OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Mike Kreidler- Insurance Commissioner

As required by

The Washington State Administrative Procedures Act

Chapter 34.05 RCW

Matter No. **R 2019-04**

CONCISE EXPANATORY STATEMENT; RESPONSIVENESS SUMMARY; RULE DEVELOPMENT PROCESS; AND IMPLEMENTATION PLAN

Relating to the adoption of

Balance Billing Protection Act rules

November 18, 2019

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Section 1: Introduction

Revised Code of Washington (RCW) 34.05.325 (6) requires the Office of Insurance Commissioner (OIC) to prepare a "concise explanatory statement" (CES) prior to filing a rule for permanent adoption. The CES shall:

1. Identify the Commissioner's reasons for adopting the rule;
2. Describe differences between the proposed rule and the final rule (other than editing changes) and the reasons for the differences; and
3. Summarize and respond to all comments received regarding the proposed rule during the official public comment period, indicating whether or not the comment resulted in a change to the final rule, or the Commissioner's reasoning in not incorporating the change requested by the comment; and
4. Be distributed to all persons who commented on the rule during the official public comment period and to any person who requests it.

Section 2: Reasons for Adopting the Rule

The 2019 legislature enacted 2SHB 1065 – the Balance Billing Protection Act (BBPA). Clarity is needed regarding several aspects of implementation and administration of the Act, which will contribute to successful implementation of the act and thus, protection of Washington State consumers from balance billing for the services encompassed in the BBPA.

Section 3: Rule Development Process

The CR-101 was filed in the Washington State Register on June 17, 2019 (WSR 19-13-077). The comment period for the CR-101 closed on July 19, 2019. Prior to filing the CR-101, on June 14, 2019, the Commissioner's staff facilitated a stakeholder meeting in Tumwater WA attended by representatives of consumers, hospitals, physicians and carriers. At the meeting, OIC solicited stakeholder input on the issues that should be addressed in rulemaking.

The Commissioner issued an initial stakeholder draft for comment on August 1, 2019. The Commissioner's staff facilitated a stakeholder meeting on August 12, 2019 in Tumwater WA to discuss the first stakeholder draft. The meeting was attended by representatives of consumers, hospitals, physicians and carriers. Thirteen written comments were received.

A second stakeholder draft was issued on September 3, 2019, with an open comment period until September 9, 2019. Twelve written comments were received.

On October 2, 2019, the CR-102 was published in the Washington State Register (WSR 19-20-112). The Commissioner accepted comments through November 4, 2019. Eleven written comments were received.

The Commissioner held a public hearing on the proposed rule text on November 5, 2019; the hearing was administered by Jane Beyer, in Tumwater WA at the Office of the Insurance Commissioner. Testimony by one person was presented at the hearing.

The CR-103 was submitted to the Code Reviser for adoption on November 19, 2019.

Section 4: Differences between Proposed and Final Rule

The proposal included rules determined by OIC, after receiving extensive stakeholder input, to be necessary to implement and administer the Balance Billing Protection Act (BBPA) and to ensure that consumers are protected from wrongful balance billing. The proposed rules address:

- Definitions of terms;
- Consumer protections against wrongful balance billing;
- Processes related to submission of claims by out-of-network providers, carrier payment for such claims and dispute resolution related to the claims, in circumstances in which balance billing is prohibited;
- The means through which providers can determine whether a patient's health plan is subject to the requirements of the BBPA;
- When and in what format an OIC consumer notice template must be used;
- Clarification of provider, facility and carrier transparency requirements, including providing consumers with sufficient information to understand whether a service they plan to, or have, received is subject to the protections of the BBPA;
- OIC review of consumer complaints and referral of "patterns of unresolved violations" by providers or facilities to the Department of Health or disciplinary authorities for review and action; and
- Processes for self-funded group health plans to elect to offer BBPA protections to their enrollees.

The final rule differs from the proposed rule in two respects.

The proposed rule included a definition of "same or similar geographic area" in WAC 284-43B-010. It defined the term as the geographic methodology adopted for the All Payer Claims Database (APCD) data set developed under RCW 43.371.100. OIC received multiple comments indicating that this methodology was intended to apply to development of the database, and that it was not appropriate to apply it to carriers'

calculation of median in-network rates to determine consumer cost-sharing under WAC 284-43B-020(1) or to establish commercially reasonable amounts under WAC 284-43B-030. Designation of geographic areas for purposes of calculating in-network provider payment rates would be inconsistent with the BBPA, which directs carriers to use their median in-network rates as a basis for calculating enrollee cost-sharing. Carriers have established geographic regions in place for purposes of calculating their in-network and out-of-network provider payment rates.

Commenters also noted that changing geographic regions would require significant systems modification prior to implementation of the BBPA. For these reasons and awareness of the upcoming January 1, 2020 effective date of the BBPA, the final rule does not include a definition of "same or similar geographic area". However, the APCD dataset will utilize the OIC geographic rating areas established in WAC 284-43-6701 for purposes of determining median allowed amounts and median billed charge amounts in the database.

The final rule revises the language of WAC 284-43B-050(4) to make a technical clarification regarding the provider network contracts that are to be posted by health care providers and facilities on their websites.

