OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

R 2024-01 Implementation of SSB 5986 and updates to the Balance Billing Protection Act (BBPA)

First Pre-publication Draft | July 17th, 2024

Comments due to OIC at rulescoordinator@oic.wa.gov by July 31, 2024

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) "Air ambulance service" has the same meaning as defined in RCW 48.43.005.

(b) "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.

(c) "Balance bill" means a bill sent to an enrollee by a nonparticipating provider, facility, behavioral health emergency services provider or air ambulance service provider 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 cost-sharing allowed under WAC 284-43B-020.

(d) "Behavioral health emergency services provider" has the same meaning as defined in RCW 48.43.005.

(e) "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.

(f) "Emergency medical condition" has the same meaning as defined in RCW 48.43.005.

(g) "Emergency services" has the same meaning as defined in RCW 48.43.005.

(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 nonemergency 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)).

~~(i)~~i) "Ground ambulance services" has the same meaning as defined in RCW 48.43.005.

(j) "Ground ambulance services organization" has the same meaning as defined in RCW 48.43.005.

(k~~i~~)"Hospital outpatient department" means an entity or site that provides outpatient services and:

(i) Is a provider-based facility under 42 C.F.R. Sec. 413.65;

(ii) Charges a hospital facility fee in billing associated with the receipt of outpatient services from the entity or site; or

(iii) Bills the consumer or their health plan under a hospital's national provider identifier or federal tax identification number.

(l) "Local governmental entity" has the same meaning as defined in RCW 48.43.005.

(mj) "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.

(kn) "Nonemergency health care services performed by nonparticipating providers at certain participating facilities" has the same meaning as defined in RCW 48.43.005.

(lo) "Offer to pay," "carrier payment," or "payment notification" means a claim that has been adjudicated and paid by a carrier to a nonparticipating provider for emergency services or for nonemergency health care services performed by nonparticipating providers at certain participating facilities.

(mp) "Out-of-network" or "nonparticipating" has the same meaning as defined in RCW 48.43.005.

(nq) "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 nonemergency health care services at certain participating facilities.

NEW WAC SECTION

WAC 284-43B-025 Balance billing prohibition and consumer cost-sharing for ground ambulance services.

(1) If an enrollee receives covered ground ambulance services:

(a) The enrollee satisfies their obligation to pay for the ground ambulance services if they pay the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The enrollee's obligation must be calculated using the allowed amount determined under WAC 284-43B-027. The carrier shall provide an

explanation of benefits to the enrollee and the nonparticipating ground ambulance services organization that reflects the cost-sharing amount determined under this subsection;

(b) The carrier, nonparticipating ground ambulance services organization, and any agent, trustee, or assignee of the carrier or nonparticipating ground ambulance services organization shall ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection;

(c) The nonparticipating ground ambulance services organization and any agent, trustee, or assignee of the nonparticipating ground ambulance services organization 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 ground ambulance services organization's ability to collect a past due balance for that cost-sharing amount with interest;

(d) The carrier shall treat any cost-sharing amounts determined under (a) of this subsection paid by the enrollee for a nonparticipating ground ambulance services organization's services in the same manner as cost-sharing for health care services provided by a participating ground ambulance services organization and must apply any cost-sharing amounts paid by the enrollee for such services toward the enrollee's maximum out-of-pocket payment obligation; and

(e) A ground ambulance services organization shall refund any amount in excess of the in-network cost-sharing amount to an enrollee within 30 business days of receipt if the enrollee has paid the nonparticipating ground ambulance services organization an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection. 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.

NEW WAC SECTION

WAC 284-43B-027 Payments to nonparticipating ground ambulance services organizations

(1) Until December 31, 2027, the allowed amount paid to a nonparticipating ground ambulance services organization for covered ground ambulance services under a health plan issued by a carrier must be one of the following amounts:

(a)(i) The rate established by the local governmental entity where the covered health care services originated for the provision of ground ambulance services by ground ambulance services organizations owned or operated by the local governmental entity and submitted to the office of the insurance commissioner; or

(ii) Where the ground ambulance services were provided by a private ground ambulance services organization under contract with the local governmental entity where the covered health care services originated, the contracted rate submitted to the office of the insurance commissioner;

(b) If a rate has not been established under (a) of this subsection, the lesser of:

(i) 325 percent of the current published rate for ambulance services as established by the federal centers for medicare and medicaid services under Title XVIII of the social security act for the same service provided in the same geographic area; or

(ii) The ground ambulance services organization's billed charges.

