
SENATE BILL 5618

State of Washington

67th Legislature

2022 Regular Session

By Senators Cleveland and Muzzall; by request of Insurance Commissioner

Prefiled 12/30/21.

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 utilization of out-of-network
28 services. To the extent that data related to self-funded group health
29 plans is available within funds appropriated for this purpose, the
30 analysis may include such data. The analysis must be published on the
31 website of the office of the insurance commissioner, with the first
32 analysis published on or before December 15, 2022.

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

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

37 (1) "Adjusted community rate" means the rating method used to
38 establish the premium for health plans adjusted to reflect
39 actuarially demonstrated differences in utilization or cost

1 attributable to geographic region, age, family size, and use of
2 wellness activities.

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

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

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

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

28 (6) "Basic health plan" means the plan described under chapter
29 70.47 RCW, as revised from time to time.

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

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

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

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

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

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

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

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

26 (i) A health benefit plan that meets the definition of
27 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
28 2010, as amended; or

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

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

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

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

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

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

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

22 (a) (i) A medical screening examination, as required under section
23 1867 of the social security act (42 U.S.C. Sec. 1395dd), that is
24 within the capability of the emergency department of a hospital,
25 including ancillary services routinely available to the emergency
26 department to evaluate that emergency medical condition((~~7~~—and
27 further medical));

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

35 (iii) Covered services provided by staff or facilities of a
36 hospital after the enrollee is stabilized and as part of outpatient
37 observation or an inpatient or outpatient stay with respect to the
38 visit during which screening and stabilization services have been
39 furnished. Poststabilization services relate to medical, mental
40 health, or substance use disorder treatment necessary in the short

1 term to avoid placing the health of the individual, or with respect
2 to a pregnant woman, the health of the woman or her unborn child, in
3 serious jeopardy, serious impairment to bodily functions, or serious
4 dysfunction of any bodily organ or part; or

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

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

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

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

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

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

- 37 (a) Ambulatory patient services;
- 38 (b) Emergency services;
- 39 (c) Hospitalization;
- 40 (d) Maternity and newborn care;

- 1 (e) Mental health and substance use disorder services, including
2 behavioral health treatment;
- 3 (f) Prescription drugs;
- 4 (g) Rehabilitative and habilitative services and devices;
- 5 (h) Laboratory services;
- 6 (i) Preventive and wellness services and chronic disease
7 management; and
- 8 (j) Pediatric services, including oral and vision care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 (b) Medicare supplemental health insurance governed by chapter
28 48.66 RCW;

29 (c) Coverage supplemental to the coverage provided under chapter
30 55, Title 10, United States Code;

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

33 (e) Disability income;

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

37 (g) Workers' compensation coverage;

38 (h) Accident only coverage;

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

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

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

4 (k) Dental only and vision only coverage;

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

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

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

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

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

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

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

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

39 (35) "Out-of-pocket maximum" or "maximum out-of-pocket" means the
40 maximum amount an enrollee is required to pay in the form of cost-

1 sharing for covered benefits in a plan year, after which the carrier
2 covers the entirety of the allowed amount of covered benefits under
3 the contract of coverage.

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

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

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

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

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

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

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

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

33 (41) "Small employer" or "small group" means any person, firm,
34 corporation, partnership, association, political subdivision, sole
35 proprietor, or self-employed individual that is actively engaged in
36 business that employed an average of at least one but no more than
37 fifty employees, during the previous calendar year and employed at
38 least one employee on the first day of the plan year, is not formed
39 primarily for purposes of buying health insurance, and in which a
40 bona fide employer-employee relationship exists. In determining the

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

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

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

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

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

1 (~~(46)~~) (45) "Wellness activity" means an explicit program of an
2 activity consistent with department of health guidelines, such as,
3 smoking cessation, injury and accident prevention, reduction of
4 alcohol misuse, appropriate weight reduction, exercise, automobile
5 and motorcycle safety, blood cholesterol reduction, and nutrition
6 education for the purpose of improving enrollee health status and
7 reducing health service costs.

