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. R2022-02

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

Relating to Implementation of E2SHB 1688 –
Balance Billing Protection Act and the No Surprises Act

December 12, 2022

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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 Commissioner is adopting rules relating to implementation of E2SHB 1688 (Chap. 283, Laws of 2022). The law amends state law related to health carrier coverage of emergency services, the Balance Billing Protection Act (BBPA) and network access provisions for services subject to the balance billing prohibition under the BBPA. Rulemaking is necessary to revise the Independent Review Organization rules at chapter 284-43A WAC, the Balance Billing Protection Act rules at chapter 284-43B WAC and OIC network access rules at chapter 284-170 WAC to be consistent with the new law. The rules will facilitate implementation of the law changes by ensuring that all affected entities understand their rights and obligations under the new law.

Section 3: Rule Development Process

The CR-101 for this rulemaking was filed in the Washington State Register on May 3, 2022 (WSR 22-10-078). The comment period for the CR-101 closed on May 31, 2022. Seven comments were received.

A first pre-publication draft was released on July 29, 2022. Comments were due by August 12, 2022. An interested parties meeting was held on August 8, 2022. Nine written comments were received on the first pre-publication draft.

A second pre-publication draft was released on September 2, 2022. Comments were due by September 13, 2022. Seven written comments were received on the second pre-publication draft.

The CR-102 for this rulemaking was published in the Washington State Register (WSR 22-21-127) on October 18, 2022. The Commissioner accepted comments through November 28, 2022. Five written comments were received on the CR-102.

The Commissioner held a public hearing on the proposed rule text on November 29, 2022; the hearing was administered by Jane Beyer as a virtual meeting due to the COVID-19 pandemic. Testimony was presented by Sean Graham, on behalf of the Washington State Medical Association.

The CR-103 was submitted to the Code Reviser for adoption on December 19, 2022.

Section 4: Differences Between Proposed and Final Rule

The proposal included rules relating to implementation of E2SHB 1688 (Chap. 263, Laws of 2022). It included necessary amendments to current rules related to the Balance Billing Protection Act and OIC network access standards so that OIC rules would align with the newly enacted statute. The proposal also addressed expanded coverage of behavioral health emergency services consistent with the newly enacted statute.

The final rule differs from the rule proposed in the CR-102 filing in the following respects:

- In WAC 284-43B-020, references to “emergency behavioral health services facilities” were corrected to read “emergency behavioral health services providers” to be consistent with the term defined in RCW 48.43.005.

- In WAC 284-43B-050(2)9b)(ii), the term “emergency behavioral health services provider” is corrected to read “behavioral health emergency services provider”.

- The Arbitration Initiation Request Form in WAC 284-43B-085 – Appendix A was modified to remove reference to attaching separate sheets. This revision makes the form in rule consistent with the electronic submission requirement in WAC 284-43B-035(1).

- In WAC 284-170-210(2)(b)(iii), the semicolon at the end of that subsection was changed to a period to correct punctuation.

- In WAC 284-170-210(3), the “alternate access delivery request” reference is corrected to read “alternate access delivery system”.

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

Section 5: Responsiveness Summary

The OIC received a total of twenty-eight written comments and suggestions regarding R 2022-02, inclusive of the CR-101, two pre-publication 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 made changes to the proposed rule as a result of the comments.

The OIC received comments from:

- Association of Washington Healthcare Plans
- Cambia Health Solutions
- Coordinated Care Corporation
- Delta Dental of Washington
- Kaiser Permanente
- Molina Healthcare of Washington
- Northwest Health Law Advocates
- PacificSource Health Plans
- Patient Coalition of Washington
- Premera
- Skagit Regional Health
- UW Medicine
- Washington State Hospital Association
- Washington State Medical Association
- Kathy Wilmering

Comments received to the CR-101, pre-publication drafts and CR-102

Comment	*OIC Response*
General comments	
The proposed language throughout this rule when mandating a requirement to be met within a certain timeframe measures the timeframe in either calendar days or business days. The lack of consistency in using one standard is going to cause greater confusion for carriers, providers, and enrollees. The commentor recommends that OIC adopt one standard for measuring timeframes.	OIC appreciates this comment. The final rule does not adopt one standard for measuring timeframes ("calendar" or "business" days) because it must align with the statute authorizing the rulemaking. The statute uses both terms to measure various time limitations and the rule is consistent with the statutory language.
The commentor expressed appreciation for OIC's leadership in last session's E2SHB 1688. They support OIC in the overall tone of the first prepublication rule draft, which hews closely to E2SHB 1688 while implementing the statute with an eye toward consumer protection, as the Legislature intended.	The Commissioner appreciates this comment.
Definitions **WAC 284-43A-010**	
By defining carrier action related to balance billing as an adverse benefit determination, the proposed amendment triggers notice requirements to members by carriers of their rights to appeal an adverse benefit determination. However, RCW 48.49.020 does not involve activities of carriers. The rule needs to clarify what action and at what point in time the need to inform the enrollee of their rights to appeal the adverse benefit determination.	OIC appreciates this comment. E2SHB 1688 includes numerous duties of carriers with respect to their enrollees. Examples were added to the definition of "adverse benefit determination" specific to actions taken by carriers under the Balance Billing Protection Act (hereinafter BBPA) or the No Surprises Act (hereinafter NSA).
The commentor appreciates the examples added to the definition of "adverse benefit determination" in the 2nd pre-publication draft.	OIC appreciates this comment.

Comment	*OIC Response*
Definitions **WAC 284-43B-010**	
The facility definition in subsection (h) should reference relevant federal NSA definitions to ensure alignment. Accordingly, the following language is recommended: "(h) "Facility" or "health care facility" means: (i) With respect to the provision of emergency services, a hospital or freestanding emergency department licensed under chapter 70.41 RCW (including an "emergency department of a hospital" or "independent freestanding emergency department" described in section 2799A-1(a)of the public health service act (42 U.S.C. Sec. 300gg-111(a)) and 45 C.F.R. Sec. 149.30) or a behavioral health emergency services provider; and (ii) With respect to provision of non-emergency services, a hospital licensed under chapter 70.41 RCW, a hospital outpatient department, a critical access hospital or an ambulatory surgical facility licensed under chapter 70.230 RCW, including a "health care facility" described in section 2799A-1(b) of the public health service act (42 U.S.C. Sec. 300gg-111(b)) and 45 C.F.R. Sec. 149.30."	OIC appreciates this comment. The requested language was added to the definition of "facility" in the final rule.
Definition of "certain participating facilities". The commentor recommends that OIC include a definition of "certain participating facilities" in WAC 284-43B-010 to read as follows: "For the purposes of this section, certain participating facilities means hospitals and ambulatory surgical centers that are providing services set forth in Ch 48.49 RCW."	OIC appreciates this comment. The final rule does not include the recommended language. The final rule defines "facility" at WAC 284-43B-010(h) and incorporates the definition of that term under the NSA. The recommended language could be interpreted as narrower than the current definition of facility in both state and federal statute and could limit consumer protections from balance billing.

