

SHB 2114 - H AMD 266

By Representative Schmick

NOT CONSIDERED 01/05/2018

1 Strike everything after the enacting clause and insert the
2 following:

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

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

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

12 (2) "Adverse benefit determination" means a denial, reduction, or
13 termination of, or a failure to provide or make payment, in whole or
14 in part, for a benefit, including a denial, reduction, termination,
15 or failure to provide or make payment that is based on a
16 determination of an enrollee's or applicant's eligibility to
17 participate in a plan, and including, with respect to group health
18 plans, a denial, reduction, or termination of, or a failure to
19 provide or make payment, in whole or in part, for a benefit resulting
20 from the application of any utilization review, as well as a failure
21 to cover an item or service for which benefits are otherwise provided
22 because it is determined to be experimental or investigational or not
23 medically necessary or appropriate.

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

27 (4) "Balance bill" means a bill sent to a covered person by an
28 out-of-network provider or facility for health care services provided
29 to the covered person after the provider or facility's billed amount
30 is not fully reimbursed by the carrier, exclusive of permitted cost-
31 sharing.

1 (5) "Basic health plan" means the plan described under chapter
2 70.47 RCW, as revised from time to time.

3 ~~((+5))~~ (6) "Basic health plan model plan" means a health plan as
4 required in RCW 70.47.060(2)(e).

5 ~~((+6))~~ (7) "Basic health plan services" means that schedule of
6 covered health services, including the description of how those
7 benefits are to be administered, that are required to be delivered to
8 an enrollee under the basic health plan, as revised from time to
9 time.

10 ~~((+7))~~ (8) "Board" means the governing board of the Washington
11 health benefit exchange established in chapter 43.71 RCW.

12 ~~((+8))~~ (9)(a) For grandfathered health benefit plans issued
13 before January 1, 2014, and renewed thereafter, "catastrophic health
14 plan" means:

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

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

29 (b) In July 2008, and in each July thereafter, the insurance
30 commissioner shall adjust the minimum deductible and out-of-pocket
31 expense required for a plan to qualify as a catastrophic plan to
32 reflect the percentage change in the consumer price index for medical
33 care for a preceding twelve months, as determined by the United
34 States department of labor. For a plan year beginning in 2014, the
35 out-of-pocket limits must be adjusted as specified in section
36 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount
37 shall apply on the following January 1st.

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

1 (i) A health benefit plan that meets the definition of
2 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
3 2010, as amended; or

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

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

15 ~~((10))~~ (11) "Concurrent review" means utilization review
16 conducted during a patient's hospital stay or course of treatment.

17 ~~((11))~~ (12) "Covered person" or "enrollee" means a person
18 covered by a health plan including an enrollee, subscriber,
19 policyholder, beneficiary of a group plan, or individual covered by
20 any other health plan.

21 ~~((12))~~ (13) "Dependent" means, at a minimum, the enrollee's
22 legal spouse and dependent children who qualify for coverage under
23 the enrollee's health benefit plan.

24 ~~((13))~~ (14) "Emergency medical condition" means a medical,
25 mental health, or substance use disorder condition manifesting itself
26 by acute symptoms of sufficient severity~~((7))~~ including, but not
27 limited to, severe pain or emotional distress, such that a prudent
28 layperson, who possesses an average knowledge of health and medicine,
29 could reasonably expect the absence of immediate medical, mental
30 health, or substance use disorder treatment attention to result in a
31 condition (a) placing the health of the individual, or with respect
32 to a pregnant woman, the health of the woman or her unborn child, in
33 serious jeopardy, (b) serious impairment to bodily functions, or (c)
34 serious dysfunction of any bodily organ or part.

35 ~~((14))~~ (15) "Emergency services" means a medical screening
36 examination, as required under section 1867 of the social security
37 act (42 U.S.C. 1395dd), that is within the capability of the
38 emergency department of a hospital, including ancillary services
39 routinely available to the emergency department to evaluate that
40 emergency medical condition, and further medical examination and

1 treatment, to the extent they are within the capabilities of the
2 staff and facilities available at the hospital, as are required under
3 section 1867 of the social security act (42 U.S.C. 1395dd) to
4 stabilize the patient. Stabilize, with respect to an emergency
5 medical condition, has the meaning given in section 1867(e)(3) of the
6 social security act (42 U.S.C. 1395dd(e)(3)).

