
SENATE BILL 5619

State of Washington

65th Legislature

2017 Regular Session

By Senators Rivers, Keiser, and Hunt; by request of Insurance
Commissioner

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

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

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

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

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

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

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

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

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

13 (5) "Basic health plan" means the plan described under chapter
14 70.47 RCW, as revised from time to time.

15 ~~((+5))~~ (6) "Basic health plan model plan" means a health plan as
16 required in RCW 70.47.060(2)(e).

17 ~~((+6))~~ (7) "Basic health plan services" means that schedule of
18 covered health services, including the description of how those
19 benefits are to be administered, that are required to be delivered to
20 an enrollee under the basic health plan, as revised from time to
21 time.

22 ~~((+7))~~ (8) "Board" means the governing board of the Washington
23 health benefit exchange established in chapter 43.71 RCW.

24 ~~((+8))~~ (9)(a) For grandfathered health benefit plans issued
25 before January 1, 2014, and renewed thereafter, "catastrophic health
26 plan" means:

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

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

1 (b) In July 2008, and in each July thereafter, the insurance
2 commissioner shall adjust the minimum deductible and out-of-pocket
3 expense required for a plan to qualify as a catastrophic plan to
4 reflect the percentage change in the consumer price index for medical
5 care for a preceding twelve months, as determined by the United
6 States department of labor. For a plan year beginning in 2014, the
7 out-of-pocket limits must be adjusted as specified in section
8 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount
9 shall apply on the following January 1st.

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

12 (i) A health benefit plan that meets the definition of
13 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
14 2010, as amended; or

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

20 ~~((9))~~ (10) "Certification" means a determination by a review
21 organization that an admission, extension of stay, or other health
22 care service or procedure has been reviewed and, based on the
23 information provided, meets the clinical requirements for medical
24 necessity, appropriateness, level of care, or effectiveness under the
25 auspices of the applicable health benefit plan.

26 ~~((10))~~ (11) "Concurrent review" means utilization review
27 conducted during a patient's hospital stay or course of treatment.

28 ~~((11))~~ (12) "Cost-sharing" means a copayment, coinsurance,
29 deductible, or any other form of financial obligation of the covered
30 person other than premium or share of premium, or any combination of
31 any of these financial obligations.

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

36 ~~((12))~~ (14) "Dependent" means, at a minimum, the enrollee's
37 legal spouse and dependent children who qualify for coverage under
38 the enrollee's health benefit plan.

39 ~~((13))~~ (15) "Emergency medical condition" means a medical or
40 behavioral health condition manifesting itself by acute symptoms of

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

9 ~~((14))~~ (16) "Emergency services" means a medical screening
10 examination, as required under section 1867 of the social security
11 act (42 U.S.C. 1395dd), that is within the capability of the
12 emergency department of a hospital, including ancillary services
13 routinely available to the emergency department to evaluate that
14 emergency medical condition, and further medical examination and
15 treatment, to the extent they are within the capabilities of the
16 staff and facilities available at the hospital, as are required under
17 section 1867 of the social security act (42 U.S.C. 1395dd) to
18 stabilize the patient. Stabilize, with respect to an emergency
19 medical condition, has the meaning given in section 1867(e)(3) of the
20 social security act (42 U.S.C. 1395dd(e)(3)).

21 ~~((15))~~ (17) "Employee" has the same meaning given to the term,
22 as of January 1, 2008, under section 3(6) of the federal employee
23 retirement income security act of 1974.

24 ~~((16))~~ (18) "Enrollee point-of-service cost-sharing" means
25 amounts paid to health carriers directly providing services, health
26 care providers, or health care facilities by enrollees and may
27 include copayments, coinsurance, or deductibles.

28 ~~((17))~~ (19) "Exchange" means the Washington health benefit
29 exchange established under chapter 43.71 RCW.

30 ~~((18))~~ (20) "Final external review decision" means a
31 determination by an independent review organization at the conclusion
32 of an external review.

33 ~~((19))~~ (21) "Final internal adverse benefit determination"
34 means an adverse benefit determination that has been upheld by a
35 health plan or carrier at the completion of the internal appeals
36 process, or an adverse benefit determination with respect to which
37 the internal appeals process has been exhausted under the exhaustion
38 rules described in RCW 48.43.530 and 48.43.535.

