HOUSE BILL REPORT
HB 1065

As Reported by House Committee On:
Health Care & Wellness
Appropriations

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

Brief Description: Protecting consumers from charges for out-of-network health care services.

Sponsors: Representatives Cody, Jinkins, Riccelli, Wylie, Ormsby, Tharinger, Macri, Robinson, Slatter, Kloba, Valdez, Appleton, Doglio, Pollet, Stanford, Frame, Reeves and Bergquist; by request of Insurance Commissioner.

Brief History:
Committee Activity:
Health Care & Wellness: 1/23/19, 2/1/19 [DPS];
Appropriations: 2/20/19, 2/25/19 [DP2S(w/o sub HCW)].

Brief Summary of Second Substitute 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 and authorizes arbitration of balance billing disputes between health carriers and out-of-network providers or facilities.
- Requires health care facilities, health care providers, and health carriers to provide patients with information about network status.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 12 members: Representatives Cody, Chair; Macri, Vice Chair; Caldier, Assistant Ranking Minority Member; Chambers, Davis, Harris, Jinkins, Riccelli, Robinson, Stonier, Thai and Tharinger.

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.

Minority Report: Do not pass. Signed by 2 members: Representatives Schmick, Ranking Minority Member; Maycumber.

Staff: Kim Weidenaar (786-7120).

Background:

Balance Billing.
When an enrollee receives covered health services from an in-network health care provider, he or she 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 an enrollee 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 enrollee'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.

Health Carrier Adjudication Procedures.
Health carriers must file procedures for review and adjudication of complaints initiated by health care providers with the Insurance Commissioner. Health carriers must provide a reasonable means allowing any health care provider aggrieved by actions of the health carrier to be heard after submitting a written request for review. If the health carrier fails to respond to a request within thirty days after it is made, the complaining health care provider may proceed as if the complaint had been rejected. A complaint that has been rejected by the health carrier may be submitted to nonbinding mediation.

Summary of Substitute 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.
A new chapter in Title 48 is created related to balance billing. An out-of-network provider or facility may not balance bill an enrollee for:

- emergency services provided to an enrollee; or
- nonemergency 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.

A carrier must hold an enrollee harmless from balance billing when emergency services are provided to an enrollee at an out-of-network hospitals in a state that borders Washington.

If an enrollee who has at least 72 hours prior to a planned scheduled procedure at an in-network hospital or in-network ambulatory surgical facility knowingly and voluntarily specifically selected the services of an out-of-network surgeon, the enrollee is subject to the contractual requirements of the enrollee's health plan for reimbursement of the out-of-network surgeon. The consumer's selection must be documented by completion of a statement created by the Insurance Commissioner (Commissioner) at least 72 hours prior to the procedure. The Commissioner in consultation with carrier, health care providers, facilities, and consumers must develop standard template language for the statement.

"Balance bill" is defined as 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 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. The provisions must be liberally construed to ensure that consumers are not billed out-of-network charges. The Commissioner may adopt rules to implement the balance billing provisions, including rules governing the dispute resolution process.

Payments by the Enrollee.

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

- The enrollee satisfies his or her obligation to pay for the services 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 the same or similar geographic region. The carrier must provide an explanation of benefits to the enrollee and the out-of-network provider that reflects the determined cost-sharing amount.
- 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 in-network cost-sharing amount, but may continue to collect a past-due balance for the cost-sharing amount plus interest.
- 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.
- If the enrollee pays an amount in excess of the in-network cost-sharing amount, the provider, facility, or carrier must refund the excess within 30 business days. After 30 business days, interest is owed on the unrefunded payment at a rate of 12 percent.

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 prohibition directly to the provider or facility. The amount paid to an out-of-network provider for health care services for which a provider may not balance bill an enrollee are limited to 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 carrier and the provider or facility do not agree to a payment amount within the 30 days it may be resolved through arbitration. Carriers must clearly indicate on enrollee identification cards if the enrollee's health plan is subject to the balance billing provisions, which may be accomplished by indicating if the plan is fully ensured.

Arbitration.
To initiate arbitration, the carrier, provider, or facility must provide written notice to the Commissioner and the non-initiating party no later than 10 days following the 30-day period of good faith negotiation, which must include the initiating party's final offer. Within 30 days of receiving the notice, the non-initiating party must provide its final offer to the initiating party. 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, who must be trained by the American Arbitration Association or the American Health Lawyers Association, and should have experience in matters related to health care services. The parties may agree on an arbitrator from the list. If they do not agree, the parties must notify the Commissioner who must provide the parties with a list of five arbitrators. Each party may then veto two of the five named arbitrators. If one arbitrator remains, that arbitrator is chosen. However, 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 of receipt of the list from the Commissioner.

Each party must submit to the arbitrator 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 are considered in default and must pay the final offer amount submitted by the party not in default. The arbitrator may require the party in default to pay arbitration expenses and reasonable attorney's fees of 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;
- the median in-network and out-of-network allowed amounts and the median billed charge amount for the service at issue in the geographic region in which the service was rendered as reported by the data set from the All Payers Claims Database prepared by the Office of Financial Management (OFM);
- the established rate that Medicare would have paid; and
- patient characteristics and the circumstances and complexity of the case, including the time and place of service and whether the service was delivered at a level I or II trauma center or a rural facility.

