A Policy Analysis of Balance Billing Legislation in Washington State

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Abstract

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Purpose: To understanding the attitudes and perceptions of Washington state hospital stakeholders toward government policy strategies intended to minimize surprise medical bills.

Setting: Washington state.

Approach: Qualitative methods were utilized in order to generate a detailed and nuanced understanding of attitudes and perceptions.

Methods: Hospitals in Washington State were contacted via cold calling with a request for a telephone interview with an individual working in leadership or administration with experience in hospital billing, finance, or contracting.

Data Collection: Semi-structured telephone interviews were conducted that explored issues relevant to hospitals with regards to implementing policies designed to limit surprise medical bills. Interviews were audio-recorded and transcribed for analysis.

Analysis: Data analysis was conducted on a continuous basis. An inductive approach was used to generate codes that represent recurring themes and concepts across participant responses.

Results: three broad themes were identified that illustrate attitudes toward policy strategies intended to minimize balance bills: 1) a concern for the unintended consequences that may arise after implementation, 2) identification of significant barriers to successful implementation, and 3) identification of the negative impact of balance billing on consumers and hospital reputation as a motivating factor in exploring implementation.

Discussion: This data suggests that there is firm support for comprehensive legislation protecting consumers from surprise medical bills. It will be important to evaluate whether new regulations may lead to additional administrative burden for hospitals or create financial uncertainty that may have an adverse impact on future organizational decisions in the public interest. Future qualitative research to elicit the perceptions of provider and health insurance stakeholders who may be affected by balance billing legislation will further contribute understanding the effects of billing policy changes.

INTRODUCTION

The cost of healthcare in the United States continues to rise, and increasingly large medical bills may lead to debt or bankruptcy which poses a significant threat to economic security for vulnerable individuals and families[1]. The recognition of income and wealth as a social determinant of health underscores the public health significance of financial liabilities generated from medical billing. Individuals without the protections of comprehensive health insurance are particularly at risk for this type of burden. However, even insured individuals in the United States may face similar hazards.

A *balance bill* (also known as a *surprise medical bill)* is a particular type of charge applied to consumers with health insurance. In recent years balance billing practices have drawn considerable attention from state and federal regulators and legislators, as well as from local and national news organizations. The term is defined as a medical bill for the services of an out-of-network healthcare provider (i.e. clinician) performed within an in-network facility (such as a hospital) which cannot reasonably be foreseen by a consumer. For example, a patient who presents for evaluation and treatment of a medical condition at an emergency department in a hospital contracted with their insurance plan may unwittingly utilize the services of a provider who is not contracted with that network, and thus may ultimately be responsible for the difference between that provider's billed charge and the amount paid by the patient's insurance plan. The consumer is thus billed for the "balance."

Prior research has been conducted to characterize the scope and prevalence of the out-of-network health services that could lead to balance bills. A survey by the Kaiser Family Foundation found that among insured individuals having difficulty with paying medical bills, an

out-of-network charge was a determinant in one-third of cases; a large majority of these bills were not expected to be out-of-network[2]. Approximately one-fifth of emergency department visits in the United States, and more than one-half of ambulance services, involve an out-of-network provider[3]. And a 2011 survey of privately insured individuals showed that among those who used an out-of-network physician, 40% experienced involuntary out-of-network care, most of which related to emergency care[4].

The scope of out-of-network status extends beyond emergency services. In a study of complaints related to surprise medical bills, insurers reported to the state of New York Department of Financial Services that over 90% of these were associated with charges related to anesthesiology, surgery, radiology, and laboratory service providers[5]. The remaining surprise bills were attributable to emergency services. Even after a negotiated insurance payment to an out-of-network provider, amounts billed to consumers may often be several thousand dollars.

