
SUBSTITUTE HOUSE BILL 1065

State of Washington

66th Legislature

2019 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Cody, Jinkins, Riccelli, Wylie, Ormsby, Tharinger, Macri, Robinson, Slatte, Kloba, Valdez, Appleton, Doglio, Pollet, Stanford, Frame, Reeves, and Bergquist; by request of Insurance Commissioner)

READ FIRST TIME 02/06/19.

1 AN ACT Relating to protecting consumers from charges for out-of-
2 network health care services; amending RCW 48.43.005, 48.43.093,
3 41.05.017, and 48.43.055; reenacting and amending RCW 18.130.180;
4 adding a new section to chapter 48.30 RCW; adding a new section to
5 chapter 70.41 RCW; adding a new section to chapter 70.230 RCW; adding
6 a new section to chapter 70.42 RCW; adding a new section to chapter
7 43.371 RCW; adding a new chapter to Title 48 RCW; creating new
8 sections; prescribing penalties; providing an effective date; and
9 providing an expiration date.

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

11 NEW SECTION. **Sec. 1.** (1) The legislature finds that:

12 (a) Consumers receive surprise bills or balance bills for
13 services provided at out-of-network facilities or by out-of-network
14 health care providers at in-network facilities;

15 (b) Consumers must not be placed in the middle of contractual
16 disputes between providers and health insurance carriers; and

17 (c) Facilities, providers, and health insurance carriers all
18 share responsibility to ensure consumers have transparent information
19 on network providers and benefit coverage, and the insurance
20 commissioner is responsible for ensuring that provider networks
21 include sufficient numbers and types of contracted providers to

1 reasonably ensure consumers have in-network access for covered
2 benefits.

3 (2) It is the intent of the legislature to:

4 (a) Ban balance billing of consumers enrolled in fully insured,
5 regulated insurance plans and plans offered to public employees under
6 chapter 41.05 RCW for the services described in section 6 of this
7 act, and to provide self-funded group health plans with an option to
8 elect to be subject to the provisions of this act;

9 (b) Remove consumers from balance billing disputes and require
10 that out-of-network providers and carriers negotiate out-of-network
11 payments in good faith under the terms of this act; and

12 (c) Provide an environment that encourages self-funded groups to
13 negotiate out-of-network payments in good faith with providers and
14 facilities in return for balance billing protections.

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

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

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

24 (2) "Adverse benefit determination" means a denial, reduction, or
25 termination of, or a failure to provide or make payment, in whole or
26 in part, for a benefit, including a denial, reduction, termination,
27 or failure to provide or make payment that is based on a
28 determination of an enrollee's or applicant's eligibility to
29 participate in a plan, and including, with respect to group health
30 plans, a denial, reduction, or termination of, or a failure to
31 provide or make payment, in whole or in part, for a benefit resulting
32 from the application of any utilization review, as well as a failure
33 to cover an item or service for which benefits are otherwise provided
34 because it is determined to be experimental or investigational or not
35 medically necessary or appropriate.

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

1 (4) "Basic health plan" means the plan described under chapter
2 70.47 RCW, as revised from time to time.

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

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

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

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

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

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

28 (b) In July 2008, and in each July thereafter, the insurance
29 commissioner shall adjust the minimum deductible and out-of-pocket
30 expense required for a plan to qualify as a catastrophic plan to
31 reflect the percentage change in the consumer price index for medical
32 care for a preceding twelve months, as determined by the United
33 States department of labor. For a plan year beginning in 2014, the
34 out-of-pocket limits must be adjusted as specified in section
35 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount
36 shall apply on the following January 1st.

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

1 (i) A health benefit plan that meets the definition of
2 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
3 2010, as amended; or

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

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

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

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

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

24 (13) "Emergency medical condition" means a medical, mental
25 health, or substance use disorder condition manifesting itself by
26 acute symptoms of sufficient severity(~~r~~) including, but not limited
27 to, severe pain or emotional distress, such that a prudent layperson,
28 who possesses an average knowledge of health and medicine, could
29 reasonably expect the absence of immediate medical, mental health, or
30 substance use disorder treatment attention to result in a condition

31 (a) placing the health of the individual, or with respect to a
32 pregnant woman, the health of the woman or her unborn child, in
33 serious jeopardy, (b) serious impairment to bodily functions, or (c)
34 serious dysfunction of any bodily organ or part.