39 ~~((20))~~ (22) "Grandfathered health plan" means a group health
40 plan or an individual health plan that under section 1251 of the

1 patient protection and affordable care act, P.L. 111-148 (2010) and
2 as amended by the health care and education reconciliation act, P.L.
3 111-152 (2010) is not subject to subtitles A or C of the act as
4 amended.

5 ~~((+21))~~ (23) "Grievance" means a written complaint submitted by
6 or on behalf of a covered person regarding service delivery issues
7 other than denial of payment for medical services or nonprovision of
8 medical services, including dissatisfaction with medical care,
9 waiting time for medical services, provider or staff attitude or
10 demeanor, or dissatisfaction with service provided by the health
11 carrier.

12 ~~((+22))~~ (24) "Health care facility" or "facility" means
13 ~~((hospices licensed under chapter 70.127 RCW, hospitals licensed
14 under chapter 70.41 RCW, rural health care facilities as defined in
15 RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12
16 RCW, nursing homes licensed under chapter 18.51 RCW, community mental
17 health centers licensed under chapter 71.05 or 71.24 RCW, kidney
18 disease treatment centers licensed under chapter 70.41 RCW,
19 ambulatory diagnostic, treatment, or surgical facilities licensed
20 under chapter 70.41 RCW, drug and alcohol treatment facilities
21 licensed under chapter 70.96A RCW, and home health agencies licensed
22 under chapter 70.127 RCW, and includes such facilities if owned and
23 operated by a political subdivision or instrumentality of the state
24 and such other facilities as required by federal law and implementing
25 regulations)) any institution, place, building, or agency, or portion
26 thereof, where health care services are provided. This includes, but
27 is not limited to, hospitals, ambulatory surgical centers, clinics,
28 outpatient surgery or care centers, laboratories and diagnostic
29 centers, and specialized care centers, such as birthing centers and
30 psychiatric care centers.~~

31 ~~((+23))~~ (25) "Health care provider" or "provider" means(~~(+~~
32 ~~(a) A person regulated under Title 18 or chapter 70.127 RCW, to
33 practice health or health-related services or otherwise practicing
34 health care services in this state consistent with state law; or
35 (b) An employee or agent of a person described in (a) of this
36 subsection, acting in the course and scope of his or her employment))
37 any health professional, health care facility, or other institution,
38 organization, or person that furnishes any health care services to a
39 covered person.~~

1 (~~(24)~~) (26) "Health care service" means that service offered or
2 provided by health care facilities and health care providers relating
3 to the prevention, cure, or treatment of illness, injury, or disease.

4 (~~(25)~~) (27) "Health carrier" or "carrier" means a disability
5 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
6 service contractor as defined in RCW 48.44.010, or a health
7 maintenance organization as defined in RCW 48.46.020, and includes
8 "issuers" as that term is used in the patient protection and
9 affordable care act (P.L. 111-148).

10 (~~(26)~~) (28) "Health plan" or "health benefit plan" means any
11 policy, contract, or agreement offered by a health carrier to
12 provide, arrange, reimburse, or pay for health care services except
13 the following:

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

16 (b) Medicare supplemental health insurance governed by chapter
17 48.66 RCW;

18 (c) Coverage supplemental to the coverage provided under chapter
19 55, Title 10, United States Code;

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

22 (e) Disability income;

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

26 (g) Workers' compensation coverage;

27 (h) Accident only coverage;

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

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

33 (k) Dental only and vision only coverage;

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

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

3 ~~((27))~~ (29) "Individual market" means the market for health
4 insurance coverage offered to individuals other than in connection
5 with a group health plan.

6 ~~((28))~~ (30) "In-network provider" or "participating provider"
7 means a provider that has a contract with a carrier or with a
8 carrier's contractor or subcontractor and has agreed to provide
9 health care services to covered persons with an expectation of
10 receiving payment, other than enrollee cost-sharing, directly or
11 indirectly from the carrier.

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

15 ~~((29))~~ (32) "Maximum out-of-pocket" means the most a covered
16 person will have to pay for covered services in a plan year. After
17 the covered person spends this amount on deductibles, copayments, and
18 coinsurance, the covered person's carrier pays one hundred percent of
19 the costs of covered benefits.