For the reasons described in the responses to the comments below, no other changes were made to the proposed rule in the final rule.

Section 5: Responsiveness Summary

The OIC received thirty-six written comments and suggestions regarding this rule, inclusive of the CR-101, stakeholder drafts and CR-102. The following information contains a description of the comments, the OIC's assessment of the comments, and information about whether the OIC included or rejected the comments.

The OIC received comments from:

- Aetna
- America's Health Insurance Plans (AHIP)
- Association of Washington Healthcare Plans (AWHP)
- Cambia
- Coordinated Care
- Kaiser Foundation Health Plan of the Northwest (KP NW)
- Kaiser Permanente of Washington (KP WA)
- Kirkland Insurance Solutions
- Molina
- National Association of Independent Review Organizations
- National Multiple Sclerosis Society (MS Society)

- Northwest Health Law Advocates (NoHLA)
- Premera
- Providence Health Plan
- United HealthCare
- URAC
- Donna Van Eaton
- Washington State Hospital Association (WSHA)
- Washington State Medical Association (WSMA)

CR-101 Comments:

Commenter	Comment	Response
Aetna	• Include emergency ambulance services in the balance billing prohibition. • Do not standardize the process in section 7(4) • Do not apply the requirements of section 30 to a provider network contractor's subcontracted providers.	• This is outside the scope of the Balance Billing Protection Act (BBPA) statute. • After discussion with stakeholders, there was agreement to use the HIPAA 271 standardized transaction for this purpose. • The final rule applies the contracting requirement to a provider network contractor's subcontracted providers. An intermediary's provider network might not contract with all of a carrier's networks. Providers participating in an intermediary network need to know which of the carrier's provider networks they are contracted with.
AWHP	• Sec. 7: Allow carriers flexibility in determining commercially reasonable amount.	• The Commissioner appreciates the comment. The rule does not further define "commercially reasonable amount".

	• Sec. 8: Post the list of arbitrators on the OIC website. • Sec. 25: No additional rules regarding provider network adequacy are needed. • Sec. 30: Allow carriers to list networks in the provider contract template, with a variable field to select the corresponding network.	• The Commissioner appreciates the comment. The list of arbitrators will be posted on the OIC website. • The Commissioner appreciates the comment. No additional provider network adequacy rules are proposed. • The OIC will approve clear contract language that permits both parties to accurately identify if they are an in-network provider. For example, the OIC has approved language that identifies the provider's in-network status by selection of a checkbox next to the appropriate networks available.
Molina	Clarify in rule how the specific provisions of section 8 regarding arbitration relate to Chapter 7.04A RCW.	WAC 284-43B-030 provides greater detail related to arbitration proceedings. RCW 48.49.040 provides that in the event of a conflict between that section and chapter 7.04A RCW, RCW 48.49.040 governs.

First Stakeholder Draft comments

Commenter	Comment	Response
284-43B-010		
Coordinated Care, Molina, WSHA, WSMA	Allow a single case agreement to be considered a contract with a provider for purposes of the BBPA. WSHA/WSMA request to limit the effect of a single care agreement to the services and parties to the agreement.	The Commissioner appreciates the comment. The rule allows this. The Commissioner appreciates the comment. The revision is included in the rule.

Commenter	Comment	Response
Premera, Cambia	Revise definition of "median in-network contracted rate" to include cost-sharing paid by the enrollee.	The Commissioner appreciates the comment. The revision is included in the rule.
WSHA	Designate geographic areas that carriers will use to calculate median in-network rate	Designation of geographic areas for purposes of calculating in-network provider payment rates would be inconsistent with the BBPA, which directs carriers to use their median in-network rates as a basis for calculating enrollee cost-sharing. Carriers have established geographic regions in place for purposes of calculating their in-network and out-of-network, provider payment rates.
National MS Society, AWHP, Coordinated Care, Molina	Comments related to the scope of provider types included in the BBPA, such as ground ambulance services.	The rule cannot add services to the prohibition that are not authorized in statute.
NoHLA	• Add several definitions to the rule so consumers can better understand their rights. • Use weighting of claims to calculate median in network rate.	• The Commissioner appreciates the comment. Several definitions were added to the rule. • The Commissioner appreciates the comment. The rule was revised to use weighting of claims to calculate the median.
284-43B-020		
Kaiser NW and KP WA	Measure the 30 day refund timeline from the date a provider receives the adjudicated claim, rather than the date the provider receives the consumer's payment.	RCW 48.49.030(1)(e) specifies that the provider or facility must refund any excess payment "within thirty days of receipt." To extend that period would be inconsistent with the statute and would weaken consumer protection by allowing a provider or facility to keep money that belongs to the consumer for a longer period of time.

