Chapter 48.49 RCW
BALANCE BILLING PROTECTION ACT

Sections

RCW 48.49.003 Findings—Intent—2019 c 427. (1) The legislature finds that:

(a) Consumers receive surprise bills or balance bills for services provided at nonparticipating facilities or by nonparticipating 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 RCW 48.49.020, and to provide self-funded group health plans with an option to elect to be subject to the provisions of this chapter;

(b) Remove consumers from balance billing disputes and require that nonparticipating providers and carriers negotiate nonparticipating provider payments in good faith under the terms of this chapter;

(c) Align Washington state law with the federal balance billing prohibitions and transparency protections in sections 2799A-1 et seq. of the public health service act (P.L. 116-260) and implementing federal regulations in effect on March 31, 2022, while maintaining provisions of this chapter that provide greater protection for consumers; and

(d) Provide an environment that encourages self-funded groups to negotiate payments in good faith with nonparticipating providers and facilities in return for balance billing protections. [2022 c 263 § 6; 2019 c 427 § 1.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.005 Short title. This chapter may be known and cited as the balance billing protection act. [2019 c 427 § 4.]

RCW 48.49.010 Definitions. The definitions in RCW 48.43.005 apply throughout this chapter unless the context clearly requires otherwise. [2019 c 427 § 5.]

RCW 48.49.020 Balance billing—When prohibited—Carrier's duty to hold an enrollee harmless from balance billing under certain circumstances. (1) A nonparticipating provider or facility may not balance bill an enrollee for the following health care services as provided in section 2799A-1(b) of the public health service act (42 U.S.C. Sec. 300gg-111(b)) and implementing federal regulations in effect on March 31, 2022:

(a) Emergency services provided to an enrollee;

(b) Nonemergency health care services performed by nonparticipating providers at certain participating facilities; or

(c) Air ambulance services.

(2) Payment for services described in subsection (1) of this section is subject to the provisions of sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022, except that:

(a) Until July 1, 2023, or a later date determined by the commissioner, RCW 48.49.160 and 48.49.040 apply to the nonparticipating provider or facility payment standard and dispute resolution process for services described in subsection (1) of this section, other than air ambulance services;

(b) A health care provider, health care facility, or air ambulance service provider may not request or require a patient at any time, for any procedure, service, or supply, to sign or otherwise execute by oral, written, or electronic means, any document that would attempt to avoid, waive, or alter any provision of RCW 48.49.020 and 48.49.030 or sections 2799A-1 et seq. of the public health service act (P.L. 116-260) and implementing federal regulations in effect on March 31, 2022;

(c) If the enrollee pays a nonparticipating provider, nonparticipating facility, or nonparticipating air ambulance service provider an amount that exceeds the in-network cost-sharing amount determined under sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations as in effect on March 31, 2022, the provider or facility must refund any amount in excess of the in-network cost-sharing amount to the enrollee within 30 business days of receipt. Interest must be paid to the enrollee for any unrefunded payments at a rate of 12 percent beginning on the first calendar day after the 30 business days; and

(d) Carriers must make available through electronic and other methods of communication generally used by a provider to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the requirements of this chapter or section 2799A-1 et seq. of the public health service act (42 U.S.C. Sec. 300gg-111 et seq.) and implementing federal regulations in effect on March 31, 2022.

(3) A behavioral health emergency services provider may not balance bill an enrollee for emergency services provided to an enrollee.

(4) Payment for emergency services provided by behavioral health emergency services providers under subsection (3) of this section is subject to RCW 48.49.030, 48.49.160, and 48.49.040.

(5) This section applies to health care providers, facilities, or behavioral health emergency services providers 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 this section and RCW 48.49.030, 48.49.160, and 48.49.040 as provided in RCW 48.49.130. [2022 c 263 § 7; 2019 c 427 § 6.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.030 Enrollee's obligation to pay for services. (1) If an enrollee receives emergency services from a behavioral health emergency services provider under the circumstances described in RCW 48.49.020(3):

(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 methodology for calculating the qualifying payment amount as described

in 45 C.F.R. Sec. 149.140 as in effect on March 31, 2022. The carrier must provide an explanation of benefits to the enrollee and the nonparticipating provider that reflects the cost-sharing amount determined under this subsection.

(b) The carrier, nonparticipating behavioral health emergency services provider, and an agent, trustee, or assignee of the carrier or nonparticipating behavioral health emergency services provider must ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection.

