

CERTIFICATION OF ENROLLMENT
ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1688

67th Legislature
2022 Regular Session

Passed by the House March 7, 2022
Yeas 88 Nays 10

**Speaker of the House of
Representatives**

Passed by the Senate March 3, 2022
Yeas 49 Nays 0

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1688** as passed by the House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

FILED

**Secretary of State
State of Washington**

ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1688

AS AMENDED BY THE SENATE

Passed Legislature - 2022 Regular Session

State of Washington 67th Legislature 2022 Regular Session

By House Appropriations (originally sponsored by Representatives Cody, Schmick, Leavitt, Ryu, Graham, Taylor, Berry, Paul, Wicks, Springer, Sells, Bateman, Valdez, Davis, Eslick, Goodman, Klicker, Macri, Ramos, Simmons, Wylie, Callan, Sullivan, Chopp, Slatter, Tharinger, Thai, Pollet, Riccelli, Ormsby, Caldier, Kloba, and Frame; by request of Insurance Commissioner)

READ FIRST TIME 02/07/22.

1 AN ACT Relating to protecting consumers from charges for out-of-
2 network health care services, by aligning state law and the federal
3 no surprises act and addressing coverage of treatment for emergency
4 conditions; amending RCW 43.371.100, 48.43.005, 48.43.093, 48.43.535,
5 48.49.003, 48.49.020, 48.49.030, 48.49.040, 48.49.050, 48.49.060,
6 48.49.070, 48.49.090, 48.49.100, 48.49.130, 48.49.150, and 48.49.110;
7 adding a new section to chapter 48.43 RCW; adding new sections to
8 chapter 48.49 RCW; adding a new section to chapter 71.24 RCW;
9 recodifying RCW 48.49.150; prescribing penalties; providing an
10 expiration date; and declaring an emergency.

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

12 **Sec. 1.** RCW 43.371.100 and 2019 c 427 s 26 are each amended to
13 read as follows:

14 (1) The office of the insurance commissioner shall contract with
15 the state agency responsible for administration of the database and
16 the lead organization to establish a data set and business process to
17 provide health carriers, health care providers, hospitals, ambulatory
18 surgical facilities, and arbitrators with data to assist in
19 determining commercially reasonable payments and resolving payment
20 disputes for out-of-network medical services rendered by health care
21 facilities or providers.

1 (a) The data set and business process must be developed in
2 collaboration with health carriers, health care providers, hospitals,
3 and ambulatory surgical facilities.

4 (b) The data set must provide the amounts for the services
5 described in RCW 48.49.020. The data used to calculate the median in-
6 network and out-of-network allowed amounts and the median billed
7 charge amounts by geographic area, for the same or similar services,
8 must be drawn from commercial health plan claims, and exclude
9 medicare and medicaid claims as well as claims paid on other than a
10 fee-for-service basis.

11 (c) The data set and business process must be available beginning
12 November 1, 2019, and must be reviewed by an advisory committee
13 established under (~~chapter 43.371 RCW~~) this chapter that includes
14 representatives of health carriers, health care providers, hospitals,
15 and ambulatory surgical facilities for validation before use.

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

21 (3) Until December 31, 2030, the office of the insurance
22 commissioner shall contract with the state agency responsible for
23 administration of the database or other organizations biennially
24 beginning in 2022, for an analysis of commercial health plan claims
25 data to assess any impact that chapter 48.49 RCW or P.L. 116-260 have
26 had or may have had on payments to participating and nonparticipating
27 providers and facilities and on the volume and percentage of claims
28 that are provided by participating compared to nonparticipating
29 providers. To the extent that data related to self-funded group
30 health plans is available within funds appropriated for this purpose,
31 the analysis may include such data. The first analysis shall compare
32 2019 claims data to the most recent full year's claims data. The
33 analysis must be published on the website of the office of the
34 insurance commissioner, with the first analysis published on or
35 before December 15, 2022.

36 **Sec. 2.** RCW 48.43.005 and 2020 c 196 s 1 are each amended to
37 read as follows:

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

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

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

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

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

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

31 (6) "Basic health plan" means the plan described under chapter
32 70.47 RCW, as revised from time to time.

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

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

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

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

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

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

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

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

29 (i) A health benefit plan that meets the definition of
30 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
31 2010, as amended; or

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

37 (11) "Certification" means a determination by a review
38 organization that an admission, extension of stay, or other health
39 care service or procedure has been reviewed and, based on the
40 information provided, meets the clinical requirements for medical

1 necessity, appropriateness, level of care, or effectiveness under the
2 auspices of the applicable health benefit plan.

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

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

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

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

23 (16) "Emergency services" means ((a)):

24 (a) (i) A medical screening examination, as required under section
25 1867 of the social security act (42 U.S.C. Sec. 1395dd), that is
26 within the capability of the emergency department of a hospital,
27 including ancillary services routinely available to the emergency
28 department to evaluate that emergency medical condition((~~and~~
29 further medical));

30 (ii) Medical examination and treatment, to the extent they are
31 within the capabilities of the staff and facilities available at the
32 hospital, as are required under section 1867 of the social security
33 act (42 U.S.C. Sec. 1395dd) to stabilize the patient. Stabilize, with
34 respect to an emergency medical condition, has the meaning given in
35 section 1867(e) (3) of the social security act (42 U.S.C. Sec.
36 1395dd(e) (3)); and

37 (iii) Covered services provided by staff or facilities of a
38 hospital after the enrollee is stabilized and as part of outpatient
39 observation or an inpatient or outpatient stay with respect to the
40 visit during which screening and stabilization services have been

1 furnished. Poststabilization services relate to medical, mental
2 health, or substance use disorder treatment necessary in the short
3 term to avoid placing the health of the individual, or with respect
4 to a pregnant woman, the health of the woman or her unborn child, in
5 serious jeopardy, serious impairment to bodily functions, or serious
6 dysfunction of any bodily organ or part; or

7 (b) (i) A screening examination that is within the capability of a
8 behavioral health emergency services provider including ancillary
9 services routinely available to the behavioral health emergency
10 services provider to evaluate that emergency medical condition;

11 (ii) Examination and treatment, to the extent they are within the
12 capabilities of the staff and facilities available at the behavioral
13 health emergency services provider, as are required under section
14 1867 of the social security act (42 U.S.C. Sec. 1395dd) or as would
15 be required under such section if such section applied to behavioral
16 health emergency services providers, to stabilize the patient.
17 Stabilize, with respect to an emergency medical condition, has the
18 meaning given in section 1867(e) (3) of the social security act (42
19 U.S.C. Sec. 1395dd(e) (3)); and

20 (iii) Covered behavioral health services provided by staff or
21 facilities of a behavioral health emergency services provider after
22 the enrollee is stabilized and as part of outpatient observation or
23 an inpatient or outpatient stay with respect to the visit during
24 which screening and stabilization services have been furnished.
25 Poststabilization services relate to mental health or substance use
26 disorder treatment necessary in the short term to avoid placing the
27 health of the individual, or with respect to a pregnant woman, the
28 health of the woman or her unborn child, in serious jeopardy, serious
29 impairment to bodily functions, or serious dysfunction of any bodily
30 organ or part.