Commenter	Comment	Response
Cambia, Coordinated Care	284-43B-020(1)(c)(ii) regarding the hold harmless provision for border hospitals should be limited to services provided by an OON border state hospital, rather than in an OON hospital. Also revise the consumer notice template accordingly.	OIC's interpretation of the statute reflects the inclusion of reference to providers in Section 6 (1)(a) of the BBPA, and the statutory definition of "emergency services." *See* RCW 48.43.005. This definition does not in any way limit the scope of services to those provided exclusively by the hospital or by employees of a hospital. Section 1(2)(a) of the BBPA states that "[I]t is the intent of the legislature to ban balance billing of consumers….for the services described in section 6 of this act." In order to meet the legislature's intent, because OIC cannot regulate the billing practices of out-of-state providers, the hold harmless provision in section 6(3) of the BBPA extends the protections of the BBPA to consumers who, due to unique circumstances or their medical needs, receive emergency services at an out-of-state hospital in a border state. If carriers were able to allow consumers to be balance billed for emergency services rendered by providers, this would defeat the purpose of the BBPA. OIC's interpretation of section 6(3), as reflected in both the consumer notice template and the proposed rule language, is consistent with the structure of the BBPA and the intent of the legislature to protect consumers from balance billing for emergency services.

Commenter	Comment	Response
Cambia	Allow carriers to use the commercially reasonable amount paid to the OON provider as a basis for calculating consumer cost-sharing.	This is inconsistent with RCW 48.49.030, which requires consumer cost-sharing to be based upon the carrier's median in-network contracted rate.
284-43B-030		
Kaiser Permanente NW and WA, Cambia, AWHP, Coordinated Care, Molina, Premera	Either require OON providers to comply with the current "clean claim" rules or provide more time for carriers to process a claim from an OON provider.	The rule does not require compliance with the clean claim rule. Instead, it specifies the information that must be included in the claim submitted by the OON provider (WAC 284-43B-030(1)).
Cambia	Allow parties to extend 30 day period of good faith negotiation and 10 day limit for initiating arbitration.	This change is not authorized by the BBPA, which sets the time limitations in RCW 48.49.040.
Molina	Allow the carrier to require an OON provider to return a claim payment that is in dispute.	This would be an undue burden on the OON provider. The amount paid by the carrier represents what the carrier is willing to pay. If negotiation or arbitration results in a higher payment, the carrier would pay the difference to the OON provider.
WSMA	Expressed concerns regarding arbitrators having a conflict of interest.	The arbitrator application process developed by OIC includes information regarding the arbitrator's practice/representation. The parties can consider this as they are choosing an arbitrator.
284-43-040		
AHIP, KP WA and NW, Cambia, Coordinated Care, Molina, AWHP,	Implementation of this provision would be impracticable and costly. The carriers do not have staff located at or near most hospitals, carriers do not have access to the information that would be required in the notice, carriers may not	The proposed rule does not include this provision, given the concerns raised by stakeholders. However, OIC remains concerned that consumers who receive emergency services at an OON

Commenter	Comment	Response
Premera, WSHA	receive notice of admission. This requirement may exceed statutory authority.	hospital may not fully understand the risk of increased costs and balance billing if they remain at the OON hospital post-stabilization. OIC encourages carriers and WSHA to work together to ensure notification of carriers by hospitals when a consumer who has received services at an OON hospital has been stabilized and to facilitate a consumer's decision whether to transfer to an in-network hospital for further care.
NoHLA, National Multiple Sclerosis Society	Supports notice to consumers post-stabilization. OIC should develop a template for the notice and translate it into multiple languages.	Given the stakeholder concerns about the impracticability of the provision, this notice is not included in the final rule.
284-43B-050		
AWHP, Premera	If the process for provider verification of whether a consumer's health plan is subject to the BBPA is going to be standardized, require OneHealthPort (OHP) to obtain stakeholder input in development.	OHP developed the standardized process through its Administrative Simplification Business and Technology Workgroup, which includes carrier and provider representatives.
WSMA	Rule should stipulate that OIC must approve the process developed by OneHealthPort.	The rule references the HIPAA standard transaction that will be used for this purpose, which indicates approval of the process developed by OHP.
284-43B-060		
KP NW and WA	It is too burdensome to include a notification on a consumer's Explanation of Benefits (EOB) as to whether the claim is subject to the protections of the BBPA.	Consumers must have information about their rights under the BBPA at a meaningful time. Inclusion of this information in the carrier's communication to consumers, such as the Explanation of

Commenter	Comment	Response
		Benefits, is critical to implementation of the BBPA.
Cambia, AWHP, Premera	It will be extremely complex to implement the requirement to inform consumers as to whether the claim is subject to the BBPA. Delay this requirement for one year.	The rule acknowledges this complexity, and delays the effective date of this provision to July 1, 2020.
WSHA/WSMA	Allow facilities and providers 30 days, rather than 7 days to update their list of health plan networks it participates in on its website.	The rule acknowledges this challenge and increases the allowable time to post this information to 14 days.
NoHLA	The rule should require OIC to translate the consumer notice template into the 6 most commonly spoken languages; and include taglines in the next 15 languages most commonly spoken stating that language assistance is available from OIC regarding the notice. OIC should include the carrier transparency requirements from section 13(2)(a) and (c)-(f) of the act in the rule. Include the requirements of sections 11(3) and 12(3) of the BBPA in the rule.	OIC will be translating the consumer notice template into eleven languages and posting those notices on its website. OIC will make carriers aware of the availability of the translations and encourage their use by providers and carriers. These requirements are addressed elsewhere in statute and rules, including RCW 48.43.007, RCW 48.43.510, WAC 284-170-260, and WAC 284-43B-050. The Commissioner appreciates the comment. This language is included in the rule.
284-43B-080		
National Multiple Sclerosis Society	Strongly supports the self-funded group health plan opt-in provision.	The Commissioner appreciates the comment.
WSMA/WSHA	Concerns regarding self-funded group health plan compliance. Amend WAC to allow OIC to terminate opt-in if GHP	When a self-funded group health plan elects to participate in the BBPA, they are modifying the