35 (14) "Emergency services" means a medical screening examination,
36 as required under section 1867 of the social security act (42 U.S.C.
37 1395dd), that is within the capability of the emergency department of
38 a hospital, including ancillary services routinely available to the
39 emergency department to evaluate that emergency medical condition,
40 and further medical examination and treatment, to the extent they are

1 within the capabilities of the staff and facilities available at the
2 hospital, as are required under section 1867 of the social security
3 act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with
4 respect to an emergency medical condition, has the meaning given in
5 section 1867(e)(3) of the social security act (42 U.S.C.
6 1395dd(e)(3)).

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

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

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

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

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

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

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

38 (22) "Health care facility" or "facility" means hospices licensed
39 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
40 rural health care facilities as defined in RCW 70.175.020,

1 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
2 licensed under chapter 18.51 RCW, community mental health centers
3 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
4 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
5 treatment, or surgical facilities licensed under chapter 70.41 RCW,
6 drug and alcohol treatment facilities licensed under chapter 70.96A
7 RCW, and home health agencies licensed under chapter 70.127 RCW, and
8 includes such facilities if owned and operated by a political
9 subdivision or instrumentality of the state and such other facilities
10 as required by federal law and implementing regulations.

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

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

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

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

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

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

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

32 (b) Medicare supplemental health insurance governed by chapter
33 48.66 RCW;

34 (c) Coverage supplemental to the coverage provided under chapter
35 55, Title 10, United States Code;

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

38 (e) Disability income;

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

4 (g) Workers' compensation coverage;

5 (h) Accident only coverage;

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

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

11 (k) Dental only and vision only coverage;

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

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

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

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

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

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

35 (31) "Premium" means all sums charged, received, or deposited by
36 a health carrier as consideration for a health plan or the
37 continuance of a health plan. Any assessment or any "membership,"
38 "policy," "contract," "service," or similar fee or charge made by a
39 health carrier in consideration for a health plan is deemed part of

1 the premium. "Premium" shall not include amounts paid as enrollee
2 point-of-service cost-sharing.

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

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

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

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

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

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

21 (38) "Allowed amount" means the maximum portion of a billed
22 charge a health carrier will pay, including any applicable enrollee
23 cost-sharing responsibility, for a covered health care service or
24 item rendered by a participating provider or facility or by a
25 nonparticipating provider or facility.

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

30 (40) "In-network" or "participating" means a provider or facility
31 that has contracted with a carrier or a carrier's contractor or
32 subcontractor to provide health care services to enrollees and be
33 reimbursed by the carrier at a contracted rate as payment in full for
34 the health care services, including applicable cost-sharing
35 obligations.

36 (41) "Out-of-network" or "nonparticipating" means a provider or
37 facility that has not contracted with a carrier or a carrier's
38 contractor or subcontractor to provide health care services to
39 enrollees.

1 (42) "Out-of-pocket maximum" or "maximum out-of-pocket" means the
2 maximum amount an enrollee is required to pay in the form of cost-
3 sharing for covered benefits in a plan year, after which the carrier
4 covers the entirety of the allowed amount of covered benefits under
5 the contract of coverage.

6 (43) "Surgical or ancillary services" means surgery,
7 anesthesiology, pathology, radiology, laboratory, or hospitalist
8 services.

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

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

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

34 (b) If an authorized representative of a health carrier
35 authorizes coverage of emergency services, the health carrier shall
36 not subsequently retract its authorization after the emergency
37 services have been provided, or reduce payment for an item or service
38 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 chapter 48.-- RCW (the new
24 chapter created in section 27 of 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 **BALANCE BILLING PROTECTION AND DISPUTE RESOLUTION**

21 NEW SECTION. **Sec. 4.** This chapter may be known and cited as the
22 balance billing protection act.

23 NEW SECTION. **Sec. 5.** The definitions in RCW 48.43.005 apply
24 throughout this chapter unless the context clearly requires
25 otherwise.

26 NEW SECTION. **Sec. 6.** (1) An out-of-network provider or facility
27 may not balance bill an enrollee for the following health care
28 services:

- 29 (a) Emergency services provided to an enrollee; or
30 (b) Nonemergency health care services provided to an enrollee at
31 an in-network hospital licensed under chapter 70.41 RCW or an in-
32 network ambulatory surgical facility licensed under chapter 70.230
33 RCW if the services:
34 (i) Involve surgical or ancillary services; and
35 (ii) Are provided by an out-of-network provider.

1 (2) (a) (i) An enrollee who has, at least seventy-two hours prior
2 to a planned and scheduled procedure at an in-network hospital or an
3 in-network ambulatory surgical facility, knowingly, voluntarily, and
4 specifically selected the services of an out-of-network surgeon is
5 subject to the contractual requirements of the enrollee's health plan
6 for reimbursement of out-of-network surgeons. The consumer's
7 selection must be documented by completion of the statement developed
8 under (b) of this subsection at least seventy-two hours prior to the
9 planned scheduled procedure.

