Washington State Hospital Association

October 10, 2018

Honorable Mike Kreidler
Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504

Re: Surprise Billing – 2019 Proposed Language

Commissioner Kreidler:

On behalf of our 107 hospital and health system members, the Washington State Hospital Association appreciates the opportunity to provide comment on the proposed balance billing legislation distributed by your office September 28. We appreciate the commissioner's efforts to find a solution that provides protection for patients from balance billing that was outside of their control, is workable for all stakeholders including carriers, hospitals, and providers, and minimizes unintended impacts to the insurance market. The draft version reflects much thought and effort. We have some remaining concerns and recommendations that we hope you will consider as you seek to improve the draft legislation.

Scope of services (Section 5). We prefer the scope of the bill be limited to emergency services where the patient has no control of the provision of services. We believe it is the carriers' responsibility to provide adequate access to in-network benefits for professional services at contracted hospitals. We believe these issues are best addressed by the network adequacy requirements in the bill that makes such provision part of the carrier's network adequacy review. This would also make the bill consistent with several other states that limit balance billing prohibitions to emergency services.

Required allowed amount (Section 6 (2)). We appreciate the concept that carriers are expected to pay a commercially reasonable amount in the absence of a contractual agreement and support the direction this language is moving. We are concerned the draft language "shall be limited to a commercially reasonable amount, …" may be misinterpreted by carriers to mean an amount that is commercially reasonable or *less*. We prefer language such as "shall be at a minimum, a commercially reasonable amount." or simply "shall be a commercially reasonable amount."

Direct payment (Section 6 (3)). We support the provision requiring carriers to pay providers and facilities directly for services that are subject to the provisions of the bill. We ask that the bill specify that the payment must be accompanied by information indicating the allowed amount for the service and a patient's deductible, coinsurance or copayment for the service. We believe this normally occurs with direct payment but may be a new requirement for some carriers or administrators of self-funded entities that elect to participate in the bill's provisions. We also ask that carriers and administrators for electing self-funded groups indicate on the payment notification if the services are subject to the bill's provisions based on the patient's coverage. This would ensure payers, patients, facilities, and providers have a clear and common understanding of which specific services are subject to the provisions of the

999 Third Ave, Suite 1400 | Seattle, WA 98104 | PHONE: (206) 281-7211 | FAX: (206) 577-1923 | www.wsha.org

bill. This is needed to avoid confusion since many entities administer a combination of fully insured and self-funded groups, often on a single reimbursement advice or payment notification. We recommend the OIC convene stakeholders to determine a standard way of indicating this on payment notifications.

Arbitration (Section 7(1)(b). We support the provisions allowing bundling of similar claims but suggest that the timeframe be expanded to six months. We believe the requirement that services occur within a two-month period would unintentionally make it difficult for providers to access arbitration other than for high cost or high-volume situations due to arbitration costs involved. We request the six-month period contained in House Bill 2114 last session.

Regarding the information to be considered by the arbitrator to determine "commercially reasonable," we request additional language in Section 7(4)(b)(ii) that would specify that the median in-network and out-of-network allowed amounts provided by the Washington State all payer claims database reflect commercial insurance and do not include Medicare, Medicaid, or other publicly funded programs for underserved individuals that typically have much lower payment rates.

Transparency (Section 9). We support the concept of providing notice to patients regarding their rights and protections under the draft bill. To avoid confusion, we recommend it make clear in the notice that the balance protections are limited to fully-insured enrollees of carriers and enrollees of self-funded groups where the self-funded group has elected to participate in the provisions of the bill.

Transparency (Section 10). We are concerned that the requirement that hospitals and providers post a listing of the provider networks with which the hospital or provider as an in-network provider may create more confusion than clarity for patients. Carriers, particularly larger ones, typically contract with hospitals and providers for some of their programs but not for others, particularly if they employ tiered networks. As a result, a patient may mistakenly believe their hospital services are in-network based on a website listing, then find out later the hospital was not included in the carrier's subnetwork for the patient's group. This requirement also creates potential confusion for patients of for hospitals in border regions as Oregon does not have a similar requirement. We recommend general language advising patients to contact their health plan directly for coverage information.

We agree with the general expectation that carriers should be aware of non-employed surgical and ancillary groups that provide services at the hospital as part of the communication between the parties during initial contracting or contracting negotiation process, as well as subsequent changes. In some cases, the contracting process could occur in less than 30 days. We request language that would address this possibility. As part of the network adequacy review in Section 25, carriers should be required to demonstrate they have made reasonable efforts to contract with non-employed surgical and ancillary groups identified by the hospital.

Enforcement (Section 13). We are concerned about enforcement provisions, as there is high potential for inadvertent violations due to ambiguity regarding what services are subject to the provisions of the bill. We appreciate the language specifying that enforcement would occur only as a result of patterns of unresolved violations of balance billing prohibitions, and not inadvertent and resolved violations. We

recommend any enforcement of hospitals and providers be delayed until mechanisms are in place to ensure providers can reliably determine which payments are applicable to the provisions of the bill.

We appreciate the provision in Section 14 indicating it is an unfair or deceptive practice for carriers to rely on arbitration as a general practice rather than contracting adequate networks or making reasonable initial payment. We would appreciate more detail in the bill regarding how OIC will monitor and enforce this provision.

We also support the provision in Section 25 affirming that as part of a carrier's network adequacy review, the carrier will be expected to have sufficient numbers and appropriate types of contracted providers at contracted facilities to reasonably ensure access to in-network benefits for covered services provided at the facility. We believe this expectation may by itself significantly reduce the volume of out-of-network services.

Self-funded groups (Section 23). We appreciate that the draft bill clearly specifies that services covered by self-funded groups are subject to the bill only if the group has enrolled with the commissioner to accept both the balance billing protections and the payment provisions of the bill. We encourage the commissioner to establish a robust mechanism to ensure enrolling self-funded groups are subject to the same payment requirements as carriers. We reiterate that the payment notices accompanying payments from both carriers and electing self-funded groups will need an indicator specifying that specific services are subject to the provisions of the bill.

WSHA appreciates the difficulty of providing a balanced approach that provides protections for patients while minimizing the potential of unintended impacts on the overall insurance market. Thank you again for the opportunity to provide input.

If you have questions, please contact Andrew Busz, WSHA Policy Director, Finance at (206) 216-2533 or andrewb@wsha.org.

Chelene Whiteaker
Senior Director, Policy Development

Andrew Busz
Policy Director, Finance