Commenter	Comment	Response
	is not complying with sections 6-8, and include reference to this authority in the election to participate attestation.	terms of their plan related to payment of certain OON provider and facility claims. Adopting a rule that would give OIC authority to terminate a plan's participation in the BBPA could arguably put OIC in the place of directly regulating the terms of a self-funded group health plan, which would raise concerns under both 29 USC §1144 (preemption) and 29 USC §1132 (exclusive remedy). If a self-funded group health plan's noncompliance with the BBPA harms an enrollee, they can pursue their rights under ERISA to challenge that action.
284-170-480		
KP NW and WA, Molina	Clarify language relating to carrier obligations and the use of templates in provider contracts for this purpose.	The Commissioner appreciates the comment. The rule makes the requested clarification.
Coordinated Care	Clarify whether carriers are required to include this information in providers' contracts with intermediaries, i.e. provider networks.	The final rule applies the contracting requirement to a provider network contractor's subcontracted providers. An intermediary's provider network might not contract with all of a carrier's networks. Providers participating in an intermediary network need to know which of the carrier's provider networks they are contracted with. RCW 48.39.010 requires a third-party payor to amend provider contracts and allows providers to reject such notices. RCW 48.43.730 requires submission of intermediary contracts and thus the requirements in this section

Commenter	Comment	Response
		(unless carved out) are applicable. The amendment to RCW 48.43.730 in the Act applies to these relationships. This WAC language brings this section into compliance with the BBPA.

2nd Stakeholder Draft comments

Commenter	Comment	Response
284-43B-010		
NoHLA, WSHA	Regarding the definition of "median in-network contracted rate", use weighting to calculate and do not include single care agreements in the calculation.	The Commissioner appreciates the comment. The rule was revised to use weighting of claims to calculate the median. Due to the complexity of identifying which claims have been paid under a single case agreement, it is impracticable to exclude claims paid under these agreements from the calculation of the median rate. Using a median, rather than an average, reduces the impact that a relatively small number of claims paid under a single case agreement would have on the median amount.
WSHA/WSMA	Define "same or similar geographic area" Clarify that if a single care agreement is entered into with a facility, it applies	Designation of geographic areas for purposes of calculating in-network provider payment rates would be inconsistent with the statute, which directs carriers to use their median in-network rates as a basis for calculating enrollee cost-sharing. Carriers have established geographic regions in place for purposes of calculating their in-network and out-of-network provider payment rates. The Commissioner appreciates the comment. The rule includes this clarification.

	only to the services and facilities in the agreement, for purposes of the definition of "in-network"	
284-43B-020		
Kaiser NW and KP WA	Measure the 30 day refund timeline from date provider receives adjudicated claim.	RCW 48.49.030(1)(e) specifies that the provider or facility must refund any excess payment "within thirty days of receipt." To extend that period would be inconsistent with the statute and would weaken consumer protection by allowing a provider or facility to keep money that belongs to the consumer for a longer period of time.
Cambia	284-43B-020(1)(c)(ii) regarding the hold harmless provision for border hospitals should be limited to services provided by an OON border state hospital, rather than in an OON hospital.	OIC's interpretation of the statute reflects the inclusion of reference to providers in Section 6 (1)(a) of the BBPA, and the statutory definition of "emergency services." *See* RCW 48.43.005. This definition does not in any way limit the scope of services to those provided exclusively by the hospital or by employees of a hospital. Section 1(2)(a) of the BBPA states that "[I]t is the intent of the legislature to ban balance billing of consumers….for the services described in section 6 of this act." In order to meet the legislature's intent, because OIC cannot regulate the billing practices of out-of-state providers, the hold harmless provision in section 6(3) of the BBPA extends the protections of the BBPA to consumers who, due to unique circumstances or their medical needs, receive emergency services at an out-of-state hospital in a border state. If carriers were

		able to allow consumers to be balance billed for emergency services rendered by providers, this would defeat the purpose of the BBPA. OIC's interpretation of section 6(3), as reflected in both the consumer notice template and the proposed rule language, is consistent with the structure of the BBPA and the intent of the legislature to protect consumers from balance billing for emergency services.
284-43B-030		
Kaiser Permanente NW and WA, Cambia, AWHP, Molina, Premera, Providence Health Plan	Either require OON providers to comply with the current "clean claim" rules or provide more time for the carrier to process a claim from an OON provider.	The rule does not require compliance with the clean claim rule. Instead, it specifies the information that must be included in the claim submitted by the OON provider (WAC 284-43B-030(1)).
Cambia	Add language specifying that a party seeking arbitration is permanently foreclosed from doing so with respect to claims for which it filed an untimely notice.	The Commissioner appreciates the comment. The rule includes this provision.
284-43B-040		
Cambia	The language of the standard message in the HIPAA 271 transaction should be posted on the OIC website.	The OIC website will include a link to this information, which is posted on the OHP website.
Premera, WSHA	Supports the use of a standard transaction developed in consultation with stakeholders.	The Commissioner appreciates this comment.

