S-4436.2

SUBSTITUTE SENATE BILL 6532

State of Washington 61st Legislature 2010 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Pflug and Keiser)

READ FIRST TIME 02/03/10.

AN ACT Relating to holding consumers harmless for balance bills generated when emergency services are rendered by nonparticipating providers in participating hospitals; amending RCW 48.43.093; adding a new section to chapter 41.05 RCW; and creating new sections.

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

NEW SECTION. **Sec. 1.** The legislature finds that there are situations in which insured consumers receive emergency health care services in a facility participating in a carrier's provider network, when other health care professionals rendering services in the facility may not be employees of the facility or participating providers in the consumer's health benefit plan. In such situations, the consumer is not aware that the providers are nonparticipating providers. Further, the consumer may have little or no direct contact with the nonparticipating providers. The legislature further finds that consumers should be held harmless for additional charges from nonparticipating providers for emergency care rendered in a participating facility. It is the intent of the legislature that consumers in these emergency situations not be billed for charges in

excess of what the applicable cost sharing would be under the consumer's health benefit plan for the use of participating providers.

The legislature further finds that some consumers intentionally use nonparticipating providers, which is the consumers' prerogative under certain health benefit plans. When consumers intentionally use a nonparticipating provider, the consumer is only entitled to benefits at the nonparticipating rate and may be subject to balance billing by the nonparticipating provider.

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

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

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

(b) If an authorized representative of a health carrier authorizes coverage of emergency services, the health carrier shall not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished

in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health condition made by the provider of emergency services.

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

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

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

(d)(i) For covered emergency services rendered to a covered person by a nonparticipating health care provider in a participating hospital on or after January 1, 2011, the benefit level shall be the same as if those services had been provided by a participating health care provider. Covered services or treatment rendered at a participating hospital, including covered ancillary services or treatment rendered by a nonparticipating provider performing the services or treatment at a participating hospital, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from a participating provider.

(ii) Any attempt by the provider to recover excess funds from the covered person in a manner inconsistent with this subsection constitutes a violation of RCW 18.130.080.

(e) If a health carrier requires preauthorization for postevaluation or poststabilization services, the health carrier shall

provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review. In order for postevaluation or poststabilization services to be covered by the health carrier, the provider or facility must make a documented good faith effort to contact the covered person's health carrier within thirty minutes of stabilization, if the covered person needs to be stabilized. The health carrier's authorized representative is required to respond to a telephone request for preauthorization from a provider or facility within thirty minutes. Failure of the health carrier to respond within thirty minutes constitutes authorization for the provision of immediately required medically necessary postevaluation and poststabilization services, unless the health carrier documents that it made a good faith effort but was unable to reach the provider or facility within thirty minutes after receiving the request.

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

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

(3) This section does not govern payment for emergency services rendered to persons who are enrolled in medicare, Title XVIII of the federal social security act.

(4) If a health plan and a provider cannot reach agreement on negotiated fees or allowable costs for emergency services, either party may initiate binding arbitration.

NEW SECTION. **Sec. 3.** A new section is added to chapter 41.05 RCW to read as follows:

(1)(a) For covered emergency services rendered to a covered person by a nonparticipating health care provider in a participating hospital on or after January 1, 2011, the benefit level shall be the same as if those services had been provided by a participating health care provider. Covered services or treatment rendered at a participating hospital, including covered ancillary services or treatment rendered by a nonparticipating provider performing the services or treatment at a participating hospital, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from a participating provider.

(b) Any attempt by the provider to recover excess funds from the covered person in a manner inconsistent with this subsection constitutes a violation of RCW 18.130.080.

(2) As used in this section, "emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition provided in a hospital emergency department, consistent with RCW 48.43.005.

(3) If a health plan and a provider cannot reach agreement on negotiated fees or allowable costs for emergency services, either party may initiate binding arbitration.

NEW SECTION. **Sec. 4.** The insurance commissioner may adopt rules to implement the provisions of this act.

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