Z-0753.1

HOUSE BILL 2447

State of Washington 64th Legislature 2016 Regular Session

By Representatives Cody, Robinson, Tharinger, Van De Wege, Jinkins, and Johnson; by request of Insurance Commissioner

Read first time 01/13/16. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to emergency health care services balanced
2 billing; amending RCW 48.43.093; and adding a new section to chapter
3 48.43 RCW.

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

5 **Sec. 1.** RCW 48.43.093 and 1997 c 231 s 301 are each amended to
6 read as follows:
7 (1) When conducting a review of the necessity and appropriateness
8 of emergency services or making a benefit determination for emergency
9 services:
10 (a) A health carrier shall cover emergency services necessary to
11 screen and stabilize a covered person if a prudent layperson acting
12 reasonably would have believed that an emergency medical condition
13 existed. In addition, a health carrier shall not require prior
14 authorization of such services provided prior to the point of
15 stabilization if a prudent layperson acting reasonably would have
16 believed that an emergency medical condition existed. With respect to
17 care obtained from a nonparticipating hospital emergency department,
18 a health carrier shall cover emergency services necessary to screen
19 and stabilize a covered person if a prudent layperson would have
20 reasonably believed that use of a participating hospital emergency
21 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)~~)) 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)~~)) <u>(d)</u> 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.

<u>NEW SECTION.</u> **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

(1) For purposes of this section, "facility-based provider" means a health care provider or other provider as defined in RCW 48.43.005 who provides emergency services to a covered person in a participating health care facility.

(2) When a covered person utilizes a participating health care facility and, due to any reason, a participating health care provider is unavailable and services are provided by a nonparticipating facility-based physician or provider, the health carrier must ensure

that the covered person will incur no greater out-of-pocket costs than the covered person would have incurred with a participating physician or provider for covered services.

(3) If a covered person agrees in writing that any benefits a covered person receives for services under the circumstances in subsection (2) of this section are assigned to the nonparticipating facility-based provider:

(a) Within thirty days after receiving the bill from the nonparticipating provider, the health carrier must provide the nonparticipating provider with a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person;

(b) The health carrier will pay any reimbursement directly to the nonparticipating facility-based provider; and

(c) The nonparticipating facility-based physician or provider must not bill the covered person, except for applicable deductible, copayment, or coinsurance amounts that would apply if the covered person utilized a participating physician or provider for covered services.

(4) If a covered person specifically rejects assignment under this section in writing to the nonparticipating facility-based provider, then the nonparticipating facility-based provider may bill the covered person for the services rendered.

(5) For bills assigned under subsection (3) of this section, the nonparticipating facility-based provider may bill the health carrier for the services rendered, and the health carrier may pay the billed amount or attempt to negotiate reimbursement with the nonparticipating facility-based provider. If attempts to negotiate reimbursement for services provided by a nonparticipating facility-based provider do not result in a resolution of the payment dispute within thirty days after receipt of written explanation of benefits by the health carrier, then a health carrier or nonparticipating facility-based physician or provider may initiate binding arbitration to determine payment for services provided on a per bill basis. The party requesting arbitration must notify the other party arbitration has been initiated and state its final offer before arbitration. In response to this notice, the nonrequesting party must inform the requesting party of its final offer before the arbitration occurs. Arbitration must be initiated by filing a request with the commissioner.

1 (6) The commissioner must publish a list of approved arbitrators
2 or entities that provide binding arbitration. These arbitrators must
3 be American arbitration association or American health lawyers
4 association trained arbitrators. Both parties must agree on an
5 arbitrator from the commissioner's list of arbitrators. If no
6 agreement can be reached, then a list of five arbitrators will be
7 provided by the commissioner. From the list of five arbitrators, the
8 health carrier can veto two arbitrators and the provider can veto two
9 arbitrators. The remaining arbitrator will be the chosen arbitrator.
10 This arbitration must consist of a review of the written submissions
11 by both parties. Binding arbitration must provide for a written
12 decision within forty-five days after the request is filed with the
13 commissioner. Both parties are bound by the arbitrator's decision.
14 The arbitrator's expenses and fees, together with other expenses, not
15 including attorneys' fees, incurred in the conduct of the
16 arbitration, must be paid as provided in the decision. RCW 48.43.055
17 does not apply to complaints arbitrated under this section.
18 (7) This section does not apply to a covered person who, after
19 being fully informed in writing that the provider is a
20 nonparticpating facility-based physician or provider, willfully
21 chooses to access a nonparticipating facility-based physician or
22 provider for health care services available through the health
23 carrier's network of participating physicians and providers. In these
24 circumstances, the contractual requirements for nonparticipating
25 facility-based provider reimbursements apply.

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