WSMA	Support using 271 transaction. This information should be made available on carrier's websites in a consistent location and format, such as OHP. Would be ideal to have a single reason adjustment "denial type" code universally used by all carriers associated with the claim response. Would be instructive to have standards for timing for this information to be provided as well as a stipulation that if eligibility info provided by carrier is incorrect, providers that relied on it are held harmless.	OIC appreciates the comment regarding use of the HIPAA 271 standard transaction. OHP acts as a portal to carriers' websites. It would be very unlikely that any consensus could be reached on standardizing how carriers design their websites to provide Balance Billing information or establishing a single reason adjustment denial type code. OIC's expectation is that carriers will provide timely and accurate information in response to provider inquiries. OIC will respond to complaints regarding any such problems.
284-43B-050		
NoHLA	The rule should require OIC to translate the consumer notice template into the most commonly spoken languages; and include taglines in the next 15 languages most commonly spoken stating that language assistance is available from OIC re the notice. OIC should include the carrier transparency requirements from section 13(2)(a) and (c)-(f) of the act in the rule. Given the extension of the requirement to notify consumers on claims	OIC will be translating the consumer notice template into eleven languages and posting those notices on its website. OIC will make carriers aware of the availability of the translations and encourage their use by providers and carriers. The carrier transparency requirements referenced by the commenter are already referenced elsewhere in OIC rules including RCW 48.43.007, RCW 48.43.510, WAC 284-170-260, and WAC 284-43B-050. The Commissioner understands this concern. However, such a

	communications, such as EOB's, that the claims is subject to the protections of the BBPA, require carriers during the period of January 1 to June 30, 2020, to include an explanation how to inquire with the carrier as to whether a claim is subject to the protections of the BBPA.	requirement would most likely need to be on an EOB, which presents the same challenges as those that prompted the extension of the requirement to July 1, 2020. Under 284-43B-050(2)(a), as of January 1, 2020, carriers must include the Consumer Notice template in any communication with an enrollee authorizing nonemergency surgical or ancillary services at an in-network facility, and must post the Consumer Notice in a prominent and relevant location on their website that addresses coverage of emergency services and authorization requirements for non-emergency surgical or ancillary services. These provisions are intended to provide consumers with information regarding their rights at the time that they would be seeking or receiving these services.
Cambia	Concerned that the language of subsection (4) could result in a facility or health care provider posting the entire contract on its website. Clarify subsection (5) to also include providers or provider groups that have privileges to practice at the facility in the provider information given to carriers.	This subsection requires listing of the names of carrier health plan provider networks. It does not require, and is not anticipated to result in posting the contracts themselves. The Commissioner appreciates this comment. The rule includes this clarification.
KP NW and WA	Extend the advance notice requirement in subsection (5) to 90 days, from 30.	This issue was not raised by any other carrier, and an extension of this duration would risk slowing down the provider contracting process.

	In subsection (6), OIC should clarify what information an in network provider should submit to a carrier regarding their network status: • Would this apply just to a hospital, or to its providers as well? • Must the contract between the carrier and provider/facility include this reporting requirement?	OIC interprets the term "network status" in subsection (6) to include information that a consumer would need to know when reviewing a provider network directory, such as location, hours of operation and whether the provider is accepting new patients. RCW 48.43.007(2) also requires carriers to provide enrollees information regarding in-network providers/facilities, including distance from patient, provider contact information, provider's credentials, affiliated providers in a facility/clinic and directions to offices. OIC assumes that carriers can take the initiative to include this provision in their provider contracts.
University of WA Medicine	Concerns regarding requiring facilities to post the health plan networks that they participate in, as it could be confusing to consumers. Several concerns with subsection (5) regarding a facility having knowledge of providers that have privileges or are contracted with the facility, as well as notice in advance of contract execution. In subsection (5), require a carrier to make a written request to a facility for an updated list of providers.	RCW 48.49.080 requires this information to be posted. It is the Commissioner's understanding that facilities are aware of all providers that have privileges to practice at, or are contracted to practice at their facility, and that contracts with carriers include an execution and effective date. The Commissioner appreciates the comment. The rule includes this provision.
284-43B-070		
WSMA/WSHA	Concerns regarding self-funded group health plan compliance. Amend WAC to allow OIC to terminate opt-in if GHP is not complying with sections 6-8, and	When a self-funded group health plan elects to participate in the BBPA, they are modifying the terms of their plan related to payment of certain OON provider and facility

