

**ESHB 2114 - H AMD 955**

By Representatives Cody, Caldier, Harris

ADOPTED 02/13/2018

1 Strike everything after the enacting clause and insert the  
2 following:

3 "NEW SECTION. **Sec. 1.** The legislature finds that consumers  
4 receive surprise bills or balance bills for services provided by out-  
5 of-network health care providers at in-network facilities, and it is  
6 the intent of the legislature to ban the balance billing of consumers  
7 for all fully insured, regulated insurance plans and plans offered to  
8 public employees. The legislature further declares that consumers  
9 must not be placed in the middle of contractual disputes between  
10 providers and health insurance carriers. The legislature intends to  
11 remove consumers from such disputes by banning balance billing and  
12 requiring that payments for noncontracted providers be made directly  
13 to providers rather than to consumers. Facilities, providers, and  
14 health insurance carriers all share responsibility to ensure  
15 consumers have transparent information on network providers and  
16 benefit coverage, and the insurance commissioner has the  
17 responsibility to ensure networks are adequate and include sufficient  
18 contracted providers to reasonably ensure consumers have in-network  
19 access for covered benefits.

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

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

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

29 (2) "Adverse benefit determination" means a denial, reduction, or  
30 termination of, or a failure to provide or make payment, in whole or  
31 in part, for a benefit, including a denial, reduction, termination,

1 or failure to provide or make payment that is based on a  
2 determination of an enrollee's or applicant's eligibility to  
3 participate in a plan, and including, with respect to group health  
4 plans, a denial, reduction, or termination of, or a failure to  
5 provide or make payment, in whole or in part, for a benefit resulting  
6 from the application of any utilization review, as well as a failure  
7 to cover an item or service for which benefits are otherwise provided  
8 because it is determined to be experimental or investigational or not  
9 medically necessary or appropriate.

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

13 (4) "Balance bill" means a bill sent to an enrollee by an out-of-  
14 network provider or facility for health care services provided to the  
15 enrollee after the provider or facility's billed amount is not fully  
16 reimbursed by the carrier, exclusive of permitted cost-sharing.

17 (5) "Basic health plan" means the plan described under chapter  
18 70.47 RCW, as revised from time to time.

19 ~~((+5))~~ (6) "Basic health plan model plan" means a health plan as  
20 required in RCW 70.47.060(2)(e).

21 ~~((+6))~~ (7) "Basic health plan services" means that schedule of  
22 covered health services, including the description of how those  
23 benefits are to be administered, that are required to be delivered to  
24 an enrollee under the basic health plan, as revised from time to  
25 time.

26 ~~((+7))~~ (8) "Board" means the governing board of the Washington  
27 health benefit exchange established in chapter 43.71 RCW.

28 ~~((+8))~~ (9)(a) For grandfathered health benefit plans issued  
29 before January 1, 2014, and renewed thereafter, "catastrophic health  
30 plan" means:

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

38 (ii) In the case of a contract, agreement, or policy covering  
39 more than one enrollee, a health benefit plan requiring a calendar  
40 year deductible of, at a minimum, three thousand five hundred dollars

1 and an annual out-of-pocket expense required to be paid under the  
2 plan (other than for premiums) for covered benefits of at least six  
3 thousand dollars, both amounts to be adjusted annually by the  
4 insurance commissioner.

5 (b) In July 2008, and in each July thereafter, the insurance  
6 commissioner shall adjust the minimum deductible and out-of-pocket  
7 expense required for a plan to qualify as a catastrophic plan to  
8 reflect the percentage change in the consumer price index for medical  
9 care for a preceding twelve months, as determined by the United  
10 States department of labor. For a plan year beginning in 2014, the  
11 out-of-pocket limits must be adjusted as specified in section  
12 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount  
13 shall apply on the following January 1st.

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

16 (i) A health benefit plan that meets the definition of  
17 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of  
18 2010, as amended; or

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

24 ~~((9))~~ (10) "Certification" means a determination by a review  
25 organization that an admission, extension of stay, or other health  
26 care service or procedure has been reviewed and, based on the  
27 information provided, meets the clinical requirements for medical  
28 necessity, appropriateness, level of care, or effectiveness under the  
29 auspices of the applicable health benefit plan.

30 ~~((10))~~ (11) "Concurrent review" means utilization review  
31 conducted during a patient's hospital stay or course of treatment.

32 ~~((11))~~ (12) "Covered person" or "enrollee" means a person  
33 covered by a health plan including an enrollee, subscriber,  
34 policyholder, beneficiary of a group plan, or individual covered by  
35 any other health plan.

36 ~~((12))~~ (13) "Dependent" means, at a minimum, the enrollee's  
37 legal spouse and dependent children who qualify for coverage under  
38 the enrollee's health benefit plan.

39 ~~((13))~~ (14) "Emergency medical condition" means a medical,  
40 mental health, or substance use disorder condition manifesting itself

1 by acute symptoms of sufficient severity(~~(7)~~) including, but not  
2 limited to, severe pain or emotional distress, such that a prudent  
3 layperson, who possesses an average knowledge of health and medicine,  
4 could reasonably expect the absence of immediate medical, mental  
5 health, or substance use disorder treatment attention to result in a  
6 condition (a) placing the health of the individual, or with respect  
7 to a pregnant woman, the health of the woman or her unborn child, in  
8 serious jeopardy, (b) serious impairment to bodily functions, or (c)  
9 serious dysfunction of any bodily organ or part.

10 ~~((14))~~ (15) "Emergency services" means a medical screening  
11 examination, as required under section 1867 of the social security  
12 act (42 U.S.C. 1395dd), that is within the capability of the  
13 emergency department of a hospital, including ancillary services  
14 routinely available to the emergency department to evaluate that  
15 emergency medical condition, and further medical examination and  
16 treatment, to the extent they are within the capabilities of the  
17 staff and facilities available at the hospital, as are required under  
18 section 1867 of the social security act (42 U.S.C. 1395dd) to  
19 stabilize the patient. Stabilize, with respect to an emergency  
20 medical condition, has the meaning given in section 1867(e)(3) of the  
21 social security act (42 U.S.C. 1395dd(e)(3)).

