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 2020-07**

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

Relating to the adoption of

Continued Implementation of the Balance Billing Protection Act rules

November 2, 2020

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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 (Chap. 427, Laws of 2019) – the Balance Billing Protection Act (BBPA). This rule provides additional clarity regarding several issues related to administration of the BBPA 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.

Section 3: Rule Development Process

The CR-101 was filed in the Washington State Register on June 2, 2020 (WSR 20-12-083). The comment period for the CR-101 closed on June 17, 2020.

The Commissioner issued an initial stakeholder draft for comment on July 22, 2020, with an open comment period until August 6, 2020. The Commissioner's staff facilitated a stakeholder meeting on August 5, 2020 via a virtual meeting, due to the COVID-19 pandemic, to discuss the first stakeholder draft. The meeting was attended by representatives of consumers, hospitals, physicians and carriers. Twelve written comments were received.

A second stakeholder draft was released on August 21, 2020, with an open comment period until August 31, 2020. Eleven written comments were received.

On October 7, 2020, the CR-102 was published in the Washington State Register (WSR 20-19-139). The Commissioner accepted comments through October 26, 2020. Four written comments were received.

The Commissioner held a public hearing on the proposed rule text on October 27, 2020; the hearing was administered by Jane Beyer, as a virtual meeting due to the COVID-19 pandemic. Testimony by one person was presented at the hearing.

The CR-103 was submitted to the Code Reviser for adoption on November 2, 2020.

Section 4: Differences between Proposed and Final Rule

The proposal included rules determined by OIC, after receiving extensive stakeholder input, to be necessary to address questions and issues that have arisen during initial implementation of the Balance Billing Protection Act (BBPA) and to ensure that consumers are protected from wrongful balance billing. The proposed rules included 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 the 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.
- Increasing consumers' 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 BBPA.
- The process for self-funded group health plans to elect to participate in the BBPA, including reducing the period of advance notice required to participate or to terminate participation.

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

- The final rule makes a technical clarification to the definition of "de-identified" in WAC 284-43B-010. It references "rule" rather than "regulation".
- The final rule revises the Arbitration Initiation Request Form to make a technical clarification regarding the information needed by OIC to process an arbitration initiation request.

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-eight written comments and suggestions regarding this rule, inclusive of the CR-101, stakeholder drafts and the 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
- Association of Washington Healthcare Plans (AWHP)
- Benjamin Chartock, Associate Fellow, Leonard Davis Institute of Health Economics, University of Pennsylvania
- Cambia
- Coordinated Care
- Evergreen Health
- Kaiser Foundation Health Plan of the Northwest (KP NW)
- Kaiser Permanente of Washington (KP WA)
- Molina
- Northwest Health Law Advocates (NoHLA)
- Premera
- Providence St. Joseph Health
- United HealthCare
- UW Medicine
- Washington State Hospital Association (WSHA)
- Washington State Medical Association (WSMA)

Stakeholder Comments to the CR-101, stakeholder drafts and CR-102

Comment	***OIC Response***
WAC 284-43B-020: Balance billing prohibition and consumer cost-sharing	
Request additional consideration of rulemaking to explicitly state that inpatient stays associated with an out-	The proposed rule was not changed. The BBPA prohibits balance billing for emergency medical services and ancillary or surgical