	include reference to this authority in the election to participate attestation.	claims. Adopting a rule that would give OIC authority to terminate a plan's participation in the BBPA could arguably put OIC in the place of directly regulating the terms of a self-funded group health plan, which would raise concerns under both 29 USC §1144 (preemption) and 29 USC §1132 (exclusive remedy). If a self-funded group health plan's noncompliance with the BBPA harms an enrollee, they can pursue their rights under ERISA to challenge that action.
284-170-480		
Coordinated Care	This requirement should not apply to contracts that are intermediary agreements (rental networks). Logistically impracticable to have intermediaries amend each provider contract in their network each time a carrier rents their network. Providers in a rental network need only know the details of their provider contract and network status with the intermediary, not that they participate in networks used by various carriers renting the networks.	The final rule applies the contracting requirement to a provider network contractor's subcontracted providers. An intermediary's provider network might not contract with all of a carrier's networks. Providers participating in an intermediary network need to know which of the carrier's provider networks they are contracted with. RCW 48.39.010 requires third-party payors to amend provider contracts and allows providers to reject such notices. RCW 48.43.730 requires submission of intermediary contracts and thus the requirements in this section (unless carved out) are applicable. The amendment to RCW 48.43.730 in the Act applies to these relationships. This WAC language brings this section into compliance with the BBPA.

CR-102 Comments

Commenter	Comment	Response
KP NW/ KP WA/ WSHA/ AWHP/ Cambia/ United	Noting the transparency of OIC's rulemaking and involvement of stakeholders.	The Commissioner appreciates the comment.
284-43B-010		
AWHP/Cambia/ KP/United/ Coordinated Care	Remove the definition of "same or similar geographic area" from WAC 284-43B-010. The definition of "same or similar geographic area" should not be the same as for the APCD data set. Carriers should have flexibility to use the same geographic areas that they use for development of their fee schedules. Creates confusion to calculating enrollee cost-sharing and determining commercially reasonable amount.	The definition is removed in the final rule. Designation of geographic areas for purposes of calculating in-network provider payment rates would be inconsistent with the BBPA, which directs carriers to use their median in-network rates as a basis for calculating enrollee cost-sharing. Carriers have established geographic regions in place for purposes of calculating their out-of-network and in-network provider payment rates.
Coordinated Care	Emergency services can only be provided in a hospital, Use of the term "facility" (defined as hospital or ASF) in the rule creates confusion. Instead, throughout the rule, explicitly reference hospital or "hospital and ASF", where applicable.	RCW 48.43.005 defines "emergency services" as being limited to a hospital. Any reference to "facility" with respect to emergency services in the rule would only apply to hospitals. Thus, a change to the language of the rule is not necessary.
284-43B-020		
Cambia/AWHP/ Coordinated Care	284-43B-020(1)(c)(ii) regarding the hold harmless provision for border hospitals should be limited to services provided by an OON border state hospital, rather than in an OON hospital. Also revise the consumer notice template accordingly.	OIC's interpretation of the statute reflects the inclusion of reference to providers in Section 6 (1)(a) of the BBPA, and the statutory definition of "emergency services." *See* RCW 48.43.005. This definition does not in any way limit the scope of services to those provided exclusively by the

		hospital or by employees of a hospital. Section 1(2)(a) of the BBPA states that "[I]t is the intent of the legislature to ban balance billing of consumers….for the services described in section 6 of this act." In order to meet the legislature's intent, because OIC cannot regulate the billing practices of out-of-state providers, the hold harmless provision in section 6(3) of the BBPA extends the protections of the BBPA to consumers who, due to unique circumstances or their medical needs, receive emergency services at an out-of-state hospital in a border state. If carriers were able to allow consumers to be balance billed for emergency services rendered by providers, this would defeat the purpose of the BBPA. OIC's interpretation of section 6(3), as reflected in both the consumer notice template and the proposed rule language, is consistent with the structure of the BBPA and the intent of the legislature to protect consumers from balance billing for emergency services.
Coordinated Care	Sub. (1): Modify WAC 284-43B-020 to read "covered" emergency services.	Emergency services are governed by the prudent layperson standard, and encompass the services defined in RCW 48.43.005. A change in the rule could place consumers at risk of

		not being fully protected under the BBPA.
284-43B-030		
URAC	The entities eligible to be arbitrators should include accredited IRO's. All components of patient care, such as medical necessity, medical appropriateness, coding and all associated fees should be part of arbitrator's review.	These suggested changes are not authorized by the statute.
Cambia	Sub. (1): Add the dollar amount billed to the required information submitted to process a claim.	The commenter notes that there is a small likelihood that this information won't be submitted with the claim. OIC agrees with this statement and thus a change in the language is not necessary.
Coordinated Care	Sub. (1): Rather than including the list of elements to be included in a claim submitted by an out-of-network provider, require that claims adhere to current CMS claim submission standards and billing guidelines.	The language of the rule was developed following extensive discussion of what information an OON provider should submit in their claim. Language similar to that suggested by the commenter was considered and rejected earlier in the rulemaking process.
284-43B-040		
WSMA	Support using 271 transaction. This information should be made available through standard web-based eligibility checks, such as OneHealthPort (OHP). Would be ideal to have a single reason adjustment "denial type" code universally used by all carriers associated with the claim response. Would be instructive to have standards for timing for this information to be	OIC appreciates the comment regarding use of the HIPAA 271 standard transaction. OHP does not have a unique eligibility check. It acts as a portal to carrier websites. It would be very unlikely that any consensus could be reached on standardizing carrier web portal location for Balance Billing information or establishing a single reason adjustment denial type code. OIC's expectation is that carriers will provide timely and accurate

