

# 2SHB 1065 (2019) Surprise/Balance Billing

May 3, 2019

<p><b>Sec. 6</b></p> <p><b>Scope of surprise/balance billing prohibition</b></p>	<ul style="list-style-type: none"> <li>• Prohibition on surprise/balance billing applies to:             <ul style="list-style-type: none"> <li>○ Emergency services; and</li> <li>○ Non-emergency surgical or ancillary services provided by an out-of-network (OON) provider at an in-network hospital or ambulatory surgical center. Surgical or ancillary services includes surgery, anesthesiology, pathology, radiology, laboratory or hospitalist services.</li> </ul> </li> <li>• When emergency services are provided in an OON hospital in a border state, the health insurer must hold the consumer harmless from balance billing. If a federal or reciprocal state law is passed in the future that makes it illegal for these hospitals to balance bill consumers, there is no longer a need for health insurers to hold consumers harmless.</li> </ul>
<p><b>Sec. 7</b></p> <p><b>Consumer Cost-Sharing Obligation and Payment Formula</b></p>	<ul style="list-style-type: none"> <li>• Consumer cost-sharing is limited to in-network cost-sharing, based upon the health insurer's median in-network contracted rate. Health insurers must send an explanation of benefits to the enrollee and the out-of-network provider.</li> <li>• Allowed amount paid to an OON provider for health care services described in section 6 of the act is a commercially reasonable amount, based on payments for the same or similar services in a similar geographic area.</li> <li>• Process:             <ul style="list-style-type: none"> <li>○ Within 30 days of receipt of a claim from OON provider, the health insurer will offer to pay the OON provider a commercially reasonable amount.</li> <li>○ If the OON provider disputes the health insurer's payment, the provider must notify the health insurer no later than 30 days after receipt of payment or payment notification from the health</li> </ul> </li> </ul>

	<p>insurer. The health insurer and provider have 30 days from the initial offer to negotiate in good faith.</p> <ul style="list-style-type: none"> <li>○ If the health insurer and the OON provider do not agree to a commercially reasonable payment amount within those 30 days, the dispute is resolved through arbitration.</li> <li>○ Directs the Insurer to pay OON provider directly rather than sending payment to consumer.</li> <li>○ Health insurers must make information available to a provider regarding whether the enrollee's health plan is subject to the balance billing prohibition.</li> </ul> <ul style="list-style-type: none"> <li>● Prohibits providers and facilities from requiring a consumer to waive their rights under the legislation.</li> </ul>
<p><b>Sec. 8</b> <b>Dispute Resolution/Arbitration</b></p>	<ul style="list-style-type: none"> <li>● Either party can initiate arbitration if an informal settlement is not reached. The Office of the Insurance Commissioner (OIC) maintains list of arbitrators/arbitration organizations and provides that information to parties to the arbitration. If parties cannot agree, OIC provides a list of five arbitrators.</li> <li>● Each party must submit its final offer amount. If the non-initiating party does not make timely required submissions, the arbitrator must choose the final offer amount of the initiating party. A nondisclosure agreement must be signed by the parties.</li> <li>● Allows claims bundling in a single arbitration to include claims that involve the identical health insurer and provider/facility parties; involve claims with the same or related CPT codes relevant to a particular procedure; and occur within a period of two months of one another.</li> <li>● Factors that must be considered by arbitrator: <ul style="list-style-type: none"> <li>○ The evidence and methodology submitted by the parties to assert that the amount to be paid is or is not commercially reasonable; and</li> <li>○ Patient characteristics and the circumstances and complexity of the case, including time and place of service, that are not already are not reflected in the provider's billing code for the service.</li> </ul> </li> </ul> <p>The arbitrator can consider additional information, including the APCD data set to be developed and available under section 26.</p> <ul style="list-style-type: none"> <li>● Arbitrator chooses a payment proposed by one of the parties.</li> <li>● Expenses of arbitration are shared equally between the parties.</li> </ul>

