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HEARINGS UNIT
OFFICE OF
INSURANCE COMMISSIONER

BEFORE THE STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

IN THE MATTER OF KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	Docket No. 15-0205 DECLARATION OF ROBIN LARMER IN SUPPORT OF KFHPNW'S MOTION FOR SUMMARY JUDGMENT

1. I am one of the attorneys retained to represent Kaiser Foundation Health Plan of the Northwest ("KFHPNW") in this matter. I am above the age of 18 and competent to testify to the matters set forth herein.

2. Attached hereto as **Exhibit A** is a true and correct copy of the OIC's Concise Explanatory Statement for the Network Access Rule Making.

3. Attached hereto as **Exhibit B** is a true and correct copy of the Washington State Health Benefit Exchange Guidance.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone (206) 624-0900

SIGNED at Seattle this 30th day of October, 2015.

ROBIN L. LARMER

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone (206) 624-0900

CERTIFICATE OF SERVICE

I, Melissa Wood, certify that at all times mentioned herein, I was and am a resident of the state of Washington, over the age of eighteen years, not a party to the proceeding or interested therein, and competent to be a witness therein. My business address is that of Stoel Rives LLP, 3600 One Union Square, 600 University Street, Seattle, Washington 98101.

On October 30, 2015, I caused a copy of the foregoing document to be served upon the following individual(s) in the manner indicated below:

Hearings Unit Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504-0255 Email: hearings@oic.wa.gov	☐hand delivery ☐facsimile transmission ☐overnight delivery ☒first class mail ☒e-mail delivery
Mandy Weeks Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504-0255 Email: MandyW@oic.wa.gov	☐hand delivery ☐facsimile transmission ☐overnight delivery ☒first class mail ☒e-mail delivery

Executed on October 30, 2015, at Seattle, Washington.

Melissa Wood, Practice Assistant

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone (206) 624-0900

CONCISE EXPLANATORY STATEMENT

NETWORK ACCESS RULEMAKING

R-2013-22

Office of the Insurance Commissioner
April 25, 2014

EXHIBIT A

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INTRODUCTION

The Administrative Procedures Act (chapter 34.05 RCW) requires agencies to prepare a Concise Explanatory Statement summarizing the rulemaking process. The provider network rule generated numerous comments, the distribution of two exposure drafts, and numerous meetings with stakeholders to discuss the rule drafts. The Commissioner directed staff to clearly understand the concerns of stakeholders and to address them in a reasonable and meaningful manner.

BACKGROUND

On September 10, 2013, the Commissioner filed a Preproposal Notice of Inquiry (CR-101) proposing to update and revise the current network provider rules in WAC 284-43. A stakeholder meeting was held on October 22, 2013 where the proposed rulemaking was discussed and questions taken. On December 4, 2013, an exposure draft was sent to interested stakeholders and the Office of the Insurance Commissioner's distribution list for rules via email. The comment period on the first exposure draft ran until December 20, 2013.

Based upon the input received, the Commissioner divided the rulemaking into two phases. After receipt of written comments and suggestions, the Commissioner circulated a second exposure draft on February 14, 2014 to interested stakeholders and the Office of the Insurance Commissioner's distribution list for rules via email. The comment period ran on the second exposure draft until February 21, 2014.

On March 19, 2014, the Commissioner filed a CR-102. A hearing was held on April 22, 2014. The Commissioner adopted the rule, filing the CR-103P, on April 25, 2014. The rule's effective date is 31 days after adoption.

BACKGROUND INFORMATION AND RESEARCH

The following documents were considered to develop the rules:

1. Compilation of Title XXVII of the Public Health Service Act (and Related Provisions), reflecting amendments made by the ACA and the Education Reconciliation Act of 2010.
2. Agency for Healthcare Research and Quality, http://www.ahrq.gov/.
3. AISHealth, Health Business Daily, "Narrow Networks Show Success in Lowering Rates, but Demand Could Expand Choices," December 18, 2013.
4. American Telemedicine Association, "Telemedicine in the Patient and Affordable Care Act (2010)," 2010.

