

RCW 41.05.028 Health plan reimbursement rates. (1) For purposes of this section:

(a) "Contractor" means a health carrier that provides medical insurance offered to public employees and their covered dependents under this chapter, or a third-party administrator contracted by the authority to provide medical coverage to public employees under this chapter.

(b) "The total amount medicare would have reimbursed for the same or similar services" means the amount of reimbursement for a claim that would be paid as if the centers for medicare and medicaid services reimbursed the claim, including applicable postclaim settlements.

(2) (a) Claims submitted for reimbursement under this section must include all the current year centers for medicare and medicaid services required modifiers so that all rebates, incentives, or adjustments that would have applied if reimbursed by medicare apply.

(b) The authority shall adopt rules to determine the equivalent amount of reimbursement for services with a low volume of medicare experience or for which there is no applicable centers for medicare and medicaid services reimbursement for a service.

(3) Beginning January 1, 2027, each contractor, for its health plans that provide medical coverage offered to public employees and their covered dependents, must meet the following requirements:

(a) Except as provided in (b) of this subsection, reimbursement to any in-network hospital licensed under chapter 70.41 RCW located in Washington for inpatient and outpatient hospital services shall be the lesser of billed charges, the contractor's contracted rate for the hospital, or 200 percent of the total amount medicare would have reimbursed for the same or similar services;

(b) Reimbursement for inpatient and outpatient hospital services to any in-network hospital licensed under chapter 70.41 RCW primarily engaged in the care and treatment of children located in:

(i) King county, shall be the lesser of billed charges, the contractor's contracted rate for the hospital, or 150 percent of the hospital-specific medicaid inpatient ratio of cost to charges as determined by the authority; and

(ii) Pierce county, shall be the lesser of billed charges, the contractor's contracted rate for the hospital, or 190 percent of the hospital-specific medicaid inpatient ratio of cost to charges as determined by the authority;

(c) Reimbursement for services provided by rural hospitals certified by the centers for medicare and medicaid services as critical access hospitals may not be less than 101 percent of allowable costs as defined by the United States centers for medicare and medicaid services for purposes of medicare cost reporting;

(d) Reimbursement for in-network primary care services, as defined by the authority, may not be less than 150 percent of the total amount medicare would have reimbursed for the same or similar services;

(e) Reimbursement for in-network nonfacility-based behavioral health services, as defined by the authority, may not be less than 150 percent of the total amount medicare would have reimbursed for the same or similar services;

(f) Except as provided in (g) of this subsection, reimbursement to any out-of-network hospital licensed under chapter 70.41 RCW located in Washington for inpatient and outpatient hospital services shall be the lesser of billed charges or 185 percent of the total

amount medicare would have reimbursed for the same or similar services;

(g) Reimbursement for inpatient and outpatient hospital services provided by a hospital licensed under chapter 70.41 RCW and located in Washington to any out-of-network hospital primarily engaged in the care and treatment of children located in:

(i) King county, shall be the lesser of billed charges or 135 percent of the hospital-specific medicaid inpatient ratio of cost to charges as determined by the authority; and

(ii) Pierce county, shall be the lesser of billed charges or 175 percent of the hospital-specific medicaid inpatient ratio of cost to charges as determined by the authority; and

(h) A provider who is reimbursed in accordance with (f) or (g) of this subsection may not charge to or collect from the patient or a person who is financially responsible for the patient an amount in addition to the reimbursement paid under (f) or (g) of this subsection other than cost-sharing amounts authorized by the terms of the health plan.

(4) Except as provided in subsection (3)(c) of this section, this section does not apply to:

(a) Rural hospitals certified by the centers for medicare and medicaid services as sole community hospitals or critical access hospitals except for hospitals that are owned or operated by a health system that owns or operates more than two acute care hospitals licensed under chapter 70.41 RCW;

(b) Hospitals located on an island operating within a public hospital district in Skagit county; or

(c) Hospitals that are not currently designated as a critical access hospital, do not meet current federal eligibility requirements for designation as a critical access hospital, have combined medicaid and medicare inpatient days greater than 60 percent of all hospital inpatient days, and are located on the land of a federally recognized Indian tribe.

(5) Nothing in this section prohibits a contractor from reimbursing a hospital through a nonfee-for-service payment methodology, so long as the payments incentivize higher quality or improved health outcomes and the contractor continues to comply with the reimbursement requirements in this section.

(6) Premiums must take into account changes in reimbursement for hospital, primary care, and behavioral health services anticipated to result from the application of this section.

(7) At the request of the authority for monitoring, enforcement, or program and quality improvement activities, a contractor must provide cost and quality of care information and data to the authority and may not enter into an agreement with a provider or third party that would restrict the contractor from providing this information or data.

(8) (a) By December 31, 2030, the authority, in consultation with the office of the insurance commissioner, shall provide a report to the governor's office and relevant committees of the legislature analyzing the initial impacts of this section on network access, enrollee premiums and cost sharing, and state expenditures for medical coverage offered to public employees under this chapter. The report may include recommendations for legislative changes to the policy established in this section.

(b) By December 31, 2034, the authority, in consultation with the office of the insurance commissioner, shall provide a second report to

the governor's office and relevant committees of the legislature providing an updated analysis on the impacts of this section on network access, enrollee premiums and cost sharing, and state expenditures for medical coverage offered to public employees under this chapter. The report may include recommendations for legislative changes to the policy established in this section.

(9) For the purposes of this section, reimbursement for inpatient and outpatient services does not include charges for professional services.

(10) The authority may adopt rules to implement this section, including rules for levying fines and taking other contract actions it deems necessary to enforce compliance with this section. [2025 c 373 s 1.]