H-1940.2

SUBSTITUTE HOUSE BILL 2114

State of Washington 65th Legislature 2017 Regular Session

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

READ FIRST TIME 02/17/17.

AN ACT Relating to protecting consumers from charges for out-of-network health services; amending RCW 48.43.005, 48.43.093, and 41.05.017; adding new sections to chapter 48.43 RCW; prescribing penalties; and providing an effective date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

((~~(13)~~)) (14) "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity((~~,~~)) including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental

health, or substance use disorder treatment attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

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

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

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

((~~(17)~~)) (18) "Exchange" means the Washington health benefit exchange established under chapter 43.71 RCW.

((~~(18)~~)) (19) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

((~~(19)~~)) (20) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

((~~(20)~~)) (21) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L.

111-152 (2010) is not subject to subtitles A or C of the act as amended.

((~~(21)~~)) (22) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

((~~(22)~~)) (23) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

((~~(23)~~)) (24) "Health care provider" or "provider" means:

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

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

((~~(24)~~)) (25) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

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

((~~(26)~~)) (27) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to

provide, arrange, reimburse, or pay for health care services except the following:

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage;

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

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

((~~(27)~~)) (28) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to covered persons with the expectation of receiving payment from the carrier.

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

((~~(28)~~)) (30) "Invasive medical procedure" means a medical procedure that invades the body, generally by cutting or puncturing the skin or by inserting a medical instrument into the body.

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

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

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

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

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

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

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

((~~(33)~~)) (38) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at

least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

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

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

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

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

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

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

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

(b) If an authorized representative of a health carrier authorizes coverage of emergency services, the health carrier shall not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health

condition made by the provider of emergency services with the patient's knowledge and consent.

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

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

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

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

reach the provider or facility within thirty minutes after receiving the request.

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

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

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

NEW SECTION. **Sec. 4.** (1) Balance billing is prohibited for the following health care services:

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

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

(i) Involve an invasive medical procedure;

(ii) Involve surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services; and

(iii) Are provided by an out-of-network provider: Because an in-network provider was unavailable; because the need for the services arose at the time the services were rendered and was unforeseen; or without the covered person's consent.

(2) Payment for services described in subsection (1) of this section is subject to sections 5 and 6 of this act. When a covered

person receives emergency or nonemergency health care services described in subsection (1) of this section, the following persons and entities must ensure that the covered person incurs no greater cost-sharing than he or she would have incurred if the services had been provided by an in-network provider: (a) The carrier; (b) the out-of-network provider; (c) any person on behalf of the carrier or the out-of-network provider; or (d) an assignee of debt of debt of the carrier or the out-of-network provider.

(3) This subchapter must be liberally construed to promote the public interest by ensuring that consumers are not billed out-of-network charges and do not receive additional bills from providers under the circumstances described in this section.

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

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

(c) An out-of-network provider or an out-of-network health care facility, or an agent, trustee, or assignee of an out-of-network provider or facility, may not:

(i) Hold the covered person financially responsible for any amount in excess of the in-network cost-sharing amounts specified in the carrier's explanation of benefits; or

(ii) Maintain an action at law against a covered person to collect sums of money owed in excess of any cost-sharing specified in the carrier's explanation of benefits.

(2) If a covered person receives health care services as described in section 4 of this act:

(a) The carrier must apply any cost-sharing amounts paid by the covered person for such services toward the limit on in-network out-of-pocket maximum expenses of the covered person;

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

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

(d) The out-of-network provider may not attempt to collect from the covered person any amount greater than the covered person's in-network cost-sharing amount, as specified in the carrier's explanation of benefits;

(e) When the covered person pays the out-of-network provider or the carrier an amount that exceeds the in-network cost-sharing amount, as specified in the carrier's explanation of benefits, the provider or carrier must refund any amount in excess of the in-network cost-sharing amount to the covered person within thirty business days of receipt. Interest must be paid to the covered person for any unrefunded payments at a rate of twelve percent interest beginning on the first calendar day after the thirty business days.