Comment	*OIC Response*
The commentor recommends that the OIC add definitions of the following terms to enhance understanding of the requirements of the law and this rule: 1. Outpatient observation 2. Outpatient stay 3. Stabilization	OIC appreciates this comment. The final rule does not include definitions of these terms. The term "stabilize" is defined in the NSA. §2799A-1/42 USC 300gg-111(3)(j) provides that "stabilize" has the meaning given in §1867(e)(3) of the Social Security Act (42 USC 1395dd(e)(3)). The definition of "emergency services" in RCW 48.43.005 also refers to the definition in the Medicare statute. The NSA sets a minimum bar for consumer protection. If definitions of the requested terms are imbedded in WAC, there is a risk that state law definitions would be narrower than a future federal rule or guidance issued by the federal agencies responsible for NSA implementation, which include the HHS Centers for Medicare and Medicaid Services (CMS), the Department of Labor (DOL) and the Treasury Department. Any conflict between state and federal law that reduces consumer protections would be preempted by the NSA.
Section 2(c) defines the term "balance bill." The commenter suggests that the term "permitted cost-sharing" could be confusing without further definition and recommends remedying the issue by adding a cross-reference to WAC 284-43B-020, which establishes parameters for consumer cost-sharing.	OIC appreciates this comment. The final rule includes a cross-reference to WAC 284-43B-020 in the definition of "balance bill".
Definition of "hospital outpatient department" The draft rule adds a new definition to WAC 284-43B-010, "outpatient hospital department," that is inconsistent with how the term is defined by HCA, CMS and DOH. As written, this definition could include any site that is affiliated with a hospital system and greatly expands the obligations of hospitals and systems beyond what currently exists	OIC appreciates this comment. The final rule retains a definition of "hospital outpatient department" but narrows it somewhat to address concerns expressed by the commentors. Neither the NSA statute nor federal rules define the term "outpatient hospital department", yet the balance billing protections of the BBPA and NSA apply to hospital services, both inpatient and

Comment	*OIC Response*
under the BBPA and NSA. The definition is overly broad and captures clinics and other non-hospital settings that are not subject to the BBPA or the NSA. Under current law and rule, only sites that are licensed as departments of the hospital and meet specific CMS requirements meet the definition of and are treated as hospital-based departments. Sites that meet these requirements are authorized to bill as hospital departments, which may include a facility billing. However, not all sites and clinics that are affiliated with hospitals are set up this way. Many are not licensed as departments of a hospital, and bills are paid as freestanding clinics or sites and should not be subjected to the same requirements as hospitals or ASC facilities. A federal CMS identifier number or national provider identifier (NPI) that matches that of a hospital is generally a reliable indicator of hospital-based status. However, the fact that a site has the same federal tax ID number as a hospital is not a reliable indicator of hospital-based status. Using a hospital's federal tax identification number in the definition will result in freestanding sites of a hospital or hospital system being subjected to different rules than freestanding sites operated by other entities. If outpatient hospital department must be defined for purposes of the BBPA, it should be consistent with how the term is defined elsewhere, such as RCW 70.01.040 and 42 CFR §413.65. The definition should be revised as follows: (i) "Hospital outpatient department" means an entity or site that is licensed	outpatient. Given the variety of ownership and licensure arrangements between hospitals and other provider entities, an outpatient department of a hospital may not be located on a hospital campus. This can cause considerable confusion for consumers with respect to whether they could be subject to balance billing or receive an additional facility fee billing. A definition of "hospital outpatient department" is needed to protect consumers. The law should prevent any situation in which a consumer could be exposed to both balance billing and payment of a facility fee associated with receiving outpatient care. The definition in the final rule is limited to hospital ownership/licensure and other relationships in which the outpatient service is financially integrated into that of the hospital.

Comment	*OIC Response*
as a hospital department and provides outpatient hospital services, that a patient may reasonably expect is part of a hospital ~~or hospital system~~, including: (i) An entity that is a provider-based facility under 42 CFR §413.65; (ii) An entity that is licensed as a hospital department and provides hospital services with consumer-facing indicia of affiliation with a hospital ~~or hospital system~~, including but not limited to: (A) Signage indicating an affiliation with a hospital or hospital system; (B) Charging ~~Inclusion of~~ a hospital facility fee in any billing associated with the receipt of outpatient services from the entity; or (C) ~~Scheduling from a central office associated with a hospital or hospital system; or~~ ~~(D)~~ Billing under a hospital's federal Center for Medicaid and Medicare Services billing identifier.	
WAC 284-43B-010(2)(h). Definitions – Facility. We strongly support the OIC in retaining and refining language which clarifies that freestanding emergency departments, hospital outpatient departments and other types of hospital-related settings are subject to balance billing requirements for facilities. This is consistent with both the intent and language of the NSA and the BBPA. As health care settings grow more varied in our state, it is critical for patients to have a clear and consistent expectation of their balance billing rights throughout their experience with a given hospital system. As the draft rule recognizes, consumers should have balance billing protections whenever they might reasonably view a health care setting as part of a hospital or hospital system due to consumer-facing indicia of affiliation, such as signage, shared billing, or facility fees.	OIC appreciates this comment. As explained above, the language adopted in the final rule was narrowed to reflect hospital ownership/licensure and other relationships in which the outpatient service is financially integrated into that of the hospital. OIC understands the concerns expressed by the commentor regarding the challenges in consumer understanding of the varied financial and operational arrangements that exist between hospitals and outpatient service providers. The definition in the final rule focuses on hospital ownership/licensure and other relationships in which the outpatient service is financially integrated into that of the hospital.

Comment	*OIC Response*
The rule should retain language in the definition of outpatient hospital department that would protect consumers from balance billing whenever they might reasonably view an outpatient setting as part of a hospital system due to "consumer-facing indicia of affiliation" such as signage or shared scheduling. The onus should not be on a consumer to understand the corporate structure or specific licensure of a health care setting which holds itself out to be affiliated with a hospital to the public. Please retain the current approach in the final proposed rule.	
Coverage of emergency services WAC 284-43B-015	
The proposed language in subsection (2) of the 1st pre-publication draft provides that a carrier cannot require transfer of an enrollee receiving poststabilization care to a participating facility. The legislative changes to RCW 48.43.093 do not include this prohibition. Instead, the legislation requires notice of stabilization (RCW 48.43.093(3)). Once the patient's medical condition has been stabilized the carrier should be permitted to review the needs of the patient and transfer the patient's care to its network providers and facilities for ongoing treatment. This is particularly important for post discharge for ongoing treatment. Part of managing care for a patient includes ensuring the patient is treated at a facility that is credentialed and understands the clinical criteria and processes of the plan to ensure that covered services are available, and care criteria are met.	OIC appreciates this comment. The final rule does not include the prohibition on a carrier requiring transfer of an enrollee received post-stabilization care to a participating facility. However, it does include the following language at WAC 284-43B-015(2): "Regardless of such notification, payment and cost-sharing for poststabilization services provided by a nonparticipating facility, provider or behavioral health emergency services provider and dispute resolution related to those services are governed by RCW 48.49.040 and RCW 48.49.160." This language is included to clarify that post-stabilization care is now considered part of emergency services and is protected from balance billing under both state and federal law. A consumer's billing for these services would be at in-network deductible or cost-sharing levels.