7 ~~((15))~~ (16) "Employee" has the same meaning given to the term,
8 as of January 1, 2008, under section 3(6) of the federal employee
9 retirement income security act of 1974.

10 ~~((16))~~ (17) "Enrollee point-of-service cost-sharing" or "cost-
11 sharing" means amounts paid to health carriers directly providing
12 services, health care providers, or health care facilities by
13 enrollees and may include copayments, coinsurance, or deductibles.

14 ~~((17))~~ (18) "Episode of care" means health care services
15 provided to a covered person after the covered person is admitted to,
16 and before the covered person is discharged from, a health care
17 facility.

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

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

23 ~~((19))~~ (21) "Final internal adverse benefit determination"
24 means an adverse benefit determination that has been upheld by a
25 health plan or carrier at the completion of the internal appeals
26 process, or an adverse benefit determination with respect to which
27 the internal appeals process has been exhausted under the exhaustion
28 rules described in RCW 48.43.530 and 48.43.535.

29 ~~((20))~~ (22) "Grandfathered health plan" means a group health
30 plan or an individual health plan that under section 1251 of the
31 patient protection and affordable care act, P.L. 111-148 (2010) and
32 as amended by the health care and education reconciliation act, P.L.
33 111-152 (2010) is not subject to subtitles A or C of the act as
34 amended.

35 ~~((21))~~ (23) "Grievance" means a written complaint submitted by
36 or on behalf of a covered person regarding service delivery issues
37 other than denial of payment for medical services or nonprovision of
38 medical services, including dissatisfaction with medical care,
39 waiting time for medical services, provider or staff attitude or

1 demeanor, or dissatisfaction with service provided by the health
2 carrier.

3 ~~((22))~~ (24) "Health care facility" or "facility" means hospices
4 licensed under chapter 70.127 RCW, hospitals licensed under chapter
5 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,
6 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
7 licensed under chapter 18.51 RCW, community mental health centers
8 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
9 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
10 treatment, or surgical facilities licensed under chapter 70.41 RCW,
11 drug and alcohol treatment facilities licensed under chapter 70.96A
12 RCW, and home health agencies licensed under chapter 70.127 RCW, and
13 includes such facilities if owned and operated by a political
14 subdivision or instrumentality of the state and such other facilities
15 as required by federal law and implementing regulations.

16 ~~((23))~~ (25) "Health care provider" or "provider" means:

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

20 (b) An employee or agent of a person described in (a) of this
21 subsection, acting in the course and scope of his or her employment.

22 ~~((24))~~ (26) "Health care service" means that service offered or
23 provided by health care facilities and health care providers relating
24 to the prevention, cure, or treatment of illness, injury, or disease.

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

31 ~~((26))~~ (28) "Health plan" or "health benefit plan" means any
32 policy, contract, or agreement offered by a health carrier to
33 provide, arrange, reimburse, or pay for health care services except
34 the following:

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

37 (b) Medicare supplemental health insurance governed by chapter
38 48.66 RCW;

39 (c) Coverage supplemental to the coverage provided under chapter
40 55, Title 10, United States Code;

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

3 (e) Disability income;

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

7 (g) Workers' compensation coverage;

8 (h) Accident only coverage;

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

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

14 (k) Dental only and vision only coverage;

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

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

24 ~~((+27))~~ (29) "In-network" or "participating" means a provider or
25 facility that has contracted with a carrier or a carrier's contractor
26 or subcontractor to provide health care services to covered persons
27 with the expectation of receiving reimbursement from the carrier at
28 specified levels as payment in full for the health care services.

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

32 ~~((+28))~~ (31) "Material modification" means a change in the
33 actuarial value of the health plan as modified of more than five
34 percent but less than fifteen percent.

35 ~~((+29))~~ (32) "Open enrollment" means a period of time as defined
36 in rule to be held at the same time each year, during which
37 applicants may enroll in a carrier's individual health benefit plan
38 without being subject to health screening or otherwise required to
39 provide evidence of insurability as a condition for enrollment.

1 ~~((+30))~~ (33) "Out-of-network" or "nonparticipating" means a
2 provider or facility that has not contracted with a carrier or a
3 carrier's contractor or subcontractor to provide health care services
4 to covered persons.

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

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

13 ~~((+31))~~ (36) "Premium" means all sums charged, received, or
14 deposited by a health carrier as consideration for a health plan or
15 the continuance of a health plan. Any assessment or any "membership,"
16 "policy," "contract," "service," or similar fee or charge made by a
17 health carrier in consideration for a health plan is deemed part of
18 the premium. "Premium" shall not include amounts paid as enrollee
19 point-of-service cost-sharing.

