PROPOSED RULE MAKING

CR-102 (October 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

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OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: September 23, 2020
TIME: 8:23 AM

WSR 20-19-139

Agency: Office of the Insurance Commissioner

☒ **Original Notice**
☐ **Supplemental Notice to WSR _____**
☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR** 20-12-083 **; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**
☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or**
☐ **Proposal is exempt under RCW _____.**

Title of rule and other identifying information: (describe subject) Continued Implementation of Chapter 427, Laws of 2019 – Balance Billing Protection Act

Insurance Commissioner Matter R 2020-07

Hearing location(s):

Date:	Time:	Location: (be specific)	Comment:
October 27, 2020	**3:00pm**	**Via Zoom: To register:** https://wa-oic.zoom.us/meeting/register/tJYpc-GvrjIpEtYA6ko3xhn6iV9en1QAS2bu	Due to the COVID-19 public health emergency, this hearing will be held via Zoom.

Date of intended adoption: October 29, 2020 (Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: Jane Beyer
Address: PO Box 40260, Olympia, WA 98504-0260
Email: rulescoordinator@oic.wa.gov
Fax: 360-586-3109
Other:
By (date) October 26, 2020

Assistance for persons with disabilities:
Contact Melanie Watness
Phone: 360-725-7013
Fax: 360-586-2023
TTY: 360-586-0241
Email: MelanieW@oic.wa.gov
Other:
By (date) October 26, 2020

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The proposal includes revisions to rules adopted in 2019 determined by OIC to be necessary for administration of the Balance Billing Protection Act. The rule includes revisions to:

- Arbitration processes, including use of standardized forms for arbitration initiation requests and arbitration decision reporting; establishment of a website for carrier arbitration contact information; arbitrator conflict of interest review, and process related to settlement of disputes.

- Provider notice as to whether a patient's health plan is subject to the Act, through use of a HIPAA standardized remittance advice transaction notice.
- Increase consumer knowledge of their rights, by requiring providers to give consumers notice of their rights under the Act following their receipt of emergency medical services and authorizing the notice to be provided electronically in certain circumstances.
- OIC enforcement of the Act.
- Self-funded group health plan election to participate, including reducing the period of advance notice required to participate or to terminate participation.

Reasons supporting proposal: The proposed rule provides additional clarity regarding several issues related to administration of the Balance Billing Protection Act that have arisen since implementation of the Act in January 2020. The revisions will contribute to continued successful implementation of the Act and its consumer protections.

Statutory authority for adoption: RCW 48.49.060, 48.49.110, 48.43.730

Statute being implemented: Chap. 427, Laws of 2019 – Balance Billing Protection Act, codified at Chapter 48.49 RCW

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:

Name of proponent: (person or organization) Mike Kreidler, Insurance Commissioner

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Jane Beyer	P.O. Box 40260, Olympia, WA	360-725-7043
Implementation:	Molly Nolette /Todd Dixon	P.O. Box 40255, Tumwater WA	360-725-7117/ 360-725-7262
Enforcement:	Toni Hood	P.O. Box 40255, Tumwater WA	360-725-7050

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Is a cost-benefit analysis required under RCW 34.05.328?

☒ Yes: A preliminary cost-benefit analysis may be obtained by contacting:

Name: Tabba Alam
Address: P.O. Box 40260, Olympia, WA 98504

Phone: 360-725-7170
Fax:
TTY:
Email: TabbaA@oic.wa.gov
Other:

☐ No: Please explain:

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.
Citation and description:

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

☐	RCW 34.05.310 (4)(b) (Internal government operations)	☐	RCW 34.05.310 (4)(e) (Dictated by statute)
☐	RCW 34.05.310 (4)(c) (Incorporation by reference)	☐	RCW 34.05.310 (4)(f) (Set or adjust fees)
☐	RCW 34.05.310 (4)(d) (Correct or clarify language)	☐	RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.
Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☒ No Briefly summarize the agency's analysis showing how costs were calculated.

Small Business Economic Impact Statement

A rule concerning amending WSR 19-23-085/Chapter 284-43B WAC to streamline rules necessary to implement and administer the Balance Billing Protection Act (BBPA)

By: Tabba Alam, Economic Policy Analyst

Background:

The purpose of this rule is to amend WSR 19-23-085/ Chapter 284-43B WAC, which pertains to rules necessary to implement and administer the Balance Billing Protection Act (BBPA) (chapter 427, Laws of 2019, codified at Chapter 48.49 RCW), ensuring that consumers are protected from wrongful balance billing.

Citation of rules affected by this rule include:

1. WAC 284-43B-035
    - Subsection (6)
    - Subsection (9)
    - Subsection (11)
2. WAC 284-43B-040
    - Subsection (1)(b)
3. WAC 284-43B-050
    - Subsection (2)

- Subsection (3)

4. WAC 284-43B-070
   - Subsection (2)

When costs to comply exceed the minor cost threshold and costs are disproportionate for small businesses, RCW 19.85.030 compels the agency to reduce costs imposed by the rule on small businesses where it is legal and feasible to do so. In this analysis we will discuss the steps taken to minimize the financial impact to small business.

Probable cost to all stakeholders:

OIC presumes that carriers will comply with the law and regulations set forth in Balance Billing Protection Act (BBPA) (chapter 427, Laws of 2019, codified at Chapter 48.49 RCW). Thus, OIC has determined that by amending WSR 19-23-085 with the sole purpose of clarifying provisions of its BBPA rules, it does not impose more than minor costs upon businesses that comply with these laws and regulations.

Further, the proposed rule clarifies “good cause” for purposes of delay in written submissions to an arbitrator to facilitate settlement negotiations. OIC has determined that having this opportunity would mean fewer disputes that may go to formal arbitration, which is a considerable cost savings to carriers and providers.

