ENGROSSED SUBSTITUTE HOUSE BILL 2114

State of Washington 65th Legislature 2017 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Cody and Pollet; by request of Insurance Commissioner)

READ FIRST TIME 02/17/17.

AN ACT Relating to protecting consumers from charges for out-of-network health services; amending RCW 48.43.005, 48.43.093, and 41.05.017; adding new sections to chapter 48.43 RCW; prescribing penalties; providing an effective date; and providing an expiration 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 bill" means a bill sent to a covered person by an out-of-network provider or facility for health care services provided to the covered person after the provider or facility's billed amount 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) "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)~~)) (13) "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)~~)) (14) "Emergency medical condition" means a medical, mental health, or substance use disorder 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, mental health, or substance use disorder treatment 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)~~)) (15) "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)~~)) (16) "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)~~)) (17) "Enrollee point-of-service cost-sharing" or "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)~~)) (18) "Episode of care" means health care services provided to a covered person after the covered person is admitted to, and before the covered person is discharged from, a health care facility.

(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.

((~~(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.

((~~(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) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to covered persons

with the expectation of receiving reimbursement from the carrier at specified levels as payment in full for the health care services.

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

((~~(28)~~)) (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) "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)~~)) (33) "Out-of-network" or "nonparticipating" means a provider or facility that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to covered persons.

(34) "Out-of-pocket maximum" means the maximum amount a covered person is required to pay in the form of cost-sharing for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

(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 16 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.

NEW SECTION. **Sec. 3.** This subchapter may be known and cited as the balance billing protection act.

NEW SECTION. **Sec. 4.** (1) An out-of-network provider or facility may not balance bill a covered person for the following health care services:

(a) Emergency services provided to a covered person; and

(b) Nonemergency health care services provided to a covered person at an in-network hospital licensed under chapter 70.41 RCW or an in-network ambulatory surgical facility licensed under chapter 70.230 RCW if the services:

(i) Involve surgical or ancillary services; and

(ii) Are provided by an out-of-network provider because an in-network provider was unavailable or the need for the services arose at the time the services were rendered and was unforeseen.

(2) Payment for services described in subsection (1) of this section is subject to sections 5 through 7 of this act.

(3) For purposes of this subchapter, "surgical or ancillary services" means surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

NEW SECTION. **Sec. 5.** (1)(a) Before billing a covered person for in-network cost-sharing for the services described in section 4 of this act, an out-of-network provider or facility must request that the carrier provide a written explanation of benefits specifying the applicable in-network cost-sharing amounts owed by the covered person. The carrier must provide the explanation of benefits within sixty days of the provider's or facility's request.

(b) A carrier must calculate the in-network cost-sharing amount for the out-of-network provider's or facility's services using the carrier's median contracted rate for similar services in the geographic area where the services were provided. If there is more than one level of cost-sharing, the carrier must use the cost-sharing amount most beneficial to the covered person.

(2) If a covered person receives emergency or nonemergency health care services under the circumstances described in section 4 of this act:

(a) The covered person satisfies his or her obligation to pay for the health care services if he or she pays the in–network cost-sharing amount specified in the carrier's explanation of benefits;

(b) A carrier, out-of-network provider, or out-of-network facility, and an agent, trustee, or assignee of a carrier, out-of-network provider, or out-of-network facility:

(i) Must ensure that the covered person incurs no greater cost than he or she would have incurred if the services had been provided by an in-network provider or at an in-network facility;

(ii) May not balance bill or otherwise attempt to collect from the covered person any amount greater than the in-network cost-sharing amount specified in the carrier's explanation of benefits;

(iii) May not report adverse information to a consumer credit reporting agency or commence a civil action against the covered person before the expiration of one hundred fifty days after the initial billing for the amount owed by the covered person under this section; and

(iv) 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;

(c) The carrier must treat any cost-sharing amounts paid by the covered person for such services in the same manner as cost-sharing for health care services provided by an in-network provider and must apply any cost-sharing amounts paid by the covered person for such

services toward the limit on the covered person's in-network out-of-pocket maximum expenses;

(d) If the covered person pays the out-of-network provider, out-of-network facility, or carrier an amount that exceeds the in-network cost-sharing amount specified in the carrier's explanation of benefits, the provider, facility, 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 beginning on the first calendar day after the thirty business days.

NEW SECTION. **Sec. 6.** (1) Upon receipt of an out-of-network provider or facility's bill for health care services described in section 4 of this act, the carrier must make payment directly to the provider or facility, rather than the covered person.

(2)(a) If the billed amount is less than three hundred dollars, the carrier must pay the out-of-network provider or facility the full billed amount.

(b) If the billed amount is more than three hundred dollars, the carrier and the out-of-network provider or facility may agree to resolve the payment dispute:

(i) Using the dispute resolution process described in section 7 of this act if the amount in dispute is two thousand dollars or more; or

(ii) Using mediation. If the amount in dispute is less than two thousand dollars, mediation expenses, not including attorneys' fees, must be divided equally among the carrier, the out-of-network provider who provided the health care services, and the in-network or out-of-network facility at which the services were provided. The provisions of chapter 7.07 RCW apply to mediations conducted under this subsection.