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

25 ~~((30))~~ (34) "Out-of-network provider" or "nonparticipating
26 provider" means a provider that does not have a contract with a
27 carrier or with a carrier's contractor or subcontractor to provide
28 health care services.

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

32 ~~((31))~~ (36) "Premium" means all sums charged, received, or
33 deposited by a health carrier as consideration for a health plan or
34 the continuance of a health plan. Any assessment or any "membership,"
35 "policy," "contract," "service," or similar fee or charge made by a
36 health carrier in consideration for a health plan is deemed part of
37 the premium. "Premium" shall not include amounts paid as enrollee
38 point-of-service cost-sharing.

39 ~~((32))~~ (37) "Review organization" means a disability insurer
40 regulated under chapter 48.20 or 48.21 RCW, health care service

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

5 ~~((+33+))~~ (38) "Small employer" or "small group" means any person,
6 firm, corporation, partnership, association, political subdivision,
7 sole proprietor, or self-employed individual that is actively engaged
8 in business that employed an average of at least one but no more than
9 fifty employees, during the previous calendar year and employed at
10 least one employee on the first day of the plan year, is not formed
11 primarily for purposes of buying health insurance, and in which a
12 bona fide employer-employee relationship exists. In determining the
13 number of employees, companies that are affiliated companies, or that
14 are eligible to file a combined tax return for purposes of taxation
15 by this state, shall be considered an employer. Subsequent to the
16 issuance of a health plan to a small employer and for the purpose of
17 determining eligibility, the size of a small employer shall be
18 determined annually. Except as otherwise specifically provided, a
19 small employer shall continue to be considered a small employer until
20 the plan anniversary following the date the small employer no longer
21 meets the requirements of this definition. A self-employed individual
22 or sole proprietor who is covered as a group of one must also: (a)
23 Have been employed by the same small employer or small group for at
24 least twelve months prior to application for small group coverage,
25 and (b) verify that he or she derived at least seventy-five percent
26 of his or her income from a trade or business through which the
27 individual or sole proprietor has attempted to earn taxable income
28 and for which he or she has filed the appropriate internal revenue
29 service form 1040, schedule C or F, for the previous taxable year,
30 except a self-employed individual or sole proprietor in an
31 agricultural trade or business, must have derived at least fifty-one
32 percent of his or her income from the trade or business through which
33 the individual or sole proprietor has attempted to earn taxable
34 income and for which he or she has filed the appropriate internal
35 revenue service form 1040, for the previous taxable year.

36 ~~((+34+))~~ (39) "Special enrollment" means a defined period of time
37 of not less than thirty-one days, triggered by a specific qualifying
38 event experienced by the applicant, during which applicants may
39 enroll in the carrier's individual health benefit plan without being

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

3 ~~((35))~~ (40) "Standard health questionnaire" means the standard
4 health questionnaire designated under chapter 48.41 RCW.

5 ~~((36))~~ (41) "Utilization review" means the prospective,
6 concurrent, or retrospective assessment of the necessity and
7 appropriateness of the allocation of health care resources and
8 services of a provider or facility, given or proposed to be given to
9 an enrollee or group of enrollees.

10 ~~((37))~~ (42) "Wellness activity" means an explicit program of an
11 activity consistent with department of health guidelines, such as,
12 smoking cessation, injury and accident prevention, reduction of
13 alcohol misuse, appropriate weight reduction, exercise, automobile
14 and motorcycle safety, blood cholesterol reduction, and nutrition
15 education for the purpose of improving enrollee health status and
16 reducing health service costs.

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

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

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

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

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

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

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

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

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

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

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

16 ~~((2))~~ (4) Nothing in this section is to be construed as
17 prohibiting the health carrier from requiring notification within the
18 time frame specified in the contract for inpatient admission or as
19 soon thereafter as medically possible but no less than twenty-four
20 hours. Nothing in this section is to be construed as preventing the
21 health carrier from reserving the right to require transfer of a
22 hospitalized covered person upon stabilization. Follow-up care that
23 is a direct result of the emergency must be obtained in accordance
24 with the health plan's usual terms and conditions of coverage. All
25 other terms and conditions of coverage may be applied to emergency
26 services.

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

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

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

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

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

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

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

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

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

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

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

4 (b) A statement that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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