Probable cost to small Business:

OIC has determined that the compliance with the proposed rule does not put any disproportionate fiscal impact on small businesses. When costs to comply exceed the minor cost threshold and costs are disproportionate for small businesses, RCW 19.85.030 compels the agency to reduce costs imposed by the rule on small businesses where it is legal and feasible to do so.

OIC had made an effort to recognize even minimal cost impacts to small businesses. Further, as there are no more than minor costs associated with these rules, OIC has applied a default cost of compliance ($100) when analyzing whether the proposed rule would have a disproportionate impact on small businesses as defined in RCW 19.85.020(3). It is to be noted here that implementation of the proposed rule will not result in any administrative, intrinsic or actual costs to the stakeholders as they at present have pre-existing process to accommodate the amendments recommended in the proposed legislation.

Below are calculations for minor cost thresholds across stakeholder that classify as a small business based on the best analogous NAICS types. Although it is unlikely these rules would result in even the full default cost of compliance, the minor cost does not exceed any of the thresholds for any of the small business stakeholders.

We have analyzed small businesses impacted by every WAC amended. Please see below:

1. WAC 284-43B-035:

- Subsection (6): Due to this proposed amendment arbitrators will need to ensure that they don’t have a conflict of interest. However, in practice, OIC believes that arbitrators routinely engage in this inquiry prior to taking a case. Also, please look at our cost analysis below.
- Subsection (9): This amendment require arbitrators to use a form included in the rule to submit information about their case. It is important to note here that arbitrators are already required to report to OIC by RCW 48.49.040 - .050. OIC believes that use of a standardized form will only further simplify and clarify the process for the stakeholder.

2019 Industry NAICS Code	Estimated Cost of Compliance	Industry Description	NAICS Code Title	Average number of employees / business within WA	Minor Cost Estimate - 1% of Avg. Annual Payroll. (0.01*AvgPay)
541110	$100.00	Offices of lawyers	Professional, scientific, and technical services	6	$990.86

541199	$100.00	All other legal services	Professional, scientific, and technical services	7	$539.82
541340	$100.00	Drafting services	Professional, scientific, and technical services	3	$497.32

2. WAC 284-43B-040:

Although the amendment to this section does not impact small business, we have analyzed the impact it will have on health insurance carriers and providers. This section requires the Health insurance companies to have an indicator in their HIPAA standard transaction 835, (this is the remittance advice that is sent to the provider by the health insurance carrier to let them know how much they have paid for a claim) indicating whether a claim is subject to the BBPA. This will be a cost limited to health insurance carriers.

OIC believes the proposed changes will provide clear information to a provider as to whether a claim is subject to the BBPA, thus making it apparent when a patient cannot be balance billed. This is the key goal of the law and we have established that the cost to carriers is outweighed by the benefit to consumers of protecting them from balance billing. The language clearly identifies those claims that can be put into dispute by providers, reducing provider costs associated with putting a claim into dispute. Please review our analysis below:

2019 Industry NAICS Code	Estimated Cost of Compliance	Industry Description	NAICS Code Title	Average number of employees / business within WA	Minor Cost Estimate - 1% of Avg. Annual Payroll. (0.01*AvgPay)
524114	$500.00	Direct health and medical insurance carriers	Finance and insurance	**118 (*Not small business*)**	$870.29

3. WAC 284-43-050

Subsection (1)(b) requires providers of emergency medical services to give the notice of BBPA consumer rights to patients after receiving emergency medical services. Providers of emergency medical services are hospital emergency rooms, which are not small employers. Consumers must have notice of their rights at meaningful times, and the BBPA protects consumers from balance billing when they're receiving out-of-network emergency medical services.

2019 Industry NAICS Code	Estimated Cost of Compliance (x 5 (small business estimated cost of compliance))	Industry Description	NAICS Code Title	Average number of employees / business within WA	Minor Cost Estimate - 1% of Avg. Annual Payroll. (0.01*AvgPay)
622110	$500	Healthcare and social assistance	**General medical and surgical hospitals**	1624	816.69
622210	$500	Healthcare and social assistance	**Psychiatric and substance abuse hospitals**	155	627.94
622310	$500	Healthcare and social assistance	**Other hospitals**	276	866.82
622	$500	Healthcare and social assistance	**Hospitals**	1198	812.91

4. WAC 284-43B-070:

Subsection (1) clarifies that if a self-funded group health plan opts in to participate in the BBPA, they must let their third party administrator know they've done so. This is de minims cost. Also, it is to be noted that this WAC section does not impose any mandated costs to self-funded insured groups but only gives them an option elect to participate in the BBPA, and thereby provide protections from balance billing to their employees.

Steps taken to reduce the costs of the rule on small businesses:

OIC has determined that the proposed legislation is unlikely to impose disproportionate fiscal impact on small businesses, if any. Since January 1, 2020, OIC has experienced implementation of a new statute. We have heard directly from stakeholders regarding questions and issues related to initial implementation and have revised internal processes to respond to some of these issues. Through rulemaking, OIC has elicited input from stakeholders related to questions or issues that needed clarification in rule – via a CR-101 comment period, distribution of two stakeholder drafts and holding two stakeholder meetings, OIC determined that some modification and clarification of the initial BBPA rules was necessary. We determined key issues and drafted the rule with the goal of minimizing the impact on small businesses. The Rule team's efforts to minimize costs are as follows:

WAC 284-43B-035(1) requires providers who want to submit an arbitration initiation request to use a standardized form specified at Appendix A. This could potentially be a cost savings to providers, as they will have both clear access to what information needs to be provided to OIC, by statute, and a standardized form to provide the information. In addition, prior to this rulemaking, the provider had to figure out the correct carrier contact information to send the arbitration initiation notice to. WAC 284-43B-035(1) establishes a streamlined way for providers to obtain this information – via a website hosted by **OneHealthPort,** Carriers will submit contact information to that website. We believe this will facilitate providers identifying accurate carrier contacts.