5. AMA, “AMA Health Insurer Code of Conduct Principles: Explanations and strategies for enforcement,” 2010.
6. California Health Benefit Exchange, “Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability: Options and Final Recommendations,” August 23, 2012.
7. Centers for Medicare & Medicaid Services, 2014 Qualified Health Plan (QHP) Series II, “Essential Community Providers (ECPs),” February 20, 2014.
8. Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services Records Schedule, September 2013.
9. Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces, February 4, 2014.
10. Centers for Medicare & Medicaid Services, “Frequently Asked Questions on Essential Community Providers”, May 13, 2013.
11. CIIO, “Chapter 7: Instructions for the Essential Community Providers Application Section.”
12. Connecticut Insurance Department, “Proposal for Essential Community Provider (ECP) Sufficiency Standards,” May 21, 2013.
13. DC Health Benefit Exchange Authority, “Network Adequacy Working Group Report,” March 5, 2013.
14. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, Health Insurance Exchange System-Wide Meeting, Exchange Final Rule: Indian Provisions, May 21-23, 2012.
15. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Explanatory Document, “Overview of Model QHP Addendum for Indian Health Care Providers,” April 4, 2013.
16. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Letter to Issuers on Federally-facilitated and State Partnership Exchanges, Affordable Exchange Guidance, April 5, 2013.
17. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicare Learning Network,” Telehealth Services: Rural Health Fact Sheet,” December 2012.
18. Federal Register, Volume 77, Number. 59, March 27, 2012.
19. Federal Register, Volume 58, Number 96, pages 29422-29425, May 20, 1993.
20. National Association of Community Health Centers, “FQHC Reimbursement for Telemedicine Services in Medicaid, State Policy Report #48,” December 2013.
21. Healthinschools.org, “Caring for Kids: Expanding Dental and Mental Health Services Through School Based Health Centers,” June/July E-Journal, Volume 8, Number 4.

22. McKinsey & Company, McKinsey Center for U.S. Health System Reform, "Hospital Networks: Configurations on the exchanges and their impact on premiums," updated December 14, 2013.
23. "Mental Health Clinical and Prevention Model: a population mental health model," MH-CCP Version 1.1, July, 19, 2001.
24. Minnesota Department of Health, "Provider Network Adequacy Instructions."
25. National Academy for State Health Policy, NASHP Fact Sheet, "Essential Community Providers: Tips to Connect Marketplace Plans," April 2013.
26. NCQA, "Network Adequacy & Exchanges," 2013.
27. NCQA, "Recommendations for Health Insurance Exchange Quality Measurement Requirements.
28. NCQA, 2014 Health Plan Accreditation Requirements.
29. NAIC, "Plan Management Function: Network Adequacy White Paper," June 27, 2012.
30. NAIC, "Statement of Consumer Representatives Regarding Network Adequacy," Health Insurance and Managed Care Committee, Interim Meeting June 2012.
31. Oregon Health Insurance Exchange, OAR 945-020-0040.
32. Patient-Centered Primary Care Collaborative, "Defining the Medical Home," http://www.pcpcc.org/about/medical-home.
33. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
34. Public Law 111 - 148, Patient Protection and Affordable Care Act of 2010; including Title IV, Section 4101 and 399Z-1.
35. http://schoolhealthcare.org/
36. State of Health Reform Assistance Network, "ACA Implications for State Network Adequacy Standards," Issue Brief, August 2013.
37. The Center for Health and Health Care in Schools, http://www.healthinschools.org/School-Based-Mental-Health.aspx.
38. Washington Alliance for School Health Care.
39. Washington State Department of Health, Health of Washington State, "Trauma and Emergency Cardiac and Stroke Systems," updated June 1, 2012.
40. Washington State Department of Health, OCRH Series on Rural-Urban Disparities, "How Many Agencies Does it Take to Define Rural?" December 2009, revised February 2010.
41. Washington State Department of Health, "Guidelines for Using Rural-Urban Classification Systems for Public Health Assessment," February, 5, 2009.
42. http://ww4.doh.wa.gov/gis/standard_maps.htm.
43. Washington State Medical Home Partnerships Project, Washington State Medical Home Plan, http://www.medicalhome.org/about/medhomeplan.cfm.