22 ~~((15))~~ (16) "Employee" has the same meaning given to the term,  
23 as of January 1, 2008, under section 3(6) of the federal employee  
24 retirement income security act of 1974.

25 ~~((16))~~ (17) "Enrollee point-of-service cost-sharing" or "cost-  
26 sharing" means amounts paid to health carriers directly providing  
27 services, health care providers, or health care facilities by  
28 enrollees and may include copayments, coinsurance, or deductibles.

29 ~~((17))~~ (18) "Exchange" means the Washington health benefit  
30 exchange established under chapter 43.71 RCW.

31 ~~((18))~~ (19) "Final external review decision" means a  
32 determination by an independent review organization at the conclusion  
33 of an external review.

34 ~~((19))~~ (20) "Final internal adverse benefit determination"  
35 means an adverse benefit determination that has been upheld by a  
36 health plan or carrier at the completion of the internal appeals  
37 process, or an adverse benefit determination with respect to which  
38 the internal appeals process has been exhausted under the exhaustion  
39 rules described in RCW 48.43.530 and 48.43.535.

1        ~~((20))~~ (21) "Grandfathered health plan" means a group health  
2 plan or an individual health plan that under section 1251 of the  
3 patient protection and affordable care act, P.L. 111-148 (2010) and  
4 as amended by the health care and education reconciliation act, P.L.  
5 111-152 (2010) is not subject to subtitles A or C of the act as  
6 amended.

7        ~~((21))~~ (22) "Grievance" means a written complaint submitted by  
8 or on behalf of a covered person regarding service delivery issues  
9 other than denial of payment for medical services or nonprovision of  
10 medical services, including dissatisfaction with medical care,  
11 waiting time for medical services, provider or staff attitude or  
12 demeanor, or dissatisfaction with service provided by the health  
13 carrier.

14        ~~((22))~~ (23) "Health care facility" or "facility" means hospices  
15 licensed under chapter 70.127 RCW, hospitals licensed under chapter  
16 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,  
17 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes  
18 licensed under chapter 18.51 RCW, community mental health centers  
19 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment  
20 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,  
21 treatment, or surgical facilities licensed under chapter 70.41 RCW,  
22 drug and alcohol treatment facilities licensed under chapter 70.96A  
23 RCW, and home health agencies licensed under chapter 70.127 RCW, and  
24 includes such facilities if owned and operated by a political  
25 subdivision or instrumentality of the state and such other facilities  
26 as required by federal law and implementing regulations.

27        ~~((23))~~ (24) "Health care provider" or "provider" means:

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

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

33        ~~((24))~~ (25) "Health care service" means that service offered or  
34 provided by health care facilities and health care providers relating  
35 to the prevention, cure, or treatment of illness, injury, or disease.

36        ~~((25))~~ (26) "Health carrier" or "carrier" means a disability  
37 insurer regulated under chapter 48.20 or 48.21 RCW, a health care  
38 service contractor as defined in RCW 48.44.010, or a health  
39 maintenance organization as defined in RCW 48.46.020, and includes

1 "issuers" as that term is used in the patient protection and  
2 affordable care act (P.L. 111-148).

3 ~~((+26+))~~ (27) "Health plan" or "health benefit plan" means any  
4 policy, contract, or agreement offered by a health carrier to  
5 provide, arrange, reimburse, or pay for health care services except  
6 the following:

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

9 (b) Medicare supplemental health insurance governed by chapter  
10 48.66 RCW;

11 (c) Coverage supplemental to the coverage provided under chapter  
12 55, Title 10, United States Code;

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

15 (e) Disability income;

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

19 (g) Workers' compensation coverage;

20 (h) Accident only coverage;

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

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

26 (k) Dental only and vision only coverage;

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

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

36 ~~((+27+))~~ (28) "In-network" or "participating" means a provider or  
37 facility that has contracted with a carrier or a carrier's contractor  
38 or subcontractor to provide health care services to enrollees for the  
39 purpose of receiving reimbursement from the carrier at specified

1 levels as payment in full for the health care services, including  
2 applicable cost-sharing obligations.

3 ~~((28))~~ (29) "Individual market" means the market for health insurance  
4 coverage offered to individuals other than in connection with a group  
5 health plan.

6 ~~((28))~~ (30) "Material modification" means a change in the  
7 actuarial value of the health plan as modified of more than five  
8 percent but less than fifteen percent.

9 ~~((29))~~ (31) "Open enrollment" means a period of time as defined  
10 in rule to be held at the same time each year, during which  
11 applicants may enroll in a carrier's individual health benefit plan  
12 without being subject to health screening or otherwise required to  
13 provide evidence of insurability as a condition for enrollment.

14 ~~((30))~~ (32) "Out-of-network" or "nonparticipating" means a  
15 provider or facility that has not contracted with a carrier or a  
16 carrier's contractor or subcontractor to provide health care services  
17 to enrollees.

18 (33) "Out-of-pocket maximum" means the maximum amount an enrollee  
19 is required to pay in the form of cost-sharing for covered benefits  
20 in a plan year, after which the carrier covers the entirety of the  
21 allowed amount of covered benefits under the contract of coverage.

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

25 ~~((31))~~ (35) "Premium" means all sums charged, received, or  
26 deposited by a health carrier as consideration for a health plan or  
27 the continuance of a health plan. Any assessment or any "membership,"  
28 "policy," "contract," "service," or similar fee or charge made by a  
29 health carrier in consideration for a health plan is deemed part of  
30 the premium. "Premium" shall not include amounts paid as enrollee  
31 point-of-service cost-sharing.

32 ~~((32))~~ (36) "Review organization" means a disability insurer  
33 regulated under chapter 48.20 or 48.21 RCW, health care service  
34 contractor as defined in RCW 48.44.010, or health maintenance  
35 organization as defined in RCW 48.46.020, and entities affiliated  
36 with, under contract with, or acting on behalf of a health carrier to  
37 perform a utilization review.