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

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

38 (19) "Essential health benefit categories" means:

39 (a) Ambulatory patient services;

40 (b) Emergency services;

1 (c) Hospitalization;
2 (d) Maternity and newborn care;
3 (e) Mental health and substance use disorder services, including
4 behavioral health treatment;
5 (f) Prescription drugs;
6 (g) Rehabilitative and habilitative services and devices;
7 (h) Laboratory services;
8 (i) Preventive and wellness services and chronic disease
9 management; and
10 (j) Pediatric services, including oral and vision care.
11 (20) "Exchange" means the Washington health benefit exchange
12 established under chapter 43.71 RCW.
13 (21) "Final external review decision" means a determination by an
14 independent review organization at the conclusion of an external
15 review.
16 (22) "Final internal adverse benefit determination" means an
17 adverse benefit determination that has been upheld by a health plan
18 or carrier at the completion of the internal appeals process, or an
19 adverse benefit determination with respect to which the internal
20 appeals process has been exhausted under the exhaustion rules
21 described in RCW 48.43.530 and 48.43.535.
22 (23) "Grandfathered health plan" means a group health plan or an
23 individual health plan that under section 1251 of the patient
24 protection and affordable care act, P.L. 111-148 (2010) and as
25 amended by the health care and education reconciliation act, P.L.
26 111-152 (2010) is not subject to subtitles A or C of the act as
27 amended.
28 (24) "Grievance" means a written complaint submitted by or on
29 behalf of a covered person regarding service delivery issues other
30 than denial of payment for medical services or nonprovision of
31 medical services, including dissatisfaction with medical care,
32 waiting time for medical services, provider or staff attitude or
33 demeanor, or dissatisfaction with service provided by the health
34 carrier.
35 (25) "Health care facility" or "facility" means hospices licensed
36 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
37 rural health care facilities as defined in RCW 70.175.020,
38 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
39 licensed under chapter 18.51 RCW, community mental health centers
40 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment

1 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
2 treatment, or surgical facilities licensed under chapter 70.41 or
3 70.230 RCW, drug and alcohol treatment facilities licensed under
4 chapter 70.96A RCW, and home health agencies licensed under chapter
5 70.127 RCW, and includes such facilities if owned and operated by a
6 political subdivision or instrumentality of the state and such other
7 facilities as required by federal law and implementing regulations.

8 (26) "Health care provider" or "provider" means:

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

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

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

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

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

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

29 (b) Medicare supplemental health insurance governed by chapter
30 48.66 RCW;

31 (c) Coverage supplemental to the coverage provided under chapter
32 55, Title 10, United States Code;

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

35 (e) Disability income;

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

39 (g) Workers' compensation coverage;

40 (h) Accident only coverage;

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

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

6 (k) Dental only and vision only coverage;

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

14 (m) Civilian health and medical program for the veterans affairs
15 administration (CHAMPVA); and

16 (n) Stand-alone prescription drug coverage that exclusively
17 supplements medicare part D coverage provided through an employer
18 group waiver plan under federal social security act regulation 42
19 C.F.R. Sec. 423.458(c).

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

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

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

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

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

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

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

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

16 (38)(a) "Protected individual" means:

17 (i) An adult covered as a dependent on the enrollee's health
18 benefit plan, including an individual enrolled on the health benefit
19 plan of the individual's registered domestic partner; or

20 (ii) A minor who may obtain health care without the consent of a
21 parent or legal guardian, pursuant to state or federal law.

22 (b) "Protected individual" does not include an individual deemed
23 not competent to provide informed consent for care under RCW
24 11.88.010(1)(e).

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

31 (40) "Sensitive health care services" means health services
32 related to reproductive health, sexually transmitted diseases,
33 substance use disorder, gender dysphoria, gender affirming care,
34 domestic violence, and mental health.

35 (41) "Small employer" or "small group" means any person, firm,
36 corporation, partnership, association, political subdivision, sole
37 proprietor, or self-employed individual that is actively engaged in
38 business that employed an average of at least one but no more than
39 fifty employees, during the previous calendar year and employed at
40 least one employee on the first day of the plan year, is not formed

1 primarily for purposes of buying health insurance, and in which a
2 bona fide employer-employee relationship exists. In determining the
3 number of employees, companies that are affiliated companies, or that
4 are eligible to file a combined tax return for purposes of taxation
5 by this state, shall be considered an employer. Subsequent to the
6 issuance of a health plan to a small employer and for the purpose of
7 determining eligibility, the size of a small employer shall be
8 determined annually. Except as otherwise specifically provided, a
9 small employer shall continue to be considered a small employer until
10 the plan anniversary following the date the small employer no longer
11 meets the requirements of this definition. A self-employed individual
12 or sole proprietor who is covered as a group of one must also: (a)
13 Have been employed by the same small employer or small group for at
14 least twelve months prior to application for small group coverage,
15 and (b) verify that he or she derived at least seventy-five percent
16 of his or her income from a trade or business through which the
17 individual or sole proprietor has attempted to earn taxable income
18 and for which he or she has filed the appropriate internal revenue
19 service form 1040, schedule C or F, for the previous taxable year,
20 except a self-employed individual or sole proprietor in an
21 agricultural trade or business, must have derived at least fifty-one
22 percent of his or her income from the trade or business through which
23 the individual or sole proprietor has attempted to earn taxable
24 income and for which he or she has filed the appropriate internal
25 revenue service form 1040, for the previous taxable year.

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

32 (43) "Standard health questionnaire" means the standard health
33 questionnaire designated under chapter 48.41 RCW.

34 (~~(44) ("Surgical or ancillary services" means surgery,~~
35 ~~anesthesiology, pathology, radiology, laboratory, or hospitalist~~
36 ~~services.~~

37 ~~(45))~~ "Utilization review" means the prospective, concurrent, or
38 retrospective assessment of the necessity and appropriateness of the
39 allocation of health care resources and services of a provider or

1 facility, given or proposed to be given to an enrollee or group of
2 enrollees.

3 ~~((46))~~ (45) "Wellness activity" means an explicit program of an
4 activity consistent with department of health guidelines, such as,
5 smoking cessation, injury and accident prevention, reduction of
6 alcohol misuse, appropriate weight reduction, exercise, automobile
7 and motorcycle safety, blood cholesterol reduction, and nutrition
8 education for the purpose of improving enrollee health status and
9 reducing health service costs.

10 (46) "Nonemergency health care services performed by
11 nonparticipating providers at certain participating facilities" means
12 covered items or services other than emergency services with respect
13 to a visit at a participating health care facility, as provided in
14 section 2799A-1(b) of the public health service act (42 U.S.C. Sec.
15 300gg-111(b)), 45 C.F.R. Sec. 149.30, and 45 C.F.R. Sec. 149.120 as
16 in effect on the effective date of this section.

17 (47) "Air ambulance service" has the same meaning as defined in
18 section 2799A-2 of the public health service act (42 U.S.C. Sec.
19 300gg-112) and implementing federal regulations in effect on the
20 effective date of this section.

21 (48) "Behavioral health emergency services provider" means
22 emergency services provided in the following settings:

23 (a) A crisis stabilization unit as defined in RCW 71.05.020;

24 (b) An evaluation and treatment facility that can provide
25 directly, or by direct arrangement with other public or private
26 agencies, emergency evaluation and treatment, outpatient care, and
27 timely and appropriate inpatient care to persons suffering from a
28 mental disorder, and which is licensed or certified as such by the
29 department of health;

30 (c) An agency certified by the department of health under chapter
31 71.24 RCW to provide outpatient crisis services;

32 (d) A triage facility as defined in RCW 71.05.020;

33 (e) An agency certified by the department of health under chapter
34 71.24 RCW to provide medically managed or medically monitored
35 withdrawal management services; or

36 (f) A mobile rapid response crisis team as defined in RCW
37 71.24.025 that is contracted with a behavioral health administrative
38 services organization operating under RCW 71.24.045 to provide crisis
39 response services in the behavioral health administrative services
40 organization's service area.

