the middle of their fight. It is impossible to verify that every single provider is in network when the consumer doesn't know who they will see for some services. Balance billing creates unnecessary burden on consumers and doesn't allow them to have predictable expenses. It is more common than many think; at dinner with six friends last night, five of the six had recently received a balance bill. Even the most informed consumer can be surprised by a billing. It is not possible to identify all the providers and predict expenses. Even after using an in-network facility, I received an out-of-network billing from the laboratory that received the information since my facility and lab didn't run that test. We should forbid a provider, like a lab, from forwarding information to another provider or lab without consent that reveals the contractual relationship.

CON: We support the concept of eliminating balance billing and moving consumers from the middle. Our main issue remains the reimbursement and we think it would be reasonable to use the statutory language that Medicaid has been using for nonparticipating providers or the federal standard fallback options. Most members at Kaiser receive care at facilities we own but there are some hospitals where we have contracts with provider groups. They have indicated they would be comfortable with the median rate in the federal standard. We participate in Medicaid which does not allow balance billing and we apply to statutory reimbursement for the non-participating providers. We also offer Exchange plans, and we are concerned if there is not a reasonable reimbursement formula in statute that the premiums will be impacted. It cannot be a percent of billed charges; that just drives up cost for everyone. We support transparency requirements that help reveal the contractual relationships. A dispute resolution process is key but we are opposed to arbitration if there are no clear standards for review, it cannot use billed charges, and there needs to be an appeals structure.

OTHER: The medical association has historically been opposed to eliminating balance billing since it has been seen as a necessary evil to provide incentive to contract but patient coverage has changed with a shift of more costs to the patient and the designs of the insurance plans, and we need to protect patients from balance bills. The enforcement mechanism in the bill provides unprecedented and unnecessary authority to the OIC over providers and facilities that balance bill and that could be done by the boards and commissions and Department of Health. We believe the arbitration criteria should look at billed charges and the charges in the service area. The transparency language may need improvement and could follow the California requirement with additional reporting categories for specialties at each hospital. A review of provider directories revealed a high error rate and we could require more frequent updates to the provider directories to ensure accuracy. Some of the requirements for providers to reveal information are not possible to comply with since providers like pathologists are not scheduled in advance and it would be impossible to provide quotes or consumer information in advance. We are committed to continuing the stakeholder conversations and believe there will be progress. As a hospital, we contract with providers and most of them have the same carrier contracts but there are some carriers that offer rates 30-40 percent below the average or won't offer contracts at all if the providers are not a group they need. The requirement in the bill to have hospitals reschedule care with a surgeon that is not contracted interferes with the patient-provider relationship. A new bill should focus on unforeseen issues like those covered in the emergency departments. Mednax is the largest provider of neonatal services and we used to have centers 100 percent contracted until a carrier terminated the contracts and refused to negotiate. Now the neonatal services are non-contracted. The network adequacy requirements could be more robust to allow the review of these specialty services. My family has had six surgeries recently and we were not able to find one anesthesiologist that was in-network. Hospitals and ambulatory surgery centers should be required to have all staff on contract and get patients out of the middle.

Persons Testifying: PRO: Representative Eileen Cody, Prime Sponsor; Representative Paul Harris; Joanna Grist, AARP; Katharine Weiss, Washington State Labor Council, AFL-CIO; Lonnie Johns-Brown, Office of the Insurance Commissioner; Jo Rodman, League of Women Voters; Melanie Smith, Washington State Long Term Care Ombudsman Program; Kimberly

Goetz, citizen.

CON: Dave Knutson, AWHP; Scott Plack, Kaiser Permanente Washington; Andrea Tull Davis, Coordinated Care; Zach Snyder, Regence; Mel Sorensen, AHIP.

OTHER: Kelly Powers, citizen; Chris Bandoli, Washington State Hospital Association; Peter Frutiger, Overlake Hospital Medical Center; Jenn Mykland, MultiCare Health System; Dr. Shane Macaulay, Washington State Medical Association; Sean Graham, Washington State Medical Association; Kate White Tudor, Washington State Society of Pathologists; Vicki Christophersen, MEDNAX Pediatrix.

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