Washington State Hospital Association

2019
POLICY BRIEF

Balance Billing Limitations

Background

WSHA has been engaged in ongoing discussions about out-of-network billing for several years. In particular, there is concern about the ability for non-contracted providers to bill patients for the difference between the insurance payment and charges for out-of-network services ("balance billing").

The Office of the Insurance Commissioner (OIC) and legislators are proposing legislation to 1) prohibit in certain circumstances balance billing of the patient for out-of-network service by a provider or hospital; 2) provide a dispute/arbitration process for cases where the carrier and provider do not agree on the payment level; 3) enable self-funded groups to "opt-in" to the patient protections and payor requirements; and 4) require the OIC to ensure carriers have enough contracted emergency and ancillary providers to provide in-network benefits at contracted hospitals.

WSHA Position

WSHA supports efforts to protect patients from unforeseeable, unexpected billings. While we are pleased the proposed bill is improved compared to earlier versions, there are items that need to be addressed to avoid confusion to patients, greater administrative cost, and destabilization of the insurance market. They include:

- A robust mechanism for patient insurance cards and provider payment statements to accurately identify services that are subject to the legislation; and
- Removal of Medicare payment rate as a factor for the arbitrator to determine a reasonable commercial rate.

We prefer an alternative approach that would create a reporting of out-of- network claims by carrier, facility, and provider group.

Key Messages

- WSHA supports efforts to protect patients from unforeseeable, unexpected billings.
- WSHA believes the bulk of balance billing issues could be addressed though more rigorous network adequacy requirements and transparency. If facilities and physicians are prohibited from balance billing, there must be a clear mechanism via patient insurance cards and payment statements to identify the relevant carrier groups and self-funded groups.
- Any process with an arbitrator to determine "commercially reasonable" payment should not include Medicare payment rates as the bill does not apply to Medicare products.

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