1 **Sec. 3.** RCW 48.43.093 and 2019 c 427 s 3 are each amended to
2 read as follows:

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

6 (a) A health carrier shall cover emergency services ~~((necessary~~
7 ~~to screen and stabilize))~~ provided to a covered person if a prudent
8 layperson acting reasonably would have believed that an emergency
9 medical condition existed. In addition, a health carrier shall not
10 require prior authorization of emergency services ~~((provided prior to~~
11 ~~the point of stabilization))~~ if a prudent layperson acting reasonably
12 would have believed that an emergency medical condition existed. With
13 respect to care obtained from ~~((an out-of-network))~~ a
14 nonparticipating hospital emergency department or behavioral health
15 emergency services provider, a health carrier shall cover emergency
16 services ~~((necessary to screen and stabilize a covered person))~~. In
17 addition, a health carrier shall not require prior authorization of
18 ~~((the))~~ emergency services ~~((provided prior to the point of~~
19 ~~stabilization))~~.

20 (b) ~~((If an authorized representative of a health carrier~~
21 ~~authorizes coverage of emergency services, the health carrier shall~~
22 ~~not subsequently retract its authorization after the emergency~~
23 ~~services have been provided, or reduce payment for an item or service~~
24 ~~furnished in reliance on approval, unless the approval was based on a~~
25 ~~material misrepresentation about the covered person's health~~
26 ~~condition made by the provider of emergency services))~~ A health
27 carrier shall cover emergency services without limiting what
28 constitutes an emergency medical condition solely on the basis of
29 diagnosis codes. Any determination of whether the prudent layperson
30 standard has been met must be based on all pertinent documentation
31 and be focused on the presenting symptoms and not solely on the final
32 diagnosis.

33 ~~((e))~~ (2) Coverage of emergency services may be subject to
34 applicable in-network copayments, coinsurance, and deductibles, as
35 provided in chapter 48.49 RCW.

36 ~~((2) If a health carrier requires preauthorization for~~
37 ~~postevaluation or poststabilization services, the health carrier~~
38 ~~shall provide access to an authorized representative twenty-four~~
39 ~~hours a day, seven days a week, to facilitate review. In order for~~
40 ~~postevaluation or poststabilization services to be covered by the~~

1 health carrier, the provider or facility must make a documented good
2 faith effort to contact the covered person's health carrier within
3 thirty minutes of stabilization, if the covered person needs to be
4 stabilized. The health carrier's authorized representative is
5 required to respond to a telephone request for preauthorization from
6 a provider or facility within thirty minutes. Failure of the health
7 carrier to respond within thirty minutes constitutes authorization
8 for the provision of immediately required medically necessary
9 postevaluation and poststabilization services, unless the health
10 carrier documents that it made a good faith effort but was unable to
11 reach the provider or facility within thirty minutes after receiving
12 the request.

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

18 ~~(4))~~ (3) Nothing in this section is to be construed as
19 prohibiting ~~((the))~~ a health carrier from ~~((requiring))~~:

20 (a) Requiring notification of stabilization or inpatient
21 admission within the time frame specified in ~~((the))~~ its contract
22 ~~((for inpatient admission))~~ with the hospital or behavioral health
23 emergency services provider or as soon thereafter as medically
24 possible but no less than twenty-four hours ~~((Nothing in this~~
25 ~~section is to be construed as preventing the health carrier from~~
26 ~~reserving the right to require transfer of a hospitalized covered~~
27 ~~person upon stabilization. Follow-up))~~; or

28 (b) Requiring a hospital or emergency behavioral health emergency
29 services provider to make a documented good faith effort to notify
30 the covered person's health carrier within 48 hours of stabilization,
31 or by the end of the business day following the day the stabilization
32 occurs, whichever is later, if the covered person needs to be
33 stabilized. If a health carrier requires such notification, the
34 health carrier shall provide access to an authorized representative
35 seven days a week to receive notifications.

36 (4) Except to the extent provided otherwise in this section,
37 follow-up care that is a direct result of the emergency must be
38 obtained in accordance with the health plan's usual terms and
39 conditions of coverage. All other terms and conditions of coverage
40 may be applied to emergency services.

1 **Sec. 4.** RCW 48.43.535 and 2012 c 211 s 21 are each amended to
2 read as follows:

3 (1) There is a need for a process for the fair consideration of
4 disputes relating to decisions by carriers that offer a health plan
5 to deny, modify, reduce, or terminate coverage of or payment for
6 health care services for an enrollee. For purposes of this section,
7 "carrier" also applies to a health plan if the health plan
8 administers the appeal process directly or through a third party.

9 (2) An enrollee may seek review by a certified independent review
10 organization of a carrier's decision to deny, modify, reduce, or
11 terminate coverage of or payment for a health care service or of any
12 adverse determination made by a carrier under RCW 48.49.020,
13 48.49.030, or sections 2799A-1 or 2799A-2 of the public health
14 service act (42 U.S.C. Secs. 300gg-111 or 300gg-112) and implementing
15 federal regulations in effect as of the effective date of this
16 section, after exhausting the carrier's grievance process and
17 receiving a decision that is unfavorable to the enrollee, or after
18 the carrier has exceeded the timelines for grievances provided in RCW
19 48.43.530, without good cause and without reaching a decision.

20 (3) The commissioner must establish and use a rotational registry
21 system for the assignment of a certified independent review
22 organization to each dispute. The system should be flexible enough to
23 ensure that an independent review organization has the expertise
24 necessary to review the particular medical condition or service at
25 issue in the dispute, and that any approved independent review
26 organization does not have a conflict of interest that will influence
27 its independence.

28 (4) Carriers must provide to the appropriate certified
29 independent review organization, not later than the third business
30 day after the date the carrier receives a request for review, a copy
31 of:

32 (a) Any medical records of the enrollee that are relevant to the
33 review;

34 (b) Any documents used by the carrier in making the determination
35 to be reviewed by the certified independent review organization;

36 (c) Any documentation and written information submitted to the
37 carrier in support of the appeal; and

38 (d) A list of each physician or health care provider who has
39 provided care to the enrollee and who may have medical records
40 relevant to the appeal. Health information or other confidential or

1 proprietary information in the custody of a carrier may be provided
2 to an independent review organization, subject to rules adopted by
3 the commissioner.

4 (5) Enrollees must be provided with at least five business days
5 to submit to the independent review organization in writing
6 additional information that the independent review organization must
7 consider when conducting the external review. The independent review
8 organization must forward any additional information submitted by an
9 enrollee to the plan or carrier within one business day of receipt by
10 the independent review organization.

11 (6) The medical reviewers from a certified independent review
12 organization will make determinations regarding the medical necessity
13 or appropriateness of, and the application of health plan coverage
14 provisions to, health care services for an enrollee. The medical
15 reviewers' determinations must be based upon their expert medical
16 judgment, after consideration of relevant medical, scientific, and
17 cost-effectiveness evidence, and medical standards of practice in the
18 state of Washington. Except as provided in this subsection, the
19 certified independent review organization must ensure that
20 determinations are consistent with the scope of covered benefits as
21 outlined in the medical coverage agreement. Medical reviewers may
22 override the health plan's medical necessity or appropriateness
23 standards if the standards are determined upon review to be
24 unreasonable or inconsistent with sound, evidence-based medical
25 practice.

26 (7) Once a request for an independent review determination has
27 been made, the independent review organization must proceed to a
28 final determination, unless requested otherwise by both the carrier
29 and the enrollee or the enrollee's representative.

30 (a) An enrollee or carrier may request an expedited external
31 review if the adverse benefit determination or internal adverse
32 benefit determination concerns an admission, availability of care,
33 continued stay, or health care service for which the claimant
34 received emergency services but has not been discharged from a
35 facility; or involves a medical condition for which the standard
36 external review time frame would seriously jeopardize the life or
37 health of the enrollee or jeopardize the enrollee's ability to regain
38 maximum function. The independent review organization must make its
39 decision to uphold or reverse the adverse benefit determination or
40 final internal adverse benefit determination and notify the enrollee

1 and the carrier or health plan of the determination as expeditiously
2 as possible but within not more than seventy-two hours after the
3 receipt of the request for expedited external review. If the notice
4 is not in writing, the independent review organization must provide
5 written confirmation of the decision within forty-eight hours after
6 the date of the notice of the decision.