(2) Until December 31, 2027, when a ground ambulance services organization provides a ground ambulance transport outside of their geographic area, the rate paid is the lesser of:

(a) The locally set rate for the geographic service area where the transport originated; or

(b) The ground ambulance service organization’s billed charges.

(3) A carrier may rely in good faith upon the applicable locally set rate submitted to the insurance commissioner under WAC 284-43B-029. If a local governmental entity’s updated rates are not submitted 90 days in advance of the effective date of the updated rate, as provided in WAC 284-43B-029, the carrier may rely upon the most recent previous rate submission for that local governmental entity for a period of 90 days following the effective date of the updated rate.

(4) A carrier shall make payments for ground ambulance services provided by nonparticipating ground ambulance services organizations directly to the organization, rather than the enrollee.

(5) The allowed amount established under this section constitutes payment in full for the services rendered. A ground ambulance services organization may not request or require a patient at any time, for any procedure, service, or supply, to sign or otherwise execute by oral, written, or electronic means, any document that would attempt to avoid, waive, or alter any provision of this section.

(6) For purposes of this section "contracted rates" means rates established in a contract or contracts between a local governmental entity and a private ground ambulance services organization to provide ground ambulance services in their geographic service area.

NEW WAC SECTION

WAC 284-43B-029 Local governmental entity rate reporting to the insurance commissioner.

(1) Each local governmental entity that has established rates for ground ambulance services provided in their geographic area must submit the rates to the office of the insurance commissioner in the form and manner prescribed by the commissioner. Rates established for ground ambulance transports include rates for services provided directly by the local governmental entity and contracted rates.

(2) Local governmental entities must include the following rate information in their submission to the commissioner for each locally set rate or contracted rate submitted to the commissioner:

(a) The local governmental entity's full legal name and address;

(b) The National Provider Identifier(s) (NPI) for any ground ambulance services organization to which the rate applies;

(c) The effective date of the rate and any known expiration date of the rate;

(d) The service area of the local governmental entity, described by listing the geographic Zone Improvement Plan (ZIP) codes established by the United States Postal Service that are included in the entity's service area;

(e) The applicable transport codes to which the rate applies, including any separate mileage code or codes;

(f) If applicable, the locally set rate for services provided to non-residents of the local governmental entity's service area, if a distinction is made in rates between services provided to residents and those provided to non-residents; and

(3) The information must be submitted electronically through the website of the office of the insurance commissioner.

(4) Local governmental entities must submit their rates to the commissioner on the following schedule:

(a) Initial rate submissions are due on or before October 31, 2024; and

(b) Updated rates must be submitted at least 90 days prior to the effective date of the updated rate. For example, if the effective date of an updated rate is January 1, 2026, the submission to the commissioner must occur on or before November 1, 2025.

(5) For purposes of this section "contracted rates" means rates established in a contract or contracts between a local governmental entity and a private ground ambulance services organization to provide ground ambulance services in their geographic service area.

WAC 284-43B-035 Arbitration initiation and selection of arbitrator.

(1)(a) To initiate arbitration, the carrier, provider, or facility must provide written notification to the commissioner and the noninitiating party no later than 10 calendar days following completion of the period of good faith negotiation under WAC 284-43B-030(3) using the arbitration initiation request form designated by the commissioner ~~found in Appendix A of this rule~~. A request must be submitted electronically through the website of the office of the insurance commissioner. When multiple claims are addressed

in a single arbitration proceeding, subsection (3) of this section governs calculation of the 10 calendar days. Each arbitration initiation request must be submitted to the commissioner individually and constitutes a distinct arbitration proceeding unless consolidation of requests is authorized by a court under chapter 7.04A RCW. The commissioner will assign a unique number or designation to each arbitration initiation request. The parties must include that designation in all communication related to that request. 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 or facility 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) and subsection (1)(a) of this section. 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. The commissioner's review does not include a review of whether particular claims included in the request are subject to chapter 48.49 RCW or whether claims are appropriately bundled under subsection (3) of this section. A party seeking to challenge whether a claim is subject to chapter 48.49 RCW or whether claims are appropriately bundled may raise those issues during arbitration.