10 (ii) For purposes of this subsection, the term "knowingly,
11 voluntarily, and specifically selected" means that the enrollee has
12 selected the services of an out-of-network surgeon with full
13 knowledge that the surgeon is out-of-network with respect to the
14 enrollee's health benefits plan, under circumstances that indicate
15 that the enrollee had the opportunity to be serviced by an in-network
16 surgeon, but instead affirmatively selected the out-of-network
17 surgeon. Disclosure by a surgeon, or a facility where the surgeon
18 practices, of the surgeon's network status does not render a covered
19 person's decision to proceed with treatment from that surgeon a
20 choice made knowingly under this subsection.

21 (b) The commissioner, in consultation with health carriers,
22 health care providers, health care facilities, and consumers, must
23 develop standard template language for the statement required in (a)
24 of this subsection. The standard template language must include
25 contact information for the office of the insurance commissioner. The
26 commissioner shall determine by rule how execution of the statement
27 must be documented.

28 (3) Payment for services described in subsection (1) of this
29 section is subject to the provisions of sections 7 and 8 of this act.

30 (4) The carrier must hold an enrollee harmless from balance
31 billing when emergency services described in subsection (1)(a) of
32 this section are provided by an out-of-network hospital in a state
33 that borders Washington state.

34 (5) This section applies to health care providers or facilities
35 providing services to members of entities administering a self-funded
36 group health plan and its plan members only if the entity has elected
37 to participate in sections 6 through 8 of this act as provided in
38 section 23 of this act.

1 NEW SECTION. **Sec. 7.** (1) If an enrollee receives emergency or
2 nonemergency health care services under the circumstances described
3 in section 6 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. The enrollee's obligation must be determined using the
8 carrier's median in-network contracted rate for the same or similar
9 service in the same or similar geographical area. The carrier must
10 provide an explanation of benefits to the enrollee and the out-of-
11 network provider that reflects the cost-sharing amount determined
12 under this subsection.

13 (b) The carrier, out-of-network provider, or out-of-network
14 facility, and an agent, trustee, or assignee of the carrier, out-of-
15 network provider, or out-of-network facility must ensure that the
16 enrollee incurs no greater cost than the amount determined under (a)
17 of this subsection.

18 (c) The out-of-network provider or out-of-network facility, and
19 an agent, trustee, or assignee of the out-of-network provider or out-
20 of-network facility may not balance bill or otherwise attempt to
21 collect from the enrollee any amount greater than the amount
22 determined under (a) of this subsection. This does not impact the
23 provider's ability to collect a past due balance for that cost-
24 sharing amount with interest.

25 (d) The carrier must treat any cost-sharing amounts paid by the
26 enrollee for an out-of-network provider or facility's services in the
27 same manner as cost-sharing for health care services provided by an
28 in-network provider or facility and must apply any cost-sharing
29 amounts paid by the enrollee for such services toward the enrollee's
30 maximum out-of-pocket payment obligation.

31 (e) If the enrollee pays the out-of-network provider or out-of-
32 network facility an amount that exceeds the in-network cost-sharing
33 amount determined under (a) of this subsection, the provider or
34 facility must refund any amount in excess of the in-network cost-
35 sharing amount to the enrollee within thirty business days of
36 receipt. Interest must be paid to the enrollee for any unrefunded
37 payments at a rate of twelve percent beginning on the first calendar
38 day after the thirty business days.

39 (2) The allowed amount paid to an out-of-network provider for
40 health care services described under section 6 of this act shall be

1 limited to a commercially reasonable amount, based on payments for
2 the same or similar services provided in a similar geographic area.
3 Within thirty calendar days of receipt of a claim from an out-of-
4 network provider or facility, the carrier shall offer to pay the
5 provider or facility a commercially reasonable amount. If the out-of-
6 network provider or facility wants to dispute the carrier's payment,
7 the provider or facility must notify the carrier no later than thirty
8 calendar days after receipt of payment or payment notification from
9 the carrier. If the out-of-network provider or facility disputes the
10 carrier's initial offer, the carrier and provider or facility have
11 thirty calendar days from the initial offer to negotiate in good
12 faith. If the carrier and the out-of-network provider or facility do
13 not agree to a commercially reasonable payment amount within thirty
14 calendar days, the dispute may be resolved through arbitration, as
15 provided in section 8 of this act.