The findings related to the nature and scope of balance bills are significant in that the consumer is often unaware of the network status of every provider who may be involved in their care. Insurance plans typically maintain a directory of participating providers as a resource to their members, but the ultimate responsibility for determining when out-of-network care may be used is generally placed on the consumer. As a practical matter, this determination can be significantly challenging and time-consuming for consumers, providers, and insurance representatives. Furthermore, consumers may be in no reasonable position to make an informed economic decision on provider choice that will limit financial risk, particularly in a life-threatening medical situation. This is in stark contrast to the calculated financial decisions that physician groups, hospitals, and insurers may regularly undertake.

For these reasons, balance billing has received increased scrutiny from lawmakers and regulatory agencies in recent years. The Affordable Care Act, signed into law in 2010, requires insurers to apply in-network cost sharing levels for out-of-network emergency services, but does not place limits on balance billing by out-of-network emergency providers[6]. It also requires health plans to report out-of-network costs to their enrollees, but this provision has not yet been implemented[7]. At the time of this writing, consideration of specific federal legislation to limit balance billing is ongoing.

Concurrently, many state governments have enacted legislation limiting balance billing practices by various means[8]. These state policies are regularly analyzed by the Commonwealth Fund and can be classified as either partial (where the law may apply only to particular healthcare settings, provider types or insurance plans, or to a specified minimum claim amount), or comprehensive. At the time of this writing, thirteen states (including Washington state) have adopted comprehensive legislation limiting balance bills, and fifteen states have adopted legislation offering partial protections.

BACKGROUND

The Washington state legislature has debated balance billing legislation for the past several years. Legislation introduced in the years leading up to 2019 received strong support from the Washington State Insurance Commissioner[10]. Over the same time period, significant concerns were raised by other stakeholders, including state healthcare provider and hospital advocacy organizations, that proposed legislative solutions may remove incentives for insurance carriers to contract with physicians, fail to ensure fair reimbursement for health services, and

create challenges in recruiting or retaining qualified providers to work in state hospitals, particularly in rural regions[11,12]. Prior to 2019, these bills reliably failed to pass both state legislative chambers.

In the 2019 legislative session the Washington state legislature unanimously passed the Balance Billing Prevention Act[9] which prohibits balance billing for many out-of-network services provided at in-network facilities for enrollees of state-regulated insurance plans, as well as larger self-funded employer-sponsored insurance plans who voluntarily participate. The law went into effect on January 1, 2020. Relevant covered services include those provided by emergency, surgery, anesthesia, laboratory, and radiology departments. In addition, a mechanism for payment dispute resolution and arbitration was established which resolves payment disagreements between an insurer and provider. The law also holds the patient harmless for any additional charges and includes requirements for network transparency and communicating changes in the network status of providers or provider groups in a timely manner.

The Washington State Hospital Association (WSHA) is an advocacy organization representing all hospitals within Washington state on matters of legislative and policy issues. During the years of debate leading to passage of the Balance Billing Protection Act, WSHA frequently provided input to state legislators regarding feasibility and workability of the regulations being considered, as well as input regarding methodology for determining proposed payment rates, which become significant in the event of dispute resolution[13].

WSHA also works to support stakeholders from Washington state's rural hospitals in advocacy efforts. As these facilities are often the sole resource essential services for local residents, their leadership and workforce face issues and circumstances distinct from those of

large urban health systems. WSHA regularly works to connect stakeholders representing rural hospital facilities with policymakers, both state and federal, to discuss relevant regulatory issues, which has included balance billing[14].

Balance billing could thus be considered a phenomenon generated by complex factors which are subject to multiple levels of government regulation, and a practice that affects a diversity of stakeholders who may have competing interests. Employing qualitative methods that can create a detailed and nuanced understanding of how key stakeholders appreciate this issue, and appraise policy responses toward it, can be a vital part of navigating that complexity. Notably, some research into balance billing has used qualitative methods in order to understand the experience of patients on the receiving end of these unexpected charges[15]. However, scant qualitative research explores the perceptions and attitudes of hospital stakeholders.