WAC 284-43B-035(9) could lead to potential cost savings to providers and carriers. As mentioned above, the proposed rule clarifies "good cause" for purposes of delay in making written submissions to an arbitrator, to facilitate settlement negotiations. OIC has determined that having this opportunity would mean fewer disputes that may go to formal arbitration, which is a considerable cost savings to both health carriers and health care providers. Further, use of a standardized form to report the results of arbitration under proposed WAC 284-43-035(12) simplifies the process and clearly identifies the information that must be submitted by arbitrators to OIC.

It is to be noted that WAC 284-43B-050(2) requires emergency medical services facilities (i.e. hospitals) to send consumers the notice of their rights under the BBPA within 72 hours of the consumer receiving emergency medical services. The rule team has taken steps to clearly outline that this requirement only applies to entities **with more than 50 employees** (and hospitals have more than 50 employees). Although, there is a minimal cost of providing this notice independently, it can be completely annulled by including it in the information that the hospital routinely provides to patients in the emergency room. It is critical that consumers receive notices of their rights at a meaningful time, which means receiving the notice when, or shortly after, they have received services that are subject to the balance billing prohibition.

WAC 284-43B-050(3) can result in cost savings to carriers and providers. The section will allow the notice to be provided electronically if the consumer has opted to receive electronic communications from the carrier or provider, negating the need for paper copies and their associated costs.

Conclusion:

There is always some degree of uncertainty in anticipating what the costs and benefits of adopted rules will ultimately be. That said, within the constraints of our resources, we have attempted to provide estimates that are as accurate as possible by performing a comprehensive analysis that is data-driven and evidence-based.

Based on the analysis from this report, L&I estimates of the total annual compliance cost for different businesses in WA and the Washington State Auditor Minor Cost Threshold Calculator July 2019, OIC establishes the proposed rules do not impose more than minor costs on businesses as defined by RCW 19.85.020(2).

****

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name: Tabba Alam

Address: PO Box 40260, Olympia, WA 98504-0260
Phone: 360-725-7170
Fax:
TTY:
Email: TabbaA@oic.wa.gov
Other:

Date: September 23, 2020	**Signature:**
Name: Mike Kreidler	
Title: Insurance Commissioner	

AMENDATORY SECTION (Amending WSR 19-23-085, filed 11/19/19, effective 12/20/19)

WAC 284-43B-010 Definitions. 1) The definitions in RCW 48.43.005 apply throughout this chapter unless the context clearly requires otherwise, or the term is defined otherwise in subsection 2) of this section.

(2) The following definitions shall apply throughout this chapter:

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

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

c) "De-identified" means, for the purposes of this regulation, the removal of all information that can be used to identify the patient from whose medical record the health information was derived.

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

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

~~e)~~)) f) "Facility" means a hospital licensed under chapter 70.41 RCW or an ambulatory surgical facility licensed under chapter 70.230 RCW.

~~f)~~)) g) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations. A single case reimbursement agreement between a provider or facility and a carrier used for the purpose described in WAC 284-170-200 constitutes a contract exclusively for purposes of this definition un-

der the Balance Billing Protection Act and is limited to the services and parties to the agreement.

~~g)~~)) h) "Median in-network contracted rate for the same or similar service in the same or similar geographical area" means the median amount negotiated for an emergency or surgical or ancillary service for participation in the carrier's health plan network with in-network providers of emergency or surgical or ancillary services furnished in the same or similar geographic area. If there is more than one amount negotiated with the health plan's in-network providers for the emergency or surgical or ancillary service in the same or similar geographic area, the median in-network contracted rate is the median of these amounts. In determining the median described in the preceding sentence, the amount negotiated for each claim for the same or similar service with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider or to the same provider for more than one claim). If no per-service amount has been negotiated with any in-network providers for a particular service, the median amount must be calculated based upon the service that is most similar to the service provided. For purposes of this subsection "median" means the middle number of a sorted list of reimbursement amounts negotiated with in-network providers with respect to a certain emergency or surgical or ancillary service, with each paid claim's negotiated reimbursement amount separately represented on the list, arranged in order from least to greatest. If there is an even number of items in the sorted list of negotiated reimbursement amounts, the median is found by taking the average of the two middlemost numbers.

~~h)~~)) i) "Offer to pay," "carrier payment," or "payment notification" means a claim that has been adjudicated and paid by a carrier to an out-of-network or nonparticipating provider for emergency services or for surgical or ancillary services provided at an in-network facility.

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

~~j)~~)) k) "Provider" means a person regulated under Title 18 RCW or chapter 70.127 RCW to practice health or health-related services or otherwise practicing health care services in this state consistent with state law, or an employee or agent of a person acting in the course and scope of his or her employment, that provides emergency services, or surgical or ancillary services at an in-network facility.

~~k)~~)) l) "Surgical or ancillary services" means surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

AMENDATORY SECTION (Amending WSR 19-23-085, filed 11/19/19, effective 12/20/19)

WAC 284-43B-020 Balance billing prohibition and consumer cost-sharing. (1) If an enrollee receives any emergency services from an out-of-network facility or provider, or any nonemergency surgical or ancillary services at an in-network facility from an out-of-network provider:

(a) The enrollee satisfies his or her obligation to pay for the health care services if he or she pays the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The enrollee's obligation must be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area. The carrier must provide an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing amount determined under this subsection.

(b) The carrier, out-of-network provider, or out-of-network facility, and any agent, trustee, or assignee of the carrier, out-of-network provider, or out-of-network facility must ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection.

(c)(i) For emergency services provided to an enrollee, the out-of-network provider or out-of-network facility, and any agent, trustee, or assignee of the out-of-network provider or out-of-network facility may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under a) of this subsection. This does not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest;

(ii) For emergency services provided to an enrollee in an out-of-network hospital located and licensed in Oregon or Idaho, the carrier must hold an enrollee harmless from balance billing; and

(iii) For nonemergency surgical or ancillary services provided at an in-network facility, the out-of-network provider and any agent, trustee, or assignee of the out-of-network provider may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest.