16 (3) The carrier must make payments for health care services
17 described in section 6 of this act provided by out-of-network
18 providers or facilities directly to the provider or facility, rather
19 than the enrollee.

20 (4) Carriers must indicate in a clear manner on their enrollee
21 identification cards whether an enrollee's health plan is subject to
22 the requirements of this act and may accomplish this by indicating
23 that the enrollee's health plan is fully insured.

24 (5) A health care provider, hospital, or ambulatory surgical
25 facility may not require a patient at any time, for any procedure,
26 service, or supply, to sign or execute by electronic means, any
27 document that would attempt to avoid, waive, or alter any provision
28 of this section.

29 (6) This section shall only apply to health care providers or
30 facilities providing services to members of entities administering a
31 self-funded group health plan and its plan members if the entity has
32 elected to participate in sections 6 through 8 of this act as
33 provided in section 23 of this act.

34 (7) An entity administering a self-funded group health plan that
35 has elected to participate in this section pursuant to section 23 of
36 this act, shall comply with the provisions of subsections (1)(a) and
37 (d), (2), and (3) of this section.

38 NEW SECTION. **Sec. 8.** (1)(a) Notwithstanding RCW 48.43.055, if
39 good faith negotiation, as described in section 7 of this act does

1 not result in resolution of the dispute, a carrier, out-of-network
2 provider, or out-of-network facility may initiate arbitration to
3 determine a commercially reasonable payment amount. To initiate
4 arbitration, the carrier, provider, or facility must provide written
5 notification to the commissioner and the noninitiating party no later
6 than ten calendar days following completion of the period of good
7 faith negotiation under section 7 of this act. The notification to
8 the noninitiating party must state the initiating party's final
9 offer. No later than thirty calendar days following receipt of the
10 notification, the noninitiating party must provide its final offer to
11 the initiating party. The parties may reach an agreement on
12 reimbursement during this time and before the arbitration proceeding.

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

- 15 (i) Involve identical carrier and provider or facility parties;
- 16 (ii) Involve claims with the same or related current procedural
17 terminology codes relevant to a particular procedure; and
- 18 (iii) Occur within a period of two months of one another.

19 (2) Within seven calendar days of receipt of notification from
20 the initiating party, the commissioner must provide the parties with
21 a list of approved arbitrators or entities that provide arbitration.
22 The arbitrators on the list must be trained by the American
23 arbitration association or the American health lawyers association
24 and should have experience in matters related to medical or health
25 care services. The parties may agree on an arbitrator from the list
26 provided by the commissioner. If the parties do not agree on an
27 arbitrator, they must notify the commissioner who must provide them
28 with the names of five arbitrators from the list. Each party may veto
29 two of the five named arbitrators. If one arbitrator remains, that
30 person is the chosen arbitrator. If more than one arbitrator remains,
31 the commissioner must choose the arbitrator from the remaining
32 arbitrators. The parties and the commissioner must complete this
33 selection process within twenty calendar days of receipt of the
34 original list from the commissioner.

35 (3) (a) Each party must make written submissions to the arbitrator
36 in support of its position no later than thirty calendar days after
37 the final selection of the arbitrator. The initiating party must
38 include in its written submission the evidence and methodology for
39 asserting that the amount proposed to be paid is or is not
40 commercially reasonable. A party that fails to make timely written

1 submissions under this section without good cause shown shall be
2 considered to be in default and the arbitrator shall require the
3 party in default to pay the final offer amount submitted by the party
4 not in default and may require the party in default to pay expenses
5 incurred to date in the course of arbitration, including the
6 arbitrator's expenses and fees and the reasonable attorneys' fees of
7 the party not in default. No later than thirty calendar days after
8 the receipt of the parties' written submissions, the arbitrator must:
9 Issue a written decision requiring payment of the final offer amount
10 of either the initiating party or the noninitiating party; notify the
11 parties of its decision; and provide the decision and the information
12 described in section 9 of this act regarding the decision to the
13 commissioner.

14 (b) In reviewing the submissions of the parties and making a
15 decision related to whether payment should be made at the final offer
16 amount of the initiating party or the noninitiating party, the
17 arbitrator must consider the following factors:

18 (i) The evidence and methodology submitted by the parties to
19 assert that their final offer amount is reasonable;

20 (ii) The median in-network and out-of-network allowed amounts and
21 the median billed charge amount for the service at issue in the
22 geographic region in which the service was rendered as reported in
23 the data set prepared by the Washington state all payer claims
24 database under section 26 of this act;

25 (iii) The established rate that medicare would pay for the same
26 service or procedure on a fee-for-service basis for the same or
27 similar service in the geographic region in which the service was
28 rendered; and

29 (iv) Patient characteristics and the circumstances and complexity
30 of the case, including time and place of service and whether the
31 service was delivered at a level I or level II trauma center or a
32 rural facility, that are not already reflected in the provider's
33 billing code for the service.