	provided as well as a stipulation that if eligibility info provided by carrier is incorrect, providers that relied on it are held harmless.	information in response to provider inquiries. OIC will respond to complaints regarding any such problems.
284-43B-050		
WSHA	The responsibility for facilities and providers to post contracts as of 1/1/2020 under subsection (4) is unclear. Are they required to post for contracts executed prior to 1/1/2020?	The Commissioner appreciates the comment. The final rule clarifies the language to state that both in-force as well as newly executed contracts must be posted.
WSMA	Information provided to enrollees in -050(3) also should be made available to providers, i.e. whether a specific claim is subject to the act.	This is not required by the BBPA. OHP has developed a "best practice" for use of the HIPAA 285 remittance advice standard transaction to make this information available to providers.
NoHLA	The rule should require OIC to translate the consumer notice template into a 6 most commonly spoken languages; and include taglines in the next 15 languages most commonly spoken stating that language assistance is available from OIC re the notice. OIC should require carriers and providers to make translations conspicuously available for communication required by subsection (2)(a)(i) [carrier authorization of services], (2)(a)(iii) [provide notice to enrollee upon request], and (2)(b)(i) [facility/provider confirming scheduling of a procedure]. OIC should include the carrier transparency requirements from section 13(2)(a) and (c)-(f) of the act in the rule.	OIC will be translating the consumer notice template into eleven languages and posting those notices on its website. OIC will make carriers aware of the availability of the translations and encourage their use by providers and carriers. Section 1557 of the ACA requires carriers to include taglines in significant communication to enrollees. OIC believes that carrier authorization of services would constitute such a communication. The carrier transparency requirements referenced by the commenter are already referenced elsewhere in OIC rules

		including RCW 48.43.007, RCW 48.43.510, WAC 284-170-260, and WAC 284-43B-050.
AWHP	The rule should specify that OIC will annually review the consumer notice template, in consultation with stakeholders.	If changes to the consumer notice template are needed due to a change in state or federal law or there are indications, such as consumer complaints, that revisions to the template are needed, OIC will undertake revisions using the same stakeholder review and comment process used to develop the current consumer notice template.
KP/AWHP	In subsection (6), OIC should clarify what information an in network provider should submit to a carrier regarding their network status. • Would this apply just to a hospital, or to its providers as well? • Must the contract between the carrier and provider/facility include this reporting requirement?	OIC interprets the term "network status" in subsection (6) to include information that a consumer would need to know when reviewing a provider network directory, such as location, hours of operation and whether the provider is accepting new patients. RCW 48.43.007(2) also requires carriers to provide enrollees information regarding in-network providers/facilities, including distance from patient, provider contact info, provider's credentials, affiliated providers in a facility/clinic and directions to offices. Carriers can take the initiative to include this provision in their provider contracts.
284-43B-060		
WSHA/WSMA	"Two or more" violations appears inconsistent with "pattern of unresolved violations". At a minimum, the rule should state that "pattern" applies to multiple violations occurring	The current rule states that the "commissioner shall consider" several circumstances in determining whether there is a pattern of unresolved violations. The listed examples are not per

	over a period of time, and not owing to a single episode of care.	se violations, as other factors can be considered as well, such as whether multiple violations arise out of a single episode of care as opposed to over a period of time. The statute directs OIC to offer providers an opportunity to cure violations. OIC's goal is to resolve potential violations through these opportunities to cure.
284-43B-070		
WSMA/WSHA	Concerns regarding self-funded group health plan compliance. Amend WAC to allow OIC to terminate opt-in if GHP is not complying with sections 6-8, and include reference to this authority in the election to participate attestation.	When a self-funded group health plan elects to participate in the BBPA, they are modifying the terms of their plan related to payment of certain OON provider and facility claims. Adopting a rule that would give OIC authority to terminate a plan's participation in the BBPA could arguably put OIC in the place of directly regulating the terms of a self-funded group health plan, which would raise concerns under both 29 USC §1144 (preemption) and 29 USC §1132 (exclusive remedy). If a self-funded group health plan's noncompliance with the BBPA harms an enrollee, they can pursue their rights under ERISA to challenge that action.
284-170-480		
WSMA	Consider whether the language should make provision for circumstances where networks are modified by carriers and providers are not notified. If this happens, provider may not be able to maintain accurate information on their website, as required.	Existing law addresses this concern. RCW 48.39.010 and WAC 284-170-421(6) include requirements for 60 day prior notice to providers if a carrier is changing compensation, or that affect health care service delivery, unless the change is required by

		federal or state law (then the timeframe required by that law would preempt the 60 day notice).
Coordinated Care	This requirement should not apply to contracts that are intermediary agreements (rental networks). Logistically impracticable to have intermediaries amend each provider contract in their network each time a carrier rents their network. Providers in a rental network need only know the details of their provider contract and network status with the intermediary, not that they participate in networks used by various carriers renting the networks.	The final rule applies the contracting requirement to a provider network contractor's subcontracted providers. An intermediary's provider network might not contract with all of a carrier's networks. Providers participating in an intermediary network need to know which of the carrier's provider networks they are contracted with. RCW 48.39.010 requires third-party payor to amend provider contracts and allows providers to reject such notices. RCW 48.43.730 requires submission of intermediary contracts and thus the requirements in this section (unless carved out) are applicable. The amendment to RCW 48.43.730 in the Act applies to these relationships. This WAC language brings this section into compliance with the BBPA.