METHODS

Study Population

Hospitals in Washington State that were listed as current members of the WSHA roster were contacted via cold calling with a request for a telephone interview with an individual working in leadership or administration with experience in hospital billing, finance, or contracting. A purposeful sampling method was used. In light of prior research noting the particular prevalence of balance billing related to certain medical specialties (including emergency medicine, anesthesiology, surgery, radiology, and laboratory services), hospitals specializing in behavioral health were excluded for the purposes of this thesis.

Interview Guide

Among individuals who agreed to participate, semi-structured telephone interviews were conducted which centered around the following general question: "What issues for your particular hospital or organization come to mind with regards to implementing policies designed to limit surprise medical bills?" The interview guide was comprised of six questions, each serving to explore a more specific balance billing policy strategy that has either been enacted into state law or detailed in academic literature as of January 2019[16,17] (See "Qualitative Interview Guide" below). Follow-up questions or clarifications were made as determined appropriate in order to enhance the depth and nuance of participant responses. Interviews were audio-recorded with consent of the participant and transcribed for analysis.

Qualitative Interview Guide

"What issues for your particular hospital come to mind with regard to implementing the following policies designed to limit surprise medical bills?"

1. A prohibition on balance billing by physicians, i.e. out-of-network providers are directly prohibited from billing insured patients beyond what their health plan pays.
2. Requiring a mediation or arbitration process between insurers and physicians to settle billing disputes.
3. A cost transparency requirement, i.e. hospitals must communicate the costs of out-of-network services to patients.
4. Standardizing payment rates for out-of-network providers, i.e. setting rates against some percentage of Medicare, or against a "usual and customary rate."
5. A "hold harmless" requirement, i.e. insurers are required to ensure that a patient will not be responsible for additional provider charges.
6. Regulating physician contracting; for example, a requirement for hospitals to sell a set "package" of emergency department services that insurance plans must purchase.

Institutional Review Board

Because the qualitative data did not require the use of protected health information and presented minimal risk of individual harm, "exempt" status was granted by the University of Washington Human Subjects Division.

Data Collection

Forty-five hospitals were contacted, and seven individuals agreed to participate; the overall response rate was approximately 15%. Five participants consented to their responses being audio recorded. For all interviews, including the two in which participants declined recording, contemporaneous notes were taken. From the five recorded interviews completed, four transcripts were generated, as one recording was unable to be preserved due to technical issues. Four organizations were identified as Washington state critical access hospitals[19]. Participants reported occupying both leadership and administrative positions; some participants held titles including chief executive officer and chief financial officer; other held executive roles relevant to quality, transformation, or network strategy.

Analysis

Data analysis was conducted on a continuous basis. Because analysis was performed by one interviewer, inter-rater reliability was not able to be assessed. An inductive approach was used to generate codes that represent recurring themes and concepts across participant responses. Because interview questions were designed to identify issues that may arise from a specific policy, responses were initially analyzed in the context of how they may bear on a particular aspect of a hospital's role, such as business operations, adaptation to the regulatory

environment, relationship with other stakeholders (including patients, physician groups, and insurance companies), and reputation in the local community. As additional interviews were conducted, coding evolved to describe the perspective elicited by an interview question. Final categories included factors perceived to serve as an obstacle to achieving a policy goal, factors perceived to lead to support for a policy goal, and factors perceived as a direct or indirect result following policy implementation (See "Qualitative Codebook" in Appendix).

RESULTS

From the resulting qualitative analysis of the interviews, three broad themes were identified that illustrate attitudes toward policy strategies intended to minimize balance bills: 1) a concern for the unintended consequences that may arise after implementation, 2) identification of significant barriers to successful implementation, and 3) identification of the negative impact of balance billing on consumers and hospital reputation as a motivating factor in exploring implementation.

Theme 1: When exploring specific policy solutions to limit balance bills in depth, there is concern for unintended consequences that may arise after implementation.