34 (c) The arbitrator may also consider other information that a
35 party believes is relevant to the factors included in (b) of this
36 subsection or other factors the arbitrator requests and information
37 provided by the parties that is relevant to such request.

38 (4) Expenses incurred in the course of arbitration, including the
39 arbitrator's expenses and fees, but not including attorneys' fees,
40 must be divided equally among the parties to the arbitration. The

1 enrollee is not liable for any of the costs of the arbitration and
2 may not be required to participate in the arbitration proceeding as a
3 witness or otherwise.

4 (5) A nondisclosure agreement must be executed by both parties
5 prior to engaging in arbitration under this section. The
6 nondisclosure agreement must not preclude the arbitrator from
7 submitting the arbitrator's decision to the commissioner under
8 subsection (3) of this section or impede the commissioner's duty to
9 prepare the annual report under section 9 of this act.

10 (6) Chapter 7.04A RCW applies to arbitrations conducted under
11 this section, but in the event of a conflict between this section and
12 chapter 7.04A RCW, this section governs.

13 (7) This section applies to health care providers or facilities
14 providing services to members of entities administering a self-funded
15 group health plan and its plan members only if the entity has elected
16 to participate in sections 6 through 8 of this act as provided in
17 section 23 of this act.

18 (8) An entity administering a self-funded group health plan that
19 has elected to participate in this section pursuant to section 23 of
20 this act shall comply with the provisions of this section.

21 NEW SECTION. **Sec. 9.** (1) The commissioner must prepare an
22 annual report summarizing the dispute resolution information provided
23 by arbitrators under section 8 of this act. The report must include
24 summary information related to the matters decided through
25 arbitration, as well as the following information for each dispute
26 resolved through arbitration: The name of the carrier; the name of
27 the health care provider; the health care provider's employer or the
28 business entity in which the provider has an ownership interest; the
29 health care facility where the services were provided; and the type
30 of health care services at issue.

31 (2) The commissioner must post the report on the office of the
32 insurance commissioner's web site and submit the report in compliance
33 with RCW 43.01.036 to the appropriate committees of the legislature,
34 annually by July 1st.

35 (3) This section expires January 1, 2024.

36 **TRANSPARENCY**

1 NEW SECTION. **Sec. 10.** (1) The commissioner, in consultation
2 with health carriers, health care providers, health care facilities,
3 and consumers, must develop standard template language for a notice
4 of consumer rights notifying consumers that:

5 (a) The prohibition against balance billing in this chapter is
6 applicable to health plans issued by carriers in Washington state and
7 self-funded group health plans that elect to participate in sections
8 6 through 8 of this act as provided in section 23 of this act;

9 (b) They cannot be balance billed for the health care services
10 described in section 6 of this act and will receive the protections
11 provided by section 7 of this act; and

12 (c) They may be balance billed for health care services under
13 circumstances other than those described in section 6 of this act or
14 if they are enrolled in a health plan to which this act does not
15 apply, and steps they can take if they are balance billed.

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

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

25 NEW SECTION. **Sec. 11.** (1)(a) A hospital or ambulatory surgical
26 facility must post the following information on its web site, if one
27 is available:

28 (i) A list of the carrier health plan provider networks with
29 which the hospital or ambulatory surgical facility is an in-network
30 provider; and

31 (ii) The notice of consumer rights developed under section 10 of
32 this act.

33 (b) If the hospital or ambulatory surgical facility does not
34 maintain a web site, this information must be provided to consumers
35 upon an oral or written request.

36 (2) Posting or otherwise providing the information required in
37 this section does not relieve a hospital or ambulatory surgical
38 facility of its obligation to comply with the provisions of this
39 chapter.

1 (3) Not less than thirty days prior to executing a contract with
2 a carrier, a hospital or ambulatory surgical facility must provide
3 the carrier with a list of the nonemployed providers or provider
4 groups contracted to provide surgical or ancillary services at the
5 hospital or ambulatory surgical facility. The hospital or ambulatory
6 surgical facility must notify the carrier within thirty days of a
7 removal from or addition to the nonemployed provider list. A hospital
8 or ambulatory surgical facility also must provide an updated list of
9 these providers within fourteen calendar days of a request for an
10 updated list by a carrier.