Comment	*OIC Response*
While the member is held harmless from balance billing for poststabilization care, the carrier is obliged to pay billed charges for the length of stay after an admission for an emergency condition. The language could be interpreted to bar hospital to hospital transfers for higher level care under EMTALA even when in the member's best interest.	
In the second prepublication draft, OIC has removed the language "A carrier cannot require transfer of an enrollee receiving post-stabilization care to a participating facility." OIC has retained the reference requiring notification of stabilization or inpatient admission, as described by RCW 48.43.093, and language that requires provider payment for such post-stabilization care to be governed by balance billing laws. However, the second prepublication draft does not clearly articulate the *consumer-facing* expectations in this scenario. As currently written, it is unclear that even after the carrier receives notification of stabilization or inpatient admission at a nonparticipating facility/provider, the consumer may choose to remain at the nonparticipating facility for post-stabilization services, with cost-sharing for such services governed by balance billing laws. That is the result that is required by WA's policy to prohibit patient waivers of balance billing protections. OIC could rectify this concern with the following edit to this section. "A carrier may require notification of stabilization of inpatient admission of an enrollee as provided in RCW 48.43.093. <u>Regardless of such notification, payment and cost-sharing for post-stabilization services provided by a nonparticipating facility, provider or</u>	OIC appreciates this comment. The final rule includes the recommended language at WAC 284-43B-015(2). This language is included to clarify that post-stabilization care is now considered part of emergency services and is protected from balance billing under both state and federal law. A consumer's billing for these services would be at in-network deductible or cost-sharing levels.

Comment	*OIC Response*
behavioral health emergency services provider and dispute resolution related to those services are governed by RCW 48.49.040 and RCW 48.49.160.**"**	
Balance billing prohibition and consumer cost-sharing WAC 284-43B-020	
The language in WAC 284-43B-020(1)(a) needs revision to simplify and clarify how an enrollee's cost-sharing must be calculated and be consistent with the provisions of the NSA. If this change is not made, insured enrollees could be subjected to higher cost-sharing as a result of the BBPA than uninsured counterparts who need only pay billed charges. The following changes to this subsection are recommended: "The enrollee's obligation must be calculated as if the total amount charged for the services were equal to the ~~qualifying payment amount, or in the case of air ambulance services~~ the lesser of the qualifying payment amount or the billed ~~charges~~ amount, determined using the methodology for calculating the qualifying payment amount, as determined under sections 2799A-1 and 27991-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and federal regulations adopted to implement those provisions of P.L. 116-260."	OIC appreciates this comment. While the "lesser of" standard as between the qualifying payment amount and billed charges is included in the NSA, the final rule applies this standard to all services subject to the BBPA other than behavioral health emergency services. RCW 48.49.030(1)(a) specifically addresses the enrollee's obligation to pay for emergency services provided by a behavioral health emergency services provider, and states as follows: "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 methodology for calculating the qualifying payment amount as described in 45 C.F.R. Sec. 149.140 as in effect on March 31, 2022." This language differs from that in RCW 48.49.020(1), which provides that payment for emergency services provided to an enrollee, nonemergency services performed by nonparticipating providers at certain participating facilities or air ambulance services, "is subject to the provisions of sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022". Because the BBPA is considered a "specified state law" under the NSA, an enrollee's cost-sharing is calculated based on the amount determined in the specified state law (See 45 CFR §149.30). For emergency services provided by emergency behavioral health

Comment	*OIC Response*
	service facilities, the standard for calculating consumer cost-sharing is the qualifying payment amount, as required in RCW 48.49.030(1).
A commentor asked what kind of cost-sharing applies if the consumer has a copay structure to their in-network plan design – would the QPA or billed charges be used to calculate cost-sharing for services subject to the BBPA in that instance, or would the in-network copay amount apply? The commentor believes the latter is the correct reading.	OIC appreciates this comment and agrees that the consumer's cost-sharing would be the fixed in-network cost-sharing amount. RCW 48.49.020(2) provides that payment for services subject to the BBPA is subject to the provisions of sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022, with certain exceptions not applicable here. 45 CFR §149.110 and 45 CFR §149.120 both prohibit a carrier from imposing cost-sharing requirements that are greater than the requirements that would apply if the services were provided by a participating provider. Where a fixed dollar copayment is the amount specified in an enrollee's health plan contract, that amount does not require calculation of the lesser of the qualifying payment amount or billed charges.
The commentor supports language in the prepublication draft that continues to protect consumers from excess cost-sharing and prohibit providers from asking consumers to "waive" these protections.	OIC appreciates this comment.
As currently written, Subsection (1)(a) replaces the BBPA methodology for determining consumer cost-sharing with the NSA's "qualifying payment amount" (QPA) methodology. Though we agree with this change, we are aware there is uncertainty with respect to pending federal litigation over the QPA. We suggest that OIC could address this uncertainty by adding language that clarifies that if the QPA is invalidated at	OIC appreciates this comment. OIC understands the uncertainty related to federal litigation. The agency will monitor ongoing litigation and consider changes to the rule in the future, if necessary.

Comment	*OIC Response*
a federal level, OIC will revert to the existing BBPA methodology for determining consumer cost-sharing.	
As currently written, Subsection (1)(e) appears to suggest that the provider should only pay 1% interest for each month that passes after the excess cost-sharing. That is inconsistent with the statute, which does not include a concept of "per annum" and instead simply says "Interest must be paid to the enrollee for any unrefunded payments at a rate of 12 percent beginning on the first calendar day after the 30 business days." RCW 48.49.020(2)(c). OIC should read the statute more plainly, which would require the provider/facility to repay the consumer with an additional 12% interest for each month (30 days) that passes after the excess billing.	OIC appreciates this comment. The language of the adopted rule has been modified to align with the statute at RCW 48.49.020(2)(c).
Subsection (3) includes strong language prohibiting providers/facilities from asking consumers to waive their balance billing protection rights. This subsection in the pre-publication draft cross references the federal No Surprises Act and implementing regulations, which explicitly *allow* such waivers in certain settings. Unless corrected, this could lead a regulated entity to misunderstand Washington law's clear prohibition on waivers of any kind. The latter portion of this subsection should be revised to clarify that consumer waivers that might be permitted under the NSA are never permitted in Washington.	OIC appreciates this comment. The adopted rule includes the following language at WAC 284-43B-020(3): "This prohibition supersedes any provision of sections 2799A-1 et seq. of the public health service act and federal regulations adopted to implement those sections of P.L. 116-260 that would authorize a provider or facility to ask a patient to consent to waive their balance billing protections."
Out of Network (OON) claim payment WAC 284-43B-030	
The commentor recommends WAC 284-43B-030 carve out air ambulance pursuant to RCW 48.49.160(1)(a), which carves out air ambulance from	OIC appreciates this comment. The final rule includes the suggested language revision.