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

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

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

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

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

28 (c) An agency certified by the department of health under chapter
29 71.24 RCW to provide outpatient crisis services;

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

31 (e) An agency certified by the department of health under chapter
32 71.24 RCW to provide medically managed or medically monitored
33 withdrawal management services; or

34 (f) A mobile rapid response crisis team as defined in RCW
35 71.24.025 that is contracted with a behavioral health administrative
36 services organization operating under RCW 71.24.045 to provide crisis
37 response services in the behavioral health administrative services
38 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.~~

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

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

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

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

12 ~~(4))~~ (3) Nothing in this section is to be construed as
13 prohibiting ~~((the))~~ a health carrier from ~~((requiring))~~:

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

22 (b) Requiring a hospital or emergency behavioral health emergency
23 services provider to make a documented good faith effort to notify
24 the covered person's health carrier within 30 minutes of
25 stabilization, if the covered person needs to be stabilized. If a
26 health carrier requires such notification, the health carrier shall
27 provide access to an authorized representative 24 hours a day, seven
28 days a week to receive notifications.

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

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

36 (1) There is a need for a process for the fair consideration of
37 disputes relating to decisions by carriers that offer a health plan
38 to deny, modify, reduce, or terminate coverage of or payment for
39 health care services for an enrollee. For purposes of this section,

1 "carrier" also applies to a health plan if the health plan
2 administers the appeal process directly or through a third party.

3 (2) An enrollee may seek review by a certified independent review
4 organization of a carrier's decision to deny, modify, reduce, or
5 terminate coverage of or payment for a health care service or of any
6 adverse determination made by a carrier under RCW 48.49.020,
7 48.49.030, or sections 2799A-1 or 2799A-2 of the public health
8 services act (42 U.S.C. Secs. 300gg-111 or 300gg-112) and
9 implementing federal regulations in effect as of the effective date
10 of this section, after exhausting the carrier's grievance process and
11 receiving a decision that is unfavorable to the enrollee, or after
12 the carrier has exceeded the timelines for grievances provided in RCW
13 48.43.530, without good cause and without reaching a decision.

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

22 (4) Carriers must provide to the appropriate certified
23 independent review organization, not later than the third business
24 day after the date the carrier receives a request for review, a copy
25 of:

26 (a) Any medical records of the enrollee that are relevant to the
27 review;

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

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

32 (d) A list of each physician or health care provider who has
33 provided care to the enrollee and who may have medical records
34 relevant to the appeal. Health information or other confidential or
35 proprietary information in the custody of a carrier may be provided
36 to an independent review organization, subject to rules adopted by
37 the commissioner.

38 (5) Enrollees must be provided with at least five business days
39 to submit to the independent review organization in writing
40 additional information that the independent review organization must

1 consider when conducting the external review. The independent review
2 organization must forward any additional information submitted by an
3 enrollee to the plan or carrier within one business day of receipt by
4 the independent review organization.

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

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

24 (a) An enrollee or carrier may request an expedited external
25 review if the adverse benefit determination or internal adverse
26 benefit determination concerns an admission, availability of care,
27 continued stay, or health care service for which the claimant
28 received emergency services but has not been discharged from a
29 facility; or involves a medical condition for which the standard
30 external review time frame would seriously jeopardize the life or
31 health of the enrollee or jeopardize the enrollee's ability to regain
32 maximum function. The independent review organization must make its
33 decision to uphold or reverse the adverse benefit determination or
34 final internal adverse benefit determination and notify the enrollee
35 and the carrier or health plan of the determination as expeditiously
36 as possible but within not more than seventy-two hours after the
37 receipt of the request for expedited external review. If the notice
38 is not in writing, the independent review organization must provide
39 written confirmation of the decision within forty-eight hours after
40 the date of the notice of the decision.

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

5 (8) Carriers must timely implement the certified independent
6 review organization's determination, and must pay the certified
7 independent review organization's charges.

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

19 (10) Each certified independent review organization must maintain
20 written records and make them available upon request to the
21 commissioner.

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

26 (12)(a) The commissioner shall adopt rules to implement this
27 section after considering relevant standards adopted by national
28 managed care accreditation organizations and the national association
29 of insurance commissioners.

30 (b) This section is not intended to supplant any existing
31 authority of the office of the insurance commissioner under this
32 title to oversee and enforce carrier compliance with applicable
33 statutes and rules.

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

36 The commissioner is authorized to enforce provisions of P.L.
37 116-260 (enacted December 27, 2020, as the consolidated
38 appropriations act of 2021) and implementing federal regulations in
39 effect on the effective date of this section, that are applicable to

1 or regulate the conduct of carriers issuing health plans or
2 grandfathered health plans to residents of Washington state on or
3 after January 1, 2022. In addition to the enforcement actions
4 authorized under RCW 48.02.080, the commissioner may impose a civil
5 monetary penalty in an amount not to exceed \$100 for each day for
6 each individual with respect to which a failure to comply with these
7 provisions occurs.