(d) For emergency services and nonemergency surgical or ancillary services provided at an in-network facility, the carrier must treat any cost-sharing amounts determined under (a) of this subsection paid or incurred by the enrollee for an out-of-network provider or facility's services in the same manner as cost-sharing for health care services provided by an in-network provider or facility and must apply any cost-sharing amounts paid or incurred by the enrollee for such services toward the enrollee's maximum out-of-pocket payment obligation.

(e) If the enrollee pays an out-of-network provider or out-of-network facility an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection, the provider or facility must refund any amount in excess of the in-network cost- sharing amount to the enrollee within thirty business days of the provider or facility's receipt of the enrollee's payment. Simple interest must be paid to the enrollee for any unrefunded payments at a rate of twelve percent per annum beginning on the first calendar day after the thirty business days.

(2) The carrier must make payments for health care services described in ~~section 6, chapter 427, Laws of 2019~~ RCW 48.49.020, provided by an out-of-network provider or facility directly to the provider or facility, rather than the enrollee.

(3) A health care provider or facility, or any of its agents, trustees or assignees may not require a patient at any time, for any procedure, service, or supply, to sign or execute by electronic means,

any document that would attempt to avoid, waive, or alter any provision of this section.

AMENDATORY SECTION (Amending WSR 19-23-085, filed 11/19/19, effective 12/20/19)

WAC 284-43B-030 Out-of-network claim payment and placing a claim into dispute ~~resolution~~)). The allowed amount paid to an out-of-network provider for health care services described under ~~section 6, chapter 427, Laws of 2019~~)) RCW 48.49.020, shall be a commercially reasonable amount, based on payments for the same or similar services provided in the same or a similar geographic area.

(1) Within thirty calendar days of receipt of a claim from an out-of-network provider or facility, the carrier shall offer to pay the provider or facility a commercially reasonable amount. Payment of an adjudicated claim shall be considered an offer to pay. The amount actually paid to an out-of-network provider by a carrier may be reduced by the applicable consumer cost-sharing determined under WAC 284-43B-020 (1)(a). The date of receipt by the provider or facility of the carrier's offer to pay is five calendar days after a transmittal of the offer is mailed to the provider or facility, or the date of transmittal of an electronic notice of payment. The claim submitted by the out-of-network provider or facility to the carrier must include the following information:

a) Patient name;

b) Patient date of birth;

c) Provider name;

d) Provider location;

(e) Place of service, including the name and address of the facility in which, or on whose behalf, the service that is the subject of the claim was provided;

f) Provider federal tax identification number;

(g) Federal Center for Medicare and Medicaid Services individual national provider identifier number, and organizational national provider identifier number, if the provider works for an organization or is in a group practice that has an organization number;

h) Date of service;

i) Procedure code; and

j) Diagnosis code.

(2) If the out-of-network provider or facility wants to dispute the carrier's offer to pay, the provider or facility must notify the carrier no later than thirty calendar days after receipt of the offer to pay or payment notification from the carrier. A carrier may not require a provider or facility to reject or return payment of the adjudicated claim as a condition of putting the payment into dispute.

3) If the out-of-network provider or facility disputes the carrier's offer to pay, the carrier and provider or facility have thirty calendar days after the provider or facility receives the offer to pay to negotiate in good faith.

(4) If the carrier and the out-of-network provider or facility do not agree to a commercially reasonable payment amount within the thirty-calendar day period under subsection (3) of this section, and the carrier, out-of-network provider or out-of-network facility chooses to pursue further action to resolve the dispute, the dispute shall be re-

solved through arbitration, as provided in ~~section 8, chapter 427, Laws of 2019~~)) RCW 48.49.040.

~~5)(a) To initiate arbitration, the carrier, provider, or facility must provide written notification to the commissioner and the noninitiating party no later than ten calendar days following completion of the period of good faith negotiation under subsection 3) of this section. The written notification to the commissioner must be made electronically and provide dates related to each of the time period limitations described in subsections 1) through 4) of this section.~~

~~b) If an out-of-network provider or out-of-network facility chooses to address multiple claims in a single arbitration proceeding as provided in section 8, chapter 427, Laws of 2019, notification must be provided no later than ten calendar days following completion of the period of good faith negotiation under subsection 3) of this section for the most recent claim that is to be addressed through the arbitration. All of the claims at issue must:~~

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

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

~~iii) Occur within a two month period of one another, such that the earliest claim that is the subject of the arbitration occurred no more than two months prior to the latest claim that is the subject of the arbitration. For purposes of this subsection, a provider or facility claim occurs on the date the service is provided to a patient or, in the case of inpatient facility admissions, the date the admission ends.~~

~~c) A notification submitted to the commissioner later than ten calendar days following completion of the period of good faith negotiation will be considered untimely and will be rejected. A party that has submitted an untimely notice is permanently foreclosed from seeking arbitration related to the claim or claims that were the subject of the untimely notice.~~

~~d) Within seven calendar days of receipt of notification from the initiating party, the commissioner must provide the parties with a list of approved arbitrators or entities that provide arbitration. The arbitrator selection process must be completed within twenty calendar days of receipt of the original list of arbitrators from the commissioner, as follows:~~

~~i) If the parties are unable to agree on an arbitrator from the original list sent by the commissioner, they must notify the commissioner within five calendar days of receipt of the original list of arbitrators. The commissioner must send the parties a list of five arbitrators within five calendar days of receipt of notice from the parties under this subsection.~~

~~ii) If, after the opportunity to veto up to two of the five named arbitrators on the list of five arbitrators sent by the commissioner to the parties, more than one arbitrator remains on the list, the parties must notify the commissioner within five calendar days of receipt of the list of five arbitrators. The commissioner will choose the arbitrator from among the remaining arbitrators on the list.~~