(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 10 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 a nonparticipating provider or nonparticipating 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 10 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, provider group or facility parties. Items and services are billed by the same provider, provider group or facility if the items or services are billed with the same national provider identifier or tax identification number;

(b) Involve the same or similar items and services. The services are considered to be the same or similar items or services if each is billed under the same service code, or a comparable code under a different procedural code system, such as current procedural terminology (CPT) codes with modifiers, if applicable, health care common procedure coding system (HCPCS) with modifiers, if applicable, or diagnosis-related group (DRG) codes with modifiers, if applicable; and

(c) Occur within the same 30-business-day period of one another, such that the earliest claim that is the subject of the arbitration occurred no more than 30 business days 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 10 calendar days following completion of the period of good faith negotiation will be considered untimely and will be rejected. Any revision to a previously timely submitted arbitration initiation request form must be submitted to the commissioner within the 10 calendar day period applicable to submission of the original request. 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 addresses for the initiating party and the noninitiating party indicated on the arbitration initiation request form for all communication related to the arbitration request. The arbitrator selection process must be completed within 20 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 two individual arbitrators and three arbitration entities 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 arbitration entities and notifying the commissioner and the other party within three calendar days of receipt of the list:

(i) Whether they are taking the opportunity to veto up to two of the five arbitrators or arbitration entities on this list, and if so, which arbitrators or arbitration entities have been vetoed; and

(ii) If there is a conflict of interest as described in subsection (6) of this section with any of the arbitrators or arbitration entities on the list, to avoid the commissioner assigning an arbitrator or arbitration entity with a conflict of interest to an arbitration.

(b) If, after the opportunity to veto up to two of the five named arbitrators or arbitration entities on the list of five arbitrators and arbitration entities sent by the commissioner to the parties, more than one arbitrator or arbitration entity remains on the list, the parties must notify the commissioner within five calendar days of receipt of the list of five arbitrators or arbitration entities. The commissioner will choose the arbitrator from among the remaining arbitrators on the list. If a party fails to timely provide the commissioner with notice of their veto, the commissioner will choose the arbitrator from among the remaining arbitrators or arbitration entities 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) Where a dispute resolution matter initiated under sections 2799A-1 and 2799A-2 of the Public Health Service Act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and federal regulations implementing those provisions of P.L. 116-260 (enacted December 27, 2020) results in a determination by a certified independent dispute resolution entity that such process does not apply to the dispute or to portions thereof, RCW 48.49.040 (3)(b) governs initiation of arbitration under this chapter.

WAC 284-43B-037 Arbitration proceedings.

(1) For purposes of calculating the date that written submissions to the arbitrator under RCW 48.49.040 are due, final selection of the arbitrator occurs on the date that the commissioner sends by electronic transmittal the notice of selection to the arbitrator. The parties must be copied on such notice.

(2) 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.

(3) If the parties agree on an out-of-network rate for the services at issue or a contract rate for arbitrations under RCW 48.43.135 after submitting an arbitration initiation request but before the arbitrator has made a decision, they must provide notice to the commissioner as provided in RCW 48.49.040(7).

(4) If an initiating party withdraws an arbitration initiation request at any point before the arbitrator has made a decision, the party must submit to the commissioner notice of the date of the withdrawal of the request, as soon as possible, but no later than three business days after the date of the withdrawal.

(5) 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.

(6) The decision of the arbitrator is final and binding on the parties and is not subject to judicial review. The arbitrator must submit to the commissioner:

(a) Their decision, including an explanation of the elements of the parties' submissions the arbitrator relied upon to make their decision and why those elements were relevant to their decision; and

(b) The information required in RCW 48.49.050 using the form designated by the commissioner ~~found in Appendix B to this rule~~, or for arbitration proceedings under RCW 48.49.135, using the form designated by the commissioner ~~found in Appendix C to this rule~~.

(7)(a) For the calendar year beginning January 1, ~~2023~~2025, arbitrators must charge a fixed fee for single claim proceedings within the range of ~~$200-$650~~ $200- $1,000. If an arbitrator chooses to charge a different fixed fee for bundled claim proceedings, that fee must be within the range of $268-$1500~~800~~. As part of the bundled determination fee, arbitrators are permitted to charge an additional fixed tiered fee within the range of $75 to $250 for every additional 25 line items within a bundled claims dispute, beginning with the 26th line item. Beginning January 1, 2024, and January 1st of each year thereafter, the arbitrator may adjust the fee range by the annual consumer price index-urban as determined annually by the United States Bureau of Labor Statistics.

(b) Expenses incurred during arbitration, including the arbitrator's expenses and fees, but not including attorneys' fees, must be divided equally among the parties to the arbitration. Arbitrator fees must be paid to the arbitrator by the parties within 30 calendar days of receipt of the arbitrator's decision by the parties.