20 ~~((+32))~~ (37) "Review organization" means a disability insurer
21 regulated under chapter 48.20 or 48.21 RCW, health care service
22 contractor as defined in RCW 48.44.010, or health maintenance
23 organization as defined in RCW 48.46.020, and entities affiliated
24 with, under contract with, or acting on behalf of a health carrier to
25 perform a utilization review.

26 ~~((+33))~~ (38) "Small employer" or "small group" means any person,
27 firm, corporation, partnership, association, political subdivision,
28 sole proprietor, or self-employed individual that is actively engaged
29 in business that employed an average of at least one but no more than
30 fifty employees, during the previous calendar year and employed at
31 least one employee on the first day of the plan year, is not formed
32 primarily for purposes of buying health insurance, and in which a
33 bona fide employer-employee relationship exists. In determining the
34 number of employees, companies that are affiliated companies, or that
35 are eligible to file a combined tax return for purposes of taxation
36 by this state, shall be considered an employer. Subsequent to the
37 issuance of a health plan to a small employer and for the purpose of
38 determining eligibility, the size of a small employer shall be
39 determined annually. Except as otherwise specifically provided, a
40 small employer shall continue to be considered a small employer until

1 the plan anniversary following the date the small employer no longer
2 meets the requirements of this definition. A self-employed individual
3 or sole proprietor who is covered as a group of one must also: (a)
4 Have been employed by the same small employer or small group for at
5 least twelve months prior to application for small group coverage,
6 and (b) verify that he or she derived at least seventy-five percent
7 of his or her income from a trade or business through which the
8 individual or sole proprietor has attempted to earn taxable income
9 and for which he or she has filed the appropriate internal revenue
10 service form 1040, schedule C or F, for the previous taxable year,
11 except a self-employed individual or sole proprietor in an
12 agricultural trade or business, must have derived at least fifty-one
13 percent of his or her income from the trade or business through which
14 the individual or sole proprietor has attempted to earn taxable
15 income and for which he or she has filed the appropriate internal
16 revenue service form 1040, for the previous taxable year.

17 ~~((34))~~ (39) "Special enrollment" means a defined period of time
18 of not less than thirty-one days, triggered by a specific qualifying
19 event experienced by the applicant, during which applicants may
20 enroll in the carrier's individual health benefit plan without being
21 subject to health screening or otherwise required to provide evidence
22 of insurability as a condition for enrollment.

23 ~~((35))~~ (40) "Standard health questionnaire" means the standard
24 health questionnaire designated under chapter 48.41 RCW.

25 ~~((36))~~ (41) "Utilization review" means the prospective,
26 concurrent, or retrospective assessment of the necessity and
27 appropriateness of the allocation of health care resources and
28 services of a provider or facility, given or proposed to be given to
29 an enrollee or group of enrollees.

30 ~~((37))~~ (42) "Wellness activity" means an explicit program of an
31 activity consistent with department of health guidelines, such as,
32 smoking cessation, injury and accident prevention, reduction of
33 alcohol misuse, appropriate weight reduction, exercise, automobile
34 and motorcycle safety, blood cholesterol reduction, and nutrition
35 education for the purpose of improving enrollee health status and
36 reducing health service costs.

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

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

4 (a) A health carrier shall cover emergency services necessary to
5 screen and stabilize a covered person if a prudent layperson acting
6 reasonably would have believed that an emergency medical condition
7 existed. In addition, a health carrier shall not require prior
8 authorization of ~~((such))~~ emergency services provided prior to the
9 point of stabilization if a prudent layperson acting reasonably would
10 have believed that an emergency medical condition existed. With
11 respect to care obtained from ~~((a nonparticipating))~~ an out-of-
12 network hospital emergency department, a health carrier shall cover
13 emergency services necessary to screen and stabilize a covered person
14 ~~((if a prudent layperson would have reasonably believed that use of a~~
15 ~~participating hospital emergency department would result in a delay~~
16 ~~that would worsen the emergency, or if a provision of federal, state,~~
17 ~~or local law requires the use of a specific provider or facility)).~~
18 In addition, a health carrier shall not require prior authorization
19 of ~~((such))~~ the services provided prior to the point of stabilization
20 ~~((if a prudent layperson acting reasonably would have believed that~~
21 ~~an emergency medical condition existed and that use of a~~
22 ~~participating hospital emergency department would result in a delay~~
23 ~~that would worsen the emergency)).~~