NEW SECTION. **Sec. 7.** (1)(a) A carrier, out-of-network provider, or out-of-network facility may initiate arbitration to resolve a payment dispute if the requirements described in section 6 of this act are met. Each arbitration proceeding may not involve more than one episode of care or more than one out-of-network provider or facility. The arbitrator may not consolidate multiple disputes for resolution in a single arbitration proceeding.

(b) To initiate arbitration, the carrier, provider, or facility must file a request with the commissioner no later than ninety days after the provider's or facility's receipt of the written explanation of benefits under section 5 of this act. The party requesting arbitration must provide the nonrequesting party with a written notification that arbitration has been initiated. The notification must state the requesting party's final offer. No later than thirty days following receipt of the notification, the nonrequesting party must provide its final offer to the requesting party.

(2)(a) Once the requesting party has filed a request for arbitration with the commissioner, the commissioner must provide the parties with a list of approved arbitrators or entities that provide binding arbitration. The arbitrators on the list must be trained by the American arbitration association or the American health lawyers association.

(b) To select an arbitrator, the parties may agree on an arbitrator from the list provided by the commissioner. If the parties do not agree on an arbitrator, the commissioner must provide the parties with the names of five arbitrators from the list. Each party may veto two of the five named arbitrators. If one arbitrator remains, that person is the chosen arbitrator. If more than one arbitrator remains, the commissioner must choose the arbitrator from the remaining arbitrators. The parties and the commissioner must complete this process within twenty days of receipt of the list from the commissioner.

(3)(a) Each party must make written submissions to the arbitrator in support of its position no later than thirty days after the request for arbitration is filed with the commissioner. No later than thirty days after the receipt of the parties' written submissions, the arbitrator must: Issue a written decision requiring payment of the final offer amount of either the requesting party or the nonrequesting party; notify the parties of its decision; and provide the decisions and the information described in section 8 of this act regarding the decision to the commissioner.

(b) In reviewing the submissions of the parties and making a decision related to the appropriate amount to be paid to the out-of-network provider or facility, the arbitrator must consider the following factors:

(i) Whether there is a gross disparity between the amount charged by the out-of-network provider or facility and: (A) Amounts paid to

the provider or facility for the same services provided to other patients by carriers with respect to which the provider or facility is out-of-network; and (B) the amounts paid by the carrier to reimburse similarly qualified out-of-network providers or facilities for the same services in the same region;

(ii) The circumstances and complexity of the case; and

(iii) Patient characteristics.

(4) Expenses incurred in the course of arbitration, including the arbitrator's expenses and fees, but not including attorneys' fees, must be paid by the party whose final offer was rejected by the arbitrator.

(5) The parties must enter into a nondisclosure agreement to protect any personal health information or fee information provided to the arbitrator.

(6) Chapter 7.04A RCW applies to arbitrations conducted under this section, but in the event of a conflict between this section and chapter 7.04A RCW, this section governs.

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

NEW SECTION. **Sec. 8.** (1) The commissioner must prepare an annual report summarizing the dispute resolution information provided by arbitrators under section 7 of this act. The report must include summary information related to the matters decided through arbitration, as well as the following information for each dispute resolved through arbitration: The carrier; the health care provider; the health care provider's employer or the business entity in which the provider has an ownership interest; the health care facility where the services were provided; and the type of health care services at issue.

(2) The commissioner must post the report on the office of the insurance commissioner's web site and submit it to the relevant committees of the legislature annually by July 1st.

(3) This section expires January 1, 2023.

NEW SECTION. **Sec. 9.** The office of the insurance commissioner, in consultation with carriers, health care providers, health care facilities, and consumers, must develop standard template language for notifying consumers that they may not be balance billed for

health care services under the circumstances described in section 4 of this act. The standard template language must include contact information for the office of the insurance commissioner so that consumers may contact the office of the insurance commissioner if they believe they have received a balance bill in violation of this subchapter.

NEW SECTION. **Sec. 10.** (1) A nonemployed provider group that provides surgical or ancillary services at a hospital or ambulatory surgical facility must notify the hospital or ambulatory surgical facility of the carriers with which the provider group contracts. The provider group must notify the hospital or ambulatory surgical facility if the contract between the provider group and a carrier will be terminated. The provider group must provide the notice as soon as practicable, but in no case less than forty-five days prior to termination of the contract.

(2) A hospital or ambulatory surgical facility must post the following information on its web site:

(a) A list of the carriers with which the hospital or ambulatory surgical facility contracts; and

(b) For each nonemployed provider group with which the hospital or ambulatory surgical facility has a contract to provide surgical or ancillary services, whether the provider group contracts with the same carriers as the hospital or ambulatory surgical facility.

(3) On a quarterly basis, a hospital or ambulatory surgical facility must provide a notice to each carrier with which it contracts regarding the network status of its contracted provider groups. The notice must include, for each type of surgical or ancillary service, whether at least seventy-five percent of the nonemployed providers providing the service in the facility were in-network with the carrier during the previous three months. If the seventy-five percent threshold is not met, the carrier must treat the facility as out-of-network for services other than emergency services, unless the facility notifies the carrier that the seventy-five percent threshold has been met. The carrier must notify the commissioner if it determines that the seventy-five percent threshold has not been met.

