SENATE BILL REPORT
2SHB 1065

As Reported by Senate Committee On:
Health & Long Term Care, March 29, 2019

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: House Committee on Appropriations (originally sponsored by 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: Passed House: 3/04/19, 84-13.
Committee Activity: Health & Long Term Care: 3/15/19, 3/29/19 [DPA-WM, w/oRec].

Brief Summary of Amended 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.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Cleveland, Chair; Randall, Vice Chair; O'Ban, Ranking Member; Bailey, Dhingra, Frockt, Keiser, Rivers and Van De Wege.

Minority Report: That it be referred without recommendation.
Signed by Senator Becker.

Staff: Evan Klein (786-7483)

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 (EMTALA), 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 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.

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

Summary of Amended 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 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 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, unless: (1) federal legislation is passed prohibiting balance billing; or (2) an interstate compact with that bordering state is enacted in Washington.

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 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:

1. 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.
2. 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.

3. 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.
4. 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 must be 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.

Arbitration. If the carrier and the provider or facility do not agree to a payment amount within the 30 days and the carrier, provider, or facility chooses to pursue further action to resolve the dispute, it must be resolved through arbitration. To initiate arbitration, the carrier, provider, or facility must provide written notice to the commissioner and the non-initiating party no later than ten 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 notification 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. If the parties do not agree on an arbitrator:

- the commissioner must provide the parties a list of five arbitrators;
- each party may then veto two of the five named arbitrators, and if only one arbitrator remains, that person is chosen as arbitrator; and
- if more than one arbitrator remains, the commissioner must choose the arbitrator from the remainder.

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 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; 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 arbitrator may consider the data set from the All Payers Claims Database (APCD).

The arbitrator may not require extrinsic evidence of authenticity of the APCD data set in order to admit the data set into evidence.

The Office of the Insurance Commissioner (OIC) must contract with OFM 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 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 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:

- involve identical carrier and provider or facility parties;
- involve claims with the same or related current procedural terminology codes relevant to the the particular procedure; and
- occur within two months of one another.

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 1st.

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 OIC so 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, based on information provided by carriers. 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, based on information provided by carriers. 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;
- upon request, an estimated range of out-of-pocket costs; and
- upon request, whether there are in-network surgical or ancillary services available at in-network facilities.

Self-funded group health plans that elect to participate in the prohibition on balance billing and carriers must notify providers through all electronic and other methods of communication generally used by providers to verity enrollee eligibility, whether an enrollee's health plan is subject to the act. Provider contracts filed by carriers must identify the network or networks to which the contract applies.

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, 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 DOH or disciplining authority. Upon completion of its review of any potential violation, 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.

All Payers Claims Database Dataset. The OIC must contract with the state agency administering the APCD to establish a data set and business process to provide carriers, providers, hospitals, ambulatory surgical facilities, and arbitrators with prevailing payment and billed charge amounts for the services for which balance billing is prohibited, by geographic area. The dataset must include commercial health plan claims, and claims paid for on other than a fee-for-service basis. The dataset must be available beginning November 1, 2019. The 2019 dataset must be based on the most recently available full calendar year of claims, and subsequent years must be adjusted by applying the consumer price index-medical component established by the United States Department of Labor.

EFFECT OF HEALTH & LONG TERM CARE COMMITTEE AMENDMENT(S):

- Removes provisions subjecting an enrollee to contractual requirements for reimbursement of out-of-network surgeons, when the enrollee knowingly and voluntarily plans a surgery with an out-of-network surgeon;
- Clarifies that the amount a carrier reimburses a facility or provider shall be a commercially reasonable amount, as opposed to shall be limited to a commercially reasonable amount;
- Clarifies that a carrier must only hold an enrollee harmless from balance billing for certain emergency services provided by an out-of-network hospital in a border state, until any federal legislation is passed prohibiting balance billing or until any interstate compact with that bordering state is enacted;
- Replaces the requirement that carriers indicate on enrollees' ID cards whether the enrollee's health plan is subject to the act, with a requirement that carriers make information available through all electronic and other methods of communication

generally used by a provider to verify enrollee eligibility, whether an enrollee's health plan is subject to the act;
- Requires entities administering a self-funded group health plan, that elect to participate in the prohibition on balance billing, to comply with provisions to make available to providers and facilities, whether an enrollee's health plan is subject to the balance billing prohibition and other requirements of the act;
- Removes the requirement that the arbitrator consider the median in-network and out-of-network allowed amounts, median billed charge amounts, and Medicare rates, as part of arbitration;
- Prohibits the arbitrator from requiring extrinsic evidence of authenticity of the data set in order to admit the data set into evidence;
- Specifies that the APCD data set may be considered by the arbitrator;
- Clarifies that facilities and providers must post the listing of carrier health plan networks for which they are in-network, based on information provided by carriers;
- Clarifies that carriers must notify enrollees, upon request, whether there are in-network surgical or ancillary services available at specified in-network facilities;
- Clarifies that OIC must contract with whichever agency is responsible for administration of the APCD in setting up the data set, as opposed to specifying that the OIC contract with OFM;
- Clarifies that the data set must include the median in-network and out-of-network allowed amounts and the median billed charge amounts by geographic area;
- Removes the requirement that the APCD data set include Medicare claims or rate information; and
- Requires provider contracts filed by carriers to identify the network or networks to which the contract applies.

Appropriation: None.

Fiscal Note: Available.

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

Effective Date: The bill contains several effective dates. Please refer to the bill.

Staff Summary of Public Testimony on Second Substitute House Bill: *The committee recommended a different version of the bill than what was heard.* PRO: The goal has always been to take consumers out of the middle. There have been several high dollar balance billing cases recently, and OIC continues to receive complaints from around the state on this issue. There is language to address when people are balance billed from out of state hospitals. A compromise is available to keep in the hold-harmless provision until a more comprehensive multi-state regulation is in place.

OTHER: There are some changes that were made to this bill, many of which were helpful. There are some wrinkles in the bill that need to be ironed out, including the reimbursement that is provided when there is not a contract in place. Insurers should be required to reimburse at a neutral standard. There is also concern that the arbitrator would consider irrelevant information, specifically Medicare rates. There is a hope that the claims bundling in this bill would be expanded from two to three months. There is a need to ensure that a

provider can know if a patient is covered by an ERISA plan. Electing self-funded groups should be required to note on ID cards whether that enrollee is covered by the balance billing provisions. Balance billing prohibitions work best, when incentives to contract with carriers are still in place. Hospitals already have lower incentives to contract with carriers, therefore it is hard for carriers to form full networks. To ensure nothing incents providers to stay out of network, there is support that limits bundling of claims to two months of services. Nothing prohibits out of state hospitals from balance billing patients. Carriers are okay with holding the patient harmless, but want to note that doing so may raise premiums. This bill is unique to other states' approach, since it tries hard to let folks know that they may be balance billed if they seek out services specifically from an out of network provider. The approach in SB 5699 is better than the approach in this current bill.

Persons Testifying: PRO: Jane Beyer, Office of the Insurance Commissioenr; Lonnie Johns-Brown, Office of the Insurance Commissioner.

OTHER: Sean Graham, Washington State Medical Association; Chris Bandoli, Washington State Hospital Association; Len Sorrin, Premera; Zach Snyder, Regence; Meg Jones, Association of Washington Healthcare Plans; Cliff Webster, Washington State Society of Anesthesiologists.

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