Z-0369.2

HOUSE BILL 1117

State of Washington 65th Legislature 2017 Regular Session

By Representatives Cody, Caldier, Jinkins, Harris, McBride, Kilduff, and Tharinger; by request of Insurance Commissioner

Read first time 01/11/17. Referred to Committee on Health Care & Wellness.

AN ACT Relating to health care services balance billing; amending RCW 48.43.005, 48.43.093, and 48.43.515; adding new sections to chapter 48.43 RCW; prescribing penalties; and providing an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 48.43.005 and 2016 c 65 s 2 are each amended to read as follows:

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to

provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

(4) "Balance billing" means charging a covered person for health care services received by the covered person when the balance of the provider's fee is not fully reimbursed by the carrier, exclusive of permitted cost-sharing.

(5) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

((~~(5)~~)) (6) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(e).

((~~(6)~~)) (7) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

((~~(7)~~)) (8) "Board" means the governing board of the Washington health benefit exchange established in chapter 43.71 RCW.

((~~(8)~~)) (9)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

(i) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars, both amounts to be adjusted annually by the insurance commissioner; and

(ii) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least six thousand dollars, both amounts to be adjusted annually by the insurance commissioner.

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

((~~(9)~~)) (10) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

((~~(10)~~)) (11) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

((~~(11)~~)) (12) "Cost-sharing" means a copayment, coinsurance, deductible, or any other form of financial obligation of the covered person other than premium or share of premium, or any combination of any of these financial obligations.

(13) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

((~~(12)~~)) (14) "Dependent" means, at a minimum, the enrollee's legal spouse and dependent children who qualify for coverage under the enrollee's health benefit plan.

((~~(13)~~)) (15) "Emergency medical condition" means a medical or behavioral health condition manifesting itself by acute symptoms of

sufficient severity, including but not limited to severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical or behavioral health attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

((~~(14)~~)) (16) "Emergency services" means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

((~~(15)~~)) (17) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

((~~(16)~~)) (18) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(17)~~)) (19) "Exchange" means the Washington health benefit exchange established under chapter 43.71 RCW.

((~~(18)~~)) (20) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

((~~(19)~~)) (21) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

((~~(20)~~)) (22) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the

patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L. 111-152 (2010) is not subject to subtitles A or C of the act as amended.

((~~(21)~~)) (23) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

((~~(22)~~)) (24) "Health care facility" or "facility" means ((~~hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations~~)) any institution, place, building, or agency, or portion thereof, where health care services are provided. This includes, but is not limited to, hospitals, ambulatory surgical centers, clinics, outpatient surgery or care centers, laboratories and diagnostic centers, and specialized care centers, such as birthing centers and psychiatric care centers.

((~~(23)~~)) (25) "Health care provider" or "provider" means((~~:~~

~~(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or~~

~~(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment~~)) any health professional, health care facility, or other institution, organization, or person that furnishes any health care services to a covered person.

((~~(24)~~)) (26) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(25)~~)) (27) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

((~~(26)~~)) (28) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 or 48.83 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Coverage supplemental to the coverage provided under chapter 55, Title 10, United States Code;

(d) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(e) Disability income;

(f) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(g) Workers' compensation coverage;

(h) Accident only coverage;

(i) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

(j) Employer-sponsored self-funded health plans;

(k) Dental only and vision only coverage;

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner; and

(m) Civilian health and medical program for the veterans affairs administration (CHAMPVA).

((~~(27)~~)) (29) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

((~~(28)~~)) (30) "In-network provider" or "participating provider" means a provider that has a contract with a carrier or with a carrier's contractor or subcontractor and has agreed to provide health care services to covered persons with an expectation of receiving payment, other than enrollee cost-sharing, directly or indirectly from the carrier.

(31) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

((~~(29)~~)) (32) "Maximum out-of-pocket" means the most a covered person will have to pay for covered services in a plan year. After the covered person spends this amount on deductibles, copayments, and coinsurance, the covered person's carrier pays one hundred percent of the costs of covered benefits.

