

2ESHB 2114 - S COMM AMD

By Committee on Health & Long Term Care

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

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

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

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

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

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

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

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

20 (5) "Basic health plan" means the plan described under chapter
21 70.47 RCW, as revised from time to time.

22 ((+5)) (6) "Basic health plan model plan" means a health plan as
23 required in RCW 70.47.060(2)(e).

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

29 ((+7)) (8) "Board" means the governing board of the Washington
30 health benefit exchange established in chapter 43.71 RCW.

31 ((+8)) (9)(a) For grandfathered health benefit plans issued
32 before January 1, 2014, and renewed thereafter, "catastrophic health
33 plan" means:

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

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

8 (b) In July 2008, and in each July thereafter, the insurance
9 commissioner shall adjust the minimum deductible and out-of-pocket
10 expense required for a plan to qualify as a catastrophic plan to
11 reflect the percentage change in the consumer price index for medical
12 care for a preceding twelve months, as determined by the United
13 States department of labor. For a plan year beginning in 2014, the
14 out-of-pocket limits must be adjusted as specified in section
15 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount
16 shall apply on the following January 1st.

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

19 (i) A health benefit plan that meets the definition of
20 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
21 2010, as amended; or

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

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

33 ~~((10))~~ (11) "Concurrent review" means utilization review
34 conducted during a patient's hospital stay or course of treatment.

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

1 ~~((12))~~ (13) "Dependent" means, at a minimum, the enrollee's
2 legal spouse and dependent children who qualify for coverage under
3 the enrollee's health benefit plan.

4 ~~((13))~~ (14) "Emergency medical condition" means a medical,
5 mental health, or substance use disorder condition manifesting itself
6 by acute symptoms of sufficient severity~~((7))~~ including, but not
7 limited to, severe pain or emotional distress, such that a prudent
8 layperson, who possesses an average knowledge of health and medicine,
9 could reasonably expect the absence of immediate medical, mental
10 health, or substance use disorder treatment attention to result in a
11 condition (a) placing the health of the individual, or with respect
12 to a pregnant woman, the health of the woman or her unborn child, in
13 serious jeopardy, (b) serious impairment to bodily functions, or (c)
14 serious dysfunction of any bodily organ or part.

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

27 ~~((15))~~ (16) "Employee" has the same meaning given to the term,
28 as of January 1, 2008, under section 3(6) of the federal employee
29 retirement income security act of 1974.

30 ~~((16))~~ (17) "Enrollee point-of-service cost-sharing" or "cost-
31 sharing" means amounts paid to health carriers directly providing
32 services, health care providers, or health care facilities by
33 enrollees and may include copayments, coinsurance, or deductibles.

34 ~~((17))~~ (18) "Exchange" means the Washington health benefit
35 exchange established under chapter 43.71 RCW.

36 ~~((18))~~ (19) "Final external review decision" means a
37 determination by an independent review organization at the conclusion
38 of an external review.

39 ~~((19))~~ (20) "Final internal adverse benefit determination"
40 means an adverse benefit determination that has been upheld by a

1 health plan or carrier at the completion of the internal appeals
2 process, or an adverse benefit determination with respect to which
3 the internal appeals process has been exhausted under the exhaustion
4 rules described in RCW 48.43.530 and 48.43.535.

5 ~~((+20+))~~ (21) "Grandfathered health plan" means a group health
6 plan or an individual health plan that under section 1251 of the
7 patient protection and affordable care act, P.L. 111-148 (2010) and
8 as amended by the health care and education reconciliation act, P.L.
9 111-152 (2010) is not subject to subtitles A or C of the act as
10 amended.

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

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

31 ~~((+23+))~~ (24) "Health care provider" or "provider" means:

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

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

37 ~~((+24+))~~ (25) "Health care service" means that service offered or
38 provided by health care facilities and health care providers relating
39 to the prevention, cure, or treatment of illness, injury, or disease.

1 (~~(25)~~) (26) "Health carrier" or "carrier" means a disability
2 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
3 service contractor as defined in RCW 48.44.010, or a health
4 maintenance organization as defined in RCW 48.46.020, and includes
5 "issuers" as that term is used in the patient protection and
6 affordable care act (P.L. 111-148).

