
HOUSE BILL 1065

State of Washington

66th Legislature

2019 Regular Session

By Representatives Cody, Jenkins, Riccelli, Wylie, Ormsby, Tharinger, Macri, Robinson, Slatter, Kloba, Valdez, Appleton, Doglio, Pollet, Stanford, Frame, Reeves, and Bergquist; by request of Insurance Commissioner

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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, and
3 41.05.017; reenacting and amending RCW 18.130.180; adding a new
4 section to chapter 48.30 RCW; adding a new section to chapter 70.41
5 RCW; adding a new section to chapter 70.230 RCW; adding a new section
6 to chapter 70.42 RCW; adding a new section to chapter 43.371 RCW;
7 adding a new chapter to Title 48 RCW; creating new sections;
8 prescribing penalties; providing an effective date; and providing an
9 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; and

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.

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

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

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

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

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

36 (4) "Basic health plan" means the plan described under chapter
37 70.47 RCW, as revised from time to time.

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

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

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

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

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

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

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

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

35 (i) A health benefit plan that meets the definition of
36 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
37 2010, as amended; or

38 (ii) A health benefit plan offered outside the exchange
39 marketplace that requires a calendar year deductible or out-of-pocket
40 expenses under the plan, other than for premiums, for covered

1 benefits, that meets or exceeds the commissioner's annual adjustment
2 under (b) of this subsection.

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

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

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

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

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

29 (14) "Emergency services" means a medical screening examination,
30 as required under section 1867 of the social security act (42 U.S.C.
31 1395dd), that is within the capability of the emergency department of
32 a hospital, including ancillary services routinely available to the
33 emergency department to evaluate that emergency medical condition,
34 and further medical examination and treatment, to the extent they are
35 within the capabilities of the staff and facilities available at the
36 hospital, as are required under section 1867 of the social security
37 act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with
38 respect to an emergency medical condition, has the meaning given in
39 section 1867(e)(3) of the social security act (42 U.S.C.
40 1395dd(e)(3)).

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

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

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

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

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

19 (20) "Grandfathered health plan" means a group health plan or an
20 individual health plan that under section 1251 of the patient
21 protection and affordable care act, P.L. 111-148 (2010) and as
22 amended by the health care and education reconciliation act, P.L.
23 111-152 (2010) is not subject to subtitles A or C of the act as
24 amended.

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

32 (22) "Health care facility" or "facility" means hospices licensed
33 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
34 rural health care facilities as defined in RCW 70.175.020,
35 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
36 licensed under chapter 18.51 RCW, community mental health centers
37 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
38 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
39 treatment, or surgical facilities licensed under chapter 70.41 RCW,
40 drug and alcohol treatment facilities licensed under chapter 70.96A

1 RCW, and home health agencies licensed under chapter 70.127 RCW, and
2 includes such facilities if owned and operated by a political
3 subdivision or instrumentality of the state and such other facilities
4 as required by federal law and implementing regulations.

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

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

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

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

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

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

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

26 (b) Medicare supplemental health insurance governed by chapter
27 48.66 RCW;

28 (c) Coverage supplemental to the coverage provided under chapter
29 55, Title 10, United States Code;

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

32 (e) Disability income;

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

36 (g) Workers' compensation coverage;

37 (h) Accident only coverage;

38 (i) Specified disease or illness-triggered fixed payment
39 insurance, hospital confinement fixed payment insurance, or other

1 fixed payment insurance offered as an independent, noncoordinated
2 benefit;

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

4 (k) Dental only and vision only coverage;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (b) If an authorized representative of a health carrier
27 authorizes coverage of emergency services, the health carrier shall
28 not subsequently retract its authorization after the emergency
29 services have been provided, or reduce payment for an item or service
30 furnished in reliance on approval, unless the approval was based on a
31 material misrepresentation about the covered person's health
32 condition made by the provider of emergency services.