11 NEW SECTION. **Sec. 12.** (1)(a) A health care provider must
12 provide the following information on its web site, if one is
13 available:

14 (i) A listing of the carrier health plan provider networks with
15 which the provider contracts; and

16 (ii) The notice of consumer rights developed under section 10 of
17 this act.

18 (b) If the health care provider does not maintain a web site,
19 this information must be provided to consumers upon an oral or
20 written request.

21 (2) Posting or otherwise providing the information required in
22 this section does not relieve a provider of its obligation to comply
23 with the provisions of this chapter.

24 (3) An in-network provider must submit accurate information to a
25 carrier regarding the provider's network status in a timely manner,
26 consistent with the terms of the contract between the provider and
27 the carrier.

28 NEW SECTION. **Sec. 13.** (1) A carrier must update its web site
29 and provider directory no later than thirty days after the addition
30 or termination of a facility or provider.

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

32 (a) A clear description of the health plan's out-of-network
33 health benefits; and

34 (b) The notice of consumer rights developed under section 10 of
35 this act;

36 (c) Notification that if the enrollee receives services from an
37 out-of-network provider or facility, under circumstances other than
38 those described in section 6 of this act, the enrollee will have the

1 financial responsibility applicable to services provided outside the
2 health plan's network in excess of applicable cost-sharing amounts
3 and that the enrollee may be responsible for any costs in excess of
4 those allowed by the health plan;

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

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

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

11 **ENFORCEMENT**

12 NEW SECTION. **Sec. 14.** (1) If the commissioner has cause to
13 believe that any health care provider, hospital, or ambulatory
14 surgical facility, has engaged in a pattern of unresolved violations
15 of section 6 or 7 of this act, the commissioner may submit
16 information to the department of health or the appropriate
17 disciplining authority for action. Prior to submitting information to
18 the department of health or the appropriate disciplining authority,
19 the commissioner may provide the health care provider, hospital, or
20 ambulatory surgical facility, with an opportunity to cure the alleged
21 violations or explain why the actions in question did not violate
22 section 6 or 7 of this act.

23 (2) If any health care provider, hospital, or ambulatory surgical
24 facility, has engaged in a pattern of unresolved violations of
25 section 6 or 7 of this act, the department of health or the
26 appropriate disciplining authority may levy a fine or cost recovery
27 upon the health care provider, hospital, or ambulatory surgical
28 facility in an amount not to exceed the applicable statutory amount
29 per violation and take other action as permitted under the authority
30 of the department or disciplining authority. Upon completion of its
31 review of any potential violation submitted by the commissioner or
32 initiated directly by an enrollee, the department of health or the
33 disciplining authority shall notify the commissioner of the results
34 of the review, including whether the violation was substantiated and
35 any enforcement action taken as a result of a finding of a
36 substantiated violation.

37 (3) If a carrier has engaged in a pattern of unresolved
38 violations of any provision of this chapter, the commissioner may

1 levy a fine or apply remedies authorized under chapter 48.02 RCW, RCW
2 48.44.166, 48.46.135, or 48.05.185.

3 (4) For purposes of this section, "disciplining authority" means
4 the agency, board, or commission having the authority to take
5 disciplinary action against a holder of, or applicant for, a
6 professional or business license upon a finding of a violation of
7 chapter 18.130 RCW or a chapter specified under RCW 18.130.040.

8 NEW SECTION. **Sec. 15.** The commissioner may adopt rules to
9 implement and administer this chapter, including rules governing the
10 dispute resolution process established in section 8 of this act.

11 NEW SECTION. **Sec. 16.** A new section is added to chapter 48.30
12 RCW to read as follows:

13 (1) It is an unfair or deceptive practice for a health carrier to
14 initiate, with such frequency as to indicate a general business
15 practice, arbitration under section 8 of this act with respect to
16 claims submitted by out-of-network providers for services included in
17 section 6 of this act that request payment of a commercially
18 reasonable amount, based on payments for the same or similar services
19 provided in a similar geographic area.

20 (2) As used in this section, "health carrier" has the same
21 meaning as in RCW 48.43.005.