(3)(a) The out-of-network provider, or any person acting on its behalf, including any assignee of the debt, may not report adverse information to a consumer credit reporting agency or commence a civil action against the covered person before the expiration of one hundred fifty days after the initial billing regarding the amount owed by the covered person under this section.

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

NEW SECTION. **Sec. 6.** (1) A carrier and an out-of-network provider may use the dispute resolution process described in this section for any dispute involving payment for services described in section 4 of this act.

(2) If the carrier's payment to the provider does not resolve the payment dispute, either the carrier or the provider may initiate binding arbitration to determine payment for services on a per-bill basis. To initiate arbitration, the carrier or the provider must file a request with the commissioner no later than ninety days after the provider's receipt of the written explanation of benefits under section 5 of this act. The party requesting arbitration must provide

the nonrequesting party with a written notification that arbitration has been initiated. The notification must state the requesting party's final offer. Upon receipt of the notification, the nonrequesting party must provide its final offer to the requesting party.

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

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

(4)(a) Each party must make written submissions to the arbitrator in support of its position no later than thirty days after the request for arbitration is filed with the commissioner. Within thirty days of the receipt of the parties' written submissions, the arbitrator must issue a written decision, notify the parties of its decision, and provide information regarding the decision to the commissioner.

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

(i) Whether there is a gross disparity between the fee charged by the out-of-network provider and: (A) Fees paid to the provider for the same services provided to other patients by carriers in instances in which the provider is out-of-network; and (B) the fees paid by the carrier to reimburse similarly qualified out-of-network providers for the same services in the same region;

(ii) The provider's training, education, and expertise;

(iii) The circumstances and complexity of the case;

(iv) Patient characteristics; and

(v) Whether the provider or carrier has a disproportionate pattern of initiating or being a respondent in dispute resolution proceedings.

(c) Upon motion or by agreement of the parties, the arbitrator may consolidate multiple disputes for resolution in a single arbitration proceeding, so long as the parties are identical for each dispute and consolidation does not violate the other requirements of this section.

(5) Each party is bound by the arbitrator's decision, which is final and not subject to appeal. Expenses incurred in the course of arbitration, including the arbitrator's expenses and fees, but not including attorneys' fees, must be divided equally between the parties. The commissioner may adopt rules modifying the division of expenses for dispute resolution proceedings if, based on the information contained in an annual report filed under section 7 of this act, the commissioner finds a pattern of disproportionate use of or involvement in dispute resolution proceedings by particular health care providers, health care provider groups, health care facilities, or carriers.

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

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

NEW SECTION. **Sec. 7.** (1) The commissioner must prepare an annual report summarizing the dispute resolution information submitted under section 6 of this act. The report must include summary information related to the matters decided through arbitration, as well as the following information for each dispute resolved through binding arbitration: The carrier; the health care provider; the health care provider's employer or the business entity in which the provider has an ownership interest; the facility where the services were provided; and the type of health care services at issue.

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

NEW SECTION. **Sec. 8.** (1) A health care facility must post the following information on its web site:

(a) A list of the carriers with which the facility contracts and hyperlinks to access the carriers' web sites;

(b) A list of any providers and provider groups providing surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services at the facility; and

(c) A notice that patients should contact their carrier for more information regarding providers' network status.

(2)(a) When a patient is scheduled for nonemergency health care services involving an invasive medical procedure, the facility must notify the patient if not all scheduled providers for the services described in subsection (1)(b) of this section are employees of the facility or participating providers in the patient's health plan network. The notice must be provided at least ten days prior to the date the service is scheduled, or within two days of the service being scheduled, whichever is earlier. The notice must include the names and contact information for the providers scheduled to provide the service and must direct patients to contact their carrier regarding the opportunity to request in-network providers.

