Chapter 284-43B WAC
BALANCE BILLING

Last Update: 11/2/20

WAC

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 rule, 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.

(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)).

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

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

(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.

(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.

(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.

(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.

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

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-010, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-010, 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 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.

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-020, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-020, filed 11/19/19, effective 12/20/19.]

WAC 284-43B-030 Out-of-network claim payment and placing a claim into dispute. The allowed amount paid to an out-of-network provider for health care services described under 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 resolved through arbitration, as provided in RCW 48.49.040.

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-030, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-030, filed 11/19/19, effective 12/20/19.]

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.

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-035, filed 11/2/20, effective 12/3/20.]

WAC 284-43B-040 Determining whether an enrollee's health plan is subject to the requirements of the act. (1) To implement RCW 48.49.030 carriers must make information regarding whether an enrollee's health plan is subject to the requirements of chapter 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;

(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.

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-040, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-040, 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 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 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.

(5) A facility or health care provider meets its obligation under 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.

(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.

(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.

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-050, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-050, 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 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.

(b) In determining whether there is cause to believe that a health care provider or facility has engaged in a pattern of unre-

solved violations, the commissioner shall consider, but is not limited to, consideration of the following:

(i) Whether there is cause to believe that the health care provider or facility has committed two or more violations of RCW 48.49.020 or 48.49.030;

(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 RCW 48.49.020 applies;

(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 RCW 48.49.020 or 48.49.030; and

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

(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 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.

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-060, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-060, 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 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 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 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).

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-070, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-070, filed 11/19/19, effective 12/20/19.]

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.

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-075, filed 11/2/20, effective 12/3/20.]

WAC 284-43B-080 Effective date. Chapter 284-43B WAC takes effect on January 1, 2020.

[Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-080, filed 11/19/19, effective 12/20/19.]

WAC 284-43B-085 Appendix A.

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

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) 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.

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-085, filed 11/2/20, effective 12/3/20.]

WAC 284-43B-090 Appendix B.

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

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.

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-090, filed 11/2/20, effective 12/3/20.]