
HOUSE BILL 1215

State of Washington

66th Legislature

2019 Regular Session

By Representatives Schmick and Sells

Read first time 01/16/19. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to prohibiting balance billing by health care
2 providers; amending RCW 48.43.005 and 41.05.017; adding new sections
3 to chapter 48.43 RCW; creating a new section; 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) "Basic health plan" means the plan described under chapter
10 70.47 RCW, as revised from time to time.

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

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

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

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

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

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

36 (b) In July 2008, and in each July thereafter, the insurance
37 commissioner shall adjust the minimum deductible and out-of-pocket
38 expense required for a plan to qualify as a catastrophic plan to
39 reflect the percentage change in the consumer price index for medical
40 care for a preceding twelve months, as determined by the United

1 States department of labor. For a plan year beginning in 2014, the
2 out-of-pocket limits must be adjusted as specified in section
3 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount
4 shall apply on the following January 1st.

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

7 (i) A health benefit plan that meets the definition of
8 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
9 2010, as amended; or

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

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

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

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

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

30 (13) "Emergency medical condition" means a medical condition
31 manifesting itself by acute symptoms of sufficient severity,
32 including severe pain, such that a prudent layperson, who possesses
33 an average knowledge of health and medicine, could reasonably expect
34 the absence of immediate medical attention to result in a condition

35 (a) placing the health of the individual, or with respect to a
36 pregnant woman, the health of the woman or her unborn child, in
37 serious jeopardy, (b) serious impairment to bodily functions, or (c)
38 serious dysfunction of any bodily organ or part.

39 (14) "Emergency services" means a medical screening examination,
40 as required under section 1867 of the social security act (42 U.S.C.

1 1395dd), that is within the capability of the emergency department of
2 a hospital, including ancillary services routinely available to the
3 emergency department to evaluate that emergency medical condition,
4 and further medical examination and treatment, to the extent they are
5 within the capabilities of the staff and facilities available at the
6 hospital, as are required under section 1867 of the social security
7 act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with
8 respect to an emergency medical condition, has the meaning given in
9 section 1867(e)(3) of the social security act (42 U.S.C.
10 1395dd(e)(3)).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (e) Disability income;

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

7 (g) Workers' compensation coverage;

8 (h) Accident only coverage;

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

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

14 (k) Dental only and vision only coverage;

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

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

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

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

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

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

38 (31) "Premium" means all sums charged, received, or deposited by
39 a health carrier as consideration for a health plan or the
40 continuance of a health plan. Any assessment or any "membership,"

1 "policy," "contract," "service," or similar fee or charge made by a
2 health carrier in consideration for a health plan is deemed part of
3 the premium. "Premium" shall not include amounts paid as enrollee
4 point-of-service cost-sharing.

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

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

1 income and for which he or she has filed the appropriate internal
2 revenue service form 1040, for the previous taxable year.

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

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

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

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

23 (38) "Balance billing" means a bill sent to an enrollee by an
24 out-of-network provider for health care services provided to the
25 enrollee after the provider or facility's billed amount is not fully
26 reimbursed by the carrier, exclusive of permitted cost-sharing.

27 (39) "In-network" means a provider or facility that has
28 contracted with a carrier or a carrier's contractor or subcontractor
29 to provide health care services to enrollees for the purposes of
30 receiving reimbursement from the carrier at specified levels as
31 payment in full for the health care services, including applicable
32 cost-sharing obligations.

33 (40) "Out-of-network" means a provider or facility that has not
34 contracted with a carrier or a carrier's contractor or subcontractor
35 to provide health care services to enrollees.

36 (41) "Out-of-pocket maximum" means the maximum amount an enrollee
37 is required to pay in the form of cost-sharing for covered benefits
38 in a plan year, after which the carrier covers the entirety of the
39 allowed amount of covered benefits under the contract of coverage.

1 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43
2 RCW to read as follows:

3 (1) An out-of-network provider that provides services at an in-
4 network facility may not balance bill an enrollee for the following
5 health care services:

6 (a) Emergency services provided to an enrollee at an in-network
7 hospital licensed under chapter 70.41 RCW; and

8 (b) Nonemergency health care services provided to an enrollee at
9 an in-network hospital licensed under chapter 70.41 RCW or an in-
10 network ambulatory surgical facility licensed under chapter 70.230
11 RCW if the services involve surgical or ancillary services.

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

16 (3) For purposes of this section, "surgical or ancillary
17 services" means surgery, anesthesiology, pathology, radiology,
18 laboratory, or hospitalist services.

19 NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43
20 RCW to read as follows:

21 If an enrollee receives emergency or nonemergency health care
22 services under the circumstances described in section 2 of this act:

23 (1) The enrollee satisfies his or her obligation to pay for the
24 health care services if he or she pays the in-network cost-sharing
25 amount specified in the enrollee's or applicable group's health plan
26 contract;

27 (2) The carrier, out-of-network provider, or an agent, trustee,
28 or assignee of the carrier or out-of-network provider must ensure
29 that the enrollee incurs no greater cost than he or she would have
30 incurred if the services had been provided by an in-network provider
31 at an in-network facility;

32 (3) The out-of-network provider or an agent, trustee, or assignee
33 of the out-of-network provider:

34 (a) May not balance bill or otherwise attempt to collect from the
35 enrollee any amount greater than the in-network cost-sharing amount
36 specified in the enrollee's or applicable group's health plan
37 contract. This does not impact the provider's ability to collect a
38 past due balance for the cost-sharing amount with interest;

1 (b) May not report adverse information to a consumer credit
2 reporting agency or commence a civil action against the enrollee
3 before the expiration of one hundred fifty days after the initial
4 billing for the amount owed by the enrollee under this section; and

5 (c) May not use wage garnishments or liens on the primary
6 residence of the enrollee as a means of collecting unpaid bills under
7 this section;

8 (4) The carrier must treat any cost-sharing amounts paid by the
9 enrollee for such services in the same manner as cost-sharing for
10 health care services provided by an in-network provider and must
11 apply any cost-sharing amounts paid by the enrollee for such services
12 toward the limit on the enrollee's in-network out-of-pocket maximum
13 expenses;

14 (5) If the enrollee pays the out-of-network provider an amount
15 that exceeds the in-network cost-sharing amount specified in the
16 carrier's explanation of benefits, the provider must refund any
17 amount in excess of the in-network cost-sharing amount to the
18 enrollee within thirty business days of receipt. Interest must be
19 paid to the enrollee for any unrefunded payments at a rate of twelve
20 percent beginning on the first calendar day after the thirty business
21 days.

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

24 Each health plan that provides medical insurance offered under
25 this chapter, including plans created by insuring entities, plans not
26 subject to the provisions of Title 48 RCW, and plans created under
27 RCW 41.05.140, are subject to the provisions of RCW 48.43.500,
28 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545,
29 48.43.550, 70.02.110, 70.02.900, 48.43.190, ~~((and))~~ 48.43.083, and
30 section 2 of this act.

31 NEW SECTION. **Sec. 5.** The insurance commissioner may adopt rules
32 to implement and administer this act.

33 NEW SECTION. **Sec. 6.** This act takes effect January 1, 2020.

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