7 (b) For claims involving experimental or investigational
8 treatments, the independent review organization must ensure that
9 adequate clinical and scientific experience and protocols are taken
10 into account as part of the external review process.

11 (8) Carriers must timely implement the certified independent
12 review organization's determination, and must pay the certified
13 independent review organization's charges.

14 (9) When an enrollee requests independent review of a dispute
15 under this section, and the dispute involves a carrier's decision to
16 modify, reduce, or terminate an otherwise covered health service that
17 an enrollee is receiving at the time the request for review is
18 submitted and the carrier's decision is based upon a finding that the
19 health service, or level of health service, is no longer medically
20 necessary or appropriate, the carrier must continue to provide the
21 health service if requested by the enrollee until a determination is
22 made under this section. If the determination affirms the carrier's
23 decision, the enrollee may be responsible for the cost of the
24 continued health service.

25 (10) Each certified independent review organization must maintain
26 written records and make them available upon request to the
27 commissioner.

28 (11) A certified independent review organization may notify the
29 office of the insurance commissioner if, based upon its review of
30 disputes under this section, it finds a pattern of substandard or
31 egregious conduct by a carrier.

32 (12)(a) The commissioner shall adopt rules to implement this
33 section after considering relevant standards adopted by national
34 managed care accreditation organizations and the national association
35 of insurance commissioners.

36 (b) This section is not intended to supplant any existing
37 authority of the office of the insurance commissioner under this
38 title to oversee and enforce carrier compliance with applicable
39 statutes and rules.

1 NEW SECTION. **Sec. 5.** A new section is added to chapter 48.43
2 RCW to read as follows:

3 The commissioner is authorized to enforce provisions of P.L.
4 116-260 (enacted December 27, 2020, as the consolidated
5 appropriations act of 2021) and implementing federal regulations in
6 effect on the effective date of this section, that are applicable to
7 or regulate the conduct of carriers issuing health plans or
8 grandfathered health plans to residents of Washington state on or
9 after January 1, 2022. In addition to the enforcement actions
10 authorized under RCW 48.02.080, the commissioner may impose a civil
11 monetary penalty in an amount not to exceed \$100 for each day for
12 each individual with respect to which a failure to comply with these
13 provisions occurs.

14 **Sec. 6.** RCW 48.49.003 and 2019 c 427 s 1 are each amended to
15 read as follows:

16 (1) The legislature finds that:

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

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

23 (c) Facilities, providers, and health insurance carriers all
24 share responsibility to ensure consumers have transparent information
25 on network providers and benefit coverage, and the insurance
26 commissioner is responsible for ensuring that provider networks
27 include sufficient numbers and types of contracted providers to
28 reasonably ensure consumers have in-network access for covered
29 benefits.

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

31 (a) Ban balance billing of consumers enrolled in fully insured,
32 regulated insurance plans and plans offered to public employees under
33 chapter 41.05 RCW for the services described in RCW 48.49.020, and to
34 provide self-funded group health plans with an option to elect to be
35 subject to the provisions of this chapter (~~(427, Laws of 2019)~~);

36 (b) Remove consumers from balance billing disputes and require
37 that (~~(out-of-network)~~) nonparticipating providers and carriers
38 negotiate (~~(out-of-network)~~) nonparticipating provider payments in

1 good faith under the terms of this chapter (~~(427, Laws of 2019)~~);
2 (~~and~~)

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

9 (d) Provide an environment that encourages self-funded groups to
10 negotiate (~~out-of-network~~) payments in good faith with
11 nonparticipating providers and facilities in return for balance
12 billing protections.

13 **Sec. 7.** RCW 48.49.020 and 2019 c 427 s 6 are each amended to
14 read as follows:

15 (1) (~~An out-of-network~~) A nonparticipating provider or facility
16 may not balance bill an enrollee for the following health care
17 services as provided in section 2799A-1(b) of the public health
18 service act (42 U.S.C. Sec. 300gg-111(b)) and implementing federal
19 regulations in effect on the effective date of this section:

20 (a) Emergency services provided to an enrollee; (~~or~~)

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

25 ~~(i) Involve surgical or ancillary services; and~~

26 ~~(ii) Are provided by an out-of-network provider)~~ performed by
27 nonparticipating providers at certain participating facilities; or

28 (c) Air ambulance services.

29 (2) Payment for services described in subsection (1) of this
30 section is subject to the provisions of (~~RCW 48.49.030 and~~
31 ~~48.49.040.~~

32 ~~(3) (a) Except to the extent provided in (b) of this subsection,~~
33 ~~the carrier must hold an enrollee harmless from balance billing when~~
34 ~~emergency services described in subsection (1) (a) of this section are~~
35 ~~provided by an out-of-network hospital in a state that borders~~
36 ~~Washington state.~~

37 ~~(b) (i) Upon the effective date of federal legislation prohibiting~~
38 ~~balance billing when emergency services described in subsection~~
39 ~~(1) (a) of this section are provided by a hospital, the carrier ne~~

1 longer has a duty to hold enrollees harmless from balance billing
2 under (a) of this subsection; or

3 (ii) Upon the effective date of an interstate compact with a
4 state bordering Washington state or enactment of legislation by a
5 state bordering Washington state prohibiting balance billing when
6 emergency services described in subsection (1)(a) of this section are
7 provided by a hospital located in that border state to a Washington
8 state resident, the carrier no longer has a duty to hold enrollees
9 harmless from balance billing under (a) of this subsection for
10 services provided by a hospital in that border state. The
11 commissioner shall engage with border states on appropriate means to
12 prohibit balance billing by out-of-state hospitals of Washington
13 state residents)) sections 2799A-1 and 2799A-2 of the public health
14 service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and
15 implementing federal regulations in effect on the effective date of
16 this section, except that:

17 (a) Until July 1, 2023, or a later date determined by the
18 commissioner, section 9 of this act and RCW 48.49.040 apply to the
19 nonparticipating provider or facility payment standard and dispute
20 resolution process for services described in subsection (1) of this
21 section, other than air ambulance services;

22 (b) A health care provider, health care facility, or air
23 ambulance service provider may not request or require a patient at
24 any time, for any procedure, service, or supply, to sign or otherwise
25 execute by oral, written, or electronic means, any document that
26 would attempt to avoid, waive, or alter any provision of RCW
27 48.49.020 and 48.49.030 or sections 2799A-1 et seq. of the public
28 health service act (P.L. 116-260) and implementing federal
29 regulations in effect on the effective date of this section;

30 (c) If the enrollee pays a nonparticipating provider,
31 nonparticipating facility, or nonparticipating air ambulance service
32 provider an amount that exceeds the in-network cost-sharing amount
33 determined under sections 2799A-1 and 2799A-2 of the public health
34 service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and
35 implementing federal regulations as in effect on the effective date
36 of this section, the provider or facility must refund any amount in
37 excess of the in-network cost-sharing amount to the enrollee within
38 30 business days of receipt. Interest must be paid to the enrollee
39 for any unrefunded payments at a rate of 12 percent beginning on the
40 first calendar day after the 30 business days; and

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

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

11 (4) Payment for emergency services provided by behavioral health
12 emergency services providers under subsection (3) of this section is
13 subject to RCW 48.49.030, section 9 of this act, and RCW 48.49.040.