7 (~~(26)~~) (27) "Health plan" or "health benefit plan" means any
8 policy, contract, or agreement offered by a health carrier to
9 provide, arrange, reimburse, or pay for health care services except
10 the following:

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

13 (b) Medicare supplemental health insurance governed by chapter
14 48.66 RCW;

15 (c) Coverage supplemental to the coverage provided under chapter
16 55, Title 10, United States Code;

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

19 (e) Disability income;

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

23 (g) Workers' compensation coverage;

24 (h) Accident only coverage;

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

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

30 (k) Dental only and vision only coverage;

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

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

1 ~~((27))~~ (28) "In-network" or "participating" means a provider or
2 facility that has contracted with a carrier or a carrier's contractor
3 or subcontractor to provide health care services to enrollees for the
4 purpose of receiving reimbursement from the carrier at specified
5 levels as payment in full for the health care services, including
6 applicable cost-sharing obligations.

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

10 ~~((28))~~ (30) "Material modification" means a change in the
11 actuarial value of the health plan as modified of more than five
12 percent but less than fifteen percent.

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

18 ~~((30))~~ (32) "Out-of-network" or "nonparticipating" means a
19 provider or facility that has not contracted with a carrier or a
20 carrier's contractor or subcontractor to provide health care services
21 to enrollees.

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

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

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

36 ~~((32))~~ (36) "Review organization" means a disability insurer
37 regulated under chapter 48.20 or 48.21 RCW, health care service
38 contractor as defined in RCW 48.44.010, or health maintenance
39 organization as defined in RCW 48.46.020, and entities affiliated

1 with, under contract with, or acting on behalf of a health carrier to
2 perform a utilization review.

3 (~~(33)~~) (37) "Small employer" or "small group" means any person,
4 firm, corporation, partnership, association, political subdivision,
5 sole proprietor, or self-employed individual that is actively engaged
6 in business that employed an average of at least one but no more than
7 fifty employees, during the previous calendar year and employed at
8 least one employee on the first day of the plan year, is not formed
9 primarily for purposes of buying health insurance, and in which a
10 bona fide employer-employee relationship exists. In determining the
11 number of employees, companies that are affiliated companies, or that
12 are eligible to file a combined tax return for purposes of taxation
13 by this state, shall be considered an employer. Subsequent to the
14 issuance of a health plan to a small employer and for the purpose of
15 determining eligibility, the size of a small employer shall be
16 determined annually. Except as otherwise specifically provided, a
17 small employer shall continue to be considered a small employer until
18 the plan anniversary following the date the small employer no longer
19 meets the requirements of this definition. A self-employed individual
20 or sole proprietor who is covered as a group of one must also: (a)
21 Have been employed by the same small employer or small group for at
22 least twelve months prior to application for small group coverage,
23 and (b) verify that he or she derived at least seventy-five percent
24 of his or her income from a trade or business through which the
25 individual or sole proprietor has attempted to earn taxable income
26 and for which he or she has filed the appropriate internal revenue
27 service form 1040, schedule C or F, for the previous taxable year,
28 except a self-employed individual or sole proprietor in an
29 agricultural trade or business, must have derived at least fifty-one
30 percent of his or her income from the trade or business through which
31 the individual or sole proprietor has attempted to earn taxable
32 income and for which he or she has filed the appropriate internal
33 revenue service form 1040, for the previous taxable year.

34 (~~(34)~~) (38) "Special enrollment" means a defined period of time
35 of not less than thirty-one days, triggered by a specific qualifying
36 event experienced by the applicant, during which applicants may
37 enroll in the carrier's individual health benefit plan without being
38 subject to health screening or otherwise required to provide evidence
39 of insurability as a condition for enrollment.

1 ~~((35))~~ (39) "Standard health questionnaire" means the standard
2 health questionnaire designated under chapter 48.41 RCW.

3 ~~((36))~~ (40) "Utilization review" means the prospective,
4 concurrent, or retrospective assessment of the necessity and
5 appropriateness of the allocation of health care resources and
6 services of a provider or facility, given or proposed to be given to
7 an enrollee or group of enrollees.

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

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

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

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

1 (b) If an authorized representative of a health carrier
2 authorizes coverage of emergency services, the health carrier shall
3 not subsequently retract its authorization after the emergency
4 services have been provided, or reduce payment for an item or service
5 furnished in reliance on approval, unless the approval was based on a
6 material misrepresentation about the covered person's health
7 condition made by the provider of emergency services.