(c) The nonparticipating behavioral health emergency services provider and an agent, trustee, or assignee of the nonparticipating behavioral health emergency services provider 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 behavioral health emergency services 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 determined under (a) of this subsection paid by the enrollee for a nonparticipating behavioral health emergency services provider's services in the same manner as cost-sharing for health care services provided by an in-network behavioral health emergency services provider 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 nonparticipating behavioral health emergency services provider an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection, the behavioral health emergency services provider 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) This section shall only apply to health care providers, facilities, or behavioral health emergency services providers 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 this section and RCW 48.49.020, 48.49.160, and 48.49.040 as provided in RCW 48.49.130. [2022 c 263 § 8; 2019 c 427 § 7.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.040 Dispute resolution process—Determination of commercially reasonable payment amount. (1) Effective July 1, 2023, or a later date determined by the commissioner, services described in RCW 48.49.020(1) other than air ambulance services are subject to the independent dispute resolution process established in sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on July 1, 2023, or a later date determined by the commissioner. Until July 1, 2023, or a later date determined by the commissioner, the arbitration process in this section governs the dispute resolution process for those services.

(2) Effective July 1, 2023, or a later date determined by the commissioner, services described in RCW 48.49.020(3) are subject to

the independent dispute resolution process established in section 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on July 1, 2023, or a later date determined by the commissioner. Until July 1, 2023, or a later date determined by the commissioner or if the federal independent dispute resolution process is not available to the state for resolution of these disputes, the arbitration process in this section governs the dispute resolution process for those services.

(3)(a) Notwithstanding RCW 48.43.055 and 48.18.200, if good faith negotiation, as described in RCW 48.49.030, does not result in resolution of the dispute, and the carrier or nonparticipating provider, facility, or behavioral health emergency services provider chooses to pursue further action to resolve the dispute, the carrier or nonparticipating provider, facility, or behavioral health emergency services provider shall initiate arbitration to determine a commercially reasonable payment amount. To initiate arbitration, the carrier or nonparticipating provider, facility, or behavioral health emergency services provider 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 RCW 48.49.030. 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) Notwithstanding (a) of this subsection (3), where a dispute resolution matter initiated under sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022, results in a determination by a certified independent dispute resolution entity that such process does not apply to the dispute or to portions thereof, a carrier, provider, facility, or behavioral health emergency services provider may initiate arbitration described in this section for such dispute:

(i) Without completing good faith negotiation under RCW 48.49.160 if the open negotiation period required under sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022, has been completed; and

(ii) By providing written notification to the commissioner and the noninitiating party no later than 10 calendar days following the date notice is received by the parties from the certified independent dispute resolution entity that the federal independent dispute resolution process is not applicable to the dispute.

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

(a) Involve identical carrier and provider, provider group, facility, or behavioral health emergency services provider parties;

(b) Involve claims with the same procedural code, or a comparable code under a different procedural code system; and

(c) Occur within the same 30 business day period.

(5) 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 must 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.

(6) 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. Each party must include in their 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.

(7) If the parties agree on an out-of-network rate for the services at issue after providing the arbitration initiation notice to the commissioner but before the arbitrator has made their decision, the amount agreed to by the parties for the service will be treated as the out-of-network rate for the service. The initiating party must send a notification to the commissioner and to the arbitrator, as soon as possible, but no later than three business days after the date of the agreement. The notification must include the out-of-network rate for the service and signatures from authorized signatories for both parties.

(8)(a) 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 *RCW 48.49.050 regarding the decision to the commissioner. The arbitrator's decision must include an explanation of the elements of the parties' submissions the arbitrator relied upon to make their decision and why those elements were relevant to their decision.

(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; and

(ii) 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 not require extrinsic evidence of authenticity for admitting data from the Washington state all-payer claims database data set developed under RCW 43.371.100 into evidence.

(d) 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, including the Washington state all-payer claims database data set developed under RCW 43.371.100.

(9) 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 commissioner may establish allowable arbitrator fee ranges or an arbitrator fee schedule by rule. Arbitrator fees must be paid to the arbitrator by a party within 30 calendar days following receipt of the arbitrator's decision by the party. 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.

(10) Within 10 business days of a party notifying the commissioner and the noninitiating party of intent to initiate arbitration, both parties shall agree to and execute a nondisclosure agreement. The nondisclosure agreement must not preclude the arbitrator from submitting the arbitrator's decision to the commissioner under subsection (6) of this section or impede the commissioner's duty to prepare the annual report under *RCW 48.49.050.

(11) The decision of the arbitrator is final and binding on the parties to the arbitration and is not subject to judicial review.

(12) 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.