Washington state's Balance Billing Protection Act provides for a mechanism for arbitration between payers and providers in order to settle billing disputes, and responses from participants were mixed on the favorability of this, though in general the concept of excluding patients' involvement in such disputes was viewed favorably. Arbitration tended to be viewed as a pathway to increased business uncertainty; examples of this were offered, including a potential

change in the ability to anticipate future administrative costs, or a need to consider adjusting accounting methods. Other perceptions included a concern that regulatory changes would lead to increasing bureaucracy, or possibly give a negotiating party an incentive to delay finalizing of disputes for as long as possible:

> *"I get a lot of the patient complaints around billing; my fear is bureaucratic systems take a long time to arbitrate things. And so the long delays in reimbursement that may result from that will have an adverse impact on our cash flow, and also have an adverse impact on patients not knowing what their liabilities are going to be."*

> *"If any legislation around surprise billing could eliminate those bills, that's one thing. If it just adds a lot of bureaucratic infrastructure to the process of getting a bill paid, that will serve no one well."*

A concern for unintended consequences also arose when participants were asked to consider a potential "cost transparency requirement" that communicates network status for patients. One respondent voiced concern that such published information may eventually be used by consumers or consumer groups to pressure facilities to reduce their charges. Another concern raised was that cost transparency information could be used amongst organizations to effectively fix prices, and thus violate existing antitrust laws.

When considering legislation that may set standardized payment rates for healthcare services, concern was raised related to the potential to unintentionally create disincentives for physician groups to work at resource-limited hospitals; if standard rates for medical care were set too low, it may lead to assessments by physicians or physician groups - particularly specialists - that the cost of doing business exceeds reimbursement, and lead to withdrawal from network participation:

> *"An unintended consequence might be that people would look to see where they would be losing money and that would result in people that live in places like this having less access, to specialty care in particular."*

Another participant identified a potential for confusion if standardized rates differ across state lines; for example, if a radiologic exam was performed in Washington state, but interpreted by a physician in Idaho - as may be possible in certain aspects of healthcare using digital information - it may be unclear whether billing for the interpretation is subject to the same rate as where the test was performed.

When asked to consider issues related to a "hold harmless" legislative solution - where insurers can only apply and providers can only collect in-network cost sharing amounts - multiple respondents expressed a perception that while this policy can be beneficial to consumers in theory, stakeholders would find another way to compensate for a resulting change in revenue:

> *"I think that insurance companies are smart entities, and if you cut off their options in one way, they find another way to make it up."*

The final potential solution to balance bills considered by participants related to the novel concept of "bundling" payment for an emergency department encounter. Bundling has been used in limited hospital settings for several years, generally organized around a structured care episode, such as an admission for a hip replacement surgery, but has never been applied to unplanned episodes of care. Zachary Taylor et al. have done extensive research on balance bills and proposed this solution to emergency-related balance bills as a means of eliminating network disparities, and of avoiding the political challenges of addressing provider billing charges or network participation. This strategy instead regulates the form of contracting between hospitals and insurers in hopes of bringing costs closer to an appropriate market rate.

When this is proposed to participants, responses were varied but skewed toward skepticism. One described the prospect as "scary," citing uncertainty as a major concern, but also conceded this may be where the healthcare market is going. Multiple participants voiced concern related to the difficulty of predicting the extent of emergency services that may be required, set against a federal mandate to provide these services before verifying any ability to pay. Further uncertainty related to how funds from a standard rate may best be allocated (such as between the facility, provider and ancillary services). Finally, one respondent noted that such a practice may interfere with organizations' access to private negotiations in the public interest.

Theme 2: Implementation of policies designed to limit balance bills may face barriers.