The OFM, the lead organization, and 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 bill charge must be drawn from commercial health plan claims and must be composed of commercial health plans and exclude Medicare and Medicaid claims as well as those paid on other than a fee-for-service basis. The data set must be available beginning November 1, 2019, and be based upon the most recently available full calendar year of claims data. 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 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.

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. Arbitration fees, not including attorney's fees, must be equally divided among the parties to the arbitration. The parties must enter into a nondisclosure agreement to protect any personal health information or fee information provided to the arbitrator.

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. The report must include for each dispute resolved the name of the carrier, the health care providers, the provider's employer, the health care facility where the service was provided, and the service at issue. The Commissioner must post the report on its website and report to the appropriate committees of the Legislature annually by July 1.

The parties must execute a nondisclosure agreement prior to engaging in arbitration. The agreement must not prevent the arbitrator from submitting the decision to the Commissioner or the Commissioner's duty to prepare the annual report.

For purposes of out-of-network payment disputes between carriers and health care providers, the arbitration provisions of this chapter apply.

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. The template must include contact information for the Office of the Insurance Commissioner (OIC) so that consumers may contact the OIC if they believe they have been improperly balance billed. The OIC must determine by rule when and in what format health carriers, health providers, and health facilities must provide consumers with the notice. Health carriers, health providers, and health facilities must post the Commissioner's notice on their website.

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 hospital or ambulatory surgical facility also must provide an updated list of these providers within 14 calendar days of a request for an updated list by a carrier.

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, consistent with the contract between the carrier and the provider.

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
- 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. Upon completion of its review of any potential violation, the DOH or the disciplining authority must notify the Commissioner of the results of the review. A pattern of violations of the balance billing provisions also constitute 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 provisions relating to balance billing 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.

Substitute Bill Compared to Original Bill:

The substitute bill:

- adds intent language stating that the bill provides an environment that encourages self-funded groups to negotiate out-of-network payments with providers in good faith in return for balance billing protections;
- allows an enrollee who has a planned scheduled procedure at an in-network hospital or in-network ambulatory surgical facility and knowingly, voluntarily, and specifically selects the services of an out-of-network surgeon if an in-network surgeon was available, to be balance bill and subject to the contractual requirements of the enrollees health plan for reimbursement of the out-of-network surgeon. The OIC must develop template language for a standard statement, which the consumer must sign indicating the consumer's selection of surgeon;
- requires a carrier to hold an enrollee harmless from balance billing when emergency services are provided at an out-of-network hospital in a border state;
- allows a carrier or out-of-network provider or facility to elect to use arbitration if the parties do not agree to a commercially reasonable rate and removes the provision that the arbitrator must practice binding arbitration;
- requires carriers to clearly indicate on enrollee identification cards if the enrollee's health plan is subject to the balance billing provisions, which may be accomplished by indicating if the plan is fully ensured;
- reduces the time period over which claims can be bundled from three months to two months;
- allows the arbitrator to consider other information that the arbitrator thinks is relevant to the factors the arbitrator must consider as well as information provided by the parties pursuant to an arbitrator's request;
- requires parties to execute a non-disclosure agreement prior to arbitration. The non-disclosure agreement cannot preclude the arbitrator from submitting the decision to the Commissioner or impede the Commissioner's duty to prepare the annual report;
- requires facilities to provide an updated list of non-employed provider groups within 14 days of a request by a carrier;
- requires the OFM to work in collaboration with health carriers, health care providers, hospitals, and ambulatory surgical facilities to provide the data set, which must be reviewed by an advisory committee established for purposes of the all-payer health care claims database for validation before use; and
- clarifies that disputes between providers and carriers regarding out-of-network payment are subject to the arbitration provisions of the balance billing chapter and not subject to other adjudication procedures a health carrier has on file with the Commissioner.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

Effective Date of Substitute Bill: The bill takes effect January 1, 2020, except for section 26, relating to the creation of the claims data set by the Office of Financial Management to be used in determining if a payment is commercially reasonable, which takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) The OIC has been working with stakeholders and has spent a lot of time looking at what other states have done, what has worked, and has met with a number of consumers. There have been a number of changes from the bill last year. There was no change in the scope of the prohibition. Last year there was a lot of debate about a formula for payment, and no agreement was reached, so the OIC borrowed New Hampshire's approach, which limits payment to a commercially reasonable amount. Each party can bring their offer to the table, and if there is a disagreement it goes to arbitration. The arbitrator chooses one party's last offer, and the parties split the cost of arbitration. However, the goal is to do whatever can be done to ensure the parties agree without arbitration. Self-funded plans can opt-in. The OIC will be seeking a modification to ensure that bordering states are included.