(c) If the parties reach an agreement before the arbitrator makes their decision, the arbitrator fees must be paid by the parties within 30 calendar days of the date the settlement is reported to the commissioner as required under RCW 48.49.040.

(8) RCW 48.49.040(13) governs arbitration proceedings initiated under RCW 48.49.135. The determination of the rate to be paid to the out-of-network or nonparticipating provider must be accomplished through a single arbitration proceeding.

WAC 284-43B-040 Determining whether an enrollee's health plan is subject to the requirements of the act.

(1) To implement RCW 48.49.170, carriers must make information regarding whether an enrollee's health plan is subject to the requirements of chapter 48.49 RCW or section 2799A-1 et seq. of the Public Health Service Act (42 U.S.C. Sec. 300gg-111 et seq.) and federal regulations implementing those provisions of P.L. 116-260 available to providers, ~~and~~ facilities, and ground ambulance services organizations 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 the most appropriate standard message that is placed in a standard location within the 271 transaction;

~~(b) Beginning April 1, 2021, and until December 31, 2022, 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;~~

~~(~~b)~~c) Beginning January 1, 2023, u~~U~~sing the appropriate 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 applicable X12 industry standard Remark Code to indicate whether a claim was processed in accordance with this state's balance billing rules or the federal No Surprises Act.

(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 most appropriate 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, 2022;

~~(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;~~

(~~c~~b) Must post on its website on or before December 1, 2022, instructions on compliant use of the appropriate X12 industry standard Remark code or codes as provided in subsection (1)(~~c~~b) of this section; and

(~~d~~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.

WAC 284-43B-050 Notice of consumer rights and transparency.

(1) The commissioner shall develop a standard template for a notice of consumer protections from balance billing under the Balance Billing Protection Act and the federal No Surprises Act (P.L. 116-260). 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 protections developed under subsection (1) of this section 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 services to be provided at facilities referenced in WAC 284-43B-010 (2)(h)(ii);

(ii) Include the notice in each explanation of benefits sent to an enrollee for items or services with respect to which the requirements of RCW 48.49.020 and WAC 284-43B-020 apply;

(iii) 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 health care services performed by nonparticipating providers at certain participating facilities; and

(iv) Provide the notice to any enrollee upon request.

(b) Health care facilities, providers, and ground ambulance services organizations must:

(i) For any facility, provider, or ground ambulance services organization that is owned and operated independently from all other businesses and that has more than 50 employees, upon confirming that a patient's health plan is subject to the Balance Billing Protection Act or the federal No Surprises Act (P.L. 116-260):

(A) Include the notice in any communication to a patient, in electronic or any other format related to scheduling of nonemergency health care services performed by nonparticipating providers at certain participating facilities. 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 services, including behavioral health emergency services providers or ground ambulance services organizations, provide or mail the notice to a patient within 72 hours following a patient's receipt of emergency services.

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

(iii) If services were provided at a health care facility or in connection with a visit to a health care facility, provide the notice to patients no later than the date and time on which the provider or facility requests payment from the patient, or with respect to a patient from who the provider or facility does not request

payment, no later than the date on which the provider or facility submits a claim to the carrier; and

(iv) 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 or section 8 of SSB 5986 (Chap. 218, Laws of 2024), 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) Carriers must ensure that notices provided under this subsection are 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. To assist in meeting this language access requirement, carriers may use translated versions of the notice of consumer protections from balance billing posted on the website of the office of the insurance commissioner.

(6) A facility, behavioral health emergency services provider, ~~or~~ health care provider, or ground ambulance services 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 14 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.

(7) Not less than 30 days prior to executing a contract with a carrier:

(a)(i) A hospital, freestanding emergency department, behavioral health emergency services provider 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, freestanding emergency department, behavioral health emergency services provider or ambulatory surgical facility;

(ii) A hospital, hospital outpatient department, critical access hospital or ambulatory surgical center must provide the carrier with a list of the nonemployed providers or provider groups that are contracted to provide nonemergency health care services at the facility.

(b) 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.

(c) Any facility providing carriers information under this subsection must notify the carrier within 30 days of a removal from or addition to the nonemployed provider list. The facility also must provide an updated list of these providers within 14 calendar days of a written request for an updated list by a carrier.

(8) A participating 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.

WAC 284-43B-060 Enforcement.