Comment	*OIC Response*
the commercially reasonable amount payment. The suggested revisions are as follows: "For services ~~subject to chapter 48.49 RCW~~ described in RCW 48.49.020(1) (other than air ambulance services) provided prior to July 1, 2023 or a later date determined by the commissioner, and for services provided by a nonparticipating emergency behavioral health services provider if the federal government does not authorize use of the federal independent dispute resolution system for these disputes,…"	
Applicable dispute resolution system WAC 284-43B-032	
WAC 284-43B-030 and WAC 284-43B-032 in the draft stipulate that until July 1, 2023, or a later date determined by the Commissioner, the commercially reasonable amount payment standard and state arbitration process remain in effect. The commentor strongly recommends the OIC set a deadline in rule by which the Commissioner will announce and post if a new date is determined for transitioning over to the federal NSA out-of-network payment standard and independent dispute resolution (IDR) process.	OIC appreciates this comment. The final rule at WAC 284-43B-032(3) includes the following language: "(3) The office of the insurance commissioner must provide a minimum of four months advance notice of the date on which the dispute resolution process will transition to the federal independent dispute resolution process. The notice must be posted on the website of the office of the insurance commissioner."
Arbitration initiation and selection of arbitrator WAC 284-43B-035	
Recommend that OIC consider the impact of not determining whether a claim that is the subject of an arbitration initiation request is subject to the BBPA. The commentor anticipates charges from arbitrators to decide whether arbitration requests are within the scope of the state's balance billing protections and/or following claim bundling requirements. Arbitration is costly and time consuming.	OIC appreciates this comment. The requested change is not included in the final rule. This issue was raised during previous OIC BBPA rulemaking. At that time, OIC concluded that a decision by OIC that a claim was not subject to BBPA or appropriately bundled could be an appealable decision, which would delay the arbitration proceeding

Comment	*OIC Response*
	and create a new administrative appeal step within OIC. At that time, OIC concluded that the question of whether a claim was subject to the BBPA would best be raised during arbitration. That conclusion has not changed.
Commentors recommend that all arbitrators be listed individually and not at the arbitration entity-level. A single arbitration entity may have many individual arbitrators. This approach will help ensure all potential arbitrators are equally considered during the selection process. The commentor notes that when the OIC provides a list of five arbitrators that includes individual arbitrators as well as an arbitration entity, they have found that the initiating party vetoes the arbitration entity in favor of individual arbitrators. This results in an artificially small pool of available arbitrators that may handle dispute resolution.	OIC appreciates this comment. RCW 48.49.040 references both individual arbitrators and arbitration entities. OIC acknowledges the concerns expressed by the commenters. However, as permitted under RCW 48.49,040, OIC decided to include individual arbitrators and arbitration entities on the list provided to the parties. The final rule at WAC 284-43B-035(5)(a) provides that the list of five arbitrators provided to the parties if the parties do not agree on an arbitrator within five calendar days of receiving the full list from OIC will include 2 individual arbitrators and 3 arbitration entities. This ensures that multiple arbitration entities will be included in the random list of five arbitrators sent to the parties and provides an opportunity for the parties to consider the qualifications of arbitrators affiliated with an arbitration entity.
The commentor recommends that the parties to the arbitration be allowed to agree to consolidate multiple arbitration requests. They propose to use an agreement to consolidate rather than seeking consolidation of matters under chapter 7.04A RCW.	OIC appreciates this comment. The requested language is not included in the final rule. The claims bundling provision at RCW 48.49.040 and WAC 284-43B-035 provide an opportunity to consolidate claims at the outset of the arbitration request. Per RCW 48.49.040, the BBPA arbitration provisions exist alongside the Uniform Arbitration Act, which allows a party to petition the court to consolidate multiple matters under RCW 7.04A.100.

Comment	*OIC Response*
The proposed language in WAC 284 – 43B – 035(3)(5) provides that bundled claims must, among other requirements: "(b) Involve claims with the same procedural code, or a comparable code under a different procedural code system." A commentor notes that the language in the pre-publication draft is open to multiple interpretations. To remove any ambiguity, the commentor recommends that the OIC clarify what "comparable code under a different procedural code system" entails.	OIC appreciates this comment. The provisions related to claims bundling in RCW 48.49.040 were revised in E2SHB 1688 to be consistent with the NSA provision related to "batched" or "bundled" claims. The final rule at WAC 284-43B-035(3)(b) incorporates language from the federal rule at 45 CFR 149.510(c)(3)(i)(C) and Federal IDR Guidance for Disputing Parties, which address the requirements to "batch" items and services for dispute resolution.
A commentor recommends the following revisions to WAC 284-43B-035(3)(a) to include common National Provider Identifiers to align with the NSA. "Involve identical carrier and provider, provider group or facility parties. Items and services are billed by the same provider, provider group or facility if the items are services are billed with the same National Provider Identifier or Tax Identification Number. ~~A provider, provider group or facility parties may bundle. Claims billed using a common federal taxpayer identification number or national provider identifier number on behalf of the provider members of the group.~~"	OIC appreciates this comment. The provisions related to claims bundling in RCW 48.49.040 were revised in E2SHB 1688 to be consistent with the NSA provision related to "batched" or "bundled" claims. The final rule at WAC 284-43B-035(3)(a) incorporates the requested language. It is consistent with the federal rule at 45 CFR 149.510(c)(3)(i)(A) and Federal IDR Guidance for Disputing Parties, which address the requirements to "batch" items and services for dispute resolution.
Notice of consumer rights and transparency **WAC 284-43B-050**	
A commentor noted that subsection 2(a) of a pre-publication draft did not require carriers to send the standard notice of consumer rights with billing or Explanation of Benefit statements related to out-of-network care. Though the subsection requires carriers to	OIC appreciates this comment. The final rule at WAC 284-43B-050(2)(a)(ii) adds a requirement that the notice of consumer protections be included in each explanation of benefits (EOB) for services that are subject to balance billing protections. An

Comment	*OIC Response*
include the notice when authorizing out-of-network care and providers to include the notice when billing for such care, it does not explain what should happen in any billing/benefits-related documents *from the carrier* for out-of-network care that was not previously authorized. The commentor recommends that OIC add language addressing this gap.	EOB is sent to a consumer any time their health plan makes a payment for a service, regardless of whether the service was subject to prior authorization. This ensures that consumers will receive the notice of balance billing protections for any service to which the prohibition applies. This change is consistent with the requirements of the NSA. See response to Question 11 in FAQ's ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 55
As currently written, Subsection (2)(b)(i) of a pre-publication draft only requires facilities/providers to comply with consumer notice requirements if the facility or provider is "owned and operated independently from all other businesses and has more than 50 employees." The commentor notes that they have not yet identified a basis for the exemption in federal law and encourage OIC to evaluate whether it remains appropriate given the newly expansive application of the NSA. The commentor notes the need for administrative simplification for small businesses, but expresses concerns that there is a *heightened* risk of inappropriate balance billing by small/independent providers/facilities who are less familiar with the parameters of state and federal law. We ask OIC to revisit this carveout in future drafts.	OIC appreciates this comment. The requested change was not included in the final rule. The final rule at WAC 284-43B-050(2)(b)(ii)-(iv) is consistent with the NSA, in that it requires the notice of consumer protections to be posted on the provider's or facility's website, provided to a patient upon request and provided to a patient when the provider bills the patient or their health plan. See WAC 284-43B-050(2)(b)(ii)-(iv). This requirement applies to all providers and facilities, regardless of size. With respect to emergency services, it is likely that providers of emergency services, such as hospitals, have more than fifty employees, and thus would be required to provide the consumer notice following receipt of emergency services. WAC 284-43B-050(2)(b)(B). OIC attempted to balance the burden on health care providers who are small employers with the importance of consumers receiving adequate notice of their protections. All carriers are required to include the notice in communications to patients that authorize non-emergency services subject to BBPA protections and in any explanation of benefits for services subject to the balance billing prohibition. OIC concluded that the requirements for carriers to provide the notice