A few specific issues were identified by hospital stakeholders as potential barriers to the effectiveness of proposed methods of avoiding balance bills. For example, while verification of insurance benefits and coverage is a standard part of hospital and insurer operations seen as

beneficial among all participants, the unpredictable nature of unplanned episodes of care (such as in emergency settings) make it difficult, if not impossible, to do so before treatment is provided. Furthermore, proactively determining provider network participation and cost information for consumers was generally seen as beneficial and not overly burdensome, including in both acute and elective settings, though some stakeholders did note potential limitations to complete information accuracy. One limitation spoke to significant variation of reimbursement rates between insurance plans, which theoretically may have an effect on the remaining balance owed by the consumer:

> *"What we get paid from [insurer] A…is different from what you may have been able to negotiate with [insurer] B for those same services."*

Another limitation is the feasibility of the consumer's ability to track provider network participation, and of insurers or facilities to successfully communicate real-time updates of network status changes. Furthermore, skepticism was expressed as to how many consumers would ultimately seek and use existing cost information to make a decision regarding where to seek care, as opposed to trusting the recommendation of a provider with whom they have a long-term relationship.

Theme 3: The potential for a negative impact on consumers, or on organizational reputation, is a motivating factor in seeking to avoid balance billing.

No participants expressed any opposition to or concerns with an outright ban on balance billing. A broad theme generated from interview responses was the priority to contract with as many insurance companies as possible to ensure adequate network status, which was informed at least in part by a desire to avoid balance billing. Many also identified "network concordance" with employed providers (defined as when providers participate in the same insurance networks that contract with the facility) as a clear priority. Among seven hospital stakeholders interviewed, six reported that their organizations currently achieve this by using a "singular contract" model, which stipulates that providers cannot decline to participate in insurance networks contracted with their facility. The seventh participant, representing a critical access hospital, reported that their hospital does contract with some non-employed ancillary and specialty providers, which creates the potential for network discordance, and reported ongoing organizational efforts to ensure network concordance that are considered important actions in avoiding balance bills.

Motivating factors these actions include a philosophy of a hospital's role as a "neighbor" among the population it serves, acknowledging value provided to consumers by having as broad an insurance network as possible, and an awareness of maintaining a positive reputation with the general public:

> *"When somebody walks into a hospital and they go into the radiology suite and they have a chest x-ray done…they have every expectation that the provider works for [us] and has the same billing practices as [us]."*

Participants also identified market power as a significant factor in ensuring physician and facility network alignment, indicating that a relative lack of physician supply, particularly specialists, may reduce leverage for rural hospitals to achieve this, and this was expressed by stakeholders who worked for both critical and non-critical access hospitals.

DISCUSSION

This research collected qualitative data that elicits the attitudes and perceptions of Washington state hospital stakeholders toward policy solutions intended to minimize balance bills. In addition to highlighting the challenges facilities face in navigating regulatory changes, the data also generates a more nuanced understanding of the relationship between healthcare stakeholders. As the healthcare system is commonly conceptualized as three broad interest groups - providers (including physicians), payers (including public and private insurance entities), and facilities (including hospitals) - that serve the needs of individual consumers, understanding relational aspects of the interplay between these groups may be of particular interest.

These findings suggest important considerations for policymakers. First, this qualitative data from these hospital stakeholders suggests that there is firm support for comprehensive legislation protecting consumers from balance bills. The general goal of avoiding balance billing has little opposition as evidenced by the responses of interview participants, demonstrating congruence with the published policy positions of state advocacy organizations. Because it applies to both emergency and non-emergency settings, multiple types of managed care plans, and provides for protection by means of both a “hold harmless” requirement and a prohibition on

balance billing, the Balance Billing Protection Act is considered comprehensive when compared to similar efforts in other states[8].

However, it will be important to evaluate whether these new regulations lead to additional bureaucratic or administrative burden for hospitals or create additional uncertainty that may have an adverse impact on future organizational decisions in the public interest. For example, the law does not contain a provision for any standardized payment rate, but rather depends upon arbitrated dispute resolution, which hospital stakeholders fear may lead to increased bureaucracy and financial uncertainty. Notably, the outcome of the arbitration process is not explicitly described in the law as legally binding, potentially creating legal uncertainty as well[8,9].