14 ~~((4))~~ (5) This section applies to health care providers ((or)),
15 facilities, or behavioral health emergency services providers
16 providing services to members of entities administering a self-funded
17 group health plan and its plan members only if the entity has elected
18 to participate in this section and RCW 48.49.030, section 9 of this
19 act, and RCW 48.49.040 as provided in RCW 48.49.130.

20 **Sec. 8.** RCW 48.49.030 and 2019 c 427 s 7 are each amended to
21 read as follows:

22 (1) If an enrollee receives emergency ~~((or nonemergency health~~
23 ~~care))~~ services from a behavioral health emergency services provider
24 under the circumstances described in RCW 48.49.020(3):

25 (a) The enrollee satisfies his or her obligation to pay for the
26 health care services if he or she pays the in-network cost-sharing
27 amount specified in the enrollee's or applicable group's health plan
28 contract. The enrollee's obligation must be determined using the
29 ~~((carrier's median in-network contracted rate for the same or similar~~
30 ~~service in the same or similar geographical area))~~ methodology for
31 calculating the qualifying payment amount as described in 45 C.F.R.
32 Sec. 149.140 as in effect on the effective date of this section. The
33 carrier must provide an explanation of benefits to the enrollee and
34 the ~~((out-of-network))~~ nonparticipating provider that reflects the
35 cost-sharing amount determined under this subsection.

36 (b) The carrier, ~~((out-of-network provider, or out-of-network~~
37 ~~facility))~~ nonparticipating behavioral health emergency services
38 provider, and an agent, trustee, or assignee of the carrier ~~((, out-~~
39 ~~of-network provider,))~~ or ~~((out-of-network facility))~~

1 nonparticipating behavioral health emergency services provider must
2 ensure that the enrollee incurs no greater cost than the amount
3 determined under (a) of this subsection.

4 (c) The (~~out-of-network provider or out-of-network facility,~~)
5 nonparticipating behavioral health emergency services provider and an
6 agent, trustee, or assignee of the (~~out-of-network provider or out-~~
7 ~~of-network facility~~) nonparticipating behavioral health emergency
8 services provider may not balance bill or otherwise attempt to
9 collect from the enrollee any amount greater than the amount
10 determined under (a) of this subsection. This does not impact the
11 behavioral health emergency services provider's ability to collect a
12 past due balance for that cost-sharing amount with interest.

13 (d) The carrier must treat any cost-sharing amounts determined
14 under (a) of this subsection paid by the enrollee for (~~an out-of-~~
15 ~~network provider or facility's~~) a nonparticipating behavioral health
16 emergency services provider's services in the same manner as cost-
17 sharing for health care services provided by an in-network (~~provider~~
18 ~~or facility~~) behavioral health emergency services provider and must
19 apply any cost-sharing amounts paid by the enrollee for such services
20 toward the enrollee's maximum out-of-pocket payment obligation.

21 (e) If the enrollee pays the (~~out-of-network provider or out-of-~~
22 ~~network facility~~) nonparticipating behavioral health emergency
23 services provider an amount that exceeds the in-network cost-sharing
24 amount determined under (a) of this subsection, the (~~provider or~~
25 ~~facility~~) behavioral health emergency services provider must refund
26 any amount in excess of the in-network cost-sharing amount to the
27 enrollee within thirty business days of receipt. Interest must be
28 paid to the enrollee for any unrefunded payments at a rate of twelve
29 percent beginning on the first calendar day after the thirty business
30 days.

31 (2) (~~The allowed amount paid to an out-of-network provider for~~
32 ~~health care services described under RCW 48.49.020 shall be a~~
33 ~~commercially reasonable amount, based on payments for the same or~~
34 ~~similar services provided in a similar geographic area. Within thirty~~
35 ~~calendar days of receipt of a claim from an out-of-network provider~~
36 ~~or facility, the carrier shall offer to pay the provider or facility~~
37 ~~a commercially reasonable amount. If the out-of-network provider or~~
38 ~~facility wants to dispute the carrier's payment, the provider or~~
39 ~~facility must notify the carrier no later than thirty calendar days~~
40 ~~after receipt of payment or payment notification from the carrier. If~~

1 ~~the out-of-network provider or facility disputes the carrier's~~
2 ~~initial offer, the carrier and provider or facility have thirty~~
3 ~~calendar days from the initial offer to negotiate in good faith. If~~
4 ~~the carrier and the out-of-network provider or facility do not agree~~
5 ~~to a commercially reasonable payment amount within thirty calendar~~
6 ~~days, and the carrier, out-of-network provider or out-of-network~~
7 ~~facility chooses to pursue further action to resolve the dispute, the~~
8 ~~dispute shall be resolved through arbitration, as provided in RCW~~
9 ~~48.49.040.~~

10 ~~(3) The carrier must make payments for health care services~~
11 ~~described in RCW 48.49.020 provided by out-of-network providers or~~
12 ~~facilities directly to the provider or facility, rather than the~~
13 ~~enrollee.~~

14 ~~(4) Carriers must make available through electronic and other~~
15 ~~methods of communication generally used by a provider to verify~~
16 ~~enrollee eligibility and benefits information regarding whether an~~
17 ~~enrollee's health plan is subject to the requirements of chapter 427,~~
18 ~~Laws of 2019.~~

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

24 ~~(6)) This section shall only apply to health care providers~~
25 ~~((~~or~~)), facilities, or behavioral health emergency services providers~~
26 ~~providing services to members of entities administering a self-funded~~
27 ~~group health plan and its plan members if the entity has elected to~~
28 ~~participate in this section and RCW 48.49.020 ((~~through~~)), section 9~~
29 ~~of this act, and RCW 48.49.040 as provided in RCW 48.49.130.~~

30 NEW SECTION. Sec. 9. A new section is added to chapter 48.49
31 RCW to read as follows:

32 (1)(a) Until July 1, 2023, or a later date determined by the
33 commissioner under RCW 48.49.040, the allowed amount paid to a
34 nonparticipating provider for health care services described under
35 RCW 48.49.020(1) other than air ambulance services shall be a
36 commercially reasonable amount, based on payments for the same or
37 similar services provided in a similar geographic area. Within 30
38 calendar days of receipt of a claim from a nonparticipating provider
39 or facility, the carrier shall offer to pay the provider or facility

1 a commercially reasonable amount. If the nonparticipating provider or
2 facility wants to dispute the carrier's payment, the provider or
3 facility must notify the carrier no later than 30 calendar days after
4 receipt of payment or payment notification from the carrier. If the
5 nonparticipating provider or facility disputes the carrier's initial
6 offer, the carrier and provider or facility have 30 calendar days
7 from the initial offer to negotiate in good faith. If the carrier and
8 the nonparticipating provider or facility do not agree to a
9 commercially reasonable payment amount within 30 calendar days, and
10 the carrier or nonparticipating provider or facility chooses to
11 pursue further action to resolve the dispute, the dispute shall be
12 resolved as provided in RCW 48.49.040.

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

17 (2)(a) The allowed amount paid to a nonparticipating behavioral
18 health emergency services provider for behavioral health emergency
19 services shall be a commercially reasonable amount, based on payments
20 for the same or similar services provided in a similar geographic
21 area. Within 30 calendar days of receipt of a claim from a
22 nonparticipating behavioral health emergency services provider, the
23 carrier shall offer to pay the behavioral health emergency services
24 provider a commercially reasonable amount. If the nonparticipating
25 behavioral health emergency services provider wants to dispute the
26 carrier's payment, the behavioral health emergency services provider
27 must notify the carrier no later than 30 calendar days after receipt
28 of payment or payment notification from the carrier. If the
29 nonparticipating behavioral health emergency services provider
30 disputes the carrier's initial offer, the carrier and behavioral
31 health emergency services provider have 30 calendar days from the
32 initial offer to negotiate in good faith. If the carrier and the
33 nonparticipating behavioral health emergency services provider do not
34 agree to a commercially reasonable payment amount within 30 calendar
35 days, and the carrier or nonparticipating behavioral health emergency
36 services provider chooses to pursue further action to resolve the
37 dispute, the dispute shall be resolved as provided in RCW 48.49.040.