38 ~~((33))~~ (37) "Small employer" or "small group" means any person,  
39 firm, corporation, partnership, association, political subdivision,  
40 sole proprietor, or self-employed individual that is actively engaged

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

29 ~~((+34+))~~ (38) "Special enrollment" means a defined period of time  
30 of not less than thirty-one days, triggered by a specific qualifying  
31 event experienced by the applicant, during which applicants may  
32 enroll in the 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 ~~((+35+))~~ (39) "Standard health questionnaire" means the standard  
36 health questionnaire designated under chapter 48.41 RCW.

37 ~~((+36+))~~ (40) "Utilization review" means the prospective,  
38 concurrent, or retrospective assessment of the necessity and  
39 appropriateness of the allocation of health care resources and



1 services of a provider or facility, given or proposed to be given to  
2 an enrollee or group of enrollees.

3 ~~((37))~~ (41) "Wellness activity" means an explicit program of an  
4 activity consistent with department of health guidelines, such as,  
5 smoking cessation, injury and accident prevention, reduction of  
6 alcohol misuse, appropriate weight reduction, exercise, automobile  
7 and motorcycle safety, blood cholesterol reduction, and nutrition  
8 education for the purpose of improving enrollee health status and  
9 reducing health service costs.

10 **Sec. 3.** RCW 48.43.093 and 1997 c 231 s 301 are each amended to  
11 read as follows:

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

15 (a) A health carrier shall cover emergency services necessary to  
16 screen and stabilize a covered person if a prudent layperson acting  
17 reasonably would have believed that an emergency medical condition  
18 existed. In addition, a health carrier shall not require prior  
19 authorization of ~~((such))~~ emergency services provided prior to the  
20 point of stabilization if a prudent layperson acting reasonably would  
21 have believed that an emergency medical condition existed. With  
22 respect to care obtained from ~~((a nonparticipating))~~ an out-of-  
23 network hospital emergency department, a health carrier shall cover  
24 emergency services necessary to screen and stabilize a covered person  
25 ~~((if a prudent layperson would have reasonably believed that use of a~~  
26 ~~participating hospital emergency department would result in a delay~~  
27 ~~that would worsen the emergency, or if a provision of federal, state,~~  
28 ~~or local law requires the use of a specific provider or facility)).~~  
29 In addition, a health carrier shall not require prior authorization  
30 of ~~((such))~~ the services provided prior to the point of stabilization  
31 ~~((if a prudent layperson acting reasonably would have believed that~~  
32 ~~an emergency medical condition existed and that use of a~~  
33 ~~participating hospital emergency department would result in a delay~~  
34 ~~that would worsen the emergency)).~~

35 (b) If an authorized representative of a health carrier  
36 authorizes coverage of emergency services, the health carrier shall  
37 not subsequently retract its authorization after the emergency  
38 services have been provided, or reduce payment for an item or service  
39 furnished in reliance on approval, unless the approval was based on a

1 material misrepresentation about the covered person's health  
2 condition made by the provider of emergency services.

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

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

19 ~~(ii) A prudent layperson possessing an average knowledge of~~  
20 ~~health and medicine would have reasonably believed that he or she~~  
21 ~~would be unable to go to a participating hospital emergency~~  
22 ~~department in a timely fashion without serious impairment to the~~  
23 ~~covered person's health)) as provided in sections 4 through 15 of~~  
24 ~~this act.~~

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

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

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

9 ~~((2))~~ (4) Nothing in this section is to be construed as  
10 prohibiting the health carrier from requiring notification within the  
11 time frame specified in the contract for inpatient admission or as  
12 soon thereafter as medically possible but no less than twenty-four  
13 hours. Nothing in this section is to be construed as preventing the  
14 health carrier from reserving the right to require transfer of a  
15 hospitalized covered person upon stabilization. Follow-up care that  
16 is a direct result of the emergency must be obtained in accordance  
17 with the health plan's usual terms and conditions of coverage. All  
18 other terms and conditions of coverage may be applied to emergency  
19 services.

20 NEW SECTION. Sec. 4. This subchapter may be known and cited as  
21 the balance billing protection act.

22 NEW SECTION. Sec. 5. (1) An out-of-network provider or facility  
23 may not balance bill an enrollee for the following health care  
24 services:

25 (a) Emergency services provided to an enrollee; and  
26 (b) Nonemergency health care services provided to an enrollee at  
27 an in-network hospital licensed under chapter 70.41 RCW or an in-  
28 network ambulatory surgical facility licensed under chapter 70.230  
29 RCW if the services:

30 (i) Involve surgical or ancillary services; and  
31 (ii) Are provided by an out-of-network provider.

32 (2) Payment for services described in subsection (1) of this  
33 section is subject to sections 6 and 7 of this act.

34 (3) For purposes of this subchapter, "surgical or ancillary  
35 services" means surgery, anesthesiology, pathology, radiology,  
36 laboratory, or hospitalist services.

1        NEW SECTION.    **Sec. 6.**    (1) If an enrollee receives emergency or  
2 nonemergency health care services under the circumstances described  
3 in section 5 of this act:

4        (a) The enrollee satisfies his or her obligation to pay for the  
5 health care services if he or she pays the in-network cost-sharing  
6 amount specified in the enrollee's or applicable group's health plan  
7 contract;

8        (b) The carrier, out-of-network provider, or out-of-network  
9 facility, and an agent, trustee, or assignee of the carrier, out-of-  
10 network provider, or out-of-network facility must ensure that the  
11 enrollee incurs no greater cost than he or she would have incurred if  
12 the services had been provided by an in-network provider or at an in-  
13 network facility;

14        (c) The out-of-network provider or out-of-network facility, and  
15 an agent, trustee, or assignee of the out-of-network provider or out-  
16 of-network facility:

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

22        (ii) May not report adverse information to a consumer credit  
23 reporting agency or commence a civil action against the enrollee  
24 before the expiration of one hundred fifty days after the initial  
25 billing for the amount owed by the enrollee under this subsection  
26 (1); and

27        (iii) May not use wage garnishments or liens on the primary  
28 residence of the enrollee as a means of collecting unpaid bills under  
29 this subsection (1);

30        (d) The carrier must:

31        (i) Calculate the in-network cost-sharing amount for the out-of-  
32 network provider or facility's services using the greater of the  
33 amounts specified in subsection (3) of this section; and

34        (ii) Treat any cost-sharing amounts paid by the enrollee for such  
35 services in the same manner as cost-sharing for health care services  
36 provided by an in-network provider and must apply any cost-sharing  
37 amounts paid by the enrollee for such services toward the limit on  
38 the enrollee's in-network out-of-pocket maximum expenses.