44. Washington State Office of Financial Management, 2012 Washington State Primary Care Nurse Practitioner Survey, Data Report, August 2012.
45. Various state and federal statutes and regulations.

RESPONSIVENESS SUMMARY

The Commissioner received numerous comments and suggestions related to the rulemaking. A description of the comments, the Commissioner's assessment of the comments, and inclusion or rejection of the comments follows. The comments and responses are organized in relation to the applicable proposed text where possible.

Comments were received from:

- AARP of Washington
- Aetna
- American Cancer Society Cancer Action Network, Inc.
- American College of Emergency Physicians, Washington Chapter
- American Civil Liberties Union of Washington
- America's Health Insurance Plans
- American Heart Association and American Stoke Association
- American Indian Health Commission for Washington State
- American Medical Association
- Association of Washington Business
- Association of Advanced Practice Psychiatric Nurses
- Association of Washington Healthcare Plans
- Arthritis Foundation
- Autoimmune Advocacy Alliance
- Bleeding Disorder Foundation of Washington
- Center for Diagnostic Imaging
- Children's Alliance
- Community Health Plan of Washington
- Coordinated Care
- Compassion & Choices of Washington
- DaVita HealthCare Partners
- Fresenius Medical Care
- First Choice Health
- Group Health Cooperative
- Health Care Authority
- Health Coalition for Children and Youth
- Kaiser Permanente
- Legal Voice NARAL Pro-Choice Washington
- Lifelong AIDS Alliance
- Leukemia & Lymphoma Society
- Lummi Indian Business Council

- March of Dimes
- Midwives Association of Washington State
- Molina Healthcare Inc.
- National Association of Dental Plans
- National Multiple Sclerosis Society; Greater Northwest Chapter
- Neighborhood House
- Northwest Health Law Advocates
- Northwest Kidney Centers
- Northwest Portland Area Indian Health Board
- Optometric Physicians of Washington
- Planned Parenthood Votes Northwest
- Port Gamble S'Klallam Tribe
- Premera Blue Cross
- Principal Financial Group
- Public Health-Seattle & King County
- Physical Therapy Association of Washington
- Providence Health & Services
- Public Hospital Districts Joint Operating Board
- Dr. Robert Parker
- Regence Blueshield
- Rural Health Clinic Association of Washington
- SEIU Healthcare 775NW
- SEIU Healthcare 1199NW
- Seth Armstrong
- Seattle Cancer Care Alliance
- Seattle Children's Hospital
- Sirianni Youtz Spoonmore Hamburger
- The Health Services Department of the Port Gamble S'Klallam Tribe
- United Healthcare Insurance Co. and United Healthcare of Washington
- Washington Academy of Family Physicians
- Washington Association of Alcoholism & Addiction Programs
- Washington Association of Community and Migrant Health Centers
- Washington Association of Naturopathic Physicians
- Washington Autism Alliance & Advocacy
- Washington East Asian Medicine Association
- Washington Community Mental Health Council
- Washington Health Benefit Exchange
- Washington State Health Insurance Pool
- Washington State Hospital Association
- Washington State Hospice and Palliative Care Organization
- Washington State Medical Association
- Washington State Nurses Association
- Washington State Podiatric Medical Association
- Washington State Psychological Association

General Comments

***Comment**: Concerns were raised about more restrictive requirements and the balance between issuers and providers in negotiating contracts. Other concerns included that the rule may stifle innovation or erode flexibility, and that the current rules were sufficient. The comments also pointed to the NCQA and other accreditation standards as providing sufficient standards.*

Response: The Commissioner recognizes the Affordable Care Act's intent to create flexibility and encourage innovation. However, it is important to balance flexibility and innovation with the need for enrollees to have access to covered services without unreasonable delay.