Finally, evaluating system-wide trends in healthcare costs following the law's implementation will be important as well, as there may be potential for an inadvertent increase in healthcare costs. Early data from New York state, which in 2015 implemented "baseball-style" arbitration as part of their own balance billing law, indicates that average arbitration amounts awarded thus far are significantly higher than in-network rates, which may potentially increase insurance premium rates[20].

Limitations

This research has several significant limitations, including a small overall sample size and response rate, and smaller sample size of participants consenting to audio recording for transcription generation. Furthermore, despite assurances of confidentiality, the inherently sensitive nature of the subject matter and the presence of an audio recorder likely leads to some

degree of response bias. Finally, the inductive approach and purposeful sampling technique suggests that the range of variation of responses is unable to be definitively known[21].

But there are some strengths. For one, little prior research has been conducted investigating the attitudes of individual hospital stakeholders toward policy responses to surprise medical bills, particularly among those affiliated with critical access hospitals. The qualitative nature of the research allowed for generating significantly richer and more nuanced data compared to quantitative or electronic survey data. This method also allowed individual respondents to share details of their own professional and personal experience beyond the policy positions of advocacy organizations representing hospital stakeholders in aggregate.

Future Research

Similar qualitative studies may elicit the perceptions of other healthcare stakeholders who will be affected by balance billing legislation, including clinicians who may frequently act as out-of-network providers, or individuals representing health insurance organizations. This would continue to inform a deeper understanding of the effects of billing policy changes on individuals who lead organizations through the challenges and uncertainty inherent in the healthcare economy and regulatory environment. Finally, the issue of insurance network discordance between a hospital and a provider or provider group, which can lead to unexpected out-of-network bills, was addressed briefly in most interviews. Research exploring the prevalence of this type of discordance, as well as the motivations and barriers to achieving concordant network participation among all providers and ancillary services within a hospital, may serve to identify further opportunities to strengthen insurance networks and reduce uncertainty for consumers.

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APPENDIX

A. Cover Letter to Respondents

Greetings,

I'm a candidate for the master's degree in public health at the University of Washington, and I'm reaching out to request an interview as part of my MPH thesis project. The thesis seeks to better understand attitudes and perceptions of Washington state hospital stakeholders toward policy strategies designed to reduce surprise medical bills. My thesis advisor is Dr. Clarence Spigner.

I'm interested in hearing the perspective of an individual in leadership or administration, perhaps one who is involved in policy or legislative affairs on behalf of your organization. The interview would be semi-structured, and generally related to the following question:

"What issues for your particular hospital come to mind with regard to implementing various strategies designed to limit surprise medical bills?"

With permission, the interview would be audio recorded, and I anticipate this would take approximately 15 minutes. All information gathered will be kept confidential and de-identified and analyzed in aggregate with other participants in order to identify general themes.
I appreciate your consideration, and I'm certainly glad to address any questions you might have.

Best,

Stephen Walston

B. Qualitative Codebook

Code	Description	Example
Barriers to success of a policy	Factors that are perceived as an obstacle to the success of a particular policy change. Does not apply to a perceived response to a policy change.	"Are we going to post all five costs for an appendectomy for all five of those anesthesia providers that might be out of network? Is that really going to be done in a way that a patient could actually understand it? Because I'm not really sure I understand it sometimes."
Motivation to support a policy	Factors perceived as a drive to support the intended end result of policy strategies to minimize balance bills.	"We're in a rural community…when I run into people in the community…you gotta be sensitive to that because you want to be in good faith in how you practice your billing."
Anticipated response to a policy	Factors that are perceived as a direct or indirect result of a proposed policy change. Can apply to an isolated or specific change, or to a more general "future state."	"An unintended consequence might be that people would look to see where they would be losing money and that would result in people that live in places like this having less access, to specialty care in particular."