2ESHB 2114 - S COMM AMD
By Committee on Ways & Means

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** The legislature finds that consumers receive surprise bills or balance bills for services provided by out-of-network health care providers at in-network facilities, and it is the intent of the legislature to ban the balance billing of consumers for the health care services described in section 5 of this act for all fully insured, regulated insurance plans and plans offered to public employees. The legislature further declares that consumers must not be placed in the middle of contractual disputes between providers and health insurance carriers. The legislature intends to remove consumers from such disputes by banning balance billing for the health care services described in section 5 of this act and requiring that payments for noncontracted providers be made directly to providers rather than to consumers. 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 has the responsibility to ensure networks are adequate and include sufficient contracted providers to reasonably ensure consumers have in-network access for covered benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Emergency services provided to an enrollee; and

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

(i) Involve surgical or ancillary services; and

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

(2) Payment for services described in subsection (1) of this section is subject to sections 6 and 7 of this act.

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

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

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

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

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

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

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

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

(d) The carrier must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Upon receipt of notification from the initiating party, the commissioner must provide the parties with a list of approved arbitrators or entities that provide binding arbitration. The arbitrators on the list must be trained by the American arbitration association or the American health lawyers association. 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 days of receipt of the list from the commissioner.

(4)(a) Each party must make written submissions to the arbitrator in support of its position no later than thirty days after the final selection of the arbitrator. 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 the reasonable attorneys' fees of the party not in default. No later than thirty days after the receipt of the parties' written submissions, the arbitrator must: Issue a written decision requiring payment of the final offer amount of either the initiating party or the noninitiating party; notify the parties of its decision; and provide the decision and the information described in section 8 of this act regarding the decision to the commissioner.

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

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

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

(iii) 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;

(iv) Patient characteristics; and

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

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

(5) Expenses incurred in the course of arbitration, including the arbitrator's expenses and fees, but not including attorneys' fees, must be paid by the party whose final offer was rejected by the arbitrator. 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.

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

(7) 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.

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

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

(3) This section expires January 1, 2023.

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

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

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

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

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

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

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

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

(2) A carrier must provide an enrollee with:

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

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

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

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

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

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

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

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

(2) If a health care provider or facility violates or has violated a provision of this subchapter, the department of health or the appropriate disciplining authority may levy a fine or cost recovery upon the person in an amount not to exceed the applicable statutory maximum 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 violates or has violated any provision of this subchapter, the commissioner may levy a fine or apply remedies authorized under chapter 48.02 RCW.

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

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

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

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

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

(b) 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 subchapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) To compel attendance of witnesses at hearings;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

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

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

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

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

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

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

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

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

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

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

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

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

November 1, 2018, and the data set must be updated annually thereafter.

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

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

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

2ESHB 2114 - S COMM AMD
By Committee on Ways & Means

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

(7) Moves the implementation date from January 1, 2019, to July 1, 2019, and pushes up the date that the data set established by OFM must be available from January 1, 2019, to November 1, 2018.

--- END ---