

# 2019 LEGISLATIVE UPDATE: Public Option and Surprise Billing

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# Today's Presenters



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# PUBLIC OPTION HEALTH PLANS (CASCADE CARE)

# The Problem

*First the cat, now the health system puts the bite on me*

Health insurance deductibles soar, leaving Americans with unaffordable bills

*Americans are closely divided over value of medical treatments, but most agree costs are a big problem*

*The (Un)Affordable Care Act and the Future of US Health Insurance*

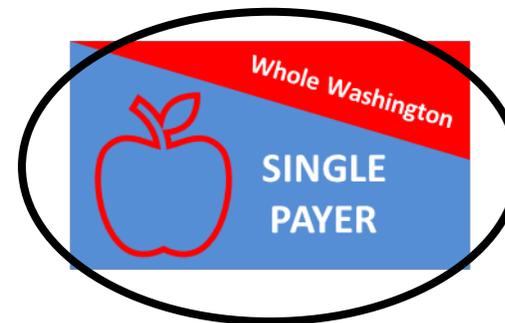
*The Health 202: Health insurance still costs too much.*

# The Political Responses

## At the National Level



## At the State Level



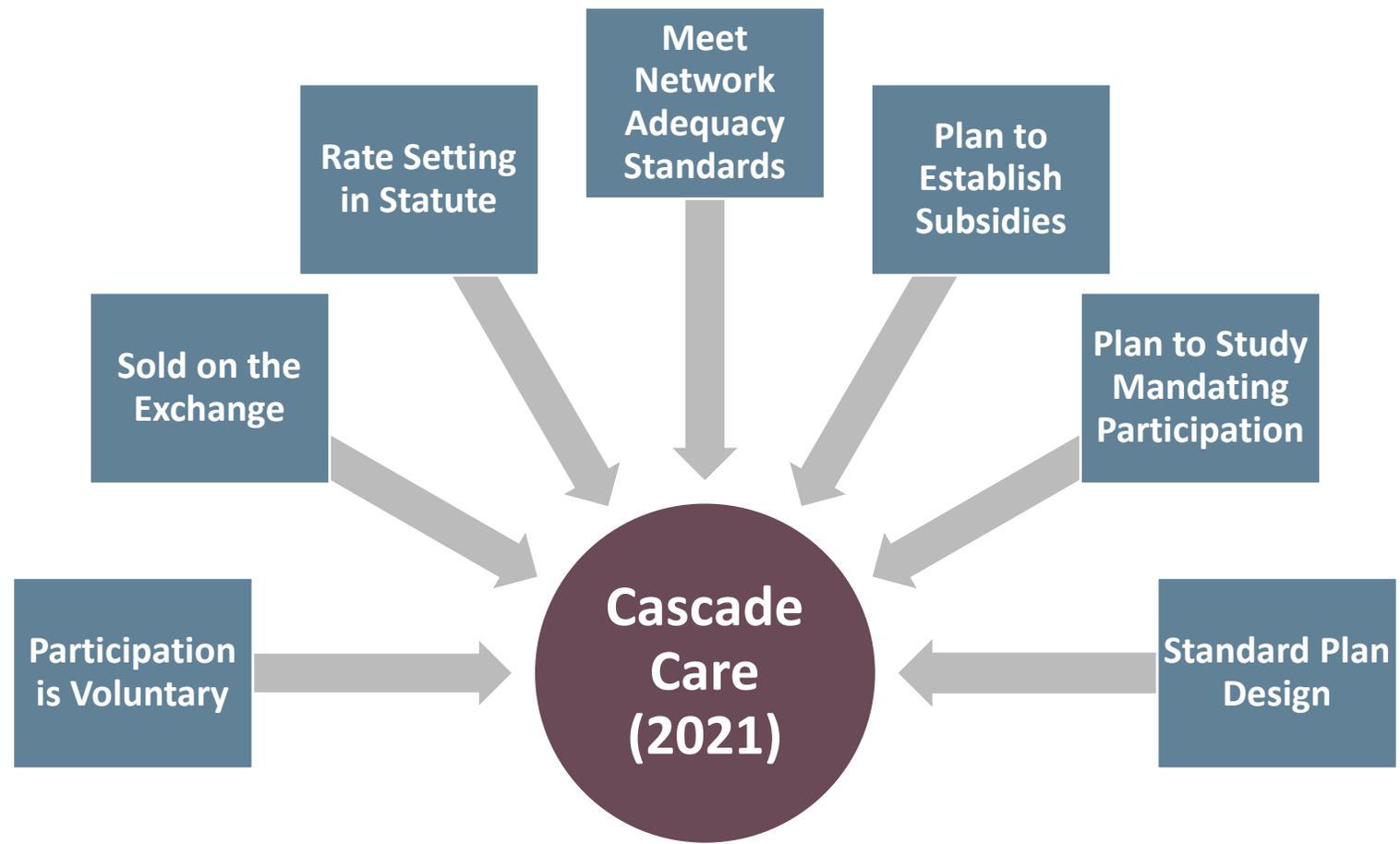
**PASSED: ESSB 5526 Public Option (Cascade Care)**