Comment	***OIC Response***
of-network emergency department are subject to these rules.	services provided at an in-network hospital or ambulatory surgical facility (see RCW 48.49.020). The provision of "emergency medical services", as defined in the BBPA, ends once a patient has been stabilized. OIC does not believe that it has statutory authority to extend BBPA protections to services provided in an out-of-network hospital post-stabilization. RCW 48.43.093(2) addresses authorization and provision of services post-stabilization.
WAC 284-43B-035: Arbitration	
The claims bundling provision should be interpreted to consider a provider group practice to be a "provider" for purposes of bundling claims.	The Commissioner appreciates this comment. WAC 284-43B-035(3) allows a provider group to bundle claims when the provider group has a common federal taxpayer identification number for the providers in a group practice.
With respect to claims bundling for arbitration, "same or related" should be applied to services within the specialty of the provider or the provider's group if it is a single specialty or group of related specialties.	The proposed rule was not changed. RCW 48.49.040(1)(b) allows claims bundling if the claims at issue "involve claims with the same or related current procedural terminology codes relevant to a particular procedure". OIC does not have statutory authority to broaden the type of claims that can be bundled as proposed in this comment.
With respect to claims bundling by a provider group, not all specialty provider groups use a single tax identification number. The rule should be amended to allow group practices that use multiple taxpayer ID numbers to bundle claims.	The proposed rule was not changed. The proposed rule included language clarifying that provider groups can bundle claims. The Department of Health licenses individual practitioners, rather than medical groups or clinics, so a DOH licensure identifier is not available. To define a medical group, the rule uses the provider group's tax identification number for this purpose. The requested amendment would weaken the goal of the rule, which is to define what qualifies as a provider group.

Comment	***OIC Response***
Please clarify that claims under WAC 284-43B-035(3)(c) can't include claims that have exceeded the 10 day timeframe within subsection (1)(a). Each claim that is included in a "bundle" should be required to meet the 10 day window for initiation of arbitration.	The proposed rule was revised to add clarifying language to WAC 284-43B-035(1)(a). When multiple claims are addressed in a single arbitration proceeding, 10 days is measured from the most recent claim. To require that each claim in the bundle be put into dispute individually would defeat the purpose of allowing claim bundling. This would be inconsistent with the statute, which authorizes claims bundling.
The OIC should work with both the health carrier/self-funded plan administrator ("health carrier") and provider groups to certify and finalize the set of claims that are eligible to be arbitrated, before the arbitration begins. The accurate scope of claims should be resolved prior to the arbitration process, with assistance from the OIC.	The proposed rule was not changed. With the addition of WAC 284-43B-040(1)(b) requiring that the HIPAA 835 standard transaction indicate whether a claim was processed in accordance with the BBPA, and access to carrier contact information through OneHealthPort, providers should have the information needed to determine whether a claim is subject to the BBPA and thus to arbitration. A carrier is not precluded from raising the issue as to whether a claim is subject to the BBPA during the period of good faith negotiation under WAC 284-43B-030(3), upon receiving a notice initiating arbitration from a provider or the pending arbitration proceeding.
Allowing OIC to terminate an arbitration based upon whether a claim is subject to the BBPA is potentially problematic. Terminating a petition for arbitration is a consequential decision. At a minimum, the specific circumstances under which arbitration may be terminated by the OIC (i.e. carrier plan type and timeliness) need to be explicitly spelled out in the rule. In the instance the OIC makes a determination that arbitration is not appropriate, there should be an opportunity for the	The proposed rule was not changed. The rule does not allow OIC to terminate an arbitration based upon a determination of whether a claim is subject to the BBPA. As noted above, with the addition of WAC 284-43B-040(1)(b) requiring that the HIPAA 835 standard transaction indicate whether a claim was processed in accordance with the BBPA, and access to carrier contact information through OneHealthPort, providers should have the information needed to determine whether a claim is subject to the BBPA and thus to arbitration.