(33) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

((~~(30)~~)) (34) "Out-of-network provider" or "nonparticipating provider" means a provider that does not have a contract with a carrier or with a carrier's contractor or subcontractor to provide health care services.

(35) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(31)~~)) (36) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(32)~~)) (37) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service

contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

((~~(33)~~)) (38) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

((~~(34)~~)) (39) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being

subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

((~~(35)~~)) (40) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

((~~(36)~~)) (41) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

((~~(37)~~)) (42) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

Sec. 2. RCW 48.43.093 and 1997 c 231 s 301 are each amended to read as follows:

(1) When conducting a review of the necessity and appropriateness of emergency services or making a benefit determination for emergency services:

(a) A health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. In addition, a health carrier shall not require prior authorization of ((~~such~~)) emergency services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from ((~~a nonparticipating~~)) an out-of-network hospital emergency department, a health carrier shall cover emergency services necessary to screen and stabilize a covered person ((~~if a prudent layperson would have reasonably believed that use of a participating hospital emergency department would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider or facility~~)). In addition, a health carrier shall not require prior authorization of ((~~such~~)) the services provided prior to the point of stabilization ((~~if a prudent layperson acting reasonably would have believed that an emergency medical condition existed and that use of a~~

~~participating hospital emergency department would result in a delay that would worsen the emergency~~)).

(b) If an authorized representative of a health carrier authorizes coverage of emergency services, the health carrier shall not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health condition made by the provider of emergency services with the patient's knowledge and consent.

(c) Coverage of emergency services may be subject to applicable in-network copayments, coinsurance, and deductibles, ((~~and a health carrier may impose reasonable differential cost-sharing arrangements for emergency services rendered by nonparticipating providers, if such differential between cost-sharing amounts applied to emergency services rendered by participating provider versus nonparticipating provider does not exceed fifty dollars. Differential cost sharing for emergency services may not be applied when a covered person presents to a nonparticipating hospital emergency department rather than a participating hospital emergency department when the health carrier requires preauthorization for postevaluation or poststabilization emergency services if:~~

~~(i) Due to circumstances beyond the covered person's control, the covered person was unable to go to a participating hospital emergency department in a timely fashion without serious impairment to the covered person's health; or~~

~~(ii) A prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that he or she would be unable to go to a participating hospital emergency department in a timely fashion without serious impairment to the covered person's health~~)) as provided in sections 3 through 17 of this act.

((~~(d)~~)) (2) If a health carrier requires preauthorization for postevaluation or poststabilization services, the health carrier shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review. In order for postevaluation or poststabilization services to be covered by the health carrier, the provider or facility must make a documented good faith effort to contact the covered person's health carrier within thirty minutes of stabilization, if the covered person needs to be

stabilized. The health carrier's authorized representative is required to respond to a telephone request for preauthorization from a provider or facility within thirty minutes. Failure of the health carrier to respond within thirty minutes constitutes authorization for the provision of immediately required medically necessary postevaluation and poststabilization services, unless the health carrier documents that it made a good faith effort but was unable to reach the provider or facility within thirty minutes after receiving the request.

((~~(e)~~)) (3) A health carrier shall immediately arrange for an alternative plan of treatment for the covered person if ((~~a nonparticipating~~)) an out-of-network emergency provider and health plan cannot reach an agreement on which services are necessary beyond those immediately necessary to stabilize the covered person consistent with state and federal laws.

((~~(2)~~)) (4) Nothing in this section is to be construed as prohibiting the health carrier from requiring notification within the time frame specified in the contract for inpatient admission or as soon thereafter as medically possible but no less than twenty-four hours. Nothing in this section is to be construed as preventing the health carrier from reserving the right to require transfer of a hospitalized covered person upon stabilization. Follow-up care that is a direct result of the emergency must be obtained in accordance with the health plan's usual terms and conditions of coverage. All other terms and conditions of coverage may be applied to emergency services.