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

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

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

30 ~~((d))~~ (2) If a health carrier requires preauthorization for
31 postevaluation or poststabilization services, the health carrier
32 shall provide access to an authorized representative twenty-four
33 hours a day, seven days a week, to facilitate review. In order for
34 postevaluation or poststabilization services to be covered by the
35 health carrier, the provider or facility must make a documented good
36 faith effort to contact the covered person's health carrier within
37 thirty minutes of stabilization, if the covered person needs to be
38 stabilized. The health carrier's authorized representative is
39 required to respond to a telephone request for preauthorization from
40 a provider or facility within thirty minutes. Failure of the health

1 carrier to respond within thirty minutes constitutes authorization
2 for the provision of immediately required medically necessary
3 postevaluation and poststabilization services, unless the health
4 carrier documents that it made a good faith effort but was unable to
5 reach the provider or facility within thirty minutes after receiving
6 the request.

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

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

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

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

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

- 34 (i) Involve surgical or ancillary services; and
 - 35 (ii) Are provided by an out-of-network provider.
- 36 (2) Payment for services described in subsection (1) of this
37 section is subject to sections 6 and 7 of this act.

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

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

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

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

17 (c) The out-of-network provider or out-of-network facility, and
18 an agent, trustee, or assignee of the out-of-network provider or out-
19 of-network facility:

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

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

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

33 (d) The carrier must:

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

37 (ii) Treat any cost-sharing amounts paid by the enrollee for such
38 services in the same manner as cost-sharing for health care services
39 provided by an in-network provider and must apply any cost-sharing

1 amounts paid by the enrollee for such services toward the limit on
2 the enrollee's in-network out-of-pocket maximum expenses.

3 (e) If the enrollee pays the out-of-network provider or out-of-
4 network facility an amount that exceeds the in-network cost-sharing
5 amount specified in the carrier's explanation of benefits, the
6 provider or facility must refund any amount in excess of the in-
7 network cost-sharing amount to the enrollee within thirty business
8 days of receipt. Interest must be paid to the enrollee for any
9 unrefunded payments at a rate of twelve percent beginning on the
10 first calendar day after the thirty business days.

11 (2) Upon receipt of an out-of-network provider or facility's bill
12 for health care services described in section 5 of this act, the
13 carrier must make its applicable payment directly to the provider or
14 facility, rather than the enrollee, subject to rules adopted by the
15 commissioner for prompt payment of claims.

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

18 (a) The median allowed amount paid to in-network providers for
19 similar services in the geographic area where the service was
20 provided as determined by reference to:

21 (i) The most recent data set prepared by the Washington state all
22 payer claims database under section 23 of this act, including any
23 applicable enrollee in-network cost-sharing requirement; or

24 (ii) The January 1, 2019, data set prepared by the Washington
25 state all payer claims database under section 23 of this act, updated
26 annually by a health care inflation factor determined by the
27 commissioner in rule, including any applicable enrollee in-network
28 cost-sharing requirement, whichever is greater;

29 (b) The median amount paid to out-of-network providers for
30 similar services in the geographic area where the service was
31 provided, as determined by reference to:

32 (i) The most recent data set prepared by the Washington state all
33 payer claims database under section 23 of this act, including any
34 applicable enrollee in-network cost-sharing requirement; or

35 (ii) The January 1, 2019, data set prepared by the Washington
36 state all payer claims database under section 23 of this act, updated
37 annually by a health care inflation factor determined by the
38 commissioner in rule, including any applicable enrollee in-network
39 cost-sharing requirement, whichever is greater; or

1 (c) One hundred seventy-five percent of the amount that would be
2 paid under medicare, Title XVIII of the federal social security act,
3 for similar services in the geographic area where the service was
4 provided, including any applicable enrollee in-network cost-sharing
5 requirement.

6 (4) The carrier remittance advice must disclose which of the
7 amounts calculated under subsection (3)(a), (b), and (c) of this
8 section was used to adjudicate the claim.

9 NEW SECTION. **Sec. 7.** (1) In the event of a dispute between a
10 carrier and an out-of-network provider or facility regarding payment
11 for the services described in section 5 of this act, a party wishing
12 to pursue a payment dispute must initiate an informal settlement
13 communication no later than thirty days after receipt of payment or
14 payment notification from the carrier. A party may not refuse to
15 participate in a teleconference if requested.