39        (e) If the enrollee pays the out-of-network provider or out-of-  
40 network facility an amount that exceeds the in-network cost-sharing

1 amount specified in the carrier's explanation of benefits, the  
2 provider or facility must refund any amount in excess of the in-  
3 network cost-sharing amount to the enrollee within thirty business  
4 days of receipt. Interest must be paid to the enrollee for any  
5 unrefunded payments at a rate of twelve percent beginning on the  
6 first calendar day after the thirty business days.

7 (2) Upon receipt of an out-of-network provider or facility's bill  
8 for health care services described in section 5 of this act, the  
9 carrier must make its applicable payment directly to the provider or  
10 facility, rather than the enrollee.

11 (3) The carrier must adjudicate the claim using an allowed amount  
12 for the health care service that is the greater of:

13 (a) The median allowed amount paid to in-network providers for  
14 the health care service provided as determined by reference to the  
15 data set prepared by the Washington state all payer claims database  
16 under section 22 of this act, including any applicable enrollee in-  
17 network cost-sharing requirement;

18 (b) The median amount paid to out-of-network providers for the  
19 health care service provided, as determined by reference to the data  
20 set prepared by the Washington state all payer claims database under  
21 section 22 of this act, including any applicable enrollee in-network  
22 cost-sharing requirement; or

23 (c) One hundred seventy-five percent of the amount that would be  
24 paid under medicare, Title XVIII of the federal social security act,  
25 for the service, including any applicable enrollee in-network cost-  
26 sharing requirement.

27 NEW SECTION. **Sec. 7.** (1) In the event of a dispute between a  
28 carrier and an out-of-network provider or facility regarding payment  
29 for the services described in section 5 of this act, a party wishing  
30 to pursue a payment dispute must initiate an informal settlement  
31 communication no later than thirty days after receipt of payment or  
32 payment notification from the carrier. A party may not refuse to  
33 participate in a teleconference or in-person meeting if requested.

34 (2)(a) If the informal settlement communication does not result  
35 in a resolution, a carrier, out-of-network provider, or out-of-  
36 network facility may initiate arbitration to determine a reasonable  
37 payment amount. To initiate arbitration, the carrier, provider, or  
38 facility must provide written notification to the commissioner and  
39 the noninitiating party no later than sixty days after initiation of

1 the informal settlement communication. The notification to the  
2 noninitiating party must state the initiating party's final offer. No  
3 later than thirty days following receipt of the notification, the  
4 noninitiating party must provide its final offer to the initiating  
5 party. The parties may reach an agreement on reimbursement during  
6 this time and before the arbitration proceeding.

7 (b) Multiple claims may be addressed in a single arbitration  
8 proceeding if the claims at issue:

9 (i) Involve identical carrier and provider or facility parties;

10 (ii) Involve claims with the same or related current procedural  
11 terminology codes relevant to a particular procedure; and

12 (iii) Occur within a period of six months of one another.

13 (3) Upon receipt of notification from the initiating party, the  
14 commissioner must provide the parties with a list of approved  
15 arbitrators or entities that provide binding arbitration. The  
16 arbitrators on the list must be trained by the American arbitration  
17 association or the American health lawyers association. The parties  
18 may agree on an arbitrator from the list provided by the  
19 commissioner. If the parties do not agree on an arbitrator, they must  
20 notify the commissioner who must provide them with the names of five  
21 arbitrators from the list. Each party may veto two of the five named  
22 arbitrators. If one arbitrator remains, that person is the chosen  
23 arbitrator. If more than one arbitrator remains, the commissioner  
24 must choose the arbitrator from the remaining arbitrators. The  
25 parties and the commissioner must complete this selection process  
26 within twenty days of receipt of the list from the commissioner.

27 (4)(a) Each party must make written submissions to the arbitrator  
28 in support of its position no later than thirty days after the final  
29 selection of the arbitrator. A party that fails to make timely  
30 written submissions under this section without good cause shown shall  
31 be considered to be in default and the arbitrator shall require the  
32 party in default to pay the final offer amount submitted by the party  
33 not in default and may require the party in default to pay the  
34 reasonable attorneys' fees of the party not in default. No later than  
35 thirty days after the receipt of the parties' written submissions,  
36 the arbitrator must: Issue a written decision requiring payment of  
37 the final offer amount of either the initiating party or the  
38 noninitiating party; notify the parties of its decision; and provide  
39 the decision and the information described in section 8 of this act  
40 regarding the decision to the commissioner.

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

5 (i) The median amounts determined under section 6(3)(a) and (b)  
6 of this act;

7 (ii) The median billed charge amount for the service at issue  
8 reported in the data set prepared by the Washington state all payer  
9 claims database under section 22 of this act;

10 (iii) The circumstances and complexity of the case, including  
11 time and place of service and whether the service was delivered at a  
12 level I or level II trauma center or a rural facility;

13 (iv) Patient characteristics; and

14 (v) The level of training, education, and experience of the  
15 provider.

16 (c) The arbitrator may also consider other information that a  
17 party believes is justified or other factors the arbitrator requests.

18 (5) Expenses incurred in the course of arbitration, including the  
19 arbitrator's expenses and fees, but not including attorneys' fees,  
20 must be paid by the party whose final offer was rejected by the  
21 arbitrator. The enrollee is not liable for any of the costs of the  
22 arbitration and may not be required to participate in the arbitration  
23 proceeding as a witness or otherwise.

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

27 (7) Chapter 7.04A RCW applies to arbitrations conducted under  
28 this section, but in the event of a conflict between this section and  
29 chapter 7.04A RCW, this section governs.