Sec. 3. RCW 48.43.515 and 2000 c 5 s 7 are each amended to read as follows:

(1) Each enrollee in a health plan must have adequate choice among health care providers.

(2) Each carrier must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. Enrollees also must be permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the enrollee's request for the change.

(3) Each carrier must have a process whereby an enrollee with a complex or serious medical or psychiatric condition may receive a

standing referral to a participating specialist for an extended period of time.

(4) Each carrier must provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted. If the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers.

(5) Each carrier shall provide enrollees with direct access to the participating chiropractor of the enrollee's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting enrollees to seeing only providers who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health services as stated in the plan's medical coverage agreement, with the exception of any provisions related to prior referral for services.

(6) Each carrier must provide, upon the request of an enrollee, access by the enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice.

(7) Each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the enrollees or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new enrollees to the terminated provider.

(8) Every carrier must include in all health care facility agreements a provision that the facility is required to provide in-network options for all health care services provided at the facility, unless the facility is unable to make available in-network options, in which event the carrier must require the facility to provide the following disclosure on the facility's web site:

(a) The names and hyperlinks for direct access to the web sites of all carriers for which the facility contracts as a network provider;

(b) A statement that:

(i) Services may be provided in the facility by in-network health care providers as well as by other health providers who are out-of-network providers and who may separately bill the covered person if no in-network provider is available at the time the health care services are either scheduled to be provided or actually provided to the covered person; and

(ii) Prospective covered persons should contact the health care provider who will provide services in the facility to determine which carriers the health care provider participates in as an in-network provider;

(c) As applicable, the names, mailing addresses, and telephone numbers of the health care providers with which the facility contracts to provide services in the facility, and instructions on how to contact the health care providers to determine which carriers the health care provider participates in as an in-network provider.

(9) Every carrier shall meet the standards set forth in this section and any rules adopted by the commissioner to implement this section. In developing rules to implement this section, the commissioner shall consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 4.** This subchapter may be known and cited as the balance billing protection act.

NEW SECTION. **Sec. 5.** (1) This subchapter provides for the protection of consumers against balance billing for emergency and other health care services when:

(a) Emergency health care services are provided to a covered person; or

(b) Health care services are provided to a covered person at an in-network facility, but are provided by an out-of-network provider when no in-network provider is available to provide the health care services.

(2) This subchapter shall be liberally construed to promote the public interest in protecting consumers of health care insurance to

ensure that consumers are not billed out-of-network charges or receive additional bills from providers in the circumstances described in this subchapter.

NEW SECTION. **Sec. 6.** (1) When a covered person utilizes emergency health care services provided by an out-of-network provider, then (a) the carrier, (b) the out-of-network provider, (c) any person acting on the behalf of any of these persons, or (d) assignees of debt of any of these persons, or any combination of (a) through (d) of this subsection, must ensure that the covered person will incur no greater cost-sharing than the covered person would have incurred with an in-network provider for covered emergency health care services.

(2) Payment for emergency health care services provided under this section are subject to sections 8 through 12 of this act.

NEW SECTION. **Sec. 7.** (1) When a covered person uses an in-network health care facility or arranges for care at an in-network health care facility and, the health care facility has not given the notice required by RCW 48.43.515(8) or the facility has given the required notice but no in-network provider is available to provide the health care services at the time the health care services are either scheduled to be provided or actually provided and the health care services are provided by an out-of-network provider, then (a) the carrier, (b) the in-network provider, (c) the out-of-network provider, (d) any person acting on the behalf of any of these persons, or (e) assignees of debt of any of these persons, or any combination of (a) through (e) of this subsection must ensure that the covered person will incur no greater cost-sharing than the covered person would have incurred with an in-network provider for covered health care services.

(2) Payment for health care services provided under this section are subject to sections 8 through 12 of this act.