	<ul style="list-style-type: none"> <li>• OIC prepares an annual report on arbitration proceedings, through CY 2023, based upon information provided by arbitrators.</li> <li>• Amends 48.18.200 and 48.43.055 to carve out arbitration under this act.</li> </ul>
<p><b>Sec. 10-13 &amp; 30</b></p> <p><b>Transparency</b></p>	<p><u>Notice of consumer rights:</u></p> <ul style="list-style-type: none"> <li>• OIC to develop standard template language for notice of consumer rights, and to adopt rules governing when and in what format providers and health insurers must provide the notice to consumers.</li> </ul> <p><u>Facilities must:</u></p> <ul style="list-style-type: none"> <li>• Post on their website a list of the health insurer’s provider networks the facility participates in and the OIC notice of consumer rights; and</li> <li>• Provide the health insurers it contracts with a list of non-employed providers under contract with the facility to provide surgical or ancillary services, not less than 30 days before signing a contract with a health insurer. Must notify the health insurer within 30 days of a provider’s removal from or addition to the non-employed provider list. Must respond to a health insurer’s request for an updated provider list within 14 days.</li> </ul> <p><u>Providers must:</u></p> <ul style="list-style-type: none"> <li>• Post on their website the health insurer provider networks they participate in and the OIC notice of consumer rights; and</li> <li>• Submit accurate information to a health insurer regarding the provider’s network status in a timely manner.</li> </ul> <p><u>Health insurers must:</u></p> <ul style="list-style-type: none"> <li>• Update their provider network website within 30 days of addition or termination of a provider.</li> <li>• Provide an enrollee with: <ul style="list-style-type: none"> <li>○ A clear description of the health plan’s OON benefits;</li> <li>○ The OIC notice of consumer rights;</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ Notification that if an enrollees receives OON services other than those protected from balance billing, what their financial responsibility is for those services and that they could be balance billed.</li> <li>○ Information on how to use the health insurer’s member transparency tools under RCW 48.43.007;</li> <li>○ Upon request, whether a provider is in-network or OON and whether there are in-network providers available to provide surgical and ancillary services at specified in-network facilities; and</li> <li>○ Upon request, an estimated range of the out-of-pocket costs for an OON service.</li> </ul> <ul style="list-style-type: none"> <li>● In provider contracts filed with OIC, health insurers must identify the provider network(s) to which the contract applies. (Amends 48.43.730)</li> </ul>
<p><b>Secs. 14-20</b> <b>Enforcement</b></p>	<ul style="list-style-type: none"> <li>● <u>Enforcement related to providers and facilities:</u> <ul style="list-style-type: none"> <li>○ The Department of Health and the applicable health profession disciplinary authority are responsible for enforcement related to violations of sections 6 or 7 of the act by providers or facilities.</li> <li>○ Prior to referral to DOH or the applicable health profession disciplinary authority for investigation/enforcement, OIC must have reasonable cause to believe that a pattern of unresolved violations of the balance billing prohibition have occurred;</li> <li>○ OIC may give a provider the opportunity to explain or cure alleged violations before reporting to DOH or the applicable health profession disciplinary authority.</li> <li>○ A pattern of violations of the balance billing prohibition constitutes “unprofessional conduct” for purposes of health care provider discipline. Allows formal or informal disciplinary actions by DOH or the applicable health profession disciplinary authority.</li> </ul> </li> <li><u>Enforcement related to health insurers :</u> <ul style="list-style-type: none"> <li>○ OIC enforces violations by health insurers when there is a pattern of unresolved violations.</li> <li>○ It is an unfair or deceptive practice for a health insurer, performed with such frequency as to indicate a general business practice, to initiate arbitration with respect to out-of-network claims that request payment of a commercially reasonable amount.</li> </ul> </li> </ul>

<p><b>Sec. 21 - 23</b> <b>Applicability</b></p>	<ul style="list-style-type: none"> <li>• Applies to commercial health insurance, state and school employee benefits plans</li> <li>• Does not apply to Medicaid, given existing law on this issue for Medicaid.</li> <li>• Provides an opportunity for self-funded group health plans to opt into participation in the prohibition on balance billing, consumer protections, OON provider payment standard and arbitration. A self-funded plan that chooses to opt in must provide notice to OIC annually.</li> </ul>
<p><b>Sec. 25</b> <b>Network Adequacy</b></p>	<ul style="list-style-type: none"> <li>• When determining the adequacy of health insurer provider networks, OIC must consider whether the insurer’s provider network includes a sufficient number of contracted providers of emergency and surgical or ancillary services at the insurer’s contracted in-network hospitals or ambulatory surgical facilities to reasonably ensure enrollees have in-network access to covered benefits delivered at that facility.</li> </ul>
<p><b>Sec. 26</b> <b>APCD data set</b></p>	<ul style="list-style-type: none"> <li>• A data set based on commercial health insurance claims will be prepared by the All Payer Claims Database, in collaboration with providers and health insurers, for use by providers, facilities, insurers, and arbitrators. The data set will include, for services referenced in section 6: <ul style="list-style-type: none"> <li>○ Median in-network allowed amount;</li> <li>○ Median OON allowed amount; and</li> <li>○ Median billed charge.</li> </ul> </li> <li>• The data set will include the most recent year’s data as a baseline, and will be inflated annually by medical Consumer Price Index (CPI-M).</li> </ul>
<p><b>Sec. 31 Effective date</b></p>	<ul style="list-style-type: none"> <li>• January 1, 2020</li> </ul>