Even when you do all the right things and make all the right decisions consumers can still be stuck holding the bag. The odds are stacked against you. Many people think they have good insurance, but still have to pay many thousands of dollars for out-of-network or specialty care. Even with negotiating with hospitals and providers to lower costs, many consumers cannot cover the costs after a serious health issue. Often times the specialty providers available are out of network.

Nurses know the emotional and financial stress than can be caused by balance billing particularly when the patient thinks they have done the right thing and gone to an in-network facility, so this bill is strongly supported. This bill is a common sense fix. Patients who are struggling to navigate the complex health care system should not be penalized.

(Opposed) None.

(Other) There is support of the efforts to ban balance billing and this bill provides a good framework. Stakeholders appreciate the opportunity to provide feedback and work with others over the years, but there are still some concerns. There should be an exclusion from the balance billing prohibition for when an enrollee knowingly opts for out-of-network providers when in-network providers are available. Ambulances should also be included in the balance billing prohibition as well. Additionally, each claim should be considered on its own merit otherwise there is a lower incentive for providers to negotiate. Most importantly this bill takes consumers out of the middle, there shouldn't be any more stories of patient getting balance billed. However, this is a concern that these prohibitions will unduly disrupt contracting and the incentives to contract need to be maintained. This bill continues to allow consolidation of multiple claims which is important because often time the discrepancy between the parties payments would be nominal, but all combined is significant. There needs to be work to ensure that the transparency portions of the bill are actually workable.

There has been great work over the past year and the structure is greatly improved. This bill establishes more fair processes and takes patients out of the middle. There are some areas where the conversation needs to continue. Medicare is listed as a criteria that the arbitrator should consider, but that is not commercially reasonable. Finally, how do hospitals or providers know if a patient is covered by a self-funded plan and not covered by the balance billing prohibition.

Persons Testifying: (In support) Lonnie Johns-Brown and Jane Beyer, Office of the Insurance Commissioner; Jamie Hansen; Amy Brackenbury, Washington State Nurses Association; and Sybill Hyppolite.

(Other) Meg Jones, Association of Washington Healthcare Plans; Leonard Sorrin, Premera Blue Cross; Zach Snyder, Regence Blue Shield; Sean Graham, Washington State Medical Association; Chris Bandoli, Washington State Hospital Association; and Ruben Krishnananthan.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 30 members: Representatives Ormsby, Chair; Bergquist, 2nd Vice Chair; Robinson, 1st Vice Chair; MacEwen, Assistant Ranking Minority Member; Rude, Assistant Ranking Minority Member; Caldier, Cody, Dolan, Dye, Fitzgibbon, Hansen, Hoff, Hudgins, Jinkins, Kraft, Macri, Mosbrucker, Pettigrew, Pollet, Ryu, Senn, Springer, Stanford, Steele, Sullivan, Sutherland, Tarleton, Tharinger, Volz and Ybarra.

Minority Report: Do not pass. Signed by 3 members: Representatives Stokesbary, Ranking Minority Member; Chandler and Schmick.

Staff: Catrina Lucero (786-7192).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

The second substitute bill clarifies that if the carrier and facility or provider cannot agree to a commercially reasonable rate, and one party chooses to pursue further action to resolve the dispute, then the dispute must be resolved through arbitration. It exempts the arbitration requirements for balance billing disputes from a provision that bans the use of mandatory arbitration clauses by insurers in insurance contracts. Additionally, the second substitute bill requires the Office of the Insurance Commissioner (OIC) to contract with the Office of Financial Management (OFM) and the lead organization to develop a data set and business process to provide data to assist with determining commercially reasonable payment during payment disputes. This must be developed in collaboration with health carriers, providers, and facilities. The substitute bill required that the OFM lead this work rather than the OIC. A null and void clauses is added.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Second Substitute Bill: The bill takes effect January 1, 2020, except for section 26, relating to the creation of the claims data set by the Office of Financial Management to be used in determining if a payment is commercially reasonable, which takes

effect 90 days after adjournment of the session in which the bill is passed. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony:

(In support) Medical debt is one of the leading causes of foreclosure. This bill will help to reduce balance billing for emergency room and approved inpatient and surgical procedures. It will take consumers out of the middle between providers and carriers. The opt-out provisions of the bill are problematic. Medical billing is complicated. Individuals may not understand the protections that they are waiving or may be in no position to negotiate. This could lead to medical debt.

(Opposed) None.

(Other) It is important to maintain the incentives to contract between physicians and insurance carriers. If these incentives are detrimentally tilted, it could lead to additional hospital costs. This bill represents improvements over prior versions. Patients who intentionally select an out-of-network provider should not be afforded the protections of this bill. This bill could pertain to care received across state lines. Carriers would have no recourse to negotiate in those cases.

Persons Testifying: (In support) Lonnie Johns-Brown, Office of the Insurance Commissioner; Janet Varon, Northwest Health Law Advocates; and Xochitl Maykovich, Washington Community Action Network.

(Opposed) None.

(Other) Sean Graham, Washington State Medical Association; Chris Bandoli, Washington State Hospital Association; and Meg Jones, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying: None.