~~e) For purposes of this subsection, the date of receipt of a list of arbitrators is the date of electronic transmittal of the list to the parties by the commissioner. The date of receipt of notice from the parties to the commissioner is the date of electronic transmittal of the notice to the commissioner by the parties.~~

~~(6) If a noninitiating party fails to timely respond without good cause to a notice initiating arbitration, the initiating party will choose the arbitrator.~~))

NEW SECTION

WAC 284-43B-035 Arbitration. (1)(a) To initiate arbitration, the carrier, provider, or facility must provide written notification to the commissioner and the noninitiating party no later than ten calendar days following completion of the period of good faith negotiation under WAC 284-43B-030(3) using the arbitration initiation request form found in Appendix A of this rule. When multiple claims are addressed in a single arbitration proceeding, subsection (3) of this section governs calculation of the ten calendar days. Any information submitted to the commissioner with the arbitration initiation request must be included in the notice to the noninitiating party under RCW 48.49.040. A provider initiating arbitration must send the arbitration initiation request form to the email address appearing on the website established by the designated lead organization for administration simplification in Washington state under (c) of this subsection. Any patient information submitted to the commissioner with an arbitration initiation request form must be de-identified to ensure that protected health information is not disclosed.

(b) The written notification to the commissioner must be made electronically and provide dates related to each of the time period limitations described in WAC 284-43B-030 (1) through (3). The commissioner's review of the arbitration initiation request form is limited to the information necessary to determine that the request has been timely submitted and is complete.

(c) Each carrier must provide the designated lead organization for administrative simplification in Washington state with the email address and telephone number of the carrier's designated contact for receipt of notices to initiate arbitration. The email address and phone number provided must be specific to the carrier staff responsible for receipt of notices or other actions related to arbitration proceedings. The initial submission of information to the designated lead organization must be made on or before November 10, 2020. The carrier must keep its contact information accurate and current by submitting updated contact information to the designated lead organization as directed by that organization.

(2) Within ten business days of a party notifying the commissioner and the noninitiating party of intent to initiate arbitration, both parties shall agree to and execute a nondisclosure agreement. The nondisclosure agreement must prohibit either party from sharing or making use of any confidential or proprietary information acquired or used for purposes of one arbitration in any subsequent arbitration proceedings. The nondisclosure agreement must not preclude the arbitrator from submitting the arbitrator's decision to the commissioner under RCW 48.49.040 or impede the commissioner's duty to prepare the annual report under RCW 48.49.050.

3) If an out-of-network provider or out-of-network facility chooses to address multiple claims in a single arbitration proceeding as provided in RCW 48.49.040, notification must be provided no later than ten calendar days following completion of the period of good

faith negotiation under WAC 284-43B-030(3) for the most recent claim that is to be addressed through the arbitration. All of the claims at issue must:

(a) Involve identical carrier and provider or facility parties. A provider group may bundle claims billed using a common federal taxpayer identification number on behalf of the provider members of the group;

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

(c) Occur within a two month period of one another, such that the earliest claim that is the subject of the arbitration occurred no more than two months prior to the latest claim that is the subject of the arbitration. For purposes of this subsection, a provider or facility claim occurs on the date the service is provided to a patient or, in the case of inpatient facility admissions, the date the admission ends.

(4) A notification submitted to the commissioner later than ten calendar days following completion of the period of good faith negotiation will be considered untimely and will be rejected. A party that has submitted an untimely notice is permanently foreclosed from seeking arbitration related to the claim or claims that were the subject of the untimely notice.

(5) Within seven calendar days of receipt of notification from the initiating party, the commissioner must provide the parties with a list of approved arbitrators or entities that provide arbitration. The commissioner will use the email address for the noninitiating party provided on the arbitration initiation request form. The arbitrator selection process must be completed within twenty calendar days of receipt of the original list of arbitrators from the commissioner, as follows:

(a) If the parties are unable to agree on an arbitrator from the original list sent by the commissioner, they must notify the commissioner within five calendar days of receipt of the original list of arbitrators. The commissioner must send the parties a list of five arbitrators within five calendar days of receipt of notice from the parties under this subsection. Each party is responsible for reviewing the list of five arbitrators and notifying the commissioner within three calendar days of receipt of the list if there is a conflict of interest as described in subsection (6) of this section with any of the arbitrators on the list to avoid the commissioner assigning an arbitrator with a conflict of interest to an arbitration.

(b) If, after the opportunity to veto up to two of the five named arbitrators on the list of five arbitrators sent by the commissioner to the parties, more than one arbitrator remains on the list, the parties must notify the commissioner within five calendar days of receipt of the list of five arbitrators. The commissioner will choose the arbitrator from among the remaining arbitrators on the list.

(6) Before accepting any appointment, an arbitrator shall ensure that there is no conflict of interest that would adversely impact the arbitrator's independence and impartiality in rendering a decision in the arbitration. A conflict of interest includes (a) current or recent ownership or employment of the arbitrator or a close family member by any health carrier; (b) serves as or was employed by a physician, health care provider, or a health care facility; (c) has a material professional, familial, or financial conflict of interest with a party to the arbitration to which the arbitrator is assigned.

(7) For purposes of this subsection, the date of receipt of a list of arbitrators is the date of electronic transmittal of the list to the parties by the commissioner. The date of receipt of notice from the parties to the commissioner is the date of electronic transmittal of the notice to the commissioner by the parties.

(8) If a noninitiating party fails to timely respond without good cause to a notice initiating arbitration, the initiating party will choose the arbitrator.

(9) Good cause for purposes of delay in written submissions to the arbitrator under RCW 48.49.040 includes a stipulation that the parties intend to complete settlement negotiations prior to making such submissions to the arbitrator.

(10) If the parties settle the dispute before the arbitrator issues a decision, the parties must submit to the commissioner notice of the date of the settlement and whether the settlement includes an agreement for the provider to contract with the carrier as an in-network provider.