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

10 (1) The legislature finds that:

11 (a) Consumers receive surprise bills or balance bills for
12 services provided at (~~(out-of-network)~~) nonparticipating facilities
13 or by (~~(out-of-network)~~) nonparticipating health care providers at
14 in-network facilities;

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

17 (c) Facilities, providers, and health insurance carriers all
18 share responsibility to ensure consumers have transparent information
19 on network providers and benefit coverage, and the insurance
20 commissioner is responsible for ensuring that provider networks
21 include sufficient numbers and types of contracted providers to
22 reasonably ensure consumers have in-network access for covered
23 benefits.

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

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

30 (b) Remove consumers from balance billing disputes and require
31 that (~~(out-of-network)~~) nonparticipating providers and carriers
32 negotiate (~~(out-of-network)~~) nonparticipating provider payments in
33 good faith under the terms of this chapter (~~(427, Laws of 2019)~~);
34 (~~and~~)

35 (c) Align Washington state law with the federal balance billing
36 prohibitions and transparency protections in sections 2799A-1 et seq.
37 of the public health services act (P.L. 116-260) and implementing
38 federal regulations in effect on the effective date of this section,

1 while maintaining provisions of this chapter that provide greater
2 protection for consumers; and

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

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

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

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

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

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

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

22 (c) Air ambulance services.

23 (2) Payment for services described in subsection (1) of this
24 section is subject to the provisions of ~~((RCW 48.49.030 and~~
25 ~~48.49.040.~~

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

31 ~~(b) (i) Upon the effective date of federal legislation prohibiting~~
32 ~~balance billing when emergency services described in subsection~~
33 ~~(1) (a) of this section are provided by a hospital, the carrier no~~
34 ~~longer has a duty to hold enrollees harmless from balance billing~~
35 ~~under (a) of this subsection; or~~

36 ~~(ii) Upon the effective date of an interstate compact with a~~
37 ~~state bordering Washington state or enactment of legislation by a~~
38 ~~state bordering Washington state prohibiting balance billing when~~
39 ~~emergency services described in subsection (1) (a) of this section are~~

1 ~~provided by a hospital located in that border state to a Washington~~
2 ~~state resident, the carrier no longer has a duty to hold enrollees~~
3 ~~harmless from balance billing under (a) of this subsection for~~
4 ~~services provided by a hospital in that border state. The~~
5 ~~commissioner shall engage with border states on appropriate means to~~
6 ~~prohibit balance billing by out-of-state hospitals of Washington~~
7 ~~state residents)) sections 2799A-1 and 2799A-2 of the public health~~
8 ~~services act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and~~
9 ~~implementing federal regulations in effect on the effective date of~~
10 ~~this section, except that:~~

11 (a) Until January 1, 2023, or a later date determined by the
12 commissioner, section 9 of this act and RCW 48.49.040 apply to the
13 nonparticipating provider or facility payment standard and dispute
14 resolution process for services described in subsection (1) of this
15 section, other than air ambulance services;

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

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

35 (d) Carriers must make available through electronic and other
36 methods of communication generally used by a provider to verify
37 enrollee eligibility and benefits information regarding whether an
38 enrollee's health plan is subject to the requirements of this chapter
39 or section 2799A-1 et seq. of the public health services act (42

1 U.S.C. Sec. 300gg-111 et seq.) and implementing federal regulations
2 in effect on the effective date of this section.

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

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

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

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

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

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

31 (b) The carrier, ~~((out-of-network provider, or out-of-network~~
32 ~~facility))~~ nonparticipating behavioral health emergency services
33 provider, and an agent, trustee, or assignee of the carrier ~~((, out-~~
34 ~~of-network provider,))~~ or ~~((out-of-network facility))~~
35 nonparticipating behavioral health emergency services provider must
36 ensure that the enrollee incurs no greater cost than the amount
37 determined under (a) of this subsection.