Section 6: Implementation Plan

A. Implementation and enforcement of the rule.

As described below, implementation of the rule will occur through numerous activities at OIC. The Rates & Forms division will rely on this rule when reviewing health plan filings. Questions related to compliance with this rule can be raised and addressed through the form review process. The Consumer Affairs Division will respond to consumer complaints, and give health care providers/facilities an opportunity to cure any violations of the rule. Through these complaints, OIC will monitor implementation of the rule. This

monitoring will identify any need to conduct further stakeholder education regarding the rule. Enforcement will occur when a carrier is determined to have violated the requirements of these rules.

B. How the Agency intends to inform and educate affected persons about the rule.

The Commissioner has already held, or has planned, multiple webinars to educate stakeholders regarding the BBPA and this rule. On November 2, OIC presented on the BBPA at a conference of the Washington State Society of Healthcare Attorneys. On November 12, a webinar was held for the Association of Washington Health Plans and on November 13, a webinar was held for a health care provider and facility audience. Additional events are planned to educate stakeholders regarding the Act and this rule. OIC's website will have extensive information for carriers, health care providers and facilities, consumers and self-funded group health plans, which will include a link to this rule and our rulemaking process.

Type of Inquiry	Division
Consumer assistance	Consumer Advocacy Program
Rule content	Policy Division
Authority for rules	Legal Division
Enforcement of rule	Company Supervision, Rates & Forms
Market Compliance	Rates & Forms, Company Supervision

C. How the Agency intends to promote and assist voluntary compliance for this rule.

The Commissioner has already held, or has planned, multiple webinars to educate stakeholders regarding the Act and this rule. On November 12, a webinar was held for the Association of Washington Health Plans and on November 13, a webinar was held for a health care provider/facility audience. On November 2, OIC presented at a conference of the Washington State Society of Healthcare Attorneys. Additional events are planned to educated stakeholders regarding the Act and this rule.

OIC will assess compliance with this rule in its annual review of health plan filings, which will provide an opportunity for carriers to fully understand and comply with these rules prior to approval of their health plans. Finally, OIC has developed processes to respond to consumer complaints related to wrongful balance billing. If OIC believes that balance billing may have wrongly occurred, under the BBPA and this rule, OIC will contact the health care provider or facility to provide an opportunity to cure any violation and educate the provider or facility regarding the requirements of the law and this rule.

D. How the Agency intends to evaluate whether the rule achieves the purpose for which it was adopted.

The goal of the Act and this rule is to protect consumers from balance billing for the services included in the Act. The primary mechanism to evaluate whether the rule achieves its purpose is through any information that OIC receives regarding consumers being incorrectly balance billed. Consumer complaints to OIC will be the primary source of this information. OIC also will be able to monitor trends in out-of-network health care provider and facility claims for services included in the Act through analysis of data in the Washington All Payer Claims Database.

Appendix A

CR-102 Hearing Summary

Summarizing Memorandum

To: Mike Kreidler
Insurance Commissioner

From: Jane Beyer
Presiding Official, Hearing on Rule-making

Matter No. R2019-04

Topic of Rule-making: Balance Billing Protection Act

This memorandum summarizes the hearing on the above-named rule-making, held on November 5, 2019 at 5000 Capitol Blvd, Tumwater, Washington over which I presided in your stead.

The following agency personnel were present: Sharon Daniel, Karen Huber, Ellen Range, Darryl Colman and Stephanie Marquis.

In attendance and testifying:

- Simon Vismantas, Senior Regulatory Affairs Consultant, Kaiser Permanente of Washington

In attendance and not testifying:

- Megan Howell, Premera
- Merlene Converse, Kaiser Foundation Health Plan of the Northwest
- Ben Beasley, Coordinated Care
- Steven Robino, United HealthCare
- Roman Daniels-Brown, Washington State Medical Association
- Megan Leni
- Jane Douthit, Regence
- Katie Hiler, Multicare
- Andrea Davis, Coordinated Care

Contents of the presentations made at hearing:
Mr. Vismantas testified on two aspects of the proposed rule:

- Clarify the language at proposed WAC 284-43B-050(6) to specify the information a provider would be supplying to the carrier under the rule, and to address the inclusion of language in carrier/provider contracts regarding the information providers are to submit to carriers under the rule.
- Remove the definition of "same or similar geographic area" in proposed WAC 284-43B-010 so that carriers can use their internal geographic models to calculate consumer cost-sharing and determine commercially reasonable amounts paid to out-of-network providers for claims subject to the Act.

The hearing was adjourned.

SIGNED this 7th day of November 2019

s/
Jane Beyer, Presiding Official