(13) For dispute resolution proceedings initiated under RCW 48.49.135(2)(b), the arbitration provisions of this section apply except that:

(a) The issue before the arbitrator will be the commercially reasonable payment for applicable services addressed in the alternate access delivery request rather than the commercially reasonable payment for single or multiple claims under subsection (4) of this section. The arbitrator shall issue a decision related to whether payment for the applicable services should be made at the final offer amount of the carrier or the final offer amount of the provider or facility. The arbitrator's decision is final and binding on the parties for services rendered to enrollees from the effective date of the amended alternate access delivery request approved under RCW 48.49.135(2)(b) to either the expiration date of the amended alternate access delivery request, or at the time that a provider contract and provider compensation agreement are executed between the parties, whichever occurs first;

(b) During the period from the effective date of the amended alternate access delivery request to issuance of the arbitrator's decision, the allowed amount paid to providers or facilities for the applicable services addressed in the amended alternate access delivery request shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area; and

(c) The proceedings are subject to the arbitration process described in this section, and not to the independent dispute resolution process established in sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(14) Air ambulance services are subject to the independent dispute resolution process established in sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(15) This section applies to health care providers, facilities, or behavioral health emergency services providers 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 RCW 48.49.020 and 48.49.030, 48.49.160, and this section as provided in RCW 48.49.130.

(16) An entity administering a self-funded group health plan that has elected to participate in this section pursuant to RCW 48.49.130 shall comply with the provisions of this section. [2022 c 263 § 11; 2019 c 427 § 8.]

***Reviser's note:** RCW 48.49.050 expired January 1, 2023.

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.060 Notice of consumer rights—Development of standard template language by commissioner. (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 of their rights under this chapter, and sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(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. [2022 c 263 § 13; 2019 c 427 § 10.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.070 Hospital, ambulatory surgical facility, or behavioral health emergency services provider—Requirement to provide certain information on website or upon consumer request—Requirement to provide carriers with nonemployed provider lists. (1)(a) A hospital, ambulatory surgical facility, or behavioral health emergency services provider must post the following information on its website, if one is available:

(i) The listing of the carrier health plan provider networks with which the hospital, ambulatory surgical facility, or behavioral health emergency services provider is an in-network provider, based upon the information provided by the carrier pursuant to RCW 48.43.730(7); and

(ii) The notice of consumer rights developed under RCW 48.49.060.

(b) If the hospital, ambulatory surgical facility, or behavioral health emergency services provider does not maintain a website, 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, ambulatory surgical facility, or behavioral health emergency services provider 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 emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist[,] and diagnostic services, including radiology and laboratory 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. [2022 c 263 § 14; 2019 c 427 § 11.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.080 Health care provider—Requirement to provide certain information on website or upon consumer request—Requirement to submit network status information to carriers. (1)(a) A health care provider must provide the following information on its website, if one is available:

(i) The listing of the carrier health plan provider networks with which the provider contracts, based upon the information provided by the carrier pursuant to RCW 48.43.730(7); and

(ii) The notice of consumer rights developed under RCW 48.49.060.

(b) If the health care provider does not maintain a website, 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. [2019 c 427 § 12.]

RCW 48.49.090 Carrier—Requirement to update website and provider directory—Requirement to provide enrollee with certain information. (1) A carrier must update its website 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;

(b) The notice of consumer rights developed under RCW 48.49.060;

(c) Notification that if the enrollee receives services from an out-of-network provider, facility, or behavioral health emergency services provider, under circumstances other than those described in RCW 48.49.020, 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 whether there are in-network providers available to provide emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist[,] and diagnostic services, including radiology and laboratory services at specified in-network hospitals or ambulatory surgical facilities; and

(f) Upon request, an estimated range of the out-of-pocket costs for an out-of-network benefit. [2022 c 263 § 15; 2019 c 427 § 13.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.100 Pattern of unresolved violations—Enforcement action by department of health or appropriate disciplining authority. (1) If the commissioner has cause to believe that any health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider, has engaged in a pattern of unresolved violations of RCW 48.49.020 or 48.49.030, 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, ambulatory surgical facility, or behavioral health emergency services provider, with an opportunity to cure the alleged violations or explain why the actions in question did not violate RCW 48.49.020 or 48.49.030.

(2) If any health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider, has engaged in a pattern of unresolved violations of RCW 48.49.020 or 48.49.030, the department of health or the appropriate disciplining authority may levy a fine or cost recovery upon the health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider 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 this chapter, 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. [2022 c 263 § 16; 2019 c 427 § 14.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.110 Rule-making authority. (1) The commissioner may adopt rules to implement and administer this chapter, including rules governing the dispute resolution process established in RCW 48.49.040.