30 NEW SECTION. **Sec. 8.** (1) The commissioner must prepare an  
31 annual report summarizing the dispute resolution information provided  
32 by arbitrators under section 7 of this act. The report must include  
33 summary information related to the matters decided through  
34 arbitration, as well as the following information for each dispute  
35 resolved through arbitration: The carrier; the health care provider;  
36 the health care provider's employer or the business entity in which  
37 the provider has an ownership interest; the health care facility  
38 where the services were provided; and the type of health care  
39 services at issue.

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

4 (3) This section expires January 1, 2023.

5 NEW SECTION. **Sec. 9.** (1) A nonemployed provider group that  
6 provides surgical or ancillary services at a hospital or ambulatory  
7 surgical facility must notify the hospital or ambulatory surgical  
8 facility of the carrier health plan networks in which the provider  
9 group is an in-network provider. The provider group must notify the  
10 hospital or ambulatory surgical facility if the contract between the  
11 provider group and such a carrier will be terminated. The provider  
12 group must provide the notice as soon as practicable, but in no case  
13 less than forty-five days prior to termination of the contract.

14 (2) A hospital or ambulatory surgical facility must post the  
15 following information on its web site, if one is available:

16 (a) A list of the carrier health plan provider networks with  
17 which the hospital or ambulatory surgical facility is an in-network  
18 provider; and

19 (b) For each nonemployed provider group with which the hospital  
20 or ambulatory surgical facility has a contract to provide surgical or  
21 ancillary services, whether the provider group contracts with the  
22 same carrier health plan provider networks as the hospital or  
23 ambulatory surgical facility.

24 NEW SECTION. **Sec. 10.** (1) A health care provider must provide  
25 information on its web site, if available, listing the carrier health  
26 plan provider networks with which the provider contracts.

27 (2) An in-network provider must submit accurate information to a  
28 carrier regarding the provider's network status in a timely manner,  
29 consistent with the terms of the contract between the provider and  
30 the carrier.

31 NEW SECTION. **Sec. 11.** (1) A carrier must update its web site  
32 and provider directory no later than thirty days after the addition  
33 or termination of a facility or provider.

34 (2) A carrier must provide an enrollee with:

35 (a) A clear description of the health plan's out-of-network  
36 health benefits;



1 (b) Notice of rights under this subchapter using the standard  
2 template language developed under section 13 of this act;

3 (c) Notification that if the enrollee receives services from an  
4 out-of-network provider or facility, under circumstances other than  
5 those described in section 5 of this act, the enrollee will have the  
6 financial responsibility applicable to services provided outside the  
7 health plan's network in excess of applicable cost-sharing amounts  
8 and that the enrollee may be responsible for any costs in excess of  
9 those allowed by the health plan;

10 (d) Information on how to use the carrier's member transparency  
11 tools under RCW 48.43.007;

12 (e) Upon request, information regarding whether a health care  
13 provider is in-network or out-of-network; and

14 (f) Upon request, an estimated range of the out-of-pocket costs  
15 for an out-of-network benefit.

16 NEW SECTION. **Sec. 12.** (1) If the commissioner has cause to  
17 believe that any person, including a health care provider or  
18 facility, is violating a provision of this subchapter, the  
19 commissioner may submit information to the department of health or  
20 the appropriate disciplining authority for action.

21 (2) If any person, including a health care provider or facility,  
22 violates or has violated a provision of this subchapter, the  
23 department of health or the appropriate disciplining authority may  
24 levy a fine upon the person in an amount not to exceed one thousand  
25 dollars per violation and take other action as permitted under the  
26 authority of the department or disciplining authority. Upon  
27 completion of its review of any potential violation submitted by the  
28 commissioner or initiated directly by an enrollee, the department of  
29 health or the disciplining authority shall notify the commissioner of  
30 the results of the review, including whether the violation was  
31 substantiated and any enforcement action taken as a result of a  
32 finding of a substantiated violation.

33 (3) If a carrier violates or has violated any provision of this  
34 subchapter, the commissioner may levy a fine or apply remedies  
35 authorized under chapter 48.02 RCW.

36 (4) For purposes of this section, "disciplining authority" means  
37 the agency, board, or commission having the authority to take  
38 disciplinary action against a holder of, or applicant for, a

1 professional or business license upon a finding of a violation of  
2 chapter 18.130 RCW or a chapter specified under RCW 18.130.040.

3 NEW SECTION. **Sec. 13.** (1) The commissioner may adopt rules to  
4 implement and administer this subchapter, including rules governing  
5 the dispute resolution process established in section 7 of this act.

6 (2)(a) The commissioner, in consultation with health carriers,  
7 health care providers, health care facilities, and consumers, must  
8 develop standard template language for notifying consumers:

9 (i) That they may not be balance billed for the health care  
10 services described in section 5 of this act and will receive the  
11 protections provided by section 6 of this act;

12 (ii) That they may be balance billed for health care services  
13 under circumstances other than those described in section 5 of this  
14 act.

15 (b) The standard template language must include contact  
16 information for the office of the insurance commissioner so that  
17 consumers may contact the office of the insurance commissioner if  
18 they believe they have received a balance bill in violation of this  
19 subchapter.

20 (c) The office of the insurance commissioner shall determine by  
21 rule when and in what format health carriers, health care providers,  
22 and health care facilities must provide consumers with the notice  
23 developed under this section.

24 NEW SECTION. **Sec. 14.** This subchapter does not apply to health  
25 plans that provide benefits under chapter 74.09 RCW.

26 NEW SECTION. **Sec. 15.** This subchapter must be liberally  
27 construed to promote the public interest by ensuring that consumers  
28 are not billed out-of-network charges and do not receive additional  
29 bills from providers under the circumstances described in section 5  
30 of this act.

31 NEW SECTION. **Sec. 16.** (1) When determining the adequacy of a  
32 proposed provider network or the ongoing adequacy of an in-force  
33 provider network, the commissioner must consider whether the  
34 carrier's proposed provider network or in-force provider network  
35 includes a sufficient number of contracted providers practicing at  
36 the same facilities with which the carrier has contracted for the

1 proposed or established provider network to reasonably ensure  
2 enrollees have in-network access for covered benefits delivered at  
3 that facility.

4 (2) A hospital or ambulatory surgical facility must provide the  
5 carrier with information about the network status of nonemployed  
6 provider groups that provide services at the hospital or ambulatory  
7 surgical facility using the information provided under section 9 of  
8 this act.