(4) When a patient is scheduled for nonemergency health care services, a hospital or ambulatory surgical facility must provide the

patient with notice as required by this subsection at least ten days prior to the scheduled admission or outpatient service.

(a) If the facility is an in-network facility with respect to the patient's health plan, the notice must:

(i) Advise the patient that he or she may request that the facility provide only in-network providers;

(ii) Disclose the names and contact information for any providers who will provide surgical or ancillary services and indicate whether each provider is in-network or out-of-network with respect to the patient's health plan;

(iii) Advise the patient of his or her rights under this subchapter using the standard template language developed under section 9 of this act; and

(iv) Provide an estimated range of the cost of services with a disclaimer that the estimate does not account for permitted cost-sharing and that the patient should contact his or her health plan for additional information regarding applicable cost-sharing requirements.

(b) If the facility is an out-of-network facility with respect to the patient's health plan, the notice must:

(i) Advise the patient that the facility is an out-of-network facility and that the patient may choose to obtain the services at an in-network facility;

(ii) Advise the patient that he or she will have the financial responsibility applicable to services provided at an out-of-network facility in excess of applicable cost-sharing amounts and that the patient may be responsible for any costs in excess of those allowed by the health plan;

(iii) Provide an estimated range of the cost of services and advise the patient to contact the carrier for further consultation on those costs; and

(iv) Inform the patient that he or she may qualify for a discount for some or all of the facility's bill, regardless of insurance status, and that the patient should contact the facility's financial assistance office.

(c) If the facility's network status with respect to the patient's health plan changes after the provision of the notice required by this section and before the services are provided, the facility must promptly notify the patient of the change.

NEW SECTION. **Sec. 11.** (1) A health care provider must provide information on its web site listing the carriers with which the provider contracts.

(2) An in-network provider must submit accurate information to a carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier.

(3) When a patient is scheduled for nonemergency health care services at an out-of-network hospital or ambulatory surgical facility, a health care provider must provide the patient with notice as required by this subsection if the provider is out-of-network with respect to the patient's health plan. The provider must provide the notice at least ten days prior to the scheduled admission or outpatient service. The notice must:

(a) Disclose that the provider is out-of-network with respect to the patient's health plan;

(b) Advise the patient that he or she may seek other alternatives, including an in-network provider;

(c) Advise the patient that because he or she will be receiving health care services at an out-of-network facility, he or she will have the financial responsibility applicable to services provided outside the health plan's network in excess of applicable cost-sharing amounts and that the patient may be responsible for any costs in excess of those allowed by the health plan; and

(d) Provide an estimated range of the cost of services and the estimated amount that the provider may bill the patient and advise the patient to contact his or her carrier for further consultation regarding those costs.

NEW SECTION. **Sec. 12.** (1) A carrier must update its web site and provider directory no later than thirty days after the addition or termination of a facility or provider, so long as the carrier had notice of the change.

(2) A carrier must provide a covered person with:

(a) A clear description of the health plan's out-of-network health benefits;

(b) Notice of rights under this subchapter using the standard template language developed under section 9 of this act;

(c) Notification that if the covered person receives services from an out-of-network provider or facility, under circumstances

other than those described in section 4 of this act, the covered person will have the financial responsibility applicable to services provided outside the health plan's network in excess of applicable cost-sharing amounts and that the covered person may be responsible for any costs in excess of those allowed by the health plan;

(d) Information on how to use the carrier's member transparency tools under RCW 48.43.007;

(e) Upon request, information regarding whether a health care provider is in-network or out-of-network; and

(f) Upon request, an estimated range of the out-of-pocket costs for an out-of-network benefit.

NEW SECTION. **Sec. 13.** (1) If the commissioner has cause to believe that any person, including a health care provider, hospital, or ambulatory surgical facility, is violating a provision of this subchapter, the commissioner may order the person to cease and desist.

(2) If any person, including a health care provider, hospital, or ambulatory surgical facility, violates or has violated a provision of this subchapter, the commissioner may levy a fine upon the person in an amount not to exceed one thousand dollars per violation and take other action as 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 rules governing the dispute resolution process established in section 7 of this act.

NEW SECTION. **Sec. 15.** This subchapter does not apply to health plans that provide benefits under chapter 74.09 RCW.

NEW SECTION. **Sec. 16.** This subchapter must be liberally construed to promote the public interest by ensuring that consumers are not billed out-of-network charges and do not receive additional bills from providers under the circumstances described in section 4 of this act.

Sec. 17. RCW 41.05.017 and 2016 c 139 s 4 are each amended to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545, 48.43.550, 70.02.110, 70.02.900, 48.43.190, ((~~and~~)) 48.43.083, and sections 3 through 16 of this act.

NEW SECTION. **Sec. 18.** Sections 3 through 16 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. 19.** This act takes effect January 1, 2018.

NEW SECTION. **Sec. 20.** 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.

--- END ---