NEW SECTION. **Sec. 8.** (1) Before billing a covered person, the out-of-network provider must request from the carrier, and the carrier must provide to the provider within sixty days, a written explanation of benefits that specifies the applicable in-network cost-sharing amounts owed by the covered person. The out-of-network provider, or any health care facility, or both, may not hold the

covered person financially responsible for any amount in excess of any cost-sharing amounts that would have been required if the health care service had been rendered by an in-network provider.

(2) To determine the in-network cost-sharing amount for out-of-network provider's services, the carriers will use one hundred twenty-five percent of the amount medicare would reimburse for similar services to substitute as its contract rate, or by another method established by the commissioner by rule. If there is more than one level of cost-sharing, the cost-sharing amount most beneficial to the covered person must be used.

(3) No provider, agent, trustee, or assignee thereof, may maintain any action at law against a covered person to collect sums of money owed in excess of any cost-sharing amounts as detailed by the carrier.

NEW SECTION. **Sec. 9.** (1) If a covered person receives health care services under either section 6 or 7 of this act, or both, the following applies:

(a) Any cost-sharing paid by the covered person for health care services provided by an out-of-network provider counts toward the limit on in-network maximum out-of-pocket expenses of the covered person;

(b) Cost-sharing arising from health care services received from an out-of-network provider must be counted toward any cost-sharing in the same manner as cost-sharing would be attributable to health care services provided by an in-network provider; and

(c) The cost-sharing paid by the covered person under this subchapter satisfies the covered person's obligation to pay for the health care services.

(2) If there is more than one level of cost-sharing, the cost-sharing amount most beneficial to the covered person must be used.

NEW SECTION. **Sec. 10.** (1) An out-of-network provider may not attempt to collect from a covered person any amount greater than the covered person's in-network cost-sharing amount, as determined in accordance with this subchapter or actually owed by the covered person under their health plan, whichever is less.

(2) The out-of-network provider, or any person acting on its behalf, including any assignee of the debt, may not report adverse information to a consumer credit reporting agency or commence any

civil action against the covered person before the expiration of one hundred fifty days after the initial billing regarding the amount owed by the covered person under this section.

(3) The out-of-network provider, or any person acting on its behalf, may not use wage garnishments or liens on the primary residence of the covered person as a means of collecting unpaid bills under this section.

(4) If an out-of-network provider or carrier has received from a covered person more than the in-network cost-sharing amount, the provider or carrier must refund any amount in excess of the in-network cost-sharing amount to the covered person within thirty business days of receipt. Interest must be paid to the covered person for any unrefunded payments at a rate of twelve percent interest beginning on the first calendar day after the thirty business days.

NEW SECTION. **Sec. 11.** (1) For emergency health care services provided to a covered person by an out-of-network provider under section 6 of this act:

(a) If the amount billed by the out-of-network provider is three hundred dollars or less, the carrier must pay the amount billed; or

(b) If the amount billed by the out-of-network provider is greater than three hundred dollars, then the carrier must pay the provider the greater of: (i) The average contracted rate, (ii) one hundred twenty-five percent of the amount medicare would reimburse on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered, or (iii) three hundred dollars.

(2) For health care services provided to a covered person by an out-of-network provider under section 7 of this act:

(a) The carrier must pay to the out-of-network provider the greater of (i) the average contracted rate, or (ii) one hundred twenty-five percent of the amount medicare would reimburse on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.

(b) By January 1, 2019, the commissioner will specify a methodology for "average contracted rate" based on data submitted by carriers.

(3) The payment by the carrier to the out-of-network provider must be made within the time limits for payment of claims applicable to the payment of in-network claims.

(4) Payment under this section does not preclude a provider from seeking additional payment from the carrier under section 12 of this act.