38 (b) The carrier must make payments for behavioral health
39 emergency services provided by nonparticipating behavioral health

1 emergency services providers directly to the provider, rather than
2 the enrollee.

3 (3) This section shall only apply to health care providers,
4 facilities, or behavioral health emergency services providers
5 providing services to members of entities administering a self-funded
6 group health plan and its plan members if the entity has elected to
7 participate in RCW 48.49.020, 48.49.030, and 48.49.040, and this
8 section as provided in RCW 48.49.130.

9 NEW SECTION. **Sec. 10.** A new section is added to chapter 48.49
10 RCW to read as follows:

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

18 (2) A health care provider, health care facility, behavioral
19 health emergency services provider, or air ambulance service provider
20 may not request or require a patient at any time, for any procedure,
21 service, or supply, to sign or otherwise execute by oral, written, or
22 electronic means, any document that would attempt to avoid, waive, or
23 alter any provision of RCW 48.49.020 and 48.49.030 or sections
24 2799A-1 et seq. of the public health service act (P.L. 116-260) and
25 implementing federal regulations in effect on the effective date of
26 this section.

27 (3) This section shall only apply to health care providers,
28 facilities, or behavioral health emergency services providers
29 providing services to members of entities administering a self-funded
30 group health plan and its plan members if the entity has elected to
31 participate in RCW 48.49.020, 48.49.030, section 9 of this act, and
32 RCW 48.49.040 as provided in RCW 48.49.130.

33 **Sec. 11.** RCW 48.49.040 and 2019 c 427 s 8 are each amended to
34 read as follows:

35 (1) Effective July 1, 2023, or a later date determined by the
36 commissioner, services described in RCW 48.49.020(1) other than air
37 ambulance services are subject to the independent dispute resolution
38 process established in sections 2799A-1 and 2799A-2 of the public

1 health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and
2 implementing federal regulations in effect on July 1, 2023, or a
3 later date determined by the commissioner. Until July 1, 2023, or a
4 later date determined by the commissioner, the arbitration process in
5 this section governs the dispute resolution process for those
6 services.

7 (2) Effective July 1, 2023, or a later date determined by the
8 commissioner, services described in RCW 48.49.020(3) are subject to
9 the independent dispute resolution process established in section
10 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs.
11 300gg-111 and 300gg-112) and implementing federal regulations in
12 effect on July 1, 2023, or a later date determined by the
13 commissioner. Until July 1, 2023, or a later date determined by the
14 commissioner or if the federal independent dispute resolution process
15 is not available to the state for resolution of these disputes, the
16 arbitration process in this section governs the dispute resolution
17 process for those services.

18 (3)(a) Notwithstanding RCW 48.43.055 and 48.18.200, if good faith
19 negotiation, as described in RCW 48.49.030, does not result in
20 resolution of the dispute, and the carrier(~~(,—out-of-network~~
21 ~~provider)) or ((~~out-of-network facility~~)) nonparticipating provider,~~
22 facility, or behavioral health emergency services provider chooses to
23 pursue further action to resolve the dispute, the carrier(~~(,—out-of-~~
24 ~~network provider,~~)) or ((~~out-of-network facility~~)) nonparticipating
25 provider, facility, or behavioral health emergency services provider
26 shall initiate arbitration to determine a commercially reasonable
27 payment amount. To initiate arbitration, the carrier(~~(,—provider,~~))
28 or ((~~facility~~)) nonparticipating provider, facility, or behavioral
29 health emergency services provider must provide written notification
30 to the commissioner and the noninitiating party no later than ten
31 calendar days following completion of the period of good faith
32 negotiation under RCW 48.49.030. The notification to the
33 noninitiating party must state the initiating party's final offer. No
34 later than thirty calendar days following receipt of the
35 notification, the noninitiating party must provide its final offer to
36 the initiating party. The parties may reach an agreement on
37 reimbursement during this time and before the arbitration proceeding.

38 (b) Notwithstanding (a) of this subsection (3), where a dispute
39 resolution matter initiated under sections 2799A-1 and 2799A-2 of the
40 public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112)

1 and implementing federal regulations in effect on the effective date
2 of this section, results in a determination by a certified
3 independent dispute resolution entity that such process does not
4 apply to the dispute or to portions thereof, a carrier, provider,
5 facility, or behavioral health emergency services provider may
6 initiate arbitration described in this section for such dispute:

7 (i) Without completing good faith negotiation under section 9 of
8 this act if the open negotiation period required under sections
9 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs.
10 300gg-111 and 300gg-112) and implementing federal regulations in
11 effect on the effective date of this section, has been completed; and

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

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

19 ((+i)) (a) Involve identical carrier and provider ((~~or~~
20 facility)), provider group, facility, or behavioral health emergency
21 services provider parties;

22 ((+ii)) (b) Involve claims with the same ((~~or related current~~
23 procedural terminology codes relevant to a particular procedure))
24 procedural code, or a comparable code under a different procedural
25 code system; and

26 ((+iii)) (c) Occur within ((a)) the same 30 business day period
27 ((~~of two months of one another~~)).

28 ((+2)) (5) Within seven calendar days of receipt of notification
29 from the initiating party, the commissioner must provide the parties
30 with a list of approved arbitrators or entities that provide
31 arbitration. The arbitrators on the list must be trained by the
32 American arbitration association or the American health lawyers
33 association and ((should)) must have experience in matters related to
34 medical or health care services. The parties may agree on an
35 arbitrator from the list provided by the commissioner. If the parties
36 do not agree on an arbitrator, they must notify the commissioner who
37 must provide them with the names of five arbitrators from the list.
38 Each party may veto two of the five named arbitrators. If one
39 arbitrator remains, that person is the chosen arbitrator. If more
40 than one arbitrator remains, the commissioner must choose the

1 arbitrator from the remaining arbitrators. The parties and the
2 commissioner must complete this selection process within twenty
3 calendar days of receipt of the original list from the commissioner.

4 ~~((3)(a))~~ (6) Each party must make written submissions to the
5 arbitrator in support of its position no later than thirty calendar
6 days after the final selection of the arbitrator. ~~((The initiating))~~
7 Each party must include in ~~((its))~~ their written submission the
8 evidence and methodology for asserting that the amount proposed to be
9 paid is or is not commercially reasonable. A party that fails to make
10 timely written submissions under this section without good cause
11 shown shall be considered to be in default and the arbitrator shall
12 require the party in default to pay the final offer amount submitted
13 by the party not in default and may require the party in default to
14 pay expenses incurred to date in the course of arbitration, including
15 the arbitrator's expenses and fees and the reasonable attorneys' fees
16 of the party not in default.

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

27 (8)(a) No later than thirty calendar days after the receipt of
28 the parties' written submissions, the arbitrator must: Issue a
29 written decision requiring payment of the final offer amount of
30 either the initiating party or the noninitiating party; notify the
31 parties of its decision; and provide the decision and the information
32 described in RCW 48.49.050 regarding the decision to the
33 commissioner. The arbitrator's decision must include an explanation
34 of the elements of the parties' submissions the arbitrator relied
35 upon to make their decision and why those elements were relevant to
36 their decision.

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

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

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

8 (c) The arbitrator may not require extrinsic evidence of
9 authenticity for admitting data from the Washington state all-payer
10 claims database data set developed under RCW 43.371.100 into
11 evidence.