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

32 (c) Coverage of emergency services may be subject to applicable
33 in-network copayments, coinsurance, and deductibles, ~~((and a health~~
34 ~~carrier may impose reasonable differential cost sharing arrangements~~
35 ~~for emergency services rendered by nonparticipating providers, if~~
36 ~~such differential between cost sharing amounts applied to emergency~~
37 ~~services rendered by participating provider versus nonparticipating~~
38 ~~provider does not exceed fifty dollars. Differential cost sharing for~~
39 ~~emergency services may not be applied when a covered person presents~~
40 ~~to a nonparticipating hospital emergency department rather than a~~

1 ~~participating hospital emergency department when the health carrier~~
2 ~~requires preauthorization for postevaluation or poststabilization~~
3 ~~emergency services if:~~

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

8 ~~(ii) A prudent layperson possessing an average knowledge of~~
9 ~~health and medicine would have reasonably believed that he or she~~
10 ~~would be unable to go to a participating hospital emergency~~
11 ~~department in a timely fashion without serious impairment to the~~
12 ~~covered person's health)) as provided in sections 3 through 16 of~~
13 ~~this act.~~

14 ~~((d))~~ (2) If a health carrier requires preauthorization for
15 postevaluation or poststabilization services, the health carrier
16 shall provide access to an authorized representative twenty-four
17 hours a day, seven days a week, to facilitate review. In order for
18 postevaluation or poststabilization services to be covered by the
19 health carrier, the provider or facility must make a documented good
20 faith effort to contact the covered person's health carrier within
21 thirty minutes of stabilization, if the covered person needs to be
22 stabilized. The health carrier's authorized representative is
23 required to respond to a telephone request for preauthorization from
24 a provider or facility within thirty minutes. Failure of the health
25 carrier to respond within thirty minutes constitutes authorization
26 for the provision of immediately required medically necessary
27 postevaluation and poststabilization services, unless the health
28 carrier documents that it made a good faith effort but was unable to
29 reach the provider or facility within thirty minutes after receiving
30 the request.

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

37 ~~((2))~~ (4) Nothing in this section is to be construed as
38 prohibiting the health carrier from requiring notification within the
39 time frame specified in the contract for inpatient admission or as
40 soon thereafter as medically possible but no less than twenty-four

1 hours. Nothing in this section is to be construed as preventing the
2 health carrier from reserving the right to require transfer of a
3 hospitalized covered person upon stabilization. Follow-up care that
4 is a direct result of the emergency must be obtained in accordance
5 with the health plan's usual terms and conditions of coverage. All
6 other terms and conditions of coverage may be applied to emergency
7 services.

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

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

- 13 (a) Emergency services provided to a covered person; and
- 14 (b) Nonemergency health care services provided to a covered
15 person at an in-network hospital licensed under chapter 70.41 RCW or
16 an in-network ambulatory surgical facility licensed under chapter
17 70.230 RCW if the services:

- 18 (i) Involve surgical or ancillary services; and
- 19 (ii) Are provided by an out-of-network provider because an in-
20 network provider was unavailable or the need for the services arose
21 at the time the services were rendered and was unforeseen.

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

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

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

34 (b) A carrier must calculate the in-network cost-sharing amount
35 for the out-of-network provider's or facility's services using the
36 carrier's median contracted rate for similar services in the
37 geographic area where the services were provided. If there is more

1 than one level of cost-sharing, the carrier must use the cost-sharing
2 amount most beneficial to the covered person.

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

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

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

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

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

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

23 (iv) May not use wage garnishments or liens on the primary
24 residence of the covered person as a means of collecting unpaid bills
25 under this section;

26 (c) The carrier must treat any cost-sharing amounts paid by the
27 covered person for such services in the same manner as cost-sharing
28 for health care services provided by an in-network provider and must
29 apply any cost-sharing amounts paid by the covered person for such
30 services toward the limit on the covered person's in-network out-of-
31 pocket maximum expenses;

32 (d) If the covered person pays the out-of-network provider, out-
33 of-network facility, or carrier an amount that exceeds the in-network
34 cost-sharing amount specified in the carrier's explanation of
35 benefits, the provider, facility, or carrier must refund any amount
36 in excess of the in-network cost-sharing amount to the covered person
37 within thirty business days of receipt. Interest must be paid to the
38 covered person for any unrefunded payments at a rate of twelve
39 percent beginning on the first calendar day after the thirty business
40 days.

