AN ACT Relating to protecting consumers from charges for out-of-network health care services; amending RCW 48.43.093; adding a new section to chapter 48.43 RCW; and providing an effective date.

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

Sec. 1. 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). Stabilization means both care delivered in the emergency department and care immediately subsequent to an emergency department visit for an emergency medical condition prior to the point at which the patient's care may be transferred to an in-network facility or provider. 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.)) When a covered person utilizes a participating health care facility for emergency services or
otherwise unscheduled services, and services are provided by a nonparticipating or out-of-network provider, the health carrier must ensure the covered person's cost-sharing in the form of copayments or coinsurance for out-of-network emergency services do not exceed the cost-sharing requirements imposed for in-network services.

(i) The health carrier must count the cost-sharing for an out-of-network provider at an in-network facility toward an in-network deductible and the in-network maximum out-of-pocket expenses allowed on the coverage.

(ii) The health carrier must pay the applicable charges for the out-of-network provider directly to the health care provider within thirty days for a clean claim, and may subsequently bill the covered person for the applicable in-network deductible and cost-sharing.

(iii) The health carrier must pay the out-of-network provider a reasonable rate to be referenced to as a minimum benefit standard set at the eightieth percentile of the geographically comparable charges, as reported by a Washington state public entity that establishes or sponsors a health care claims database or by a commercially available usual, customary, and reasonable fee schedule database provider. Such a database provider may not have an ownership or controlling interest in, or be an affiliate of, any entity with a pecuniary interest in the application of the database, including an insurer, health care provider, or trade association in the field of insurance, health benefits, or provider of health care. The charges must be benchmarked to 2016 rates and updated on an annual basis with the relevant health care consumer price index adjustor calculated by the bureau of labor statistics.

(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 services.
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) 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.

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

(1) A carrier must maintain each provider network of in-network
providers and facilities for each health plan in a manner that is
sufficient in numbers and types of providers and facilities to assure
that, to the extent feasible based on the number and type of
providers and facilities in the service area, enrollees may access
in-network options for all health plan services in a timely manner
appropriate for the enrollee's condition and the place of service.

(2) A carrier must demonstrate that for each health plan's
defined service area, it has established a network of participating
providers and facilities to provide a comprehensive range of primary,
specialty, institutional, and ancillary services, as well as
emergency services that are accessible twenty-four hours per day,
seven days per week without unreasonable delay.

(3) If a carrier has an insufficient number or type of in-network
participating providers or facilities to provide a particular covered
health care service, the carrier must ensure that the enrollee
obtains the covered service from a nonnetwork provider or facility
within reasonable proximity and a timely manner, consistent with the
generally accepted standards of care, to the enrollee at no greater
cost to the enrollee than if the service were obtained from in-
network providers and facilities.

(4) In assessing a carrier's provider network under this section
and rules adopted by the commissioner, the commissioner shall
consider the relative availability of providers and facilities and
the willingness of providers and facilities in a service area to
contract with the carrier under reasonable terms and conditions,
including the provider reimbursement amount. The reimbursement amount
set forth in RCW 48.43.093 does not in and of itself constitute a
reasonable compensation amount for the purposes of establishing
network adequacy.

(5) A carrier may not state or imply in communications with or
directed toward enrollees or potential enrollees that a hospital
licensed under chapter 70.41 RCW is an in-network health care
facility if the health care providers who provide the following
specialty services to the hospital do not also participate in the
carrier's network: Anesthesiology; emergency medicine; radiology; and
pathology.

NEW SECTION. Sec. 3. This act takes effect January 1, 2018.

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