(2) The commissioner may adopt rules to adopt or incorporate by reference without material change federal regulations adopted on or after March 31, 2022, that implement P.L. 116-260 (enacted December 27, 2020). [2022 c 263 § 20; 2019 c 427 § 15.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.120 No application of chapter to health plans under chapter 74.09 RCW. This chapter does not apply to health plans that provide benefits under chapter 74.09 RCW. [2019 c 427 § 22.]

RCW 48.49.130 Application of chapter to self-funded group health plans that elect to participate in balance billing protection provisions—Annual notice to commissioner. As authorized in 45 C.F.R. Sec. 149.30 as in effect on March 31, 2022, the provisions of this chapter apply to a self-funded group health plan whether governed by or exempt from 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 RCW 48.49.020 and 48.49.030, 48.49.160, and 48.49.040. 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 RCW 48.49.020 and 48.49.030, 48.49.160, and 48.49.040. An entity administering a self-funded health benefits plan that elects to participate under this section, shall comply with the provisions of RCW 48.49.020 and 48.49.030, 48.49.160, and 48.49.040. [2022 c 263 § 17; 2019 c 427 § 23.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.135 Determining the adequacy of provider networks—Required considerations. (1) When determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, the commissioner must review the carrier's proposed provider network or in-force provider network to determine whether the network includes a sufficient number of contracted providers of emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist[,] and diagnostic services, including radiology and laboratory 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.

(2)(a) When determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, the commissioner may allow a carrier to submit an alternate access delivery request. The commissioner shall define the circumstances under which a carrier may submit an alternate access delivery request and the requirements for submission and approval of such a request in rule. To submit an alternate access delivery request, a carrier shall:

(i) Ensure that enrollees will not bear any greater cost of receiving services under the alternate access delivery request than if the provider or facility was contracted with the carrier or make other arrangements acceptable to the commissioner;

(ii) Provide substantial evidence of good faith efforts on its part to contract with providers or facilities. If a carrier is submitting an alternate access delivery request for the same service and geographic area as a previously approved request, the carrier shall provide new or additional evidence of good faith efforts to contract associated with the current request;

(iii) Demonstrate that there is not an available provider or facility with which the carrier can contract to meet the commissioner's provider network standards; and

(iv) For services for which balance billing is prohibited under RCW 48.49.020, notify out-of-network providers or facilities that deliver the services referenced in the alternate access delivery request within five days of submitting the request to the commissioner. Any notification provided under this subsection shall include contact information for carrier staff who can provide detailed information to the affected provider or facility regarding the submitted alternate access delivery request.

(b) For services for which balance billing is prohibited under RCW 48.49.020, a carrier may not treat its payment of nonparticipating providers or facilities under this chapter or P.L. 116-260 (enacted December 27, 2020) as a means to satisfy network access standards established by the commissioner unless all requirements of this subsection are met.

(i) If a carrier is unable to obtain a contract with a provider or facility delivering services addressed in an alternate access delivery request to meet network access requirements, the carrier may ask the commissioner to amend the alternate access delivery request if the carrier's communication to the commissioner occurs at least three months after the effective date of the alternate access delivery request and demonstrates substantial evidence of good faith efforts on its part to contract for delivery of services during that three-month time period. If the carrier has demonstrated substantial evidence of good faith efforts on its part to contract, the commissioner shall allow a carrier to use the dispute resolution process provided in RCW 48.49.040 to determine the amount that will be paid to providers or facilities for services referenced in the alternate access delivery request. The commissioner may determine by rule the associated processes for use of the dispute resolution process under this subsection.

(ii) Once notification is provided by the carrier to a provider or facility under (a) of this subsection, a carrier is not responsible for reimbursing a provider's or facility's charges in excess of the amount charged by the provider or facility for the same or similar service at the time the notification was provided. The provider or facility shall accept this reimbursement as payment in full.

(3) When determining the adequacy of a carrier's proposed provider network or the ongoing adequacy of an in-force provider network, beginning January 1, 2023, the commissioner shall require that the carrier's proposed provider network or in-force provider network include a sufficient number of contracted behavioral health emergency services providers. [2022 c 263 § 18; 2019 c 427 § 25. Formerly RCW 48.49.150.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.140 Liberal construction of chapter to promote public interest. 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 RCW 48.49.020. [2019 c 427 § 24.]