38 (c) The ~~((out-of-network provider or out-of-network facility,))~~
39 nonparticipating behavioral health emergency services provider and an

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

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

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

26 (2) (~~The allowed amount paid to an out-of-network provider for~~
27 ~~health care services described under RCW 48.49.020 shall be a~~
28 ~~commercially reasonable amount, based on payments for the same or~~
29 ~~similar services provided in a similar geographic area. Within thirty~~
30 ~~calendar days of receipt of a claim from an out-of-network provider~~
31 ~~or facility, the carrier shall offer to pay the provider or facility~~
32 ~~a commercially reasonable amount. If the out-of-network provider or~~
33 ~~facility wants to dispute the carrier's payment, the provider or~~
34 ~~facility must notify the carrier no later than thirty calendar days~~
35 ~~after receipt of payment or payment notification from the carrier. If~~
36 ~~the out-of-network provider or facility disputes the carrier's~~
37 ~~initial offer, the carrier and provider or facility have thirty~~
38 ~~calendar days from the initial offer to negotiate in good faith. If~~
39 ~~the carrier and the out-of-network provider or facility do not agree~~
40 ~~to a commercially reasonable payment amount within thirty calendar~~

1 ~~days, and the carrier, out-of-network provider or out-of-network~~
2 ~~facility chooses to pursue further action to resolve the dispute, the~~
3 ~~dispute shall be resolved through arbitration, as provided in RCW~~
4 ~~48.49.040.~~

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

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

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

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

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

27 (1)(a) Until January 1, 2023, or a later date determined by the
28 commissioner under RCW 48.49.040, the allowed amount paid to a
29 nonparticipating provider for health care services described under
30 RCW 48.49.020(1) other than air ambulance services shall be a
31 commercially reasonable amount, based on payments for the same or
32 similar services provided in a similar geographic area. Within 30
33 calendar days of receipt of a claim from a nonparticipating provider
34 or facility, the carrier shall offer to pay the provider or facility
35 a commercially reasonable amount. If the nonparticipating provider or
36 facility wants to dispute the carrier's payment, the provider or
37 facility must notify the carrier no later than 30 calendar days after
38 receipt of payment or payment notification from the carrier. If the
39 nonparticipating provider or facility disputes the carrier's initial

1 offer, the carrier and provider or facility have 30 calendar days
2 from the initial offer to negotiate in good faith. If the carrier and
3 the nonparticipating provider or facility do not agree to a
4 commercially reasonable payment amount within 30 calendar days, and
5 the carrier or nonparticipating provider or facility chooses to
6 pursue further action to resolve the dispute, the dispute shall be
7 resolved as provided in RCW 48.49.040.

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

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

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

37 (3) This section shall only apply to health care providers,
38 facilities, or behavioral health emergency services providers
39 providing services to members of entities administering a self-funded
40 group health plan and its plan members if the entity has elected to

1 participate in RCW 48.49.020, 48.49.030, and 48.49.040, and this
2 section as provided in RCW 48.49.130.

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

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

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

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

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

29 (1) Effective January 1, 2023, or a later date determined by the
30 commissioner, services described in RCW 48.49.020(1) other than air
31 ambulance services are subject to the independent dispute resolution
32 process established in sections 2799A-1 and 2799A-2 of the public
33 health services act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and
34 implementing federal regulations in effect on January 1, 2023, or a
35 later date determined by the commissioner. Until January 1, 2023, or
36 a later date determined by the commissioner, the arbitration process
37 in this section governs the dispute resolution process for those
38 services.

1 (2) Effective January 1, 2023, or a later date determined by the
2 commissioner, services described in RCW 48.49.020(3) are subject to
3 the independent dispute resolution process established in section
4 2799A-1 and 2799A-2 of the public health services act (42 U.S.C.
5 Secs. 300gg-111 and 300gg-112) and implementing federal regulations
6 in effect on January 1, 2023, or a later date determined by the
7 commissioner. Until January 1, 2023, or a later date determined by
8 the commissioner or if the federal independent dispute resolution
9 process is not available to the state for resolution of these
10 disputes, the arbitration process in this section governs the dispute
11 resolution process for those services.