Comment	*OIC Response*
	to patients described above provide a sufficient basis to not extend the notice requirement applicable to scheduling nonemergency procedures to providers who are small employers.
Subsection 2(b)(i)(A) allows the use of text links to a provider/facility webpage to implement notice requirements. The Washington Attorney General has repeatedly warned Washington consumers never to click on unsolicited text links, as this technology is frequently used to prey on consumers in text-message "phishing" attacks (known as "smishing"). OIC should align with AGO on efforts to combat fraud. The commentor recommends removing mention of text-based noticing from this section.	OIC appreciates this comment. The final rule does not remove mention of text-based noticing. WAC 284-43B-050 limits the use of a link to the provider's webpage in a text message to a patient only when the text message is used as a reminder or follow-up after a patient has already received the full text of the notice. The link must also take the patient directly to the notice.
WAC 284-43B-050 is missing any mention of language and disability accommodations for patients and enrollees who need this kind of assistance to understand their legal rights. Please add reference to such accommodations, reviewing federal regulations implementing the NSA at 45 CFR §149.420, as well as OIC's existing nondiscrimination rules for carriers (WAC 284-43-5940) and other state laws that apply to providers/facilities (e.g., WA Law Against Discrimination, Ch. 49.60 RCW) to determine appropriate content for the standard notice and its dissemination. Following revisions in the 2nd pre-publication draft, a commentor noted their strong support for clarifying that carrier notices must be accessible to individuals with disabilities or limited English proficiency, in accordance with WAC 284-43-5940 through WAC 284-43-5965. The same commentor expressed concerns that the reference to OIC	OIC appreciates this comment. The final rule at WAC 284-43B-050(5) requires carriers to ensure that the notice of consumer protections is inclusive for those patients who may have disabilities or limited-English proficiency, consistent with carriers' obligations under WAC 284-43-5940 through 284-43-5965. OIC notes that it has posted translations of the notice into ten languages on its website. OIC will monitor the federal rulemaking currently underway related to §1557 of the Affordable Care Act. Once new federal rules are adopted, OIC will determine whether amendments to the rules at WAC 284-43-5940 through 294-43-5965, or to this rule are necessary. Once new federal rules are adopted, the OIC would also determine whether to issue guidance about federal nondiscrimination protections.

Comment	*OIC Response*
nondiscrimination rules may be insufficient given ongoing changes at the federal level that may strengthen federal nondiscrimination protections. To address the possibility of other nondiscrimination laws that ultimately may be more protective of consumers than the 2017 federal regulations, the commentor noted that it may be valuable for OIC to refer to "WAC 284-43-5940 through WAC 284-43-5965 and other relevant state and federal nondiscrimination laws" to ensure the highest standard of meaningful access is available to enrollees. The commentor noted that if OIC does not include their requested language in the final rule, OIC should include information in the Concise Explanatory Statement to explain how OIC intends to approach nondiscrimination protections if the Biden Administration moves forward with its proposed §1557 rules.	
The commentor recommends that providing the required taglines along with the explanation of benefits and accompanying notice of BBPA protections accomplishes the OIC's intent of providing language access to members. The translated versions of the notice posted on the OIC website may be provided to members upon request.	Given the financial consequences to consumers of illegal balance billing and the need to be vigilant regarding equitable access to health insurance and health care services, OIC believes it is critical that consumers understand their balance billing protections. For this reason, OIC has posted translations of the notice of balance billing protections for ten additional languages on its website. When a carrier has information indicating an enrollee's primary language is not English, it is not unreasonable to provide the notice in the enrollee's primary language when OIC has made translations of the notice easily available through its website. For languages other than those available on the OIC website, a carrier may use taglines, consistent with rules at WAC 284-43-5940 through 294-43-5965.

Comment	*OIC Response*
Appendix A: AIRF	
Two revisions to the arbitration initiation request form are requested. 1. In section 3, add a check-box to indicate whether the person filing out the form is the legal representative of the filing party. 2. Section 8(c) of the form should be revised to align to the federal notice of IDR initiation by requesting line itemized amounts rather than a total final offer amount.	OIC appreciates this comment. The suggested revisions are included in Appendix A of the final rule.
AADR **WAC 284-170-210**	
In subsection (2) (b), a definition of how often good faith efforts are required to be conducted should be added to the rule language, e.g. once a year, once every six months, or once a quarter? The commentor appreciates the other new definitions as to what the documentation of good faith efforts entails.	OIC appreciates this comment. The final rule does not add a requirement related to the frequency of efforts to contract. The final rule sets forth examples of documentation of good faith efforts to contract that a carrier may present to the OIC. WAC 284-170-210(2)(b). WAC 284-170-210 provides a remedy that allows a carrier to continue to offer a health plan when it is unable to deliver the services guaranteed in the plan. Each alternative access delivery request is fact-specific and unique. OIC approval is contingent upon the carrier demonstrating to the Commissioner's satisfaction that it has made good faith efforts to contract.
WAC 284-170-210(2)(b) outlines the requirements for carriers to submit evidence of good faith efforts to contract with providers. Those requirements include confirmation from a carrier that “appropriate staff” of the provider were contacted. The term “appropriate staff” is vague and recommend that either further detail is provided surrounding	OIC appreciates this comment. In determining whether a carrier has made good faith efforts to contract, OIC considers whether the carrier has demonstrated outreach and whether an offer to contract has occurred at correct levels of the provider organization.

Comment	*OIC Response*
this requirement or the requirement is removed from the rule.	To clarify this requirement, the final rule at WAC 284-170-210(2)(b)(i) includes revised language as follows: “that staff or a designated person that has been authorized to negotiate or sign a contract on behalf of the provider has been contacted”.
WAC 284-170-210(2)(c) states that an alternate access delivery request (AADR) may be approved for the earlier of: one health plan year, one calendar year, or until a provider contract is executed. Subsection (5) states that an approved AADR expires on the earlier of December 31 of the year the request was approved, or the date a provider contract is executed. As currently written, WAC 284-170-210(2)(c) and WAC 284-170-210(5) appear to conflict. The underlying statute in RCW 48.49.135 does not specify the time period for which an AADR may be approved. The OIC has the latitude to approve an AADR for a 12-month period rather than a calendar year, and we urge the OIC to make this change. Recommend revising the language in those subsections to clarify the termination date for approved AADRs or deleting subsection (5).	The final rule includes language to clearly distinguish AADR’s submitted for services not subject to the BBPA from those submitted for services subject to the BBPA under RCW 48.49.020. Services subject to the BBPA most often include facility-based providers, such as emergency physicians, anesthesiologists and surgeons. Given the necessity of having a hospital that is located in a county in a carrier’s service area under contract, challenging contracting dynamics can occur. Having an AADR for services subject to the BBPA expire on December 31 of the year the request was approved creates an incentive for the carrier and provider to either reach agreement on a contract or resolve the dispute through arbitration.
In WAC 284-170-210 (3), the language states that an AADR effective date is the date on which the Commissioner notifies the issuer that the AADR has been approved. Historically, the OIC has instructed carriers to reprocess claims for alternative access providers back to the beginning of the plan year. It is unclear from the draft language if this will continue to be the expectation. Please clarify the topic of reprocessing claims as it relates to the effective date of the AADR.	OIC appreciates this comment. OIC provides specific direction for claims handling based upon the circumstances that precipitated filing an AADR, which may include regulatory action up to and including enforcement action. For this reason, OIC declines to place limitations in the rule.