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

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

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

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

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

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

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

37 (2)(a) Once the requesting party has filed a request for
38 arbitration with the commissioner, the commissioner must provide the
39 parties with a list of approved arbitrators or entities that provide

1 binding arbitration. The arbitrators on the list must be trained by
2 the American arbitration association or the American health lawyers
3 association.

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

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

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

27 (i) Whether there is a gross disparity between the amount charged
28 by the out-of-network provider or facility and: (A) Amounts paid to
29 the provider or facility for the same services provided to other
30 patients by carriers with respect to which the provider or facility
31 is out-of-network; and (B) the amounts paid by the carrier to
32 reimburse similarly qualified out-of-network providers or facilities
33 for the same services in the same region;

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

35 (iii) Patient characteristics.

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

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

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

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

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

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

23 (3) This section expires January 1, 2023.

24 NEW SECTION. **Sec. 9.** The office of the insurance commissioner,
25 in consultation with carriers, health care providers, health care
26 facilities, and consumers, must develop standard template language
27 for notifying consumers that they may not be balance billed for
28 health care services under the circumstances described in section 4
29 of this act. The standard template language must include contact
30 information for the office of the insurance commissioner so that
31 consumers may contact the office of the insurance commissioner if
32 they believe they have received a balance bill in violation of this
33 subchapter.

34 NEW SECTION. **Sec. 10.** (1) A nonemployed provider group that
35 provides surgical or ancillary services at a hospital or ambulatory
36 surgical facility must notify the hospital or ambulatory surgical
37 facility of the carriers with which the provider group contracts. The

1 provider group must notify the hospital or ambulatory surgical
2 facility if the contract between the provider group and a carrier
3 will be terminated. The provider group must provide the notice as
4 soon as practicable, but in no case less than forty-five days prior
5 to termination of the contract.

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

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

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

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

27 (4) When a patient is scheduled for nonemergency health care
28 services, a hospital or ambulatory surgical facility must provide the
29 patient with notice as required by this subsection at least ten days
30 prior to the scheduled admission or outpatient service.

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (3) When a patient is scheduled for nonemergency health care
38 services at an out-of-network hospital or ambulatory surgical
39 facility, a health care provider must provide the patient with notice

1 as required by this subsection if the provider is out-of-network with
2 respect to the patient's health plan. The provider must provide the
3 notice at least ten days prior to the scheduled admission or
4 outpatient service. The notice must:

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

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

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

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

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

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

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

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

28 (c) Notification that if the covered person receives services
29 from an out-of-network provider or facility, under circumstances
30 other than those described in section 4 of this act, the covered
31 person will have the financial responsibility applicable to services
32 provided outside the health plan's network in excess of applicable
33 cost-sharing amounts and that the covered person may be responsible
34 for any costs in excess of those allowed by the health plan;

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

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

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

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

8 (2) If any person, including a health care provider, hospital, or
9 ambulatory surgical facility, violates or has violated a provision of
10 this subchapter, the commissioner may levy a fine upon the person in
11 an amount not to exceed one thousand dollars per violation and take
12 other action as permitted under this title for a violation of this
13 title.

14 NEW SECTION. **Sec. 14.** The commissioner may adopt rules to
15 implement and administer this subchapter, including rules governing
16 the dispute resolution process established in section 7 of this act.

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

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

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

26 Each health plan that provides medical insurance offered under
27 this chapter, including plans created by insuring entities, plans not
28 subject to the provisions of Title 48 RCW, and plans created under
29 RCW 41.05.140, are subject to the provisions of RCW 48.43.500,
30 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545,
31 48.43.550, 70.02.110, 70.02.900, 48.43.190, ((and)) 48.43.083, and
32 sections 3 through 16 of this act.

1 NEW SECTION. **Sec. 18.** Sections 3 through 16 of this act are
2 each added to chapter 48.43 RCW and codified with the subchapter
3 heading of "health care services balance billing."

4 NEW SECTION. **Sec. 19.** This act takes effect January 1, 2018.

5 NEW SECTION. **Sec. 20.** If any provision of this act or its
6 application to any person or circumstance is held invalid, the
7 remainder of the act or the application of the provision to other
8 persons or circumstances is not affected."