(11) Any enrollee or patient information submitted to the arbitrator in support of the final offer shall be de-identified to ensure that protected health information is not disclosed.

12) The arbitrator must submit to the commissioner:

a) Their decision; and

(b) The information required in RCW 48.49.050 using the form found in Appendix B to this rule.

AMENDATORY SECTION (Amending WSR 19-23-085, filed 11/19/19, effective 12/20/19)

WAC 284-43B-040 Determining whether an enrollee's health plan is subject to the requirements of the act. 1) To implement ~~section 7, chapter 427, Laws of 2019,~~)) RCW 48.49.030 carriers must make information regarding whether an enrollee's health plan is subject to the requirements of chapter ~~427, Laws of 2019,~~)) 48.49 RCW available to providers and facilities by:

a) Using the most current version of the Health Insurance Portability and Accountability Act (HIPAA) mandated X12 Health Care Eligibility Benefit Response (271) transaction information through use of a standard message that is placed in a standard location within the 271 transaction; and

b) Beginning April 1, 2021, using the most current version of the Health Insurance Portability and Accountability Act HIPAA) mandated X12 Health Care Claim Payment and Remittance Advice 835) transaction through compliant use of the X12 industry standard Remark Code N830 to indicate that the claim was processed in accordance with this state's balance billing rules.

2) The designated lead organization for administrative simplification in Washington state((~~,~~)):

a) After consultation with carriers, providers and facilities through a new or an existing workgroup or committee, must post the language of the standard message and the location within the 271 transaction in which the message is to be placed on its website on or before November 1, 2019((~~. This~~));

b) Must post on its website on or before December 1, 2020, instructions on compliant use of the X12 industry standard Remark Code

N830 in the X12 Health Care Claim Payment and Remittance Advice (835) transaction; and

c) Must post on its website on or before December 1, 2020, the information reported by carriers under WAC 284-43B-035 1) .

3) A link to the information referenced in subsection 2) of this section also must be posted on the website of the office of the insurance commissioner.

AMENDATORY SECTION (Amending WSR 19-23-085, filed 11/19/19, effective 12/20/19)

WAC 284-43B-050 Notice of consumer rights and transparency. 1) The commissioner shall develop a standard template for a notice of consumer rights under the Balance Billing Protection Act. The notice may be modified periodically, as determined necessary by the commissioner. The notice template will be posted on the public website of the office of the insurance commissioner.

(2) The standard template for the notice of consumer rights under the Balance Billing Protection Act must be provided to consumers enrolled in any health plan issued in Washington state as follows:

a) Carriers must:

(i) Include the notice in the carrier's communication to an enrollee, in electronic or any other format, that authorizes nonemergency surgical or ancillary services at an in-network facility;

(ii) Post the notice on their website in a prominent and relevant location, such as in a location that addresses coverage of emergency services and prior authorization requirements for nonemergency surgical or ancillary services performed at in-network facilities; and

iii) Provide the notice to any enrollee upon request.

b) Health care facilities and providers must:

(i) For any facility or provider that is owned and operated independently from all other businesses and that has more than fifty employees, upon confirming that a patient's health plan is subject to the Balance Billing Protection Act((~~,~~)):

A) Include the notice in any communication to a patient, in electronic or any other format((~~, confirming the~~)) related to scheduling of nonemergency surgical or ancillary services at a facility. Text messaging used as a reminder or follow-up after a patient has already received the full text of the notice under this subsection may provide the notice through a link to the provider's webpage that takes the patient directly to the notice. Telephone calls to patients following the patient's receipt of the full text of the notice under this subsection do not need to include the notice; and

B) For facilities providing emergency medical services, provide or mail the notice to a patient within seventy-two hours following a patient's receipt of emergency medical services.

(ii) Post the notice on their website, if the provider or facility maintains a website, in a prominent and relevant location near the list of the carrier health plan provider networks with which the provider or facility is an in-network provider; and

iii) Provide the notice upon request of a patient.

3) The notice required in this section may be provided to a patient or an enrollee electronically if it includes the full text of the notice and if the patient or enrollee has affirmatively chosen to

receive such communications from the carrier, provider, or facility electronically. Except as authorized in subsection 2)(b)(i)(A) of this section, the notice may not be provided through a hyperlink in an electronic communication.

4) For claims processed on or after July 1, 2020, when processing a claim that is subject to the balance billing prohibition in ~~section 6, chapter 427, Laws of 2019~~ RCW 48.49.020, the carrier must indicate on any form used by the carrier to notify enrollees of the amount the carrier has paid on the claim:

(a) Whether the claim is subject to the prohibition in the act; and

(b) The federal Center for Medicare and Medicaid Services individual national provider identifier number, and organizational national provider identifier number, if the provider works for an organization or is in a group practice that has an organization number.

~~4)~~)) 5) A facility or health care provider meets its obligation under ~~section 11 or 12, chapter 427, Laws of 2019~~)) RCW 48.49.070 or 48.49.080, to include a listing on its website of the carrier health plan provider networks in which the facility or health care provider participates by posting this information on its website for in-force contracts, and for newly executed contracts within fourteen calendar days of receipt of the fully executed contract from a carrier. If the information is posted in advance of the effective date of the contract, the date that network participation will begin must be indicated.

~~5)~~)) 6) Not less than thirty days prior to executing a contract with a carrier, a hospital or ambulatory surgical facility must provide the carrier with a list of the nonemployed providers or provider groups that have privileges to practice at the hospital or ambulatory surgical facility or are contracted to provide surgical or ancillary services at the hospital or ambulatory surgical facility. The list must include the name of the provider or provider group, mailing address, federal tax identification number or numbers and contact information for the staff person responsible for the provider's or provider group's contracting. The hospital or ambulatory surgical facility must notify the carrier within thirty days of a removal from or addition to the nonemployed provider list. A hospital or ambulatory surgical facility also must provide an updated list of these providers within fourteen calendar days of a written request for an updated list by a carrier.