9 **Sec. 17.** RCW 18.130.050 and 2016 c 81 s 13 are each amended to  
10 read as follows:

11 Except as provided in RCW 18.130.062, the disciplining authority  
12 has the following authority:

13 (1) To adopt, amend, and rescind such rules as are deemed  
14 necessary to carry out this chapter;

15 (2) To investigate all complaints or reports of unprofessional  
16 conduct as defined in this chapter;

17 (3) To hold hearings as provided in this chapter;

18 (4) To issue subpoenas and administer oaths in connection with  
19 any investigation, consideration of an application for license,  
20 hearing, or proceeding held under this chapter;

21 (5) To take or cause depositions to be taken and use other  
22 discovery procedures as needed in any investigation, hearing, or  
23 proceeding held under this chapter;

24 (6) To compel attendance of witnesses at hearings;

25 (7) In the course of investigating a complaint or report of  
26 unprofessional conduct, to conduct practice reviews and to issue  
27 citations and assess fines for failure to produce documents, records,  
28 or other items in accordance with RCW 18.130.230;

29 (8) To take emergency action ordering summary suspension of a  
30 license, or restriction or limitation of the license holder's  
31 practice pending proceedings by the disciplining authority. Within  
32 fourteen days of a request by the affected license holder, the  
33 disciplining authority must provide a show cause hearing in  
34 accordance with the requirements of RCW 18.130.135. In addition to  
35 the authority in this subsection, a disciplining authority shall,  
36 except as provided in RCW 9.97.020:

37 (a) Consistent with RCW 18.130.370, issue a summary suspension of  
38 the license or temporary practice permit of a license holder  
39 prohibited from practicing a health care profession in another state,

1 federal, or foreign jurisdiction because of an act of unprofessional  
2 conduct that is substantially equivalent to an act of unprofessional  
3 conduct prohibited by this chapter or any of the chapters specified  
4 in RCW 18.130.040. The summary suspension remains in effect until  
5 proceedings by the Washington disciplining authority have been  
6 completed;

7 (b) Consistent with RCW 18.130.400, issue a summary suspension of  
8 the license or temporary practice permit if, under RCW 74.39A.051,  
9 the license holder is prohibited from employment in the care of  
10 vulnerable adults based upon a department of social and health  
11 services' final finding of abuse or neglect of a minor or abuse,  
12 abandonment, neglect, or financial exploitation of a vulnerable  
13 adult. The summary suspension remains in effect until proceedings by  
14 the disciplining authority have been completed;

15 (9) To conduct show cause hearings in accordance with RCW  
16 18.130.062 or 18.130.135 to review an action taken by the  
17 disciplining authority to suspend a license or restrict or limit a  
18 license holder's practice pending proceedings by the disciplining  
19 authority;

20 (10) To use a presiding officer as authorized in RCW  
21 18.130.095(3) or the office of administrative hearings as authorized  
22 in chapter 34.12 RCW to conduct hearings. Disciplining authorities  
23 identified in RCW 18.130.040(2) shall make the final decision  
24 regarding disposition of the license unless the disciplining  
25 authority elects to delegate in writing the final decision to the  
26 presiding officer. Disciplining authorities identified in RCW  
27 18.130.040(2)(b) may not delegate the final decision regarding  
28 disposition of the license or imposition of sanctions to a presiding  
29 officer in any case pertaining to standards of practice or where  
30 clinical expertise is necessary, including deciding any motion that  
31 results in dismissal of any allegation contained in the statement of  
32 charges. Presiding officers acting on behalf of the secretary shall  
33 enter initial orders. The secretary may, by rule, provide that  
34 initial orders in specified classes of cases may become final without  
35 further agency action unless, within a specified time period:

36 (a) The secretary upon his or her own motion determines that the  
37 initial order should be reviewed; or

38 (b) A party to the proceedings files a petition for  
39 administrative review of the initial order;

1 (11) To use individual members of the boards to direct  
2 investigations and to authorize the issuance of a citation under  
3 subsection (7) of this section. However, the member of the board  
4 shall not subsequently participate in the hearing of the case;

5 (12) To enter into contracts for professional services determined  
6 to be necessary for adequate enforcement of this chapter;

7 (13) To contract with license holders or other persons or  
8 organizations to provide services necessary for the monitoring and  
9 supervision of license holders who are placed on probation, whose  
10 professional activities are restricted, or who are for any authorized  
11 purpose subject to monitoring by the disciplining authority;

12 (14) To adopt standards of professional conduct or practice;

13 (15) To grant or deny license applications, and in the event of a  
14 finding of unprofessional conduct by an applicant or license holder,  
15 to impose any sanction against a license applicant or license holder  
16 provided by this chapter. After January 1, 2009, all sanctions must  
17 be issued in accordance with RCW 18.130.390;

18 (16) To restrict or place conditions on the practice of new  
19 licensees in order to protect the public and promote the safety of  
20 and confidence in the health care system;

21 (17) To designate individuals authorized to sign subpoenas and  
22 statements of charges;

23 (18) To establish panels consisting of three or more members of  
24 the board to perform any duty or authority within the board's  
25 jurisdiction under this chapter;

26 (19) To review and audit the records of licensed health  
27 facilities' or services' quality assurance committee decisions in  
28 which a license holder's practice privilege or employment is  
29 terminated or restricted. Each health facility or service shall  
30 produce and make accessible to the disciplining authority the  
31 appropriate records and otherwise facilitate the review and audit.  
32 Information so gained shall not be subject to discovery or  
33 introduction into evidence in any civil action pursuant to RCW  
34 70.41.200(3);

35 (20) To levy a fine in an amount not to exceed one thousand  
36 dollars per violation and take other action as permitted under the  
37 authority of the disciplining authority, if a report of a potential  
38 violation of sections 4 through 16 of this act by a health care  
39 provider is substantiated.