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

32 (b) Notwithstanding (a) of this subsection (3), where a dispute
33 resolution matter initiated under sections 2799A-1 and 2799A-2 of the
34 public health services act (42 U.S.C. Secs. 300gg-111 and 300gg-112)
35 and implementing federal regulations in effect on the effective date
36 of this section, results in a determination by a certified
37 independent dispute resolution entity that such process does not
38 apply to the dispute or to portions thereof, a carrier, provider,
39 facility, or behavioral health emergency services provider may
40 initiate arbitration described in this section for such dispute:

1 (i) Without completing good faith negotiation under section 9 of
2 this act if the open negotiation period required under sections
3 2799A-1 and 2799A-2 of the public health services act (42 U.S.C.
4 Secs. 300gg-111 and 300gg-112) and implementing federal regulations
5 in effect on the effective date of this section, has been completed;
6 and

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

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

14 ~~((i))~~ (a) Involve identical carrier and provider (or
15 facility), provider group, facility, or behavioral health emergency
16 services provider parties;

17 ~~((ii))~~ (b) Involve claims with the same (or related current
18 procedural terminology codes relevant to a particular procedure)
19 procedural code, or a comparable code under a different procedural
20 code system; and

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

23 ~~((2))~~ (5) Within seven calendar days of receipt of notification
24 from the initiating party, the commissioner must provide the parties
25 with a list of approved arbitrators or entities that provide
26 arbitration. The arbitrators on the list must be trained by the
27 American arbitration association or the American health lawyers
28 association and ((should)) must have experience in matters related to
29 medical or health care services. The parties may agree on an
30 arbitrator from the list provided by the commissioner. If the parties
31 do not agree on an arbitrator, they must notify the commissioner who
32 must provide them with the names of five arbitrators from the list.
33 Each party may veto two of the five named arbitrators. If one
34 arbitrator remains, that person is the chosen arbitrator. If more
35 than one arbitrator remains, the commissioner must choose the
36 arbitrator from the remaining arbitrators. The parties and the
37 commissioner must complete this selection process within twenty
38 calendar days of receipt of the original list from the commissioner.

39 ~~((3-a))~~ (6) Each party must make written submissions to the
40 arbitrator in support of its position no later than thirty calendar

1 days after the final selection of the arbitrator. (~~The initiating~~)
2 Each party must include in (~~its~~) their written submission the
3 evidence and methodology for asserting that the amount proposed to be
4 paid is or is not commercially reasonable. A party that fails to make
5 timely written submissions under this section without good cause
6 shown shall be considered to be in default and the arbitrator shall
7 require the party in default to pay the final offer amount submitted
8 by the party not in default and may require the party in default to
9 pay expenses incurred to date in the course of arbitration, including
10 the arbitrator's expenses and fees and the reasonable attorneys' fees
11 of the party not in default.

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

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

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

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

38 (ii) Patient characteristics and the circumstances and complexity
39 of the case, including time and place of service and whether the
40 service was delivered at a level I or level II trauma center or a

1 rural facility, that are not already reflected in the provider's
2 billing code for the service.

3 (c) The arbitrator may not require extrinsic evidence of
4 authenticity for admitting data from the Washington state all-payer
5 claims database data set developed under RCW 43.371.100 into
6 evidence.

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

13 ~~((4))~~ (9) Expenses incurred in the course of arbitration,
14 including the arbitrator's expenses and fees, but not including
15 attorneys' fees, must be divided equally among the parties to the
16 arbitration. The commissioner may establish allowable arbitrator fee
17 ranges or an arbitrator fee schedule by rule. Arbitrator fees must be
18 paid to the arbitrator by a party within 30 calendar days following
19 receipt of the arbitrator's decision by the party. The enrollee is
20 not liable for any of the costs of the arbitration and may not be
21 required to participate in the arbitration proceeding as a witness or
22 otherwise.

23 ~~((5))~~ (10) Within ~~((ten))~~ 10 business days of a party notifying
24 the commissioner and the noninitiating party of intent to initiate
25 arbitration, both parties shall agree to and execute a nondisclosure
26 agreement. The nondisclosure agreement must not preclude the
27 arbitrator from submitting the arbitrator's decision to the
28 commissioner under subsection ~~((3))~~ (6) of this section or impede
29 the commissioner's duty to prepare the annual report under RCW
30 48.49.050.

31 ~~((6))~~ (11) The decision of the arbitrator is final and binding
32 on the parties to the arbitration and is not subject to judicial
33 review.

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

37 ~~((7))~~ (13) Air ambulance services are subject to the
38 independent dispute resolution process established in sections
39 2799A-1 and 2799A-2 of the public health services act (42 U.S.C.

1 Secs. 300gg-111 and 300gg-112) and implementing federal regulations
2 in effect on the effective date of this section.

3 (14) This section applies to health care providers ~~((or)),~~
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 only if the entity has elected
7 to participate in RCW 48.49.020 and 48.49.030, section 9 of this act,
8 and this section as provided in RCW 48.49.130.