Comment	***OIC Response***
provider to appeal that determination and provide documentation to support its position. And allowing carriers to petition to arbitrators directly is unnecessary if the process exists through the OIC. Supports the 2nd stakeholder draft removing the allowance for carriers to petition OIC that arbitration be terminated because a claim is not subject to the BBPA.	
Carriers should not be required to include arbitration contact information in the HIPAA 835 standard transaction. OIC or OneHealthPort (OHP) should maintain a list of carrier arbitration contacts on their webpage. There is the need for a centralized website that hosts a list of health carrier contact information whereby providers can easily identify where to send their notice to initiate payment disputes or arbitration to carriers.	The Commissioner appreciates the comment. WAC 284-43B-035(1)(c) provides that OneHealthPort will host a centralized list of carrier arbitration contacts, and requires carriers to provide that information to OneHealthPort so that the list can be available to providers.
With respect to the arbitration contact information that carriers are required to provide to OHP, the rule should provide that the carrier provide "necessary contact information" and should direct that updated information be provided to OHP "as needed" rather than "as directed by" OHP.	The proposed rule was not changed. WAC 284-43B-035(1)(c) requires that the carrier provide an e-mail address and telephone number of the carrier's designated contact for receipt of arbitration initiation requests. This ensures that contact information will be sufficiently specific to meet the goal of the provision. OneHealthPort should have authority to identify the details as to what information is needed and how that information should be provided by carriers in order to meet the goal of the provision.
The initiating party should also be required to enclose a copy of their mandated notice with the arbitration initiation form, so that the OIC can easily verify if the requisite notice was	The proposed rule was not changed. The provider initiating an arbitration request must attest on the Arbitration Initiation Request Form that "the other party has been included as a courtesy copied recipient to this emailed

Comment	***OIC Response***
indeed provided to the other party as attested on the form.	request. Their email address has been verified and is the correct contact."
OIC should clarify the role of third-party entities that act on behalf of provider groups during the dispute process. Guidelines should be established for those entities. They should be required to demonstrate they have authorization to act on behalf of the named provider groups and be required to adhere to confidentiality standards to avoid sharing information among their clients. If the OIC chooses to recognize the ability of third-party entities to act on behalf of provider groups, the regulations should clearly state that separate arbitrations are still required for each provider group, and that consolidation is not permitted simply because a common third-party entity is managing the dispute.	The proposed rule was not changed. The Arbitration Initiation Request Form requires that an entity filing the request identify themselves as filing the request on behalf of a provider, facility or carrier and provide their contact information. Separate arbitrations are required for each provider group. Claims that are bundled for arbitration, under the statute and the rule, must involve identical provider or facility parties. Neither the statute nor the proposed or final rule authorize a third party to bundle claims from multiple provider groups in a single arbitration. Language was added to WAC 284-43B-035(2) to require that the nondisclosure agreement 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. This prohibition extends to entities representing a party.
Allow an extension of the good faith negotiation timeline in the BBPA if both parties agree to attempt further negotiations.	The Commissioner appreciates this comment. OIC does not have statutory authority to extend the period of good-faith negotiation. However, the rule interprets RCW 48.49.040(3) and provides that good cause for 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 submissions to the arbitrator.
Per the provision in the stakeholder draft allowing delay in written submissions to the arbitrator, please provide more clarity regarding how this	Once arbitration has been initiated, OIC is not involved in the proceedings. The OIC does not need to have notice of the parties' decision to engage in continued settlement negotiations.

Comment	*OIC Response*
stipulation would be communicated to the commissioner and how the commissioner would ensure it is by mutual agreement of the parties.	
Request that OIC develop a standard Nondisclosure Agreement template for parties to use during the arbitration process.	Once arbitration has been initiated, OIC is not involved in the proceedings. The parties may choose their own nondisclosure agreement, as long as it meets the requirements of RCW 48.49.040(5).
The Commissioner's annual report on arbitration should include, in addition to the information required in RCW 48.49.050: • If the arbitration was settled by the parties prior to the arbitration decision, • If the arbitration decision was in favor of the carrier • If the arbitration decision was in favor of the facility/provider • Arbitration final offer dollar amounts	WAC 284-43B-035(10) adds language to the rule requiring that the parties submit to OIC notice of the date of any settlement and whether the settlement includes an agreement for the provider to contract with the carrier as an in-network provider. The Arbitration Initiation Request Form includes the final offer amount of the entity initiating arbitration. OIC will consider including settlement information submitted under this rule or other additional information in its report to the legislature under RCW 48.49.050. OIC is reviewing the language and intent of the BBPA and the Washington state Public Disclosure Act.
Recommend that the information in the Commissioner's annual report does not include the specific offer amount that was selected by the arbitrator as this would nullify the intent of the non-disclosure agreement.	Neither the BBPA statute nor the rule reference including the amount of the offer chosen by the arbitrator in the annual report.
In instances where a party is jeopardizing another party's ability to effectively pursue dispute resolution, the provisions of RCW 48.49.040(3)(a) should apply, making the offending party "considered to be in default" and required to reimburse the final offer of the other party, or the billed charge of a	The rule language was not changed. OIC does not have statutory authority to adopt this policy in rule. If a carrier's actions are in violation of the BBPA, OIC has enforcement authority.