The Commissioner's experience with networks and the changing marketplace environment demonstrated a need to update and align the network regulations with federal standards. The original rule text was based in a large part upon the NAIC Model Rule #74 drafted in 1996 and the NAIC white paper on network adequacy.

Additionally, while recognizing and considering accreditation standards in drafting rule text, it is still necessary to have regulations specific to the Washington State marketplace. This rule provides a level playing field for all the issuers in the marketplace and for those issuers contemplating entrance into the market, both inside and outside the exchange. While there are certainly new criteria and requirements, this rule also codifies reporting requirements and criteria that were already required, but not in rule. By codifying these reporting requirements and criteria there is greater transparency in the overall process for the issuers, providers, and consumers.

Specifically for consumers, the rule provides greater transparency by requiring that certain information about providers and networks be accessible and current. In drafting these rules, the Commissioner considered comments from a broad range of stakeholders with competing interests and concerns. The result is a measured and informed balance between the needs of consumers, interests of the providers, and concerns of the issuers.

***Comment:** Concerns were raised about the timeline of the rule and the ability of issuers to comply with the new reporting requirements, gathering necessary information, meeting contracting deadlines, and the ability to file by May 1, 2014. Specifically, concerns were raised regarding the geographic network maps, access plans, and re-contracting issues.*

Response: The Commissioner recognizes and is mindful of the timeline of this rule and the unavoidable tension with filing deadlines and contracting issues. Based upon the comments received, additional safe harbors and exceptions were built into the rule. A few safe harbors and exemptions were in the rule prior to the most recent amendments, including that the

Commissioner may extend time to file reports for good cause shown. Additionally, the rule addresses re-contracting by requiring any necessary re-contracting to happen by January 1, 2015, but allowing the issuer to make a written request to the Commissioner for a one-year extension. Specifically addressing the new reporting requirements, there is a safe harbor provision for geographic mapping reports and access plans. If issuers cannot meet the filing requirements for these two reports, issuers must identify which of those two reporting pieces cannot be met, why the reports cannot be filed, and provide the Commissioner with the plan to remedy the inability to file the required reports. This safe harbor is only for the 2015 filings. Finally, while issuers need to file by May 1st, the Commissioner recognizes the need to work with the issuers after filing to meet the new filing requirements and during the evaluation of the networks.

Comment: *Set a baseline for the concept of network adequacy and define network adequacy. The network baseline would be adequate when it addresses the requirements for inclusion of Essential Community Providers and meets federal network adequacy standards. Include a safe harbor standard where a network that includes a minimum percentage of provider type located in a specific area is deemed adequate as long as the issuer's enrollment for that network in that location is no more than a percentage of the population.*

Response: The Commissioner declines to set a baseline and define network adequacy in this manner as it ignores the intent of the rule, which is access to covered services. Only requiring inclusion, at the federal level, of Essential Community Providers would leave enrollees without sufficient numbers and types of providers in a network. Additionally, the safe harbor standard does not allow the Commissioner to actually determine whether the network meets an access standard; it instead would create a rubber-stamp process on network access standards which will not serve the consumers of the state. The Commissioner also declines to adopt the federal network adequacy standards as it only pertains to qualified health plans and is only evaluating networks on a "reasonable access" standard focusing on hospitals, mental health providers, oncology, and primary care providers as stated in the final 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM) issued on March 14, 2014. This standard ignores many types of providers and facilities whose inclusion in networks needs to be evaluated and fails to account for the unique nature of Washington State insurance markets, both inside and outside of the exchange. The Commissioner is committed to protecting consumers in Washington State and the more robust network access standards will allow the Commissioner to closely examine networks and address issues with the networks in a thorough and comprehensive manner.

