Washington State Hospital Association

November 29, 2016

Honorable Mike Kreidler
Office of the Insurance Commissioner
Via e-mail

Subject: Balance Billing

Dear Commissioner Kreidler,

On behalf of our 107 member hospitals in Washington State, we want to respond to your request for additional input on the issue of balance billing. We appreciate your efforts to bring together stakeholders to discuss a solution, and your vetting of alternative approaches. We also want to find a solution to help address the issue. Patients who cannot determine they are using out-of-network providers should not be subject to increased cost sharing through balance billing. At the same time, it is unclear how frequently these instances arise. A solution is difficult because it has the potential to upset the current market, and either tip the contracting position in favor of providers or insurers, depending on how the fall back rate is selected.

Given the complexities of any solution, we feel strongly that Washington State proceed carefully. Our main interest in this draft legislation is not to extend it widely. We believe there may be an issue with balance billing in some cases, but see it as limited. If there is a solution, a remedy should be used for emergency services as well as facility based providers, including anesthesia, radiology and pathology. We do not see any need to broaden the scope of a solution to include referrals or specialty consults and we believe doing so will cause harm to negotiations. For example, some of our hospital facilities get most if not all of their cases through referrals, and the insurers may not have any incentive to directly contract, depending on how the fall back rate is determined. Specialty consults pose additional complications. Depending on how the rate is set, may restrict providers' willingness to provide this service.

We also believe that some of the issues can be better settled by ensuring network adequacy, to make sure that there is sufficient coverage of services by an insurer. We hope to be able to discuss this solution more.

After the last meeting, you asked some additional questions, and our responses are below.

1. **What reimbursement level for providers in the covered surprise billing circumstances would be fair and why?**

We think any proposal with a fall back rate is going to create market problems. By definition, it is unfair to one side or the other. While we do not think the proposed approach is the right one, if the Commissioner and legislators go down this path, the rate should be based on a market rate, and even potentially should be above the going rate in order to provide an incentive for negotiation.
One of the options discussed was having the default rate based on a proportion of a plan's usual contracted rate for in-network services. We are concerned about a method based on a plan's own rates because our understanding is most contractual disputes occur when a plan offers significantly less than

what providers are being paid by other plans for similar products and services. If plan contracted rates are considered, the rate should be based on the greater of the plan's rates or the rates paid by all plans for similar services in the region.

We are very concerned about the proposal to define a default "UCR" payment rate based on 80 percent of the plan's normal in-network contracted rate. While the plans claim the threat of lower payment would make providers more likely to contract, we are concerned that instead, this would create an environment where plans would be less inclined to negotiate in good faith with providers, as they would be able to pay 20% less than if they contracted with them at their normal contracted rate. While we do not support a default rate approach, we understand that under the California law, which takes an average contract rate approach, has a robust system where plans must submit information substantiating in-network contract rates for like services of the same specialty in each geographic region. The intent is that plans would pay a market rate comparable to the full amount that they would pay if the services were provided by an in-network provider.

2. What else would need to be included in the legislation to make the level workable/acceptable?

As stated above, we do not think this type of solution is the right one. If this approach is adopted, we feel strongly that it should be limited to emergency physicians, and anesthesia, radiology and pathology. We also feel that if there is an arbitration clause, then the legislation should specify the standards that should be used in the arbitration. Leaving it up to an arbitrator without any guidelines seems to make the decision making process a random event.

3. **If one, or more, states have surprise billing laws that you support, which are they and why do you support them?**

We do not think any of the approaches currently adopted are ones we would support. As we mentioned above, we think that an approach on examining network adequacy may have more potential and avoid some of the downsides mentioned here.

Thank you again for your work on this and we are happy to discuss our responses further.

Sincerely,

Claudia Sanders

Claudia Sanders, Senior Vice President, Policy Development

cc.: Lonnie Johns-Brown