9 Correct the title.

EFFECT: (1) Clarifies that an out-of-network provider or facility may not balance bill a covered person for the specified health care services. Modifies the nonemergency services for which balance billing is prohibited by removing reference to invasive medical procedures and removing services by an out-of-network provider without the covered person's consent.

(2) Applies cost-sharing and dispute resolution provisions to health care facilities, in addition to health care providers. Requires carriers to calculate the in-network cost-sharing rate using the carrier's median (rather than average) contracted rate. Requires carriers to make payments directly to providers and facilities.

(3) Requires carriers to pay a billed amount of less than \$300. Permits, when the billed amount is \$300 or more, a carrier and out-of-network provider or facility to use mediation or, if the amount in dispute is \$2000 or more, arbitration. Requires mediation expenses to be divided equally among the carrier, provider, and facility, if the amount in dispute is less than \$2000.

(4) Removes language providing that arbitration is binding and not subject to appeal. Prohibits consolidation of multiple claims, and limits each arbitration proceeding to one episode of care and one provider or facility. Requires the nonrequesting party to provide its final offer within 30 days (rather than upon receipt), and requires the arbitrator to issue a decision selecting one party's final offer. Remove factors related to the provider's training and disproportionate pattern of involvement in arbitration. Requires arbitration expenses to be paid by the party whose final offer was rejected. Applies the Uniform Arbitration Act to balance billing arbitrations, except in cases of conflict. Expires the section requiring the Insurance Commissioner (Commissioner) to report arbitration information on January 1, 2023.

(5) Requires a nonemployed provider group providing surgical or ancillary services to notify facilities regarding its network status. Requires hospitals and ambulatory surgical facilities to notify the carriers with which they contract of the network status of their contracted provider groups. Requires the notice to include, for each type of surgical or ancillary service, whether at least 75 percent of the providers providing the service were in-network during the previous three months. Requires the carrier to treat the facility as out-of-network for nonemergency services if the 75 percent threshold

is not met, and requires the carrier to notify the Commissioner if the 75 percent threshold is not met.

(6) Requires the Commissioner, in consultation with stakeholders, to develop standard template language for notifying consumers of the circumstances under which they may not be balance billed.

(7) Modifies transparency requirements applicable to facilities to:

(a) Apply the requirements to hospitals and ambulatory surgical facilities (rather than all health care facilities);

(b) Modify the information facilities must post on their web sites to include whether each nonemployed provider group providing surgical or ancillary services contracts with the same carriers as the facility;

(c) Require notice to be provided when a patient is scheduled for nonemergency health care services (rather than for nonemergency health care services involving an invasive medical procedure when not all scheduled providers are in-network);

(d) Require the notice to be provided 10 days before the service (instead of the earlier of 10 days before or within two days of the service being scheduled);

(e) Require notices from in-network facilities to: Advise the patient that he or she may request an in-network provider; disclose the names and network status of providers who will provide surgical or ancillary services; advise the patient of his or her rights under the bill using the standard template language; and provide an estimated range of the cost (rather than include names for scheduled providers and advice to contact the carrier regarding requests for in-network providers); and

(f) Remove the requirement that a facility make a good faith effort to identify and schedule in-network providers upon request.

(8) Modifies transparency requirements applicable to providers to:

(a) Require notice to be provided when a patient is scheduled for nonemergency health care services at an out-of-network hospital or ambulatory surgical facility (rather than for nonemergency health care services involving an invasive medical procedure);

(b) Require the notice to be provided 10 days before the service (instead of the earlier of 10 days before or within two days of the service being scheduled);

(c) Require the notice to include an estimated range of the cost of services and the amount the provider may bill; and

(d) Require in-network providers to submit accurate information to a carrier regarding network status in a timely manner.

(9) Modifies transparency requirements applicable to carriers to:

(a) Require provider directories to be updated within 30 (instead of 20) days, and remove the requirement to cover services if a covered person reasonably relied on an inaccurate provider directory;

(b) Remove the notice requirement applicable to scheduled nonemergency health care services involving an invasive medical procedure;

(c) Require the carrier to provide a covered person with notice of his or her rights under the bill using the standard template language; and

(d) Remove the requirement that a carrier provide the covered person with providers' names when the covered person receives preauthorization for certain services.

(10) Clarifies that the Commissioner's enforcement authority extends to providers, hospitals, and ambulatory surgical facilities.

(11) Excludes Medicaid plans from the bill.

(12) Modifies definitions and phrasing and corrects typographical errors.

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