12 (d) The arbitrator may also consider other information that a
13 party believes is relevant to the factors included in (b) of this
14 subsection or other factors the arbitrator requests and information
15 provided by the parties that is relevant to such request, including
16 the Washington state all-payer claims database data set developed
17 under RCW 43.371.100.

18 ~~((4))~~ (9) Expenses incurred in the course of arbitration,
19 including the arbitrator's expenses and fees, but not including
20 attorneys' fees, must be divided equally among the parties to the
21 arbitration. The commissioner may establish allowable arbitrator fee
22 ranges or an arbitrator fee schedule by rule. Arbitrator fees must be
23 paid to the arbitrator by a party within 30 calendar days following
24 receipt of the arbitrator's decision by the party. The enrollee is
25 not liable for any of the costs of the arbitration and may not be
26 required to participate in the arbitration proceeding as a witness or
27 otherwise.

28 ~~((5))~~ (10) Within ~~((ten))~~ 10 business days of a party notifying
29 the commissioner and the noninitiating party of intent to initiate
30 arbitration, both parties shall agree to and execute a nondisclosure
31 agreement. The nondisclosure agreement must not preclude the
32 arbitrator from submitting the arbitrator's decision to the
33 commissioner under subsection ~~((3))~~ (6) of this section or impede
34 the commissioner's duty to prepare the annual report under RCW
35 48.49.050.

36 ~~((6))~~ (11) The decision of the arbitrator is final and binding
37 on the parties to the arbitration and is not subject to judicial
38 review.

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

4 ((7)) (13) For dispute resolution proceedings initiated under
5 RCW 48.49.150(2)(b) (as recodified by this act), the arbitration
6 provisions of this section apply except that:

7 (a) The issue before the arbitrator will be the commercially
8 reasonable payment for applicable services addressed in the alternate
9 access delivery request rather than the commercially reasonable
10 payment for single or multiple claims under subsection (4) of this
11 section. The arbitrator shall issue a decision related to whether
12 payment for the applicable services should be made at the final offer
13 amount of the carrier or the final offer amount of the provider or
14 facility. The arbitrator's decision is final and binding on the
15 parties for services rendered to enrollees from the effective date of
16 the amended alternate access delivery request approved under RCW
17 48.49.150(2)(b) (as recodified by this act) to either the expiration
18 date of the amended alternate access delivery request, or at the time
19 that a provider contract and provider compensation agreement are
20 executed between the parties, whichever occurs first;

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

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

34 (14) Air ambulance services are subject to the independent
35 dispute resolution process established in sections 2799A-1 and
36 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111
37 and 300gg-112) and implementing federal regulations in effect on the
38 effective date of this section.

39 (15) This section applies to health care providers ((or)),
40 facilities, or behavioral health emergency services providers

1 providing services to members of entities administering a self-funded
2 group health plan and its plan members only if the entity has elected
3 to participate in RCW 48.49.020 and 48.49.030, section 9 of this act,
4 and this section as provided in RCW 48.49.130.

5 ~~((8))~~ (16) An entity administering a self-funded group health
6 plan that has elected to participate in this section pursuant to RCW
7 48.49.130 shall comply with the provisions of this section.

8 **Sec. 12.** RCW 48.49.050 and 2019 c 427 s 9 are each amended to
9 read as follows:

10 (1) The commissioner must prepare an annual report summarizing
11 the dispute resolution information provided by arbitrators under RCW
12 48.49.040. The report must include summary information related to the
13 matters decided through arbitration, as well as the following
14 information for each dispute resolved through arbitration: The name
15 of the carrier; the name of the health care provider; the health care
16 provider's employer or the business entity in which the provider has
17 an ownership interest; the health care facility where the services
18 were provided; and the type of health care services at issue.

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

23 (3) This section expires January 1, ~~((2024))~~ 2023.

24 **Sec. 13.** RCW 48.49.060 and 2019 c 427 s 10 are each amended to
25 read as follows:

26 (1) The commissioner, in consultation with health carriers,
27 health care providers, health care facilities, and consumers, must
28 develop standard template language for a notice of consumer rights
29 notifying consumers ~~((that:~~

30 ~~(a) The prohibition against balance billing in this chapter is~~
31 ~~applicable to health plans issued by carriers in Washington state and~~
32 ~~self-funded group health plans that elect to participate in RCW~~
33 ~~48.49.020 through 48.49.040 as provided in RCW 48.49.130;~~

34 ~~(b) They cannot be balance billed for the health care services~~
35 ~~described in RCW 48.49.020 and will receive the protections provided~~
36 ~~by RCW 48.49.030; and~~

37 ~~(c) They may be balance billed for health care services under~~
38 ~~circumstances other than those described in RCW 48.49.020 or if they~~

1 ~~are enrolled in a health plan to which chapter 427, Laws of 2019 does~~
2 ~~not apply, and steps they can take if they are balance billed))~~ of
3 their rights under this chapter, and sections 2799A-1 and 2799A-2 of
4 the public health service act (42 U.S.C. Secs. 300gg-111 and
5 300gg-112) and implementing federal regulations in effect on the
6 effective date of this section.

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

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

16 **Sec. 14.** RCW 48.49.070 and 2019 c 427 s 11 are each amended to
17 read as follows:

18 (1)(a) A hospital ~~((~~or~~))~~, ambulatory surgical facility, or
19 behavioral health emergency services provider must post the following
20 information on its website, if one is available:

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

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

27 (b) If the hospital ~~((~~or~~))~~, ambulatory surgical facility, or
28 behavioral health emergency services provider does not maintain a
29 website, this information must be provided to consumers upon an oral
30 or written request.

31 (2) Posting or otherwise providing the information required in
32 this section does not relieve a hospital ~~((~~or~~))~~, ambulatory surgical
33 facility, or behavioral health emergency services provider of its
34 obligation to comply with the provisions of this chapter.

35 (3) Not less than thirty days prior to executing a contract with
36 a carrier, a hospital or ambulatory surgical facility must provide
37 the carrier with a list of the nonemployed providers or provider
38 groups contracted to provide ~~((~~surgical or ancillary~~))~~ emergency
39 medicine, anesthesiology, pathology, radiology, neonatology, surgery,

1 hospitalist, intensivist and diagnostic services, including radiology
2 and laboratory services at the hospital or ambulatory surgical
3 facility. The hospital or ambulatory surgical facility must notify
4 the carrier within thirty days of a removal from or addition to the
5 nonemployed provider list. A hospital or ambulatory surgical facility
6 also must provide an updated list of these providers within fourteen
7 calendar days of a request for an updated list by a carrier.

8 **Sec. 15.** RCW 48.49.090 and 2019 c 427 s 13 are each amended to
9 read as follows:

10 (1) A carrier must update its website and provider directory no
11 later than thirty days after the addition or termination of a
12 facility or provider.

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

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

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

17 (c) Notification that if the enrollee receives services from an
18 out-of-network provider (~~or~~), facility, or behavioral health
19 emergency services provider, under circumstances other than those
20 described in RCW 48.49.020, the enrollee will have the financial
21 responsibility applicable to services provided outside the health
22 plan's network in excess of applicable cost-sharing amounts and that
23 the enrollee may be responsible for any costs in excess of those
24 allowed by the health plan;

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

27 (e) Upon request, information regarding whether a health care
28 provider is in-network or out-of-network, and whether there are in-
29 network providers available to provide (~~surgical or ancillary~~)
30 emergency medicine, anesthesiology, pathology, radiology,
31 neonatology, surgery, hospitalist, intensivist and diagnostic
32 services, including radiology and laboratory services at specified
33 in-network hospitals or ambulatory surgical facilities; and

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

36 **Sec. 16.** RCW 48.49.100 and 2019 c 427 s 14 are each amended to
37 read as follows:

1 (1) If the commissioner has cause to believe that any health care
2 provider, hospital, ~~((or))~~ ambulatory surgical facility, or
3 behavioral health emergency services provider, has engaged in a
4 pattern of unresolved violations of RCW 48.49.020 or 48.49.030, the
5 commissioner may submit information to the department of health or
6 the appropriate disciplining authority for action. Prior to
7 submitting information to the department of health or the appropriate
8 disciplining authority, the commissioner may provide the health care
9 provider, hospital, ~~((or))~~ ambulatory surgical facility, or
10 behavioral health emergency services provider, with an opportunity to
11 cure the alleged violations or explain why the actions in question
12 did not violate RCW 48.49.020 or 48.49.030.