~~6)~~)) 7) An in-network provider must submit accurate information to a carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier.

AMENDATORY SECTION (Amending WSR 19-23-085, filed 11/19/19, effective 12/20/19)

WAC 284-43B-060 Enforcement. 1) a) If the commissioner has cause to believe that any health facility or provider has engaged in a pattern of unresolved violations of ~~section 6 or 7, chapter 427, Laws of 2019~~)) RCW 48.49.020 or 48.49.030, the commissioner may submit information to the department of health or the appropriate disciplining authority for action.

~~2)~~)) b) In determining whether there is cause to believe that a health care provider or facility has engaged in a pattern of unresolved violations, the commissioner shall consider, but is not limited to, consideration of the following:

~~a)~~)) i) Whether there is cause to believe that the health care provider or facility has committed two or more violations of ~~section 6 or 7, chapter 427, Laws of 2019~~)) RCW 48.49.020 or 48.49.030;

~~b)~~)) ii) Whether the health care provider or facility has failed to submit claims to carriers containing all of the elements required in WAC 284-43B-030(1) on multiple occasions, putting a consumer or consumers at risk of being billed for services to which the prohibition in ~~section 6, chapter 427, Laws of 2019 applies~~ RCW 48.49.020 applies;

~~c)~~)) iii) Whether the health care provider or facility has been nonresponsive to questions or requests for information from the commissioner related to one or more complaints alleging a violation of ~~section 6 or 7, chapter 427, Laws of 2019~~)) RCW 48.49.020 or 48.49.030; and

~~d)~~)) iv) Whether, subsequent to correction of previous violations, additional violations have occurred.

~~3)~~)) c) Prior to submitting information to the department of health or the appropriate disciplining authority, the commissioner may provide the health care provider or facility with an opportunity to cure the alleged violations or explain why the actions in question did not violate ~~section 6 or 7, chapter 427, Laws of 2019~~)) RCW 48.49.020 or 48.49.030.

2) In determining whether a carrier has engaged in a pattern of unresolved violations of any provision of this chapter, the commissioner shall consider, but is not limited to, consideration of the following:

a) Whether a carrier has failed to timely respond to arbitration initiation request notifications from providers or facilities;

b) Whether a carrier has failed to comply with the requirements of WAC 284-43-035 related to choosing an arbitrator or arbitration entity;

c) Whether a carrier has met its obligation to maintain current and accurate carrier contact information related to initiation of arbitration proceedings under WAC 284-43-035;

d) Whether a carrier has complied with the requirements of WAC 284-43-040;

e) Whether a carrier has complied with the consumer notice requirements under WAC 284-43-050; and

f) Whether a carrier has committed two or more violations of chapter 48.49 RCW or this chapter.

AMENDATORY SECTION (Amending WSR 19-23-085, filed 11/19/19, effective 12/20/19)

WAC 284-43B-070 Self-funded group health plan opt in. (1) A self-funded group health plan that elects to participate in ~~sections 6 through 8, chapter 427, Laws of 2019~~ RCW 48.49.020 through 48.49.040, shall provide notice to the commissioner of their election decision on a form prescribed by the commissioner. The completed form

must include an attestation that the self-funded group health plan has elected to participate in and be bound by ~~sections 6 through 8, chapter 427, Laws of 2019~~)) RCW 48.49.020 through 48.49.040 and rules adopted to implement those sections of law. If the form is completed by the self-funded group health plan, the plan must inform any entity that administers the plan of their election to participate. The form will be posted on the commissioner's public website for use by self-funded group health plans.

(2) A self-funded group health plan election to participate is for a full year. The plan may elect to initiate its participation on January 1st of any year or in any year on the first day of the self-funded group health plan's plan year.

(3) A self-funded group health plan's election occurs on an annual basis. On its election form, the plan must indicate whether it chooses to affirmatively renew its election on an annual basis or whether it should be presumed to have renewed on an annual basis until the commissioner receives advance notice from the plan that it is terminating its election as of either December 31st of a calendar year or the last day of its plan year. Notices under this subsection must be submitted to the commissioner at least ~~thirty~~)) fifteen days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

4) A self-funded plan operated by an out-of-state employer that has at least one employee who resides in Washington state may elect to participate in balance billing protections as provided in RCW 48.49.130 on behalf of their Washington state resident employees and dependents. If a self-funded group health plan established by Washington state employer has elected to participate in balance billing protections under RCW 48.49.130 and has employees that reside in other states, those employees are protected from balance billing when receiving care from a Washington state provider.

5) Self-funded group health plan sponsors and their third party administrators may develop their own internal processes related to member notification, member appeals and other functions associated with their fiduciary duty to enrollees under the Employee Retirement Income Security Act of 1974 (ERISA).

NEW SECTION

WAC 284-43B-075 Severability. If any provision of this chapter or its application to any person or circumstance is for any reason held to be invalid by a court, the remainder of this chapter and the application of the provisions to other persons or circumstances shall not be affected.

NEW SECTION

WAC 284-43B-085 Appendix A.

To be completed by OIC	OIC Tracking Number:

Balance Billing Protection Act Arbitration Initiation Request Form

Read the information on the back of the form. Submit completed form to: BBPA_Arbitration@oic.wa.gov

	1. VERIFICATION: ***You must check all applicable boxes or this will be rejected.***
	The patient's plan is regulated by the OIC or is a self-funded group health plan that has elected to participate in the BBPA *(See information on back.)* IF NOT, DO NOT SUBMIT.
	I have attached a copy of the notice of payment that shows **the date(s) of payments** and attest that the most recent date of payment was in the last 40 days. IF IT'S NOT, IT'S UNTIMELY. DO NOT SUBMIT.
	I have not attached anything that requires encryption or password protection.
	If this is a request for multiple claims, I have checked that all the claims involve the same carrier and provider/facility. IF NOT, YOU MUST SUBMIT INDIVIDUAL CLAIMS.
	The other party has been included as a courtesy copied recipient to this emailed request. Their email address has been verified and is the correct contact.