16 (2)(a) If the informal settlement communication does not result
17 in a resolution, a carrier, out-of-network provider, or out-of-
18 network facility may initiate arbitration to determine a reasonable
19 payment amount. To initiate arbitration, the carrier, provider, or
20 facility must provide written notification to the commissioner and
21 the noninitiating party no later than sixty days after initiation of
22 the informal settlement communication. The notification to the
23 noninitiating party must state the initiating party's final offer. No
24 later than thirty days following receipt of the notification, the
25 noninitiating party must provide its final offer to the initiating
26 party. The parties may reach an agreement on reimbursement during
27 this time and before the arbitration proceeding.

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

- 30 (i) Involve identical carrier and provider or facility parties;
31 (ii) Involve claims with the same or related current procedural
32 terminology codes relevant to a particular procedure; and
33 (iii) Occur within a period of six months of one another.

34 (3) Upon receipt of notification from the initiating party, the
35 commissioner must provide the parties with a list of approved
36 arbitrators or entities that provide binding arbitration. The
37 arbitrators on the list must be trained by the American arbitration
38 association or the American health lawyers association. The parties
39 may agree on an arbitrator from the list provided by the

1 commissioner. If the parties do not agree on an arbitrator, they must
2 notify the commissioner who must provide them with the names of five
3 arbitrators from the list. Each party may veto two of the five named
4 arbitrators. If one arbitrator remains, that person is the chosen
5 arbitrator. If more than one arbitrator remains, the commissioner
6 must choose the arbitrator from the remaining arbitrators. The
7 parties and the commissioner must complete this selection process
8 within twenty days of receipt of the list from the commissioner.

9 (4)(a) Each party must make written submissions to the arbitrator
10 in support of its position no later than thirty days after the final
11 selection of the arbitrator. A party that fails to make timely
12 written submissions under this section without good cause shown shall
13 be considered to be in default and the arbitrator shall require the
14 party in default to pay the final offer amount submitted by the party
15 not in default and may require the party in default to pay the
16 reasonable attorneys' fees of the party not in default. No later than
17 thirty days after the receipt of the parties' written submissions,
18 the arbitrator must: Issue a written decision requiring payment of
19 the final offer amount of either the initiating party or the
20 noninitiating party; notify the parties of its decision; and provide
21 the decision and the information described in section 8 of this act
22 regarding the decision to the commissioner.

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

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

29 (ii) The median billed charge amount for the service at issue
30 reported in the data set prepared by the Washington state all payer
31 claims database under section 23 of this act;

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

35 (iv) Patient characteristics; and

36 (v) The level of training, education, and experience of the
37 provider.

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

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

7 (6) The parties must enter into a nondisclosure agreement to
8 protect any personal health information or fee information provided
9 to the arbitrator.

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

13 NEW SECTION. **Sec. 8.** (1) The commissioner must prepare an
14 annual report summarizing the dispute resolution information provided
15 by arbitrators under section 7 of this act. The report must include
16 summary information related to the matters decided through
17 arbitration, as well as the following information for each dispute
18 resolved through arbitration: The carrier; the health care provider;
19 the health care provider's employer or the business entity in which
20 the provider has an ownership interest; the health care facility
21 where the services were provided; and the type of health care
22 services at issue.

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

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

27 NEW SECTION. **Sec. 9.** (1) A hospital or ambulatory surgical
28 facility must post the following information on its web site, if one
29 is available:

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

33 (b) A disclosure that nonemployed providers or provider groups
34 contracted by the hospital or ambulatory surgical facility to provide
35 surgical or ancillary services may not participate in the same health
36 plan provider networks as the hospital or ambulatory surgical
37 facility.

1 (2) Not less than thirty days prior to executing a contract with
2 a carrier, a hospital or ambulatory surgical facility must provide
3 the carrier with a list of the nonemployed providers or provider
4 groups contracted to provide surgical or ancillary services at the
5 hospital or ambulatory surgical facility. The hospital or ambulatory
6 surgical facility must notify the carrier within thirty days of a
7 removal from or addition to the provider list.

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

18 (2) A health care provider must provide information on its web
19 site, if available, listing the carrier health plan provider networks
20 with which the provider contracts.

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

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

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

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

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

33 (c) Notification that if the enrollee receives services from an
34 out-of-network provider or facility, under circumstances other than
35 those described in section 5 of this act, the enrollee will have the
36 financial responsibility applicable to services provided outside the
37 health plan's network in excess of applicable cost-sharing amounts

1 and that the enrollee may be responsible for any costs in excess of
2 those allowed by the health plan;

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

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

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

9 NEW SECTION. **Sec. 12.** (1) If the commissioner has cause to
10 believe that a health care provider or facility is violating sections
11 5 through 7 of this act, the commissioner may submit information to
12 the department of health or the appropriate disciplining authority
13 for action.