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

(i) Advise the patient that the services will be provided on an out-of-network basis;

(ii) Advise the patient that he or she may choose an in-network facility;

(iii) Advise the patient that he or she will have the financial responsibility applicable to services provided at an out-of-network facility in excess of the patient's deductible, coinsurance and copayment, and that the patient may be responsible for any costs in excess of those allowed by the health benefit plan;

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

(v) Inform the patient that discounts may be available for some or all of the hospital bill and that the patient should contact the facility's financial assistance office.

(c) If the facility's network status changes after the provision of the notice required by this subsection and the date the service is

provided, the facility must notify the patient of the change promptly.

(3) If a patient requests in-network providers, a facility must make a good faith effort to identify and schedule in-network providers for the service by using the provider directory published on the carrier's web site.

NEW SECTION. **Sec. 9.** (1) A health care provider must provide information on its web site listing the carriers with which the provider contracts.

(2)(a) When a patient is scheduled for nonemergency health care services involving an invasive medical procedure, a provider must notify the patient if the provider is out-of-network with respect to the patient's health benefit plan. The notice must be provided at least ten days prior to the date the service is scheduled, or within two days of the service being scheduled, whichever is earlier.

(b) The notice must:

(i) Disclose the provider's network status;

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

(iii) Advise the patient that he or she will have the financial responsibility applicable to services provided at an out-of-network facility in excess of the patient's deductible, coinsurance and copayment, and that the patient may be responsible for any costs in excess of those allowed by the health benefit plan.

NEW SECTION. **Sec. 10.** (1) A carrier must update its web site and provider directory no later than twenty days after the addition or termination of a facility or provider, so long as the carrier had notice of the change.

(2) When a covered person is scheduled for nonemergency health care services involving an invasive medical procedure, the covered person's health plan must provide the covered person with a notice regarding out-of-network benefits. The notice must be provided at least ten days prior to the date the service is scheduled, or within two days of the service being scheduled, whichever is earlier. The notice must include the following information:

(a) A clear description of the plan's out-of-network health benefits and that the covered person will have the financial responsibility applicable to services provided by an out-of-network

provider in excess of the covered person's deductible, coinsurance, and copayment and the covered person may be responsible for any costs in excess of those allowed by the health benefit plan;

(b) Information in response to a covered person's request whether a health care provider is in-network or out-of-network and, upon contacting the carrier directly, an estimated range of the out-of-pocket costs for an out-of-network benefit; and

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

(3) When a covered person receives preauthorization for nonemergency health care services involving an invasive medical procedure scheduled at an in-network facility, the carrier must provide the covered person with the names of the providers and provider groups with which the carrier contracts for surgery, anesthesiology, pathology, radiology, laboratory, and hospitalist services. The carrier must also notify the covered person that other providers may not be in-network.

NEW SECTION. **Sec. 11.** (1) If the commissioner has cause to believe that any person is violating a provision of this subchapter, the commissioner may order the person to cease and desist.

(2) If any person violates or has violated a provision of this subchapter, the commissioner may levy a fine upon the person in an amount not to exceed one thousand dollars per violation and take other action as permitted under this title for a violation of this title.

(3) If the commissioner determines that a covered person reasonably relied on an inaccurate provider directory to access the services described in section 4 of this act, the health plan must provide coverage for health care services provided to the enrollee by any facility or provider in the carrier's provider directory. In addition, the carrier must reimburse the covered person for any cost-sharing the covered person paid in excess of the in-network cost-sharing amount.

NEW SECTION. **Sec. 12.** The commissioner may adopt rules to implement and administer this subchapter, including rules governing the dispute resolution process established in section 6 of this act.

Sec. 13. RCW 41.05.017 and 2016 c 139 s 4 are each amended to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545, 48.43.550, 70.02.110, 70.02.900, 48.43.190, ((~~and~~)) 48.43.083, and sections 3 through 12 of this act.

NEW SECTION. **Sec. 14.** Sections 3 through 12 of this act are each added to chapter 48.43 RCW and codified with the subchapter heading of "health care services balance billing."

NEW SECTION. **Sec. 15.** This act takes effect January 1, 2018.

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

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