1       **Sec. 18.** RCW 18.130.180 and 2010 c 9 s 5 are each amended to  
2 read as follows:

3       The following conduct, acts, or conditions constitute  
4 unprofessional conduct for any license holder under the jurisdiction  
5 of this chapter:

6       (1) The commission of any act involving moral turpitude,  
7 dishonesty, or corruption relating to the practice of the person's  
8 profession, whether the act constitutes a crime or not. If the act  
9 constitutes a crime, conviction in a criminal proceeding is not a  
10 condition precedent to disciplinary action. Upon such a conviction,  
11 however, the judgment and sentence is conclusive evidence at the  
12 ensuing disciplinary hearing of the guilt of the license holder of  
13 the crime described in the indictment or information, and of the  
14 person's violation of the statute on which it is based. For the  
15 purposes of this section, conviction includes all instances in which  
16 a plea of guilty or nolo contendere is the basis for the conviction  
17 and all proceedings in which the sentence has been deferred or  
18 suspended. Nothing in this section abrogates rights guaranteed under  
19 chapter 9.96A RCW;

20       (2) Misrepresentation or concealment of a material fact in  
21 obtaining a license or in reinstatement thereof;

22       (3) All advertising which is false, fraudulent, or misleading;

23       (4) Incompetence, negligence, or malpractice which results in  
24 injury to a patient or which creates an unreasonable risk that a  
25 patient may be harmed. The use of a nontraditional treatment by  
26 itself shall not constitute unprofessional conduct, provided that it  
27 does not result in injury to a patient or create an unreasonable risk  
28 that a patient may be harmed;

29       (5) Suspension, revocation, or restriction of the individual's  
30 license to practice any health care profession by competent authority  
31 in any state, federal, or foreign jurisdiction, a certified copy of  
32 the order, stipulation, or agreement being conclusive evidence of the  
33 revocation, suspension, or restriction;

34       (6) Except when authorized by RCW 18.130.345, the possession,  
35 use, prescription for use, or distribution of controlled substances  
36 or legend drugs in any way other than for legitimate or therapeutic  
37 purposes, diversion of controlled substances or legend drugs, the  
38 violation of any drug law, or prescribing controlled substances for  
39 oneself;

1 (7) Violation of any state or federal statute or administrative  
2 rule regulating the profession in question, including any statute or  
3 rule defining or establishing standards of patient care or  
4 professional conduct or practice;

5 (8) Failure to cooperate with the disciplining authority by:

6 (a) Not furnishing any papers, documents, records, or other  
7 items;

8 (b) Not furnishing in writing a full and complete explanation  
9 covering the matter contained in the complaint filed with the  
10 disciplining authority;

11 (c) Not responding to subpoenas issued by the disciplining  
12 authority, whether or not the recipient of the subpoena is the  
13 accused in the proceeding; or

14 (d) Not providing reasonable and timely access for authorized  
15 representatives of the disciplining authority seeking to perform  
16 practice reviews at facilities utilized by the license holder;

17 (9) Failure to comply with an order issued by the disciplining  
18 authority or a stipulation for informal disposition entered into with  
19 the disciplining authority;

20 (10) Aiding or abetting an unlicensed person to practice when a  
21 license is required;

22 (11) Violations of rules established by any health agency;

23 (12) Practice beyond the scope of practice as defined by law or  
24 rule;

25 (13) Misrepresentation or fraud in any aspect of the conduct of  
26 the business or profession;

27 (14) Failure to adequately supervise auxiliary staff to the  
28 extent that the consumer's health or safety is at risk;

29 (15) Engaging in a profession involving contact with the public  
30 while suffering from a contagious or infectious disease involving  
31 serious risk to public health;

32 (16) Promotion for personal gain of any unnecessary or  
33 inefficacious drug, device, treatment, procedure, or service;

34 (17) Conviction of any gross misdemeanor or felony relating to  
35 the practice of the person's profession. For the purposes of this  
36 subsection, conviction includes all instances in which a plea of  
37 guilty or nolo contendere is the basis for conviction and all  
38 proceedings in which the sentence has been deferred or suspended.  
39 Nothing in this section abrogates rights guaranteed under chapter  
40 9.96A RCW;

1 (18) The procuring, or aiding or abetting in procuring, a  
2 criminal abortion;

3 (19) The offering, undertaking, or agreeing to cure or treat  
4 disease by a secret method, procedure, treatment, or medicine, or the  
5 treating, operating, or prescribing for any health condition by a  
6 method, means, or procedure which the licensee refuses to divulge  
7 upon demand of the disciplining authority;

8 (20) The willful betrayal of a practitioner-patient privilege as  
9 recognized by law;

10 (21) Violation of chapter 19.68 RCW or sections 4 through 15 of  
11 this act;

12 (22) Interference with an investigation or disciplinary  
13 proceeding by willful misrepresentation of facts before the  
14 disciplining authority or its authorized representative, or by the  
15 use of threats or harassment against any patient or witness to  
16 prevent them from providing evidence in a disciplinary proceeding or  
17 any other legal action, or by the use of financial inducements to any  
18 patient or witness to prevent or attempt to prevent him or her from  
19 providing evidence in a disciplinary proceeding;

20 (23) Current misuse of:

21 (a) Alcohol;

22 (b) Controlled substances; or

23 (c) Legend drugs;

24 (24) Abuse of a client or patient or sexual contact with a client  
25 or patient;

26 (25) Acceptance of more than a nominal gratuity, hospitality, or  
27 subsidy offered by a representative or vendor of medical or health-  
28 related products or services intended for patients, in contemplation  
29 of a sale or for use in research publishable in professional  
30 journals, where a conflict of interest is presented, as defined by  
31 rules of the disciplining authority, in consultation with the  
32 department, based on recognized professional ethical standards.

33 NEW SECTION. **Sec. 19.** A new section is added to chapter 70.41  
34 RCW to read as follows:

35 If the insurance commissioner reports that a hospital has  
36 violated sections 4 through 16 of this act, the department may levy a  
37 fine upon the hospital in an amount not to exceed one thousand  
38 dollars per violation and take other action as permitted under the  
39 authority of the department.



1        NEW SECTION.    **Sec. 20.**    A new section is added to chapter 70.230  
2    RCW to read as follows:

3        If the insurance commissioner reports that an ambulatory surgical  
4    facility has violated sections 4 through 16 of this act, the  
5    department may levy a fine upon the ambulatory surgical facility in  
6    an amount not to exceed one thousand dollars per violation and take  
7    other action as permitted under the authority of the department.