14 (2) If a health care provider or facility violates or has
15 violated a provision of this subchapter, the department of health or
16 the appropriate disciplining authority may levy a fine or cost
17 recovery upon the person in an amount not to exceed the applicable
18 statutory maximum amount per violation and take other action as
19 permitted under the authority of the department or disciplining
20 authority. Upon completion of its review of any potential violation
21 submitted by the commissioner or initiated directly by an enrollee,
22 the department of health or the disciplining authority shall notify
23 the commissioner of the results of the review, including whether the
24 violation was substantiated and any enforcement action taken as a
25 result of a finding of a substantiated violation.

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

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

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

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

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

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

10 (b) The standard template language must include contact
11 information for the office of the insurance commissioner so that
12 consumers may contact the office of the insurance commissioner if
13 they believe they have received a balance bill in violation of this
14 subchapter.

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

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

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

26 NEW SECTION. **Sec. 16.** (1) When determining the adequacy of a
27 proposed provider network or the ongoing adequacy of an in-force
28 provider network, the commissioner must consider whether the
29 carrier's proposed provider network or in-force provider network
30 includes a sufficient number of contracted providers practicing at
31 the same facilities with which the carrier has contracted for the
32 proposed or established provider network to reasonably ensure
33 enrollees have in-network access for covered benefits delivered at
34 that facility.

35 (2) A hospital or ambulatory surgical facility must provide the
36 carrier with information about the nonemployed providers or provider

1 groups that provide services at the hospital or ambulatory surgical
2 facility using the information provided under section 9 of this act.

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

5 Except as provided in RCW 18.130.062, the disciplining authority
6 has the following authority:

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

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

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

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

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

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

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

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

31 (a) Consistent with RCW 18.130.370, issue a summary suspension of
32 the license or temporary practice permit of a license holder
33 prohibited from practicing a health care profession in another state,
34 federal, or foreign jurisdiction because of an act of unprofessional
35 conduct that is substantially equivalent to an act of unprofessional
36 conduct prohibited by this chapter or any of the chapters specified
37 in RCW 18.130.040. The summary suspension remains in effect until
38 proceedings by the Washington disciplining authority have been
39 completed;

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

9 (9) To conduct show cause hearings in accordance with RCW
10 18.130.062 or 18.130.135 to review an action taken by the
11 disciplining authority to suspend a license or restrict or limit a
12 license holder's practice pending proceedings by the disciplining
13 authority;

14 (10) To use a presiding officer as authorized in RCW
15 18.130.095(3) or the office of administrative hearings as authorized
16 in chapter 34.12 RCW to conduct hearings. Disciplining authorities
17 identified in RCW 18.130.040(2) shall make the final decision
18 regarding disposition of the license unless the disciplining
19 authority elects to delegate in writing the final decision to the
20 presiding officer. Disciplining authorities identified in RCW
21 18.130.040(2)(b) may not delegate the final decision regarding
22 disposition of the license or imposition of sanctions to a presiding
23 officer in any case pertaining to standards of practice or where
24 clinical expertise is necessary, including deciding any motion that
25 results in dismissal of any allegation contained in the statement of
26 charges. Presiding officers acting on behalf of the secretary shall
27 enter initial orders. The secretary may, by rule, provide that
28 initial orders in specified classes of cases may become final without
29 further agency action unless, within a specified time period:

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

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

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

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

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

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

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

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

15 (17) To designate individuals authorized to sign subpoenas and
16 statements of charges;

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

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

29 (20) To levy a fine or cost recovery in an amount not to exceed
30 the amount authorized in RCW 18.130.160 or 18.130.172 per violation
31 and take other formal or informal disciplinary action as permitted
32 under the authority of the disciplining authority, if a report of a
33 potential violation of sections 5 through 7 of this act by a health
34 care provider is substantiated.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38 (19) The offering, undertaking, or agreeing to cure or treat
39 disease by a secret method, procedure, treatment, or medicine, or the
40 treating, operating, or prescribing for any health condition by a

1 method, means, or procedure which the licensee refuses to divulge
2 upon demand of the disciplining authority;

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

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

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

15 (23) Current misuse of:

16 (a) Alcohol;

17 (b) Controlled substances; or

18 (c) Legend drugs;

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

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

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

30 If the insurance commissioner has cause to believe that a
31 hospital has violated sections 5 through 7 of this act, the
32 commissioner may submit that information to the department. If the
33 department finds that a violation has occurred, the department may
34 levy a fine upon the hospital in an amount not to exceed one thousand
35 dollars per violation and take other action as permitted under the
36 authority of the department.