RCW 48.49.160 Allowed amounts paid to nonparticipating providers. (1)(a) Until July 1, 2023, or a later date determined by the commissioner under RCW 48.49.040, the allowed amount paid to a nonparticipating provider for health care services described under RCW 48.49.020(1) other than air ambulance services shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. Within 30 calendar days of receipt of a claim from a nonparticipating provider or facility, the carrier shall offer to pay the provider or facility a commercially reasonable amount. If the nonparticipating provider or facility wants to dispute the carrier's payment, the provider or facility must notify the carrier no later than 30 calendar days after receipt of payment or payment notification from the carrier. If the nonparticipating provider or facility disputes the carrier's initial offer, the carrier and provider or facility have 30 calendar days from the initial offer to negotiate in good faith. If the carrier and the nonparticipating provider or facility do not agree to a commercially reasonable payment amount within 30 calendar days, and the carrier or nonparticipating provider or facility chooses to pursue further action to resolve the dispute, the dispute shall be resolved as provided in RCW 48.49.040.

(b) The carrier must make payments for health care services described in RCW 48.49.020(1) provided by nonparticipating providers or facilities directly to the provider or facility, rather than the enrollee.

(2)(a) The allowed amount paid to a nonparticipating behavioral health emergency services provider for behavioral health emergency services shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. Within 30 calendar days of receipt of a claim from a nonparticipating behavioral health emergency services provider, the carrier shall offer to pay the behavioral health emergency services provider a commercially reasonable amount. If the nonparticipating behavioral health emergency services provider wants to dispute the carrier's payment, the behavioral health emergency services provider must notify the carrier no later than 30 calendar days after receipt of payment or payment notification from the carrier. If the nonparticipating behavioral health emergency services provider

disputes the carrier's initial offer, the carrier and behavioral health emergency services provider have 30 calendar days from the initial offer to negotiate in good faith. If the carrier and the nonparticipating behavioral health emergency services provider do not agree to a commercially reasonable payment amount within 30 calendar days, and the carrier or nonparticipating behavioral health emergency services provider chooses to pursue further action to resolve the dispute, the dispute shall be resolved as provided in RCW 48.49.040.

(b) The carrier must make payments for behavioral health emergency services provided by nonparticipating behavioral health emergency services providers directly to the provider, rather than the enrollee.

(3) This section shall only apply to health care providers, facilities, or behavioral health emergency services providers 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 RCW 48.49.020, 48.49.030, and 48.49.040, and this section as provided in RCW 48.49.130. [2022 c 263 § 9.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.170 Application of state and federal requirements—Applicability information access—Waivers prohibited. (1) Carriers must make available through electronic and other methods of communication generally used by a provider or facility to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the requirements of this chapter or section 2799A-1 et seq. of the public health service act (42 U.S.C. Sec. 300gg-111 et seq.) and implementing federal regulations in effect on March 31, 2022.

(2) A health care provider, health care facility, behavioral health emergency services provider, or air ambulance service provider may not request or require a patient at any time, for any procedure, service, or supply, to sign or otherwise execute by oral, written, or electronic means, any document that would attempt to avoid, waive, or alter any provision of RCW 48.49.020 and 48.49.030 or sections 2799A-1 et seq. of the public health service act (P.L. 116-260) and implementing federal regulations in effect on March 31, 2022.

(3) This section shall only apply to health care providers, facilities, or behavioral health emergency services providers 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 RCW 48.49.020, 48.49.030, 48.49.160, and 48.49.040 as provided in RCW 48.49.130. [2022 c 263 § 10.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.180 Commissioner authority—Enforcement—Penalties. The commissioner is authorized to enforce provisions of P.L. 116-260 (enacted December 27, 2020, as the consolidated appropriations act of 2021) that are applicable to or regulate the conduct of carriers issuing health plans or grandfathered health plans to residents of Washington state on or after January 1, 2022. In addition to the enforcement actions authorized under RCW 48.02.080, the commissioner

may impose a civil monetary penalty in an amount not to exceed $100 for each day for each individual with respect to which a failure to comply with these provisions occurs. [2022 c 263 § 19.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.190 Reports to legislature. (1) On or before October 1, 2023, the commissioner, in collaboration with the health care authority and the department of health, must submit a report and any recommendations to the appropriate policy and fiscal committees of the legislature as to how balance billing for ground ambulance services can be prevented and whether ground ambulance services should be subject to the balance billing restrictions of this chapter. In developing the report and any recommendations, the commissioner must:

(a) Consider any recommendations made to congress by the advisory committee established in section 117 of P.L. 116-260 to review options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing; and

(b) Consult with the department of health, the health care authority, the state auditor, consumers, hospitals, carriers, private ground ambulance service providers, fire service agencies, and local governmental entities that operate ground ambulance services, and include their perspectives in the final report.

(2) For purposes of this section, "ground ambulance services" means organizations licensed by the department of health that operate one or more ground vehicles designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation. [2022 c 263 § 21.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.49.900 Effective date—2019 c 427. Except for section 26 of this act, this act takes effect January 1, 2020. [2019 c 427 § 31.]