H-1275.2

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, Slatter, Kloba, Valdez, Appleton, Doglio, Pollet, Stanford, Frame, Reeves, and Bergquist; by request of Insurance Commissioner)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(ii) A prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that he or she would be unable to go to a participating hospital emergency department in a timely fashion without serious impairment to the covered person's health~~)) as provided in chapter 48.-- RCW (the new chapter created in section 27 of this act).

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

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

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

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

BALANCE BILLING PROTECTION AND DISPUTE RESOLUTION

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

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

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

(a) Emergency services provided to an enrollee; or

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

(i) Involve surgical or ancillary services; and

(ii) Are provided by an out-of-network provider.

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

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

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

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

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

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

NEW SECTION. **Sec. 7.** (1) If an enrollee receives emergency or nonemergency health care services under the circumstances described in section 6 of this act:

(a) The enrollee satisfies his or her obligation to pay for the health care services if he or she pays the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The enrollee's obligation must be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area. The carrier must provide an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing amount determined under this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) This section expires January 1, 2024.

TRANSPARENCY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) A carrier must provide an enrollee with:

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

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

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

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

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

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

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

ENFORCEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

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

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

(26) Violation of RCW 18.130.420;

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

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

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

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

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

NEW SECTION. **Sec. 20.** A new section is added to chapter 70.42 RCW to read as follows:

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

APPLICABILITY

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

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

NEW SECTION. **Sec. 22.** This chapter does not apply to health plans that provide benefits under chapter 74.09 RCW.

NEW SECTION. **Sec. 23.** The provisions of this chapter apply to a self-funded group health plan governed by the provisions of the federal employee retirement income security act of 1974 (29 U.S.C. Sec. 1001 et seq.) only if the self-funded group health plan elects to participate in the provisions of sections 6 through 8 of this act. To elect to participate in these provisions, the self-funded group health plan shall provide notice, on an annual basis, to the commissioner in a manner prescribed by the commissioner, attesting to the plan's participation and agreeing to be bound by sections 6 through 8 of this act. An entity administering a self-funded health benefits plan that elects to participate under this section, shall comply with the provisions of sections 6 through 8 of this act.

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 30.** If any provision of this act or its application to any person or circumstance is held invalid, the

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

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