Comment	*OIC Response*
provider in instances where a provider group was unable to engage the carrier in dispute resolution.	
WAC 284-43B-040: Determining whether an enrollee's health plan is subject to the requirements of the act.	
There should be no additional requirement on carriers to identify which of their health plans are subject to the BBPA. The current use of the 270/271 HIPAA standard transaction and notice on the enrollee's Explanation of Benefits is sufficient.	The proposed rule was not changed. A consumer's risk of being incorrectly balance billed is greatly reduced if the out-of-network provider has direct information that a service or claim is subject to the protections of the BBPA. The Explanation of Benefits is received by the plan enrollee, and the 270/271 HIPAA standard transaction is not specific to the service provided to a consumer.
The text of language to be included in the HIPAA X12 835 transaction should be that of the N830 Standard Remark Code approved by the X12 national standards organization for use by carriers in states that have surprise billing laws.	The Commissioner appreciates this comment. WAC 284-43-040(1)(b) references use of the N830 Standard Remark Code.
OIC should establish quarterly audits to ensure the BBPA messaging sent by the payers in the HIPAA 270/271 and 835 transactions is accurate. Providers and facilities rely on this information to inform patients.	If a provider believes that a carrier is not complying with requirements related to BBPA messages in these HIPAA transactions, the provider should file a complaint with OIC. OIC will investigate those complaints and take action as needed to ensure compliance by the carrier.
OIC should offer a comprehensive list of all health plans subject to the BBPA.	Thousands of health plans are filed with OIC each year. Under the current rule, carriers already are obligated to note on the HIPAA 270/271 standard transaction whether a health plan is subject to the BBPA. Under this

Comment	*OIC Response*
	rulemaking, carriers also will be required to indicate on the HIPAA 835 standard transaction whether a claim is subject to the BBPA. This is a more effective alternative to OIC including a list of fully insured plans on its website. OIC already includes a list of the self-funded group health plans that have elected to participate in the BBPA on its website.
WAC 284-43B-050: Notice of consumer rights and transparency.	
Reduce the timing of when the Consumer Notice is required to be presented to the patient. Limiting the notice to no more than every quarter provides value without being redundant especially if a patient has frequent visits. If a patient makes multiple appointments in a single day, then only one notice should be issued.	The proposed rule was not changed. Consumers must have notice of their rights at a meaningful time and in a meaningful manner. Having the notice when a procedure is scheduled ensures that this information is provided to consumers at a meaningful time.
Is there an expectation to provide the consumer notice related to receipt of emergency medical services when a consumer is admitted to the hospital from the emergency department, is an "ED boarder" patient, is immediately admitted for surgery/labor & delivery from the ED, is awaiting a psych bed or is transferred to another facility?	Yes. The fact that a consumer has received emergency medical services triggers their right to be protected from balance billing. A consumer may receive services in the emergency department, e.g. evaluation or stabilization, and then be admitted to the hospital or transferred to another facility. The consumer must have timely information needed to understand that they cannot be balance billed for the emergency medical services received, but that they are at risk of being balance billed if they receive care at an out-of-network hospital post-stabilization.
The requirement to provide notice to the consumer following receipt of emergency medical services should be be withdrawn. If retained, the 48 hour	OIC recognizes the challenges associated with a requirement to provide notice to a consumer within 48 hours of receiving emergency medical services. WAC 284-43B-050(2)(b)(i)(A)