Comment	*OIC Response*
The commentor is concerned that the language in subsection (2)(b)(iii) may require the carrier to submit the entire contract offer made to a provider, including confidential reimbursement rates. Recommend that carriers be permitted, by rule, to redact any confidential or proprietary information from written contract offers or that this subsection simply require the date each offer was made. The commentor recommends the following revisions to the language in WAC 284-170-210(2)(b)(iii): (iii)~~Written contract offers made to the provider, including t~~**T**he date each **written contract** offer was made **to the provider** and confirmation by the issuer that the appropriate staff of the provider was contacted;"	OIC appreciates this comment. The requested revision was not included in the final rule. WAC 284-170-210(2)(b)(iii) clearly limits the type of records that must be provided and does not include "substantive contract terms offered by either the issuer or the provider".
Subsection (2)(b) should be revised to clarify that the OIC is providing examples of what may constitute evidence of good faith efforts to contract and that the examples provided in this subsection are not mandatory. Recommend the following revision to the language in WAC 284-170-210(2)(b): "(b) Evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider. Documentation of good faith efforts to contract **may** include~~s~~, but is not limited to:"	OIC appreciates this comment. The language of WAC 284-170-210(2)(b) in the final rule was revised as requested by the commentor.
Subsection (3) states "The effective date of an alternate access delivery system is the date that the commissioner notifies the issuer that the alternate access delivery system	OIC appreciates this comment. Health carriers are required to meet network access standards set out in state and federal law. Recognizing there may be limited

Comment	*OIC Response*
has been approved." The commentor recommends that OIC define, in rule, when the AADR is deemed approved if OIC takes no action after a certain period. The commentor also recommends additional flexibility surrounding the effective date of an AADR. AADRs may be submitted well in advance of when they are needed, such as in anticipation of a future provider contract termination or in advance of a previous AADR expiring. If the AADR request defines a future effective date, such as the start of the next calendar year, the regulations should allow for that, where appropriate. For the reasons provided above, OIC should incorporate the following revisions to WAC 284-170-210(3): "(3) **Unless otherwise indicated within an approved alternate access delivery request,** ~~T~~**t**he effective date of an alternate access delivery system is the date that the commissioner notifies the issuer that the alternate access delivery system has been approved. **If the commissioner takes no action within thirty calendar days after submission, the alternate access delivery system is deemed approved except that the commissioner may extend the approval period upon giving notice before the expiration of the initial thirty-day period."**	situations in which a health carrier is unable to meet those standards, OIC adopted the alternative access delivery request process to provide market stability during four (4) specific situations (WAC 284-170-200(15)) when the carrier is unable to secure an in-network contract with providers. This process gives the health carrier an opportunity to justify why OIC should not take regulatory action and propose a remedy for the health carrier's inability to meet required state and federal law. OIC declines to include language in the rule that would diminish the Commissioner's authority to approve or disapprove the health carrier's justification when it cannot deliver covered services through in-network contract providers as required by law.
As currently written, Subsection 1(b)(i) states that copayments and deductibles must apply to AADRs at the same level as in-network services. We recommend broadening this statement to include all forms of consumer cost-sharing, including coinsurance and out-of-pocket maximum accruals.	OIC appreciates this comment. This recommendation is not included in the final rule language. The OIC carefully drafted the network access rule in 2013 and has reviewed it several times since its adoption. The AADR specifically requires that the member receive the service at no greater cost than if they were seen by an in-network provider and limits carriers to

Comment	*OIC Response*
	permit collection of fixed dollar cost-shares including copay and deductible. An AADR cannot include a request to collect any amounts that are based upon a percentage of amount that is not explicitly defined by a health benefit plan or provider contract. This includes a coinsurance amount that is not limited by the provider's acceptance of a negotiated allowed amount and the hold harmless protections that a contracted in-network provider must comply with. OIC finds the requirement that any non-fixed cost share amount be waived by the carrier as part of the AADR approval to be both a consumer protection as well as an appropriate incentive for the carrier to offer a fair and reasonable contract.
WAC 284-170-210 (3) states that the effective date of an AADR is the date that the commissioner notifies the issuer that the AADR has been approved. There has been inconsistency about how and when issuers are notified. It would be helpful if the regulation states how the notification will be provided (e.g., via email).	OIC appreciates this comment. The final rule includes the following statement at WAC 284-170-210(3) to address this concern: "(3) The effective date of an alternate access delivery system is the date that the commissioner notifies the issuer that the alternate access delivery system has been approved. The commissioner will notify the carrier in writing that the alternate access delivery request has been approved, and will include the effective date of the approval." The final rule language does not specify the exact means through which the approval will be communicated. This provides the opportunity for OIC to identify more efficient means of communication with issuers in the future.
In WAC 284-170-210(5) the draft regulation states that an approved AADR expires on December 31 of the year that the request was approved, or the effective date of a contract executed by the issuer and	OIC appreciates this comment. The requested language is not included in the final rule. RCW 48.49.135 gives OIC authority to determine the duration of amended AADRs.

Comment	*OIC Response*
a provider, whichever occurs earlier. It omits reference to "one health plan year." The commentor recommends that the time frame for expiration in subsection (5) align with time frame for an approved AADR in (2)(c) for consistency.	Given the unique nature of amended AADRs, it is appropriate to limit the duration to a calendar year. This creates an incentive for the parties to continue good faith negotiations until an agreement is reached or to move to arbitration for resolution of the dispute.
WAC 284-170-210(3) states that an AADR effective date is the date on which the Commissioner notifies the issuer that the AADR has been approved. Historically, the OIC has instructed carriers to reprocess claims for alternative access providers back to the beginning of the plan year. It is unclear from the draft language if this will continue to be the expectation. Please clarify the topic of reprocessing claims as it relates to the effective date of the AADR.	OIC appreciates this comment. The final rule language does not include this recommended change. The goal of an AADR is to have the AADR in place before any claims are submitted to an issuer by a nonparticipating provider. When an issuer does not obtain an approved AADR in advance of claims submission, OIC will determine the most appropriate means to bring the issuer into compliance. Given that this would be a compliance issue, it is not appropriate to specify this in a rule addressing AADR submission and approval. Each AADR resolution is at OIC's discretion.
Please clarify if it is permissible to specify more than one county in a single AADR for a specific type of service. For example, if an AADR is for two or more counties that requires two or more provider contracts to address the network access gap, would separate AADR's be submitted for each provider and county combination? There are currently inconsistencies in the draft language that raise this question.	OIC appreciates this comment. The final rule uses the term "geographic location" consistently in WAC 284-170-210 and -220. It does not limit geographic location to a single county. WAC 284-170-220(1) requires carriers to use forms provided by OIC when filing an AADR. OIC Network Access Form E will allow an amended AADR to be filed for one or more counties. As has been OIC's practice, we will provide an opportunity for carriers to review the new Form E draft and accompanying instructions.
Under WAC 284-170-210(5) RCW 48.39.020 is referenced, that covers	OIC appreciates this comment. The citation is corrected in the final rule to read RCW 48.49.020.