13 (2) If any health care provider, hospital, ~~((or))~~ ambulatory
14 surgical facility, or behavioral health emergency services provider,
15 has engaged in a pattern of unresolved violations of RCW 48.49.020 or
16 48.49.030, the department of health or the appropriate disciplining
17 authority may levy a fine or cost recovery upon the health care
18 provider, hospital, ~~((or))~~ ambulatory surgical facility, or
19 behavioral health emergency services provider in an amount not to
20 exceed the applicable statutory amount per violation and take other
21 action as permitted under the authority of the department or
22 disciplining authority. Upon completion of its review of any
23 potential violation submitted by the commissioner or initiated
24 directly by an enrollee, the department of health or the disciplining
25 authority shall notify the commissioner of the results of the review,
26 including whether the violation was substantiated and any enforcement
27 action taken as a result of a finding of a substantiated violation.

28 (3) If a carrier has engaged in a pattern of unresolved
29 violations of any provision of this chapter, the commissioner may
30 levy a fine or apply remedies authorized under this chapter, chapter
31 48.02 RCW, RCW 48.44.166, 48.46.135, or 48.05.185.

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

37 **Sec. 17.** RCW 48.49.130 and 2019 c 427 s 23 are each amended to
38 read as follows:

1 ((The)) As authorized in 45 C.F.R. Sec. 149.30 as in effect on
2 the effective date of this section, the provisions of this chapter
3 apply to a self-funded group health plan whether governed by or
4 exempt from the provisions of the federal employee retirement income
5 security act of 1974 (29 U.S.C. Sec. 1001 et seq.) only if the self-
6 funded group health plan elects to participate in the provisions of
7 RCW 48.49.020 ((through)) and 48.49.030, section 9 of this act, and
8 RCW 48.49.040. To elect to participate in these provisions, the self-
9 funded group health plan shall provide notice, on an annual basis, to
10 the commissioner in a manner prescribed by the commissioner,
11 attesting to the plan's participation and agreeing to be bound by RCW
12 48.49.020 ((through)) and 48.49.030, section 9 of this act, and RCW
13 48.49.040. An entity administering a self-funded health benefits plan
14 that elects to participate under this section, shall comply with the
15 provisions of RCW 48.49.020 ((through)) and 48.49.030, section 9 of
16 this act, and RCW 48.49.040.

17 **Sec. 18.** RCW 48.49.150 and 2019 c 427 s 25 are each amended to
18 read as follows:

19 (1) When determining the adequacy of a proposed provider network
20 or the ongoing adequacy of an in-force provider network, the
21 commissioner must ((consider whether)) review the carrier's proposed
22 provider network or in-force provider network to determine whether
23 the network includes a sufficient number of contracted providers of
24 ((emergency and surgical or ancillary)) emergency medicine,
25 anesthesiology, pathology, radiology, neonatology, surgery,
26 hospitalist, intensivist and diagnostic services, including radiology
27 and laboratory services at or for the carrier's contracted in-network
28 hospitals or ambulatory surgical facilities to reasonably ensure
29 enrollees have in-network access to covered benefits delivered at
30 that facility.

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

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

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

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

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

22 (b) For services for which balance billing is prohibited under
23 RCW 48.49.020, a carrier may not treat its payment of
24 nonparticipating providers or facilities under this chapter or P.L.
25 116-260 (enacted December 27, 2020) as a means to satisfy network
26 access standards established by the commissioner unless all
27 requirements of this subsection are met.

28 (i) If a carrier is unable to obtain a contract with a provider
29 or facility delivering services addressed in an alternate access
30 delivery request to meet network access requirements, the carrier may
31 ask the commissioner to amend the alternate access delivery request
32 if the carrier's communication to the commissioner occurs at least
33 three months after the effective date of the alternate access
34 delivery request and demonstrates substantial evidence of good faith
35 efforts on its part to contract for delivery of services during that
36 three-month time period. If the carrier has demonstrated substantial
37 evidence of good faith efforts on its part to contract, the
38 commissioner shall allow a carrier to use the dispute resolution
39 process provided in RCW 48.49.040 to determine the amount that will
40 be paid to providers or facilities for services referenced in the

1 alternate access delivery request. The commissioner may determine by
2 rule the associated processes for use of the dispute resolution
3 process under this subsection.

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

11 (3) When determining the adequacy of a carrier's proposed
12 provider network or the ongoing adequacy of an in-force provider
13 network, beginning January 1, 2023, the commissioner shall require
14 that the carrier's proposed provider network or in-force provider
15 network include a sufficient number of contracted behavioral health
16 emergency services providers.

17 NEW SECTION. Sec. 19. A new section is added to chapter 48.49
18 RCW to read as follows:

19 The commissioner is authorized to enforce provisions of P.L.
20 116-260 (enacted December 27, 2020, as the consolidated
21 appropriations act of 2021) that are applicable to or regulate the
22 conduct of carriers issuing health plans or grandfathered health
23 plans to residents of Washington state on or after January 1, 2022.
24 In addition to the enforcement actions authorized under RCW
25 48.02.080, the commissioner may impose a civil monetary penalty in an
26 amount not to exceed \$100 for each day for each individual with
27 respect to which a failure to comply with these provisions occurs.

28 **Sec. 20.** RCW 48.49.110 and 2019 c 427 s 15 are each amended to
29 read as follows:

30 (1) The commissioner may adopt rules to implement and administer
31 this chapter, including rules governing the dispute resolution
32 process established in RCW 48.49.040.

33 (2) The commissioner may adopt rules to adopt or incorporate by
34 reference without material change federal regulations adopted on or
35 after the effective date of this section that implement P.L. 116-260
36 (enacted December 27, 2020).

1 NEW SECTION. **Sec. 21.** A new section is added to chapter 48.49
2 RCW to read as follows:

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

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

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

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

26 NEW SECTION. **Sec. 22.** A new section is added to chapter 71.24
27 RCW to read as follows:

28 If the insurance commissioner reports to the department that he
29 or she has cause to believe that a provider licensed under this
30 chapter has engaged in a pattern of violations of RCW 48.49.020 or
31 48.49.030, and the report is substantiated after investigation, the
32 department may levy a fine upon the provider in an amount not to
33 exceed \$1,000 per violation and take other formal or informal
34 disciplinary action as permitted under the authority of the
35 department.

36 NEW SECTION. **Sec. 23.** RCW 48.49.150 is recodified as a section
37 in chapter 48.49 RCW, to be codified before RCW 48.49.140.

1 NEW SECTION. **Sec. 24.** If any provision of this act or its
2 application to any person or circumstance is held invalid, the
3 remainder of the act or the application of the provision to other
4 persons or circumstances is not affected.

5 NEW SECTION. **Sec. 25.** This act is necessary for the immediate
6 preservation of the public peace, health, or safety, or support of
7 the state government and its existing public institutions, and takes
8 effect immediately.

--- END ---