Comment	***OIC Response***
requirement will be difficult to meet. The notification requirement should be extended to 10 days following the provision of emergency services. If a patient is admitted to the hospital from the ED, the copy of the BBPA notice of consumer rights should be provided with other required notices upon discharge.	was revised in the proposed rule to state that the notice must be provided or mailed to a patient within 72 hours following a patient's receipt of emergency medical services. A consumer who is admitted to an out-of-network hospital from an emergency department must have notice of their rights prior to discharge. A transfer to an in-network hospital, where balance billing would be prohibited, might be arranged if a consumer is aware of the risk of balance billing.
The notice related to scheduled nonemergency surgical or ancillary services should apply only to written or electronic communication regarding the scheduled procedure and does not include the telephone call where the service is scheduled. To require the scheduling response be accompanied by the notice will cause lags in scheduling communications and unnecessarily delay care.	The rule addresses this concern. WAC 284-43B-050(2)(b)(i)(A) provides that telephone calls to patients after receiving the full notice do not need to include the notice again. In addition, text messages can be used as a reminder or follow-up after a patient has already received the full text of the notice. In this situation, the text message could provide the notice through a link to the provider's webpage.
Requiring that an electronic notice to patients include the entire text of the notice rather than allowing a link to the notice essentially removes texting as a medium for the communication due to the normal 160-character limit for text messages.	The rule was not changed. It is critical that consumers receive full notice of their rights. OIC is also concerned that consumers will not click on a link. People who click on links in text messages can be exposed to scams, downloaded malware, or disclosure of personal information. The FTC and the Washington Attorney General advise people not to click on links in text messages. Any person who follows this advice will not see the consumer notice.
The second stakeholder draft also specifies that hospitals can send electronic notice only in cases where the patient has affirmatively chosen to receive communications electronically. While we understand the reasons for	Where a consumer has affirmatively chosen to receive communication electronically, they will expect to receive notices electronically and thus the notice of rights will be more likely to be recognized and reviewed. Allowing routine provision of an electronic notice when other

Comment	*OIC Response*
these requirements, the effect is that a smaller proportion of the communications will be able to be sent electronically and communication to increased proportion or patients will need to occur through regular mail or paper copy at the time of service.	communication is occurring through paper copies creates too great a risk that a consumer will not review or recognize the notice of their rights.
We greatly appreciate and support the newly-added prohibition on using hyperlinks to convey the notice of balance billing rights. We also appreciate the addition of the language limiting electronic communications to patients and enrollees who have "affirmatively chosen to receive such communications from the carrier, provider or facility electronically." These are both steps in the right direction. However, we are still concerned about the limitations and potential ineffectiveness of the "affirmative choice" provision. Electronic notice can be helpful as a supplement to a written notice, but it should not be a replacement. Electronic notice may not be effective in reaching a patient.	The proposed rule was not changed. OIC's goal is to ensure that consumers receive notice of their rights at a meaningful time and in a meaningful manner. If a consumer affirmatively chooses to receive communication from a carrier, provider or facility electronically, that consumer is choosing their most effective method of communication. This approach balances the consumer's preferences, effective delivery of the notice of their rights and administrative efficiency.
The notice of balance billing rights should be provided to all patients whose plans are subject to the BBPA, rather than limiting this notice to those at facilities that are "owned and operated independently from all other businesses and that [have] more than fifty employees." Notice of these rights is important and should go to all patients, even when a provider can't determine whether they are covered.	The proposed rule was not changed. BBPA protections apply to consumers who have received emergency medical services at a hospital, and to consumers who receive nonemergency surgical or ancillary services at an in-network hospital or ambulatory surgical facility. Under WAC 284-43-050(2)(b), the consumer notice must be provided in communication related to scheduling of nonemergency surgical or ancillary services at a facility when a provider or facility has more than fifty employees. The average number of employees at hospitals in Washington state is 1198. Thus, consumers protected by the BBPA are very likely to receive notice of their rights.