Comment	*OIC Response*
Medicaid reimbursement and should be RCW 48.49.020	
WAC 284-170-210(1)(b). The commentor continues to support OIC in its approach to provider reimbursement when an AADR is in effect. They agree with OIC's current approach in the second prepublication draft: an AADR *may* result in billed charges for the first three months (rather than must), followed by the arbitrated rate for the remainder of the year. This approach offers maximum opportunity for negotiation between the parties and avoids inflationary pressure on prices, rather than locking carriers into payment of billed charges for the first three months of the AADR.	OIC appreciates this comment.
Amended AADR for services subject to the BBPA WAC 284-170-220	
WAC 284-170-220(1)(d) states that an amended AADR terminates on December 31. Not all health plans use the calendar year for plan years. It is common in the large group market to use plan years that begin and end mid-year. For that reason, the commentor recommends the language in this subsection be revised as follows: "(d) The Amended Alternate Access Delivery Request terminates on December 31 or the last day of the plan year."	OIC appreciates this comment. WAC 284-170-220(1)(d) is not amended in the final rule as requested. RCW 48.49.135 gives OIC authority to define the circumstances under which a carrier may submit an alternate access delivery request and the requirements for submission and approval of such a request in rule. The amended AADR process is limited to services subject to the BBPA and is designed to address relatively unique situations in which it is particularly important for carriers and

Comment	*OIC Response*
	providers to either reach agreement on a contract or proceed to arbitration to determine a commercially reasonable payment rate. RCW 48.43.135 includes requirements that are unique to amended AADR's for BBPA services, such as the requirement to show good faith efforts to negotiate for three months after the effective date of the AADR. A consistent December 31 termination date for all markets for both the BBPA AADR approval (which starts the new negotiation good faith attempts log) and when the Amended AADR approval ends is necessary to provide clarity for carriers, providers and consumers impacted by BBPA AADR's.
Please clarify what a "service" is for purposes of this AADR, since the proposed regulation limits each of these AADR types to a "service," and envisions filing multiple AADRs for differing services. Is this at a CPT code level or is this under a larger umbrella of "hospital services," "neonatology services," etc? The purpose of the AADR should be set out as part of this regulation so that drafters of the AADRs have that context to guide them.	OIC appreciates this comment. The final rule does not include additional specificity regarding the services that can be subject to an amended AADR under WAC 284-170-220. Services that are subject to BBPA protections are set out in RCW 48.49.020. The purpose of the amended AADR under RCW 48.49.135 is to address situations in which an issuer and provider are unable to reach agreement on a contract for a service subject to the BBPA. OIC declines to further define "services" as doing so could have the unintended effect of narrowing the scope of the statute authorizing establishment of amended AADR's.
The proposed rule does not explicitly require carriers to reimburse at billed charges as a term of an AADR for services subject to the BBPA. It instead directs that AADRs "may result" in payment at billed charges. In the interest of incenting carriers to negotiate with providers potentially subject to an AADR, requiring carriers to reimburse providers at billed charges maintains an equilibrium of incentives where carriers want to avoid paying billed charges and physicians want to avoid being locked into an arbitrated	OIC appreciates this comment. The final rule does not include the requested change. The purpose of an AADR is to provide assurances to OIC that when a carrier lacks contracted in-network providers for one or more covered services, the carrier's enrollees will be ensured access to covered services at a cost no greater than what the enrollee would incur if they had received services from an in-network provider.

Comment	*OIC Response*
rate for the remainder of the year, forwarding the shared goal that voluntary contracting remain the expectation and norm. To ensure this equilibrium, it must be specified that for those AADRs that include services covered by the BBPA, carriers are explicitly required to reimburse at billed charges for the three-month period that precedes the ability to petition for arbitration to establish a commercially reasonable payment rate for the duration of the AADR. Language should be added to proposed WAC 284-170-220 of the prepublication draft rule as follows: "(b) The amended alternate access delivery request must include attestation from the issuer of reimbursing the provider at billed charges for the 3 months after the effective date of the alternate access delivery request approval by the commissioner."	To protect enrollees from excess cost-sharing, it is not uncommon for OIC to require, as a condition of granting an AADR, that the carrier pay out-of-network providers at their full billed charge for services addressed in the AADR. OIC acknowledges that the amended AADR process established in RCW 48.49.135 and implemented through WAC 284-170-220 establishes a mechanism to incentivize carriers and providers to reach agreement on a contract and uses the BBPA arbitration process to determine payment levels if an agreement cannot be reached. However, OIC is equally concerned regarding cost impacts on consumers if payment of full billed charges is required in this context, as higher rates or prices often result in increased premiums for employers and their employees as well as individuals purchasing health plans. A carrier requesting an amended AADR must show how health plan enrollees will be protected from any additional cost sharing. OIC has the authority to require carriers to pay full billed charges in order to protect enrollees. However, if a carrier can offer an alternative to payment of full billed charges under an amended AADR that ensures enrollees will not incur excess cost-sharing, OIC should have the flexibility to consider the proposed alternative.
Commentor is appreciative of the stipulation that a single instance of arbitration will establish reimbursement for the duration of an AADR, and that AADRs will be limited in duration to one year, both of which were prior requests of WSMA and the physician community.	OIC appreciates this comment.
The commentor supports this section of the draft and related language, which appropriately implements provisions of E2SHB 1688 related to provider reimbursement when an AADR is in	OIC appreciates this comment.

Comment	*OIC Response*
effect. As the Legislature intended, this section of the draft recognizes the serious problem of inflationary pressure that can arise during provider-issuer contractual disputes and offers a system-level mechanism to manage such costs while protecting consumers who need access to the provider in question.	
WAC 284-170-220(1) references RCW 48.49.150 (2)(b) which no longer exists, and this RCW should be updated to reference RCW 48.49.135 (2)(b). Under WAC 284-170-220 (1)(c) it states, "this requirement does not restrict a carrier from filing. . .", however, it should state "issuer" instead of carrier here for consistency with other portions of the regulation.	OIC appreciates this comment. OIC made revisions in the final rule language to correct the citation and use the term "issuer" consistently.
Network reports -- Format WAC 284-170-280	
Does the proposed distance standard apply to behavioral health emergency providers in the aggregate or for each separate type listed in the definition of behavioral health emergency providers in RCW 48.43.005?	OIC appreciates this comment. The final rule language at WAC 284-170-280 does not include references to specific types of behavioral health emergency services providers. OIC notes that the network adequacy standard in WAC 284-170-200 applies to behavioral health emergency services providers as a category of providers and that carriers have some flexibility regarding the specific types of providers necessary to meet the network access standard.