8        **Sec. 21.**    RCW 41.05.017 and 2016 c 139 s 4 are each amended to  
9    read as follows:

10        Each health plan that provides medical insurance offered under  
11    this chapter, including plans created by insuring entities, plans not  
12    subject to the provisions of Title 48 RCW, and plans created under  
13    RCW 41.05.140, are subject to the provisions of RCW 48.43.500,  
14    70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545,  
15    48.43.550, 70.02.110, 70.02.900, 48.43.190, ((and)) 48.43.083, and  
16    sections 4 through 15 of this act.

17        NEW SECTION.    **Sec. 22.**    A new section is added to chapter 43.371  
18    RCW to read as follows:

19        The office of financial management, with the lead organization,  
20    shall establish a data set and business process to provide health  
21    carriers, health care providers, and arbitrators with prevailing  
22    payment and billed charge amounts for the services described in  
23    section 5 of this act to assist in determining allowed amounts and  
24    resolving payment disputes for out-of-network medical services  
25    rendered by health care providers. The data and business process must  
26    be available beginning January 1, 2019.

27        NEW SECTION.    **Sec. 23.**    Sections 4 through 16 of this act are  
28    each added to chapter 48.43 RCW and codified with the subchapter  
29    heading of "health care services balance billing."

30        NEW SECTION.    **Sec. 24.**    Sections 1 through 21 and 23 of this act  
31    take effect January 1, 2019.

32        NEW SECTION.    **Sec. 25.**    If any provision of this act or its  
33    application to any person or circumstance is held invalid, the

1 remainder of the act or the application of the provision to other  
2 persons or circumstances is not affected."

3 Correct the title.

EFFECT: Insurance Coverage of Emergency Services: Removes the requirement that the patient know of, and consent to, material misrepresentations that would allow an insurer to rescind coverage of emergency services.

Balance Billing Prohibition: Prohibits balance billing for all nonemergency surgical or ancillary services provided in in-network hospitals and ambulatory surgical facilities by out-of-network providers, instead of only in cases where an in-network provider was unavailable or the need for the services was unforeseen.

Cost Sharing Amounts: (1) Removes the requirement that an out-of-network provider or facility request an explanation of benefits from the patient's insurer prior to billing him or her for in-network cost sharing amounts. (2) Requires the cost-sharing amount to be determined based on the insurance contract and the amount the provider was reimbursed, instead of on the insurer's median contracted rate. (3) Clarifies that the balance billing prohibition does not affect a provider's ability to collect past-due cost sharing amounts.

Out-of-Network Provider Reimbursement: (1) Removes the reimbursement methodology that requires the amount an insurer reimburses to an out-of-network provider to be determined by paying the billed charges, mediation, or arbitration, depending on the billed amount. (2) Requires the All Payer Claims Database (APCD) to establish a data set and business process to provide information on prevailing payment and billed charges amounts. (3) Requires the insurer to pay the out-of-network provider the greater of: (a) the median allowed amount paid to in-network providers for the service as determined by the APCD data set, (b) the median amount paid to out-of-network providers for the service as determined by the APCD data set, or (c) 175% of the Medicare rate.

Arbitration: (1) Allows an insurer or an out-of-network provider to enter into arbitration to resolve any reimbursement dispute, instead of only disputes of \$2,000 or more. (2) Requires the party seeking arbitration to first initiate an informal settlement process. (3) Requires arbitration to be initiated no more than sixty days after initiation of the informal settlement process, instead of no more than 90 days after the receipt of the explanation of benefits. (4) Allows arbitration claims to be bundled if they involve identical parties, involve claims with the same or related CPT codes, and occur within the same six-month period. (5) Clarifies that the claim may be settled at any time before the arbitration proceeding. (6) Holds a party who is unresponsive in the arbitration party in default and requires that party to pay the final offer and attorneys' fees of the nondefaulting party. (7) Changes the factors the arbitrator must consider by (a) removing gross disparity as a factor, (b) including the median payment amounts determined by the APCD data set, (c) including the median billed charge amounts as determined by the APCD data set, (d) including the time and place of the service and whether the service was delivered at a level I or II trauma center or a rural facility, (e) including the level of training, education, and experience of the provider. (8) Allows the arbitrator to consider

other information a party believes is justified or factors requested by the arbitrator.

Reporting/Notice Requirements: (1) Removes the requirement that hospitals and ambulatory surgical facilities provide notice to insurers about the network status of their contracted providers. (2) Removes the requirement that hospitals, ambulatory surgical facilities, and providers provide notice to patients regarding network status and balance billing. (3) Requires an insurer to update its web site and provider directory within 30 days after the addition or termination of a facility or provider, instead of only when the insurer had notice of the change. (4) Expands the information in the standard template to include information on balance billing protections and that they may be balanced billed in other circumstances. (5) Requires the Insurance Commissioner to adopt rules specifying when and how the standard template must be provided.

Network Adequacy: (1) Requires the Insurance Commissioner, when determining the adequacy of provider networks, to consider whether an insurer's network includes a sufficient number of contracted providers practicing at the same facilities with which the insurer has contracted for the network to reasonably ensure that enrollees have in-network access for covered benefits delivered at the facilities. (2) Requires a hospital or ambulatory surgical facility to provide an insurer with information about the network status of nonemployed provider groups that provide services at the hospital or ambulatory surgical facility.

Enforcement: (1) Changes the enforcing entity for provider and facility violations from the Insurance Commissioner to the Department of Health. (2) Requires the Insurance Commissioner to notify the Department of Health of possible violations. (3) Gives the Department of Health and health professions disciplining authorities the authority to levy fines if a report of a potential violation is substantiated. (4) Makes violations of balance billing protections unprofessional conduct under the Uniform Disciplinary Act. (5) Requires the Department of Health or the disciplining authority to notify the Insurance Commissioner of the results of a review.

Intent Section: Inserts an intent section.

Effective Date: Changes the effective date to January 1, 2019, instead of January 1, 2018.

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