NEW SECTION. **Sec. 12.** For any dispute involving balance billing in excess of the amount paid to the out-of-network provider under section 11 of this act, which is not otherwise resolved by the other provisions of this subchapter, the following dispute resolution process must be followed:

(1) If the payment to the out-of-network provider does not result in a resolution of the payment dispute within thirty days after receipt of written explanation of benefits by the carrier, then the carrier or out-of-network provider may initiate binding arbitration to determine payment for services provided on a per bill basis. The party requesting arbitration must notify the other party arbitration has been initiated and state its final offer before the arbitration process begins. In response to this notice, the nonrequesting party must inform the requesting party of its final offer before materials are submitted to the arbitrator. Arbitration must be initiated by filing a request with the commissioner no later than ninety days after receipt of written explanation of benefits by the carrier.

(2) The commissioner will provide a list of approved arbitrators or entities that provide binding arbitration. These arbitrators must be American arbitration association or American health lawyers association trained arbitrators. Both parties must agree on an arbitrator from the commissioner's list of arbitrators. If no agreement can be reached, then a list of five arbitrators will be provided by the commissioner. From the list of five arbitrators, the carrier can veto two arbitrators and the out-of-network provider can veto two arbitrators. If one arbitrator remains, under this process or by the agreement of the parties, that arbitrator is the chosen arbitrator. If more than one arbitrator remains, the commissioner will choose the arbitrator from the remaining arbitrators. This process must be completed by the parties within twenty days.

(3) Both parties must make written submissions, such as arguments and evidence, supporting their position to the arbitrator within thirty days after the request for arbitration is filed with the commissioner. The arbitration must consist of a review of the written submissions by both parties. Binding arbitration must provide for a written decision that must be issued within thirty days after the

written submissions are provided to the arbitrator. In determining the amount that the carrier must pay the out-of-network provider, the arbitrator must select either the carrier's payment amount or the out-of-network provider's payment amount. Both parties are bound by the arbitrator's decision, which is final and not subject to appeal. The arbitrator's expenses and fees, together with other expenses, not including attorneys' fees, incurred in the conduct of the arbitration, must be paid as provided in the decision. RCW 48.43.055 does not apply to complaints arbitrated under this section.

(4) Upon motion or by agreement of the parties to the arbitration, the arbitrator may consolidate multiple disputes for resolution in a single arbitration proceeding, provided that the parties are identical for each dispute, and provided that the consolidation does not violate the other requirements of this section.

(5) The covered person is not liable for any of the costs of the arbitration, and may not be required to participate as a witness or otherwise in the arbitration proceeding.

NEW SECTION. **Sec. 13.** (1) If the commissioner has cause to believe that any person is violating any provision of this subchapter, the commissioner may order the person to cease and desist.

(2) If any person violates or has violated any provision of this subchapter, in addition to or in lieu of any order to cease and desist, the commissioner may levy a fine upon the person in an amount not to exceed one thousand dollars per violation.

(3) If any provision of this subchapter is violated, the commissioner may take other or additional action as is permitted under this title for a violation of this title.

NEW SECTION. **Sec. 14.** The commissioner may adopt rules to implement and administer this subchapter including, but not limited to, rules for arbitration and dispute resolution, to establish a different cost-sharing amount to be paid by the covered person, and payment by the carrier to the provider based upon the all payer claims database when the database has collected eighty percent of the commercial market data, or other method established by the commissioner.

NEW SECTION. **Sec. 15.** The legislature finds that the practices covered by this subchapter are matters vitally affecting the public interest for the purpose of applying the consumer protection act, chapter 19.86 RCW. A violation of this subchapter is not reasonable in relation to the development and preservation of business and is an unfair or deceptive act in trade or commerce and an unfair method of competition for the purpose of applying the consumer protection act, chapter 19.86 RCW.

NEW SECTION. **Sec. 16.** Sections 4 through 15 of this act are each added to chapter 48.43 RCW and codified with the subchapter heading of "health care services balance billing."

NEW SECTION. **Sec. 17.** This act takes effect January 1, 2018.

NEW SECTION. **Sec. 18.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

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