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

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

8 NEW SECTION. **Sec. 21.** A new section is added to chapter 70.42
9 RCW to read as follows:

10 If the insurance commissioner has cause to believe that a medical
11 test site has violated sections 5 through 7 of this act, the
12 commissioner may submit that information to the department. If the
13 department finds that a violation has occurred, the department may
14 levy a fine upon the medical test site in an amount not to exceed one
15 thousand dollars per violation and take other action as permitted
16 under the authority of the department.

17 **Sec. 22.** RCW 41.05.017 and 2016 c 139 s 4 are each amended to
18 read as follows:

19 Each health plan that provides medical insurance offered under
20 this chapter, including plans created by insuring entities, plans not
21 subject to the provisions of Title 48 RCW, and plans created under
22 RCW 41.05.140, are subject to the provisions of RCW 48.43.500,
23 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545,
24 48.43.550, 70.02.110, 70.02.900, 48.43.190, ((and)) 48.43.083,
25 sections 4 through 15 of this act and section 16 of this act for
26 plans subject to the provisions of Title 48 RCW.

27 NEW SECTION. **Sec. 23.** A new section is added to chapter 43.371
28 RCW to read as follows:

29 The office of financial management shall establish a data set
30 drawn from commercial fully insured health plans in Washington state
31 and a business process to provide health carriers, health care
32 providers, and arbitrators with prevailing payment and billed charge
33 amounts for the services described in section 5 of this act to assist
34 in determining allowed amounts and resolving payment disputes for
35 out-of-network medical services rendered by health care providers.
36 The data set and business process must be available beginning January
37 1, 2019, and the data set must be updated annually thereafter.

1 NEW SECTION. **Sec. 24.** Sections 4 through 16 of this act are
2 each added to chapter 48.43 RCW and codified with the subchapter
3 heading of "health care services balance billing."

4 NEW SECTION. **Sec. 25.** Sections 1 through 22 and 24 of this act
5 take effect January 1, 2019.

6 NEW SECTION. **Sec. 26.** If any provision of this act or its
7 application to any person or circumstance is held invalid, the
8 remainder of the act or the application of the provision to other
9 persons or circumstances is not affected."

2ESHB 2114 - S COMM AMD

By Committee on Health & Long Term Care

10 On page 1, line 2 of the title, after "services;" strike the
11 remainder of the title and insert "amending RCW 48.43.005, 48.43.093,
12 18.130.050, 18.130.180, and 41.05.017; adding new sections to chapter
13 48.43 RCW; adding a new section to chapter 70.41 RCW; adding a new
14 section to chapter 70.230 RCW; adding a new section to chapter 70.42
15 RCW; adding a new section to chapter 43.371 RCW; creating a new
16 section; prescribing penalties; providing an effective date; and
17 providing an expiration date."

EFFECT: (1) Adds a requirement that out-of-network provider payment is subject to prompt claim payment standards adopted by the commissioner.

(2) Modifies the payment formula used when a carrier adjudicates a claim to note that the median in-network and out-of-network allowed amounts are based on data from a similar geographic area. Also adds language, so that in determining "median allowed amounts" for both in and out-of-network calculations, median allowed amount is the greater of the amount in the most recently updated APCD data set or the amount in the 2019 APCD data set, inflated annually by a health care inflation factor set by the insurance commissioner.

(3) Removes the requirement that an in-person meeting be part of the informal settlement process.

(4) Removes the requirement that a facility post on its web site the health plan networks that its nonemployed contracted provider groups participate in. Adds requirement that the facility disclose that nonemployed providers may not be in the same health plan provider network as the facility. It also requires the facility to provide carriers it contracts with, with a list of nonemployed providers under contract with the facility to provide surgical or ancillary services, within 30 days before signing a contract with a

carrier. The facility must also notify the carrier within 30 days of a provider's removal from or addition to the list.

(5) Clarifies that the OIC may report a potential violation to the DOH or disciplinary authorities, who then determine whether to investigate and to take any currently allowable informal or formal disciplinary action.

(6) Clarifies that the APCD data set will be updated annually.

--- END ---