Comment	*OIC Response*
Sec. 18(3) of E2SHB 1688, now codified as RCW 48.49.135(3), requires a carrier's proposed provider network include a "sufficient number of contracted behavioral health emergency services providers." The definition of "behavioral health emergency services providers" found in RCW 48.43.005(10) includes several types of providers and facilities capable of delivering those services. The commentor supported the first prepublication draft's provisions that required carriers to include behavioral health emergency services providers in their network and demonstrate within a geographic network map that all enrollees have access to behavioral health emergency services within 30 minutes in an urban area and 60 minutes in a rural area. However, in the second prepublication draft, WAC 284-170-280(3)(e)(i)(J) requires carriers to demonstrate that access standard for "…at least three types of behavioral health emergency services providers defined in RCW 48.43.005, one of which must include a mobile rapid response crisis team." Requiring 100% enrollee access at the 30/60 minute urban/rural standard for three separate provider types, and specifically to mobile rapid response crisis teams, will be difficult for most commercial carriers to meet. Because behavioral health emergency services were added to the BBPA, enrollees are protected and inherently gain access to these services at in-network levels. For those reasons, the commentor requests that OIC revert this subsection back to the first draft language, which sets the access standard at the behavioral health emergency services provider category level.	OIC appreciates this comment and understands that the behavioral health crisis delivery system, which is composed of behavioral health emergency services providers, is both under development and is often based upon regional service areas. The final rule removes the requirement for carriers to include specific types of behavioral health emergency services providers in their Geographic Network Reports maps. Carriers should use their access plans to describe how enrollees will have access to behavioral health emergency services providers, including access to behavioral health crisis service delivery within the network service area. Regardless of the standard Geographic Network reporting requirements, health carriers must meet the network access standard established under WAC 284-170-200 related to behavioral health emergency services. Based upon this information, OIC may require specific Geographic Network maps to illustrate the information reported in the access plan.

Comment	*OIC Response*
OIC should delay the effective date of WAC 284-170-280 until January 1, 2024. Work is currently underway within the industry to define the operational mechanisms needed to support the contracting and claims payment processes which will be required to support the addition of behavioral health emergency services providers to commercial carrier networks, but due to the complexity of the issues being worked, it is not reasonable for carriers to complete the contracting process to support a January 1, 2023 effective date.	OIC appreciates this comment and understands the challenges associated with behavioral health emergency services provider contracting. However, RCW 48.49.135(3) directs OIC to require, beginning January 1, 2023, that a carrier's proposed provider network or in-force provider network include a sufficient number of contracted behavioral health emergency services providers. OIC and the Health Care Authority have engaged in extensive discussions with carriers, behavioral health administrative service organizations and behavioral health provider agencies over the past several months regarding implementation of this network access requirement, with facilitation support from OneHealthPort. In light of the good faith efforts of all parties and the need to continue to work through a number of identified issues, OIC has communicated that carriers will be able to file an AADR related to these services for CY 2023. The AADR request must include clear demonstration of engagement in this multi-party effort, actions on the carriers' part that show progress in implementation planning and a clear plan for full CY 2024 implementation.
WAC 284-170-280(3)(j). Network Reports. The commentor supports OIC in requiring carriers to demonstrate greater detail about their behavioral health emergency services networks. They agree that it is reasonable for OIC to require more granular reporting about behavioral emergency services providers to support the new statutory requirement that a carrier's provider network include a "sufficient number of contracted behavioral health emergency services providers" on or before January 1, 2023. RCW 48.49.135. The commentors urges OIC to resist industry efforts to delay or weaken this requirement, which reflects the long-standing requirements of federal and	OIC appreciates this comment but also notes the challenges described in the response to the previous comment. OIC has indicated that the agency will not defer enforcement of this network adequacy requirement in CY 2023, but will provide an opportunity for carriers to submit an AADR for these services as described in the response to the previous comment.

Comment	*OIC Response*
state mental health parity law. Carriers ought to have implemented those laws long ago and should not permitted to delay now, in the midst of a severe behavioral health crisis that has worsened during the pandemic.	
Mental health and substance use disorder web page model format and required content WAC 284-170-285	
WAC 284-170-285 uses “carriers” throughout the section, please check to see if the term should actually be “issuers” to align with other portions of the regulation.	OIC appreciates this comment and acknowledges that chapter 284-170 WAC generally uses the term “issuer”. However, WAC 284-170-285 was adopted to implement RCW 48.43.765, which uses the defined term “carrier”. RCW 48.43.005(30). For this reason, the rule language is consistent with the related statute.

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 and carrier network access filings. Questions related to compliance with this rule can be raised and addressed through the form review process and network access 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 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.

Type of Inquiry	Division
Consumer assistance	Consumer Advocacy Program
Rule content	Policy Division
Authority for rules	Legal Division
Enforcement of rule	Legal Division

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

OIC has and will respond to inquiries from carriers, health care providers and facilities, Balance Billing Protection Act arbitrators and consumers related to implementation of E2SHB 1688 and associated rules. OIC conducted a series of educational webinars regarding the provisions of E2SHB 1688 for carriers, providers, consumers and BBPA arbitrators in April and May 2022. These activities have and will provide these entities and the public with an opportunity to fully understand and comply with these rules. OIC also stands ready to meet with interested organizations to respond to questions and share perspectives on implementation of the rule.

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

The goal of this rulemaking is to ensure that E2SHB 1688 is implemented in accordance with the law and that conflicts between prior BBPA and network access rules and current law are resolved. OIC will monitor consumer and health care provider complaints related to balance billing and will conduct additional investigations or enforcement actions where appropriate.

Appendix A

CR-102 Hearing Summary

Summarizing Memorandum

To: Mike Kreidler
Insurance Commissioner

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

Matter No. R2022-02

Topic of Rulemaking: Relating to Implementation of E2SHB 1688 – Balance Billing Protection Act and the No Surprises Act

This memorandum summarizes the hearing on the CR-102 for the above-named rule making, held on November 29, 2022 at 4:00pm via Zoom, due to the COVID-19 public health emergency, over which I presided in your stead.

The following agency personnel were present: Jennifer Kreitler, Sharon Daniel, Sarah Hilliard, Sofia Pasarow, Wendy Conway, Joanne Najdzin, Jesse Wolff and Ailina Cunningham.

In attendance:

Melanie Anderson, United Healthcare
Lori Berry, CoordinatedCare
Rebecca Boyd, AJG
Katie Brough, Molina Healthcare
Andrew Busz, Washington State Hospital Assn.
Merlene Converse, Kaiser Permanente
Kara Costello, United Healthcare
Thalia Cronin, Community Health Plan of Washington
Amy Do, Molina Healthcare
Jane Douthit, Regence
Jennifer Emory-Morelli, United Healthcare
Rahewa Gebreab, Molina Healthcare
Liana Gomes, Molina Healthcare

Lee Graham, Radiax
Sean Graham, Washington State Medical Assn.
Carl Kester, Lakeside Milam
Yaohua Ji, Molina Health Care
Frankie Kaiser, Kaiser Permanente
Christine Lynch
Lisa Ness, Common Spirit
Ronnae Pesce, Molina Healthcare
Christina Rae, United Healthcare
Beau Reitz, Providence
Melissa Saiz, Molina Healthcare
Sherleen Satushek, Premera
Katherine Therrien, Aetna
Alexander Thompson, Molina Healthcare
Jomar Thompson, Molina Healthcare
Carolyn Walker, Multicare
Cameron Watson, Washington State Health Care Authority
Samuel Wilcoxson, Premera
Taylor Wolff, Optum

Testifying and testimony

Sean Graham testified on behalf of the Washington State Medical Association. He testified that when a carrier submits an amended alternative access delivery request under RCW 48.49.135, carriers should be required to attest that they will reimburse the provider referenced in the AADR at full billed charges for the 3 months after the effective date of the alternate access delivery request approval by the commissioner.

The hearing was adjourned.

SIGNED this 29th day of November 2022

_ Jane Beyer_____
[NAME], Presiding Official