33 (c) Coverage of emergency services may be subject to applicable
34 in-network copayments, coinsurance, and deductibles, ~~((and a health~~
35 ~~carrier may impose reasonable differential cost-sharing arrangements~~
36 ~~for emergency services rendered by nonparticipating providers, if~~
37 ~~such differential between cost-sharing amounts applied to emergency~~
38 ~~services rendered by participating provider versus nonparticipating~~
39 ~~provider does not exceed fifty dollars. Differential cost sharing for~~
40 ~~emergency services may not be applied when a covered person presents~~

1 to a nonparticipating hospital emergency department rather than a
2 participating hospital emergency department when the health carrier
3 requires preauthorization for postevaluation or poststabilization
4 emergency services if:

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

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

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

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

38 ((2)) (4) Nothing in this section is to be construed as
39 prohibiting the health carrier from requiring notification within the
40 time frame specified in the contract for inpatient admission or as

1 soon thereafter as medically possible but no less than twenty-four
2 hours. Nothing in this section is to be construed as preventing the
3 health carrier from reserving the right to require transfer of a
4 hospitalized covered person upon stabilization. Follow-up care that
5 is a direct result of the emergency must be obtained in accordance
6 with the health plan's usual terms and conditions of coverage. All
7 other terms and conditions of coverage may be applied to emergency
8 services.

9 **BALANCE BILLING PROTECTION AND DISPUTE RESOLUTION**

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

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

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

- 18 (a) Emergency services provided to an enrollee; and
- 19 (b) Nonemergency health care services provided to an enrollee at
20 an in-network hospital licensed under chapter 70.41 RCW or an in-
21 network ambulatory surgical facility licensed under chapter 70.230
22 RCW if the services:

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

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

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

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

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

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

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

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

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

36 (2) The allowed amount paid to an out-of-network provider for
37 health care services described under section 6 of this act shall be
38 limited to a commercially reasonable amount, based on payments for
39 the same or similar services provided in a similar geographic area.
40 Within thirty calendar days of receipt of a claim from an out-of-

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

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

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

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

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

31 NEW SECTION. **Sec. 8.** (1)(a) If good faith negotiation, as
32 described in section 7 of this act does not result in resolution of
33 the dispute, a carrier, out-of-network provider, or out-of-network
34 facility may initiate arbitration to determine a commercially
35 reasonable payment amount. To initiate arbitration, the carrier,
36 provider, or facility must provide written notification to the
37 commissioner and the noninitiating party no later than ten calendar
38 days following completion of the period of good faith negotiation
39 under section 7 of this act. The notification to the noninitiating

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

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

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

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

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

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

27 (3) (a) Each party must make written submissions to the arbitrator
28 in support of its position no later than thirty calendar days after
29 the final selection of the arbitrator. The initiating party must
30 include in its written submission the evidence and methodology for
31 asserting that the amount proposed to be paid is or is not
32 commercially reasonable. A party that fails to make timely written
33 submissions under this section without good cause shown shall be
34 considered to be in default and the arbitrator shall require the
35 party in default to pay the final offer amount submitted by the party
36 not in default and may require the party in default to pay expenses
37 incurred to date in the course of arbitration, including the
38 arbitrator's expenses and fees and the reasonable attorneys' fees of
39 the party not in default. No later than thirty calendar days after
40 the receipt of the parties' written submissions, the arbitrator must:

1 Issue a written decision requiring payment of the final offer amount
2 of either the initiating party or the noninitiating party; notify the
3 parties of its decision; and provide the decision and the information
4 described in section 9 of this act regarding the decision to the
5 commissioner.

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

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

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

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

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

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

28 (4) Expenses incurred in the course of arbitration, including the
29 arbitrator's expenses and fees, but not including attorneys' fees,
30 must be divided equally among the parties to the arbitration. The
31 enrollee is not liable for any of the costs of the arbitration and
32 may not be required to participate in the arbitration proceeding as a
33 witness or otherwise.

34 (5) The parties must enter into a nondisclosure agreement to
35 protect any personal health information or fee information provided
36 to the arbitrator.

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

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

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

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

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

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

24 **TRANSPARENCY**

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

29 (a) The prohibition against balance billing in this chapter is
30 applicable to health plans issued by carriers in Washington state and
31 self-funded group health plans that elect to participate in sections
32 6 through 8 of this act as provided in section 23 of this act;

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

36 (c) They may be balance billed for health care services under
37 circumstances other than those described in section 6 of this act or

1 if they are enrolled in a health plan to which this act does not
2 apply, and steps they can take if they are balance billed.