Comment	*OIC Response*
WAC 284-43B-060: Enforcement	
The same standard of what constitutes a "pattern" of violations imposed on facilities and providers under WAC 284-43B-060 should be extended to carriers, i.e. two or more violations potentially constituting a pattern.	The Commissioner appreciates the comment. The rule adds language to WAC 284-43B-060 detailing the actions that OIC will consider in determining whether a carrier has engaged in a pattern of unresolved violations of the BBPA. The commissioner must consider situations in which a carrier has engaged in two or more violations of the BBPA statute or rules.
Would appreciate an opportunity in the future to establish a definition of "pattern" that is defined as two or more violations.	The language of the rule provides that the Commissioner "will consider" whether two or more violations establish a pattern of unresolved violations. The Commissioner can consider other circumstances in determining whether a pattern is present.
WAC 284-43B-070: Self-funded group health plan opt-in	
The rule should tie the initiation or termination of participation in the BBPA to the self-funded group health plan's plan year only, or to January 1 if the plan's third party administrator permits that. The current system, i.e. January 1 or plan year, creates confusion and difficulty administering the benefit, as groups, health carriers and TPAs are tracking multiple dates. This policy could be applied prospectively.	The rule was not changed. The opportunity for self-funded group health plans to elect to participate in the BBPA expands the number of Washington state residents that can be protected from balance billing. Given the importance of these protections to consumers, the opportunity to elect to participate on a calendar year or plan year basis is retained.
Self-funded health plans should have the opportunity to begin their participation on either a calendar year or plan year basis.	The Commissioner appreciates this comment. The options are retained.
The 30 day advance notice requirement for self-funded group health plans to	The Commissioner appreciates this comment. The rule reduces the 30 day advance notice

Comment	*OIC Response*
notify OIC of their election to participate in the BBPA is resulting in delayed access for some Washington consumers to the important protections under the BBPA. Recommend that OIC allow for exceptions to that requirement.	requirement to 15 days to provide greater opportunity for self-funded group health plans to elect to provide BBPA protections to their members.
The addition of WAC 284-43B-070(4) may expand the scope of the Balance Billing Protection Act beyond its original intent, which was to protect Washington consumers enrolled on Washington issued health plans from balance billing by Washington providers. For this reason alone, we recommend OIC remove this provision entirely. Additionally, this provision would create administrative challenges for the third-party administrators of the out-of-state self-funded employer health plans.	The proposed rule was not changed. RCW 48.49.003 provides that it is the intent of the legislature to ban balance billing of consumers enrolled in fully insured health plans, public employee health plans and to provided self-funded group health plans with an option to elect to be subject to provisions of the BBPA. RCW 48.49.140 provides that the BBPA should be liberally construed to promote the public interest by ensuring that consumers do not receive additional bills from providers under the circumstances described in RCW 48.49.020. Allowing a self-funded group health plan operated by an out-of-state employer to protect its Washington state employees from balance billing is consistent with the intent of the BBPA. OIC assumes that an employer sponsoring a self-funded plan will have had an opportunity to work with its third party administrator to implement these protections for its employees.
Request that OIC opt-in process generate an e-mail to the submitter confirming the submission.	The operational process by which self-funded group health plans opt-in to BBPA participation is not addressed in this rule. OIC will review this request.
We recommend OIC revise the opt-in form to allow for a comments section in order to identify any specific health plans under a self-funded employer group that are opting out	The operational process by which self-funded group health plans opt-in to BBPA participation is not addressed in this rule. OIC will review this request.
It would be helpful for the OIC to send notice of receipt of a plan sponsor's	The Commissioner appreciates this comment. The rule adds language to WAC 284-43-070(1)