9 ~~((8))~~ (15) An entity administering a self-funded group health
10 plan that has elected to participate in this section pursuant to RCW
11 48.49.130 shall comply with the provisions of this section.

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

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

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

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

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

30 (1) The commissioner, in consultation with health carriers,
31 health care providers, health care facilities, and consumers, must
32 develop standard template language for a notice of consumer rights
33 notifying consumers ~~((that:~~

34 ~~(a) The prohibition against balance billing in this chapter is~~
35 ~~applicable to health plans issued by carriers in Washington state and~~
36 ~~self-funded group health plans that elect to participate in RCW~~
37 ~~48.49.020 through 48.49.040 as provided in RCW 48.49.130;~~

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

4 ~~(c) They may be balance billed for health care services under~~
5 ~~circumstances other than those described in RCW 48.49.020 or if they~~
6 ~~are enrolled in a health plan to which chapter 427, Laws of 2019 does~~
7 ~~not apply, and steps they can take if they are balance billed)) of~~
8 ~~their rights under this chapter, and sections 2799A-1 and 2799A-2 of~~
9 ~~the public health services act (42 U.S.C. Secs. 300gg-111 and~~
10 ~~300gg-112) and implementing federal regulations in effect on the~~
11 ~~effective date of this section.~~

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

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

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

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

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

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

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

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

1 (3) Not less than thirty days prior to executing a contract with
2 a carrier, a hospital or ambulatory surgical facility must provide
3 the carrier with a list of the nonemployed providers or provider
4 groups contracted to provide (~~(surgical or ancillary)~~) emergency
5 medicine, anesthesiology, pathology, radiology, neonatology, surgery,
6 hospitalist, intensivist and diagnostic services, including radiology
7 and laboratory services at the hospital or ambulatory surgical
8 facility. The hospital or ambulatory surgical facility must notify
9 the carrier within thirty days of a removal from or addition to the
10 nonemployed provider list. A hospital or ambulatory surgical facility
11 also must provide an updated list of these providers within fourteen
12 calendar days of a request for an updated list by a carrier.

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

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

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

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

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

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

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

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

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

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

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

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

32 (3) If a carrier has engaged in a pattern of unresolved
33 violations of any provision of this chapter, the commissioner may
34 levy a fine or apply remedies authorized under this chapter, chapter
35 48.02 RCW, RCW 48.44.166, 48.46.135, or 48.05.185.

36 (4) For purposes of this section, "disciplining authority" means
37 the agency, board, or commission having the authority to take
38 disciplinary action against a holder of, or applicant for, a

1 professional or business license upon a finding of a violation of
2 chapter 18.130 RCW or a chapter specified under RCW 18.130.040.

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

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

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

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

34 (2) When determining the adequacy of a proposed provider network
35 or the ongoing adequacy of an in-force provider network, the carrier
36 may not treat its payment of nonparticipating providers or facilities
37 under this chapter or P.L. 116-260 (enacted December 27, 2020) as a

1 means to satisfy network access standards established by the
2 commissioner.

3 NEW SECTION. **Sec. 19.** A new section is added to chapter 48.49
4 RCW to read as follows:

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

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

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

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

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

25 (1) On or before October 1, 2023, the commissioner, in
26 collaboration with the health care authority and the department of
27 health, must submit recommendations to the appropriate policy and
28 fiscal committees of the legislature as to how balance billing for
29 ground ambulance services can be prevented and whether ground
30 ambulance services should be subject to the balance billing
31 restrictions of this chapter. In developing the recommendations, the
32 commissioner must:

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

1 (b) Consult with the department of health, the health care
2 authority, the state auditor, consumers, hospitals, carriers, private
3 ground ambulance service providers, fire districts, and local
4 governmental entities that operate ground ambulance services.

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

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

12 If the insurance commissioner reports to the department that he
13 or she has cause to believe that a provider licensed under this
14 chapter has engaged in a pattern of violations of RCW 48.49.020 or
15 48.49.030, and the report is substantiated after investigation, the
16 department may levy a fine upon the provider in an amount not to
17 exceed \$1,000 per violation and take other formal or informal
18 disciplinary action as permitted under the authority of the
19 department.

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

22 NEW SECTION. **Sec. 24.** This act is necessary for the immediate
23 preservation of the public peace, health, or safety, or support of
24 the state government and its existing public institutions, and takes
25 effect immediately.

--- END ---