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

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

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

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

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

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

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

27 (3) Not less than thirty days prior to executing a contract with
28 a carrier, a hospital or ambulatory surgical facility must provide
29 the carrier with a list of the nonemployed providers or provider
30 groups contracted to provide surgical or ancillary services at the
31 hospital or ambulatory surgical facility. The hospital or ambulatory
32 surgical facility must notify the carrier within thirty days of a
33 removal from or addition to the nonemployed provider list.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 **ENFORCEMENT**

35 NEW SECTION. **Sec. 14.** (1) If the commissioner has cause to
36 believe that any health care provider, hospital, or ambulatory
37 surgical facility, has engaged in a pattern of unresolved violations

1 of section 6 or 7 of this act, the commissioner may submit
2 information to the department of health or the appropriate
3 disciplining authority for action. Prior to submitting information to
4 the department of health or the appropriate disciplining authority,
5 the commissioner may provide the health care provider, hospital, or
6 ambulatory surgical facility, with an opportunity to cure the alleged
7 violations or explain why the actions in question did not violate
8 section 6 or 7 of this act.

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

22 (3) If a carrier has engaged in a pattern of unresolved
23 violations of any provision of this chapter, the commissioner may
24 levy a fine or apply remedies authorized under chapter 48.02 RCW, RCW
25 48.44.166, 48.46.135, or 48.05.185.

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

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

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

36 (1) It is an unfair or deceptive practice for a health carrier to
37 initiate, with such frequency as to indicate a general business
38 practice, arbitration under section 8 of this act with respect to

1 claims submitted by out-of-network providers for services included in
2 section 6 of this act that request payment of a commercially
3 reasonable amount, based on payments for the same or similar services
4 provided in a similar geographic area.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (17) Conviction of any gross misdemeanor or felony relating to
2 the practice of the person's profession. For the purposes of this
3 subsection, conviction includes all instances in which a plea of
4 guilty or nolo contendere is the basis for conviction and all
5 proceedings in which the sentence has been deferred or suspended.
6 Nothing in this section abrogates rights guaranteed under chapter
7 9.96A RCW;

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

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

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

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

19 (22) Interference with an investigation or disciplinary
20 proceeding by willful misrepresentation of facts before the
21 disciplining authority or its authorized representative, or by the
22 use of threats or harassment against any patient or witness to
23 prevent them from providing evidence in a disciplinary proceeding or
24 any other legal action, or by the use of financial inducements to any
25 patient or witness to prevent or attempt to prevent him or her from
26 providing evidence in a disciplinary proceeding;

27 (23) Current misuse of:

28 (a) Alcohol;

29 (b) Controlled substances; or

30 (c) Legend drugs;

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

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

40 (26) Violation of RCW 18.130.420;

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

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

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

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

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

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

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

32 **APPLICABILITY**

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

1 Each health plan that provides medical insurance offered under
2 this chapter, including plans created by insuring entities, plans not
3 subject to the provisions of Title 48 RCW, and plans created under
4 RCW 41.05.140, are subject to the provisions of RCW 48.43.500,
5 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545,
6 48.43.550, 70.02.110, 70.02.900, 48.43.190, ~~((and))~~ 48.43.083, and
7 chapter 48.--- RCW (the new chapter created in section 27 of this
8 act).

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

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

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

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

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

3 (1) The office of financial management, with the lead
4 organization, shall establish a data set and business process to
5 provide health carriers, health care providers, hospitals, ambulatory
6 surgical facilities, and arbitrators with prevailing payment and
7 billed charge amounts for the services described in section 6 of this
8 act to assist in determining commercially reasonable payments and
9 resolving payment disputes for out-of-network medical services
10 rendered by health care providers. The data set shall be composed of
11 commercial health plan claims, and shall exclude medicare and
12 medicaid claims as well as claims paid on other than a fee-for-
13 service basis. The data and business process must be available
14 beginning November 1, 2019.

15 (2) The 2019 data set must be based upon the most recently
16 available full calendar year of claims data. The data set for each
17 subsequent year must be adjusted by applying the consumer price
18 index-medical component established by the United States department
19 of labor, bureau of labor statistics to the previous year's data set.

20 NEW SECTION. **Sec. 27.** Sections 5 through 15, 22 through 25, and
21 28 of this act constitute a new chapter in Title 48 RCW.

22 NEW SECTION. **Sec. 28.** Except for section 26 of this act, this
23 act takes effect January 1, 2020.

24 NEW SECTION. **Sec. 29.** If any provision of this act or its
25 application to any person or circumstance is held invalid, the
26 remainder of the act or the application of the provision to other
27 persons or circumstances is not affected.

--- END ---