(1)(a) If the commissioner has cause to believe that any health facility, behavioral health emergency services provider, provider, or ground ambulance services provider has engaged in a pattern of unresolved violations of RCW 48.49.020, ~~or~~ 48.49.030, or section 8 of SSB 5986 (Chap. 218, Laws of 2024), 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, behavioral health emergency services provider, ~~or~~ facility, or ground ambulance services organization has engaged in a pattern of unresolved 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, behavioral health emergency services provider, ~~or~~ facility, or ground ambulance services organization has committed two or more violations of RCW 48.49.020, ~~or~~ 48.49.030 or section 8 of SSB 5986 (Chap. 218, Laws of 2024);

(ii) Whether the health care provider, behavioral health emergency services provider, ~~or~~ facility, or ground ambulance services organization 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 or section 8 of SSB 5986 (Chap. 218, Laws of 2024) applies;

(iii) Whether the health care provider, behavioral health emergency services provider, ~~or~~ facility, or ground ambulance services organization 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 or section 8 of SSB 5986 (Chap. 218, Laws of 2024); 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, behavioral health emergency services provider, ~~or~~ facility, or ground ambulance services organization 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, or section 8 of SSB 5986 (Chap. 218, Laws of 2024).

(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.

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, ~~and~~ 48.49.160, and section 8 of SSB 5986 (Chap. 218, Laws of 2024), 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, 48.49.160, section 8 of SSB 5986 (Chap. 218, Laws of 2024) 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 15 days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

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

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

NEW WAC SECTION

WAC 284-43B –105 Forms.

All required forms referenced in this chapter, shall be on forms designated by the commissioner for that purpose. The forms will be available on the commissioner's website. Any new or updated forms will be posted on the commissioner's website at least 30 days before their effective date.

~~**WAC 284-43B-085 Appendix A.**~~

~~**WAC 284-43B-090 Appendix B.**~~

~~**WAC 284-43B-095 Appendix C.**~~

~~**WAC 284-43B-100 Appendix D.**~~

WAC 284-170-205. Behavioral health emergency services provider contracting

(1) Issuers must meet the network access standards of this chapter related to emergency mental health services and substance use disorder services, including services provided by behavioral health emergency services providers. An issuer that is unable to meet these standards must file an alternative access delivery request as provided in this chapter.

(2) In paying claims from nonparticipating behavioral health emergency services providers for behavioral health emergency services under RCW 48.43.093, issuers must:

(a) Accept and reimburse claims submitted by behavioral health agencies that are licensed in good standing and certified to provide crisis services by the Washington state department of health under chapter 246-341 WAC and are defined as behavioral health emergency services providers under RCW 48.43.005 or from behavioral health administrative services organizations, as described in RCW 71.24.045;

(b) Accept and reimburse billing codes for behavioral health crisis services included in the service encounter reporting instructions issued and periodically updated by the Washington state health care authority.

(3) In contracting with behavioral health emergency services providers, issuers must:

(a) To reduce administrative burden on behavioral health emergency services providers, initially engage in good faith efforts to contract with behavioral health administrative service organizations, as described in RCW 71.24.045, that have contracts with a sufficient number of behavioral health emergency services providers in their region. If a behavioral health administrative services organization is unwilling or unable to contract with an issuer, the issuer must engage in good faith efforts to contract directly with a sufficient number and type of behavioral health emergency services providers to meet the network access standards of this chapter;

(b) Contract with behavioral health emergency services providers as licensed behavioral health agencies, as provided in subsection (c). RCW 48.43.005 defines "health care provider" as a person regulated under Title 18 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. As such, contracting for behavioral health emergency services cannot be limited to health care providers whose scope of practice includes independent practice. If a health care provider holding, for example, an associate license under RCW 18.225.145 or an agency-affiliated counselor license under Chap. 18.19 RCW is employed by a behavioral health emergency services provider, that license holder or the provider, on their behalf, must be allowed to bill the issuer for emergency services, as defined in RCW 48.43.005.

(c) With respect to credentialing:

(i) For contracts with behavioral health administrative services organizations, the carrier must delegate credentialing of behavioral health emergency services providers to the behavioral health administrative service organization; and

(ii) For contracts directly with behavioral health emergency services providers, and for credentialing delegated to behavioral health administrative service organizations under (i) of this subsection, the issuer's credentialing standards must be satisfied by a showing that the behavioral health emergency services provider is licensed in good standing and certified to provide crisis services by the Washington state department of health under chapter 246-341 WAC. The issuer may not impose additional credentialing requirements.

(d) With respect to claims processing and payment, accept and reimburse billing codes for behavioral health crisis services that are included in the service encounter reporting instructions issued and periodically updated by the Washington state health care authority.