Comment*: Urged to either use provider neutral language in the rule when referencing primary care providers or specifically call out a sub-set of providers, more specifically medical doctors,*

naturopathic doctors, advance registered nurse practitioners, and doctors of osteopathic medicine.

Response: Provider neutral language is used in the rule, based not only on the need to balance issuers' concerns of building networks in certain areas, but also on the interests of provider and consumer groups. Provider neutral language is inclusive of all categories of providers that currently, or in the future, have primary care in the scope of their practice, including those particular categories of providers identified in the comments. Also, by not listing specific primary care providers, the rule avoids inadvertently excluding a provider category. Provider neutral language also provides more options and flexibility for the carriers when identifying and contracting with primary care providers and more choice for consumers when finding a primary care provider.

Comment*: Multiple concerns about balance billing were raised, specifically as it relates to services provided by non-network physicians at in-network emergency departments. There was a request to prohibit balance billing in the rule. One comment stated that balance billing is a symptom of an inadequate network and is unfair to patients. Also, comments received that balance billing should be the median negotiated rate, standard rate, or Medicare rate, whichever is greater.*

Response: Per RCW 48.43.730, the Commissioner has authority to review provider contracts. This includes reviewing all the terms in a provider contract, including compensation amounts, to ensure there is no violation of state or federal law. This statute does not give the Commissioner authority to impose specific provider reimbursement amounts. RCW 48.43.730(3). Based on the particular licensure, an issuer must deliver covered services through a network of contracted providers. However, the Commissioner has no authority to require any specific party to contract with another party. Given this, the Commissioner's authority to regulate balance billing is limited in situations where an enrollee receives care from an out-of-network provider. The rule attempts, within these limits, to prevent situations in which balance billing may occur, and requires advance notice to enrollees regarding those situations.

Comment*: Certain services and provider types need to be included in each network, including, pediatric subspecialties such as rheumatology and oncology, mental health services, pediatric oral services, multiple sclerosis centers, NCI-designated comprehensive cancer centers, transplant Centers of Excellence, and abortion providers.*

Response: As stated above, the Commissioner has no authority to require any party to contract with another party or to set provider contract terms such as reimbursement rates. However, the

rulemaking is important to ensure that issuers have a network sufficient in number and choice of providers and facilities to provide enrollees access to covered services.

***Comment**: Multiple comments were received that the rule requires contracting with certain providers and leans towards the creation of an "any willing provider" model where issuers must accept all providers in the network regardless of cost, efficiency, or outcomes. Comments were also received that issuers should be required to contract with providers or facilities that are willing to contract under reasonable terms and conditions for their services with any plan.*

Response: As stated above, the Commissioner has no authority to require any party to contract with another party or to set provider contract terms such as reimbursement rates. The rule also specifically states that an issuer is not required to accede to any request by any individual provider for the inclusion in any network or any health plan. WAC 284-43-205(4). However, the rulemaking is important to ensure that issuers have a network, sufficient in number and choice of providers and facilities, to provide enrollees access to covered services. There are specific provisions in the rule, including school-based health centers and Indian health care providers, in which a contract must be offered upon request. WAC 284-43-222(4) and (5). However, this is a requirement to offer the opportunity to contract, not a mandate that a contract must be entered into by the parties.

***Comment:** Prohibit closed panels in network evaluations. Conversely, require the issuers to demonstrate sufficient open practices in assessment of the network. Comment requesting a requirement for issuers to identify and indicate whether providers are accepting new patients.*

Response: While a panel may be closed to new patients at the time of network evaluation, there are still existing patients of that particular provider that are accessing the services. Additionally, while the panel is closed at the time the network was formed or the issuer filed with the OIC, it may subsequently open to new patients. The rule requires notification of closed practices only for direct access providers as it would be administratively burdensome to require this for all provider types and plans.