Comment	*OIC Response*
election form to the carrier, health plan, or third-party administrator.	noting that if a self-funded group health plan submits its election to participate to OIC directly, the plan must inform their third party administrator of their election to participate.
We appreciate the clarification that in the stakeholder draft that election by a self-funded health plan operated by an out of state employer only applies to enrollees of that group that are Washington state residents. We also appreciate the clarification that election by a self-funded in-state employer also applies to out of state residents that receive care from Washington state employers. We believe this is the correct interpretation and application of the BBPA but will be more challenging for hospitals and providers to administer. Because the BBPA applies differently to enrollees of in-state and out of state self-funded employer groups, is crucial that providers are able to determine whether the electing self-funded group in sponsored by an in-state or out of state employer.	The operational process by which self-funded group health plans opt-in to BBPA participation is not addressed in this rule. OIC will review this request.
Appendix A: Arbitration Initiation Request Form	
Support use of a standardized form to initiate arbitration. This will enhance the efficiency of the process. Request that the form retain the ability of providers and carriers to include any additional information they believe relevant.	The Commissioner appreciates the comment.
The information requested in sections 7(C) and (D) of the Arbitration Initiation Request Form is highly sensitive. The payment information outlined in sections 7(C) and (D) could give competitors, providers, and others	RCW 48.49.040(1)(a) requires that the notification to the noninitiating party must state the initiating party's final offer. That information must be included in the AIRF. The information in item 7(c) is not necessary to OIC's processing of the arbitration initiation

Comment	*OIC Response*
insights into a carrier's rates, which could result in an advantage during business negotiations. The rule should make clear that this information will be redacted before publicly releasing the form.	and has been removed from the form in the final rule. Unless explicitly exempted in statute, the form and any attachments submitted are subject to public disclosure laws. Personal health information (PHI) disclosed to OIC is not subject to public disclosure under RCW 48.02.068.

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 by OIC to have violated the requirements of these rules, when a health professional is determined by the applicable disciplinary authority to have violated the requirements of the statute or when a health care facility is determined by the Washington State Department of Health to have violated the requirements of the statute.

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

OIC has developed a BBPA website that has extensive information for carriers, health care providers and facilities, consumers and self-funded group health plans. The information on the website is consistent with the terms of the BBPA and rules adopted to implement the act.

OIC Policy staff will distribute the final rule and the Concise Explanatory Statement (CES) to all interested parties by posting and sharing the documents through the OIC's standard rule making listserv and emailing the documents to stakeholder participants. The OIC Rules Coordinator will post the CR-103 documents on the OIC's website.

OIC also has developed a listserv to receive updates on BBPA implementation that includes over two thousand participants. All of these individuals and organizations have received GovDelivery notices regarding this rulemaking.

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.

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 or 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 Rulemaking

Matter No. R2020-07

Topic of Rulemaking: Continued Implementation of the Balance Billing Protection Act

This memorandum summarizes the hearing on the above-named rule-making, held on October 27, 2020, via a virtual meeting over which I presided in your stead.

The following agency personnel were present: Darryl Colman, Ellen Range, Jennifer Kreitler and Julia Eisentrout.

In attendance and testifying:

- Cheryl Sullivan, UW Medicine

In attendance and not testifying:

- Clifton Able, Aetna
- Randy Adair, Providence
- Zachary Brunnet
- Andrew Busz, Washington State Hospital Association
- Merlene Converse, Kaiser Foundation Health Plan of the Northwest
- Jane Douthit, Regence Blue Shield
- Tayra Dunn
- Sean Graham, Washington State Medical Association
- Megan Howell, Premera
- Meg Jones, PacificSource
- Julie Mitchell, Lakeside Milam
- Samuel Morones, Coordinated Care
- Todd Reno, SupportMed
- Amber Rivera, Molina HealthCare
- Travis Sanders, Premera

- Mel Sorensen
- Melissa Thammavongsa, Molina Health Care
- Simon Vismantis, Kaiser Fdn Health Plan of Washington

Contents of the presentations made at hearing:

Ms. Sullivan testified on one aspect of the proposed rule:

- When a medical provider is communicating with a patient related to scheduling nonemergency surgical or ancillary services at a facility by text message, can the provider send a link to a UW Medicine webpage versus a PDF document to alleviate concerns about clicking on a link?

The hearing was adjourned.

SIGNED this 27th day of October 2020

s/
Jane Beyer, Presiding Official