**PASSED: Appropriations to Support a Universal Health Care Task Force**

# The Legislative Landscape of Public Option



# Highlights of Washington's Public Option



# Moving Forward with Public Option

## The State

- HCA to determine how to calculate the 160% of the statewide aggregate of Medicare payment cap
- HCA to determine other criteria for public option health plans
  - To control pharmacy expenses
  - To reduce barriers to maintain/improve health and align to state's VBP
- HBE to develop a plan for premium subsidies for consumers at less than 500% of FPL

## Hospitals & Providers

- Prepare for conversations with carriers for plan year 2021 about participating in public option plans' network
  - Understand how your current payment rates through exchange plans compare with Medicare rates
  - For Critical Access Hospitals, understand how your payment rates compare to costs (to be paid at least 101% of allowable costs)
  - For primary care providers, understand how your payment rates compare to Medicare (to be paid at least 135% of Medicare)



# Questions? Comments?

*Please use the chat box*



# SURPRISE BILLING

# Congressional Proposals

## Lots of interest at Federal level. Proposals include:

- Hold harmless and balance billing prohibitions for out of network emergency services
- Default payment rate for OON services determined by state or according to formula
- Mandatory independent dispute resolution process, such as baseball-style arbitration
- Bundled hospital and physician payment
- In-network guarantee

# Federal Issues

- Regulation of commercial insurance generally done at state level
- States have limited authority to regulate ERISA self-funded plans
- Unclear if Congress would modify ERISA and subject them to payment requirements
- **CONCERN:** balance billing prohibitions without a corresponding mechanism to ensure plans pay reasonable rates could undermine insurance market

# Principles

- Defined and limited scope
  - Out of network emergency services
  - Out of network care at in-network facilities
- Protect the patient financially
- Preserve role of negotiation between health plans and providers
- Promote network adequacy and accurate carrier information
- Support state laws that work

# State Issues

- Work on state bill in process or about 10 years
- Significant OIC and Legislative enthusiasm for a solution
- Historical barriers:
  - Solution to ERISA self-funded plan issue
  - Default payment

# House Bill 1065 at a Glance

- OIC bill would prohibit balance billing on:
  - Out of network emergency services
  - Out of network anesthesia, lab, radiology, surgery if services provided at an in-network facility
- Payors subject to “commercially reasonable” payment standard
- Arbitration process if payment level disputed
- Applies to fully insured plans, PEBB and SEBB. ERISA self-funded groups can elect to opt-in
- Transparency and notification requirements for facilities, providers, and carriers

# ERISA Groups

Provisions of bill apply to services to enrollees of ERISA groups **only** if the self-funded group voluntarily elects to participate

- Annual notice of election and attestation through OIC process
- Enrollees of participating groups receive balance billing protections
- Self-funded group agrees to the payment and arbitration provisions of the bill

# Identification of Patients

- Carriers and electing self-funded groups must make payment to providers and facilities directly.
- Carriers must make available through electronic and other methods of communication generally used by a provider to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the requirements of this act.

# Dispute Resolution

- Carrier must pay out-of-network provider commercially reasonable amount (undefined)
- 30-day informal negotiation period if dispute over payment amount
- Arbitration process if unresolved
  - Bundling of claims (similar services, same carrier in two-month period)
  - Baseball-style arbitration (choice between 'best offers')
  - Arbitrator can refer to all payer claims data base information

# Dispute Resolution: All Payer Claims Database (APCD) Information

- Median in-network allowed amount for similar services in same geographic area
- Median out-of-network allowed amount for similar services in same geographic area
- Median billed charge amount for similar services in same geographic area
- ***Removed in final bill:*** Medicare allowed amount for similar services

# Transparency

- Hospitals and providers must post on their website listing of carrier networks which they are in-network
  - Provider contracts shall identify the network or networks to which the contract applies. Hospitals and providers will be able to rely on information provided by the carrier in the provider contract
- Hospital and providers must also provide the standard notice of consumer rights (notice and manner to be developed by OIC and stakeholders)
- Hospitals must provide carriers with listing of non-employed groups providing emergency and ancillary services as part of the carrier contracting process

# Network Adequacy

When determining a carrier's provider network adequacy, the commissioner must consider:

- Whether the carrier's proposed provider network or in-force provider network includes **a sufficient number of contracted providers of emergency and surgical or ancillary services** at or for the carrier's contracted in network hospitals or ambulatory surgical facilities to reasonably ensure enrollees have in-network access to covered benefits delivered at that facility.

# Enforcement

- OIC may report hospitals and provider groups believed to engage in “a pattern of violations” to the Department of Health for investigation and enforcement.
- Enforcement includes fines up to \$1000 per violation.

**Effective date: January 1, 2020**

# Implementation

## **State / OIC:**

- Standard enrollee notice, all payer claims database, and self-funded election process, rulemaking

## **Carriers and Electing Plans:**

- Benefit changes and enrollee identification, election for self-funded plans

## **Hospitals and Providers:**

- Mechanism to accurately identify services and patients to which the law applies, website communications and communications to contracted carriers

# Implementation

## Washington State Hospital Association

- Public Option Bulletin:  
<https://www.wsha.org/articles/public-option-health-plans-cascade-care-on-the-health-benefit-exchange/>
- Surprise Billing Bulletin:  
<https://www.wsha.org/articles/house-bill-1065-protecting-consumers-from-charges-for-out-of-network-health-care-services/>

## Washington State Medical Association

- WSMA Membership Memo
- Advocacy Council meetings
- Physician workgroup

Surprise Billing: Interest in implementation calls for hospitals and providers to share best practices?