2. DATE CHECK:	
(a) Date of most recent payment – *must be within last 40 days or will be rejected.*	**(b) Date of completion of 30-day** period of good faith negotiation
(c) Date of notice to non-initiating party (notice to initiate arbitration)	**(d) Date(s) of service**. If multiple claims, note the date of service for each claim

3. FILING INFORMATION:

If the person filing the request to initiate arbitration is filing on behalf of a provider, facility or carrier, please provide the following information: Please indicate if you are a legal representative of the filing party.

Name(s):

Address: Telephone: Email:

4. INITIATING PARTY:

The requesting entity is a: [ ] Health care facility *If checked, provide License type:
[ ] Health care provider *If checked, provide Specialty type:
[ ] Carrier/Third Party Administrator

Name(s):

Address: Telephone: Email:

5. NON-INITIATING PARTY:

The non-initiating party is a: [ ] Carrier/third-party administrator [ ] Health care [ ] provider [ ] facility

Name:

Address: Telephone: Email:

6. DESCRIPTION OF HEALTH CARE SERVICES PROVIDED (including any applicable CPT codes):

Description:

7. ADDITIONAL INFORMATION: (if multiple claims, can attach on separate sheet)

(a) Group/plan number(s):

(b) Claim number(s):

(c) Carrier/third party administrator payment amount(s) for each claim:

(d) Initiating party's final offer:

Please review important information on the back of this form prior to submitting this request.

1. This form and any attachments submitted will become public records and are subject to public disclosure laws. Do not provide sensitive or confidential information that is not necessary for the OIC to assign the claim to arbitration (you will have the opportunity to submit relevant information during the arbitration). OIC may dispose of any documents filed that are not necessary to process a claim for arbitration. Personal health information (PHI) disclosed to OIC is not subject to public disclosure under RCW 48.02.068.

2. Only claim payments made in connection with health insurance plans regulated by OIC and self-funded group health plans that have elected to participate in balance billing protections can use the arbitration process. Examples of health insurance plans that are not included are:

- Medicare and Medicaid
- Federal employee benefit plans

Please check the list of self-funded group health plans at https://www.insurance.wa.gov/self-funded-group-health-plans to determine whether a self-funded group health plan has elected to participate in balance billing protections for their members.

3. An out-of-network provider or facility providing emergency, surgical or ancillary services at an in-network facility may submit this request if it is believed that the payment made for the covered services was not a commercially reasonable amount. A carrier or self-funded group health plan that has elected to participate in balance billing protections for its members may also submit a request for arbitration.

4. Upon OIC review and acceptance of a request for arbitration, both the initiating and non-initiating parties will be provided with a list of approved arbitrators and arbitration entities by OIC. If the parties cannot agree on an arbitrator or arbitration entity, OIC will choose one and notify the parties, using the process outlined in WAC 284-43B-035(5). Within 10 business days of the initiating party notifying the commissioner and the non-initiating party of intent to initiate arbitration, both parties must agree to and execute a nondisclosure agreement.

5. Once the arbitrator has been chosen, OIC will send the arbitrator/arbitration entity a copy of the Arbitration Initiation Request Form and both parties will have 30 days to make written submissions to the arbitrator. A party that fails to make timely written submissions without good cause shown will be considered to be in default and will be ordered to pay the final offer amount submitted by the party not in default. They arbitrator also can require the party in default to pay expenses incurred to date in the course of arbitration, including the arbitrator's expenses and fees and the reasonable attorneys' fees of the party not in default.

6. No later than 30 calendar days after the receipt of the parties' written submissions, the arbitrator will: Issue a written decision requiring payment of the final offer amount of either the initiating party or the non-initiating party, notify the parties of its decision, and provide the decision as well as the information described in RCW 48.49.050 regarding the decision to OIC.

NEW SECTION

WAC 284-43B-090 Appendix B.

Please complete the form below and send it with the corresponding Arbitration Initiation Request Form and your decision to BBPA_Arbitration@oic.wa.gov

ARBITRATOR DECISION REPORTING FORM		
ARBITRATOR'S INFORMATION		
Your name and contact Information:		
Date of your decision:	OIC Tracking Number:	
DISPUTE RESOLUTION INFORMATION This information is required under RCW 48.49.050		
Name of carrier:		
Name of health care provider:		
Name and address of the health care provider's employer or business entity in which provider has ownership interest:		
Name and address of the health care facility where services were provided:		
Type of health care services at issue:		
The arbitrator reporting statutory provisions are noted on the back of this form.		

RELEVANT STATUTORY PROVISIONS

RCW 48.49.040

Dispute resolution process—Determination of commercially reasonable payment amount. *(Effective January 1, 2020.)*

... (3)(a) Each party must make written submissions to the arbitrator in support of its position no later than thirty calendar days after the final selection of the arbitrator. The initiating party must include in its written submission the evidence and methodology for asserting that the amount proposed to be paid is or is not commercially reasonable. A party that fails to make timely written submissions under this section without good cause shown shall be considered to be in default and the arbitrator shall require the party in default to pay the final offer amount submitted by the party not in default and may require the party in default to pay expenses incurred to date in the course of arbitration, including the arbitrator's expenses and fees and the reasonable attorneys' fees of the party not in default. No later than thirty calendar days after the receipt of the parties' written submissions, the arbitrator must: Issue a written decision requiring payment of the final offer amount of either the initiating party or the noninitiating party; notify the parties of its decision; and provide the decision and the information described in RCW 48.49.050 regarding the decision to the commissioner.

RCW 48.49.050

Commissioner's annual report on dispute resolution information regarding arbitration over commercially reasonable payment amounts. *(Effective January 1, 2020, until January 1, 2024.)*

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

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

(3) This section expires January 1, 2024.