22 **Sec. 17.** RCW 18.130.180 and 2018 c 300 s 4 and 2018 c 216 s 2
23 are each reenacted and amended to read as follows:

24 The following conduct, acts, or conditions constitute
25 unprofessional conduct for any license holder under the jurisdiction
26 of this chapter:

27 (1) The commission of any act involving moral turpitude,
28 dishonesty, or corruption relating to the practice of the person's
29 profession, whether the act constitutes a crime or not. If the act
30 constitutes a crime, conviction in a criminal proceeding is not a
31 condition precedent to disciplinary action. Upon such a conviction,
32 however, the judgment and sentence is conclusive evidence at the
33 ensuing disciplinary hearing of the guilt of the license holder of
34 the crime described in the indictment or information, and of the
35 person's violation of the statute on which it is based. For the
36 purposes of this section, conviction includes all instances in which
37 a plea of guilty or nolo contendere is the basis for the conviction

1 and all proceedings in which the sentence has been deferred or
2 suspended. Nothing in this section abrogates rights guaranteed under
3 chapter 9.96A RCW;

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

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

7 (4) Incompetence, negligence, or malpractice which results in
8 injury to a patient or which creates an unreasonable risk that a
9 patient may be harmed. The use of a nontraditional treatment by
10 itself shall not constitute unprofessional conduct, provided that it
11 does not result in injury to a patient or create an unreasonable risk
12 that a patient may be harmed;

13 (5) Suspension, revocation, or restriction of the individual's
14 license to practice any health care profession by competent authority
15 in any state, federal, or foreign jurisdiction, a certified copy of
16 the order, stipulation, or agreement being conclusive evidence of the
17 revocation, suspension, or restriction;

18 (6) Except when authorized by RCW 18.130.345, the possession,
19 use, prescription for use, or distribution of controlled substances
20 or legend drugs in any way other than for legitimate or therapeutic
21 purposes, diversion of controlled substances or legend drugs, the
22 violation of any drug law, or prescribing controlled substances for
23 oneself;

24 (7) Violation of any state or federal statute or administrative
25 rule regulating the profession in question, including any statute or
26 rule defining or establishing standards of patient care or
27 professional conduct or practice;

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

29 (a) Not furnishing any papers, documents, records, or other
30 items;

31 (b) Not furnishing in writing a full and complete explanation
32 covering the matter contained in the complaint filed with the
33 disciplining authority;

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

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

1 (9) Failure to comply with an order issued by the disciplining
2 authority or a stipulation for informal disposition entered into with
3 the disciplining authority;

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

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

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

9 (13) Misrepresentation or fraud in any aspect of the conduct of
10 the business or profession;

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

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

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

18 (17) Conviction of any gross misdemeanor or felony relating to
19 the practice of the person's profession. For the purposes of this
20 subsection, conviction includes all instances in which a plea of
21 guilty or nolo contendere is the basis for conviction and all
22 proceedings in which the sentence has been deferred or suspended.
23 Nothing in this section abrogates rights guaranteed under chapter
24 9.96A RCW;

25 (18) The procuring, or aiding or abetting in procuring, a
26 criminal abortion;

27 (19) The offering, undertaking, or agreeing to cure or treat
28 disease by a secret method, procedure, treatment, or medicine, or the
29 treating, operating, or prescribing for any health condition by a
30 method, means, or procedure which the licensee refuses to divulge
31 upon demand of the disciplining authority;

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

34 (21) Violation of chapter 19.68 RCW or a pattern of violations of
35 section 6 or 7 of this act;

36 (22) Interference with an investigation or disciplinary
37 proceeding by willful misrepresentation of facts before the
38 disciplining authority or its authorized representative, or by the
39 use of threats or harassment against any patient or witness to
40 prevent them from providing evidence in a disciplinary proceeding or

1 any other legal action, or by the use of financial inducements to any
2 patient or witness to prevent or attempt to prevent him or her from
3 providing evidence in a disciplinary proceeding;

4 (23) Current misuse of:

5 (a) Alcohol;

6 (b) Controlled substances; or

7 (c) Legend drugs;

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

10 (25) Acceptance of more than a nominal gratuity, hospitality, or
11 subsidy offered by a representative or vendor of medical or health-
12 related products or services intended for patients, in contemplation
13 of a sale or for use in research publishable in professional
14 journals, where a conflict of interest is presented, as defined by
15 rules of the disciplining authority, in consultation with the
16 department, based on recognized professional ethical standards;

17 (26) Violation of RCW 18.130.420;

18 (27) Performing conversion therapy on a patient under age
19 eighteen.

20 NEW SECTION. **Sec. 18.** A new section is added to chapter 70.41
21 RCW to read as follows:

22 If the insurance commissioner reports to the department that he
23 or she has cause to believe that a hospital has engaged in a pattern
24 of violations of section 6 or 7 of this act, and the report is
25 substantiated after investigation, the department may levy a fine
26 upon the hospital in an amount not to exceed one thousand dollars per
27 violation and take other formal or informal disciplinary action as
28 permitted under the authority of the department.

29 NEW SECTION. **Sec. 19.** A new section is added to chapter 70.230
30 RCW to read as follows:

31 If the insurance commissioner reports to the department that he
32 or she has cause to believe that an ambulatory surgical facility has
33 engaged in a pattern of violations of section 6 or 7 of this act, and
34 the report is substantiated after investigation, the department may
35 levy a fine upon the ambulatory surgical facility in an amount not to
36 exceed one thousand dollars per violation and take other formal or
37 informal disciplinary action as permitted under the authority of the
38 department.

1 NEW SECTION. **Sec. 24.** This chapter must be liberally construed
2 to promote the public interest by ensuring that consumers are not
3 billed out-of-network charges and do not receive additional bills
4 from providers under the circumstances described in section 6 of this
5 act.

6 NEW SECTION. **Sec. 25.** When determining the adequacy of a
7 proposed provider network or the ongoing adequacy of an in-force
8 provider network, the commissioner must consider whether the
9 carrier's proposed provider network or in-force provider network
10 includes a sufficient number of contracted providers of emergency and
11 surgical or ancillary services at or for the carrier's contracted in-
12 network hospitals or ambulatory surgical facilities to reasonably
13 ensure enrollees have in-network access to covered benefits delivered
14 at that facility.

15 NEW SECTION. **Sec. 26.** A new section is added to chapter 43.371
16 RCW to read as follows:

17 (1) The office of financial management, with the lead
18 organization and in collaboration with health carriers, health care
19 providers, hospitals, and ambulatory surgical facilities, shall
20 establish a data set and business process to provide health carriers,
21 health care providers, hospitals, ambulatory surgical facilities, and
22 arbitrators with data to assist in determining commercially
23 reasonable payments and resolving payment disputes for out-of-network
24 medical services rendered by health care facilities or providers. The
25 data set must provide the amounts referenced in section 8(3)(b) of
26 this act for the services described in section 6 of this act. The
27 data used to calculate the median in-network and out-of-network
28 allowed amounts and the median billed charge amounts must be drawn
29 from commercial health plan claims, and exclude medicare and medicaid
30 claims as well as claims paid on other than a fee-for-service basis.
31 The data set and business process must be available beginning
32 November 1, 2019, and must be reviewed by an advisory committee
33 established under chapter 43.371 RCW that includes representatives of
34 health carriers, health care providers, hospitals, and ambulatory
35 surgical facilities for validation before use.

36 (2) The 2019 data set must be based upon the most recently
37 available full calendar year of claims data and the most recently
38 available medicare claims or rate information. The data set for each

1 subsequent year must be adjusted by applying the consumer price
2 index-medical component established by the United States department
3 of labor, bureau of labor statistics to the previous year's data set.

4 NEW SECTION. **Sec. 27.** Sections 5 through 15, 22 through 25, and
5 28 of this act constitute a new chapter in Title 48 RCW.

6 **Sec. 28.** RCW 48.43.055 and 2005 c 172 s 19 are each amended to
7 read as follows:

8 (1) Except as provided by subsection (2) of this section, each
9 health carrier as defined under RCW 48.43.005 shall file with the
10 commissioner its procedures for review and adjudication of complaints
11 initiated by health care providers. Procedures filed under this
12 section shall provide a fair review for consideration of complaints.
13 Every health carrier shall provide reasonable means allowing any
14 health care provider aggrieved by actions of the health carrier to be
15 heard after submitting a written request for review. If the health
16 carrier fails to grant or reject a request within thirty days after
17 it is made, the complaining health care provider may proceed as if
18 the complaint had been rejected. A complaint that has been rejected
19 by the health carrier may be submitted to nonbinding mediation.
20 Mediation shall be conducted under chapter 7.07 RCW, or any other
21 rules of mediation agreed to by the parties. This section is solely
22 for resolution of provider complaints. Complaints by, or on behalf
23 of, a covered person are subject to the grievance processes in RCW
24 48.43.530.

25 (2) For purposes of out-of-network payment disputes between a
26 health carrier and health care provider covered under the provisions
27 of chapter 48.--- RCW (the new chapter created in section 27 of this
28 act), the arbitration provisions of chapter 48.--- RCW (the new
29 chapter created in section 27 of this act) apply.

30 NEW SECTION. **Sec. 29.** Except for section 26 of this act, this
31 act takes effect January 1, 2020.

32 NEW SECTION. **Sec. 30.** 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.

--- **END** ---