The Commissioner is mindful of the interplay and tension of capacity of providers and facilities with an adequate and accessible network. However, the Commissioner cannot assess capacity because providers are outside of the Commissioner's regulatory authority. The rule attempts to balance this issue within the regulatory authority of the Office of the Insurance Commissioner.
With that in mind, the intent of the rule is to ensure access to covered services. It is the role of the issuer to build networks with sufficient numbers and types of providers to provide enrollees

this access. If an enrollee is unable to access covered services because there is a lack of providers, for whatever reason, then the issuer has not provided sufficient access.

Comment: *Ensure the rules address reimbursement parity, require reimbursement rates that are reasonable in relation to premium charged and cost-sharing risks, require that reimbursement is reasonable in relation to services provided, and require submission of notices of reimbursement to providers and the justification for changes in reimbursement rates.*

Response: As stated above, the Commissioner has no authority to require any party to contract with another party or to set provider contract terms such as reimbursement rates. Under RCW 48.43.730, the Commissioner has authority to review provider contracts including the terms in a provider contract and compensation amounts, to ensure there is no violation of state or federal law. The Commissioner has also left unchanged his authority to review terms offered in contract negotiations where an issuer alleges that it is unable to meet network standards due to unwillingness of providers to contract with it, WAC 284-43-230(2). However, the Commissioner's remedy when a violation is found is disapproval of the provider agreement. This statute does not give the Commissioner authority to impose specific provider reimbursement amounts. RCW 48.43.730(3). To this end, where the rule referenced reimbursement rates, the reference was deleted or the language clarified to ensure the statutory limits were respected.

Comment*: Update the definition of "Indian health care provider." Comment included suggested definition.*

Response: The Commissioner adopted the suggested definition of Indian health care provider in the rule.

Comment*: The rule uses "services" and "providers" inter-changeably and not consistently. Services are covered benefits and not types of providers.*

Response: The Commissioner took this comment into consideration, reviewed the use the terms "services" and "providers" for consistency, and made changes as needed.

Comment*: The rule uses "providers" and "practitioners" inter-changeably and not consistently.*

Response: The Commissioner took this comment into consideration, reviewed the use the terms "practitioners" and "providers" for consistency, and made changes as needed.

Comment: *Remove any references to prior authorization because prior authorization is already governed by other requirements and exceeds the scope of this rulemaking. Alternatively, include cross references to rules related to utilization and medical necessity determination where appropriate. Similar comments regarding post-service authorization.*

Response: The Commissioner agrees that prior authorization is governed by other rules, specifically the rule regarding utilization review and prior authorization, WAC 284-43-410 and WAC 284-43-860. Similarly, post-service authorization is governed by WAC 284-43-410. Additionally, the Commissioner took these comments into consideration and to the extent that prior authorization is included in the network access rule, it is only for the limited purpose of determining whether prior authorization is creating barriers to access of covered services for enrollees. To the extent medical necessity is referenced in the rule, it is to ensure that enrollees are provided information and ensure there are no barriers to access created. Post-service authorization was not included as it would not be considered a barrier to access of covered service.

Comment*: Many comments were received asking that the Commissioner require issuers to include information or create a monitoring mechanism that identifies providers and facilities that restrict services based upon conscience or religion, and identify those services that are restricted.*

The rights of individuals to receive services and the rights of providers, religiously sponsored health carriers or health care facilities to refuse to participate in or pay for services for reason of conscience or religion are expressly covered in RCW 48.43.065. RCW 48.43.065 is not intended to result in an enrollee being denied timely access to any covered service. Each issuer refusing to participate in the provision of, or pay for services, for reason of conscience or religion is required to provide enrollees with written information stating the services the issuer refuses to cover for reason of conscience or religion, and written information describing how an enrollee may directly access services in an expeditious manner, upon enrollment.

Issuers who do not assert a conscious or religious objection, but contract with providers that refuse to participate in the provision of covered services for reason of conscience or religion, are still required to have sufficient providers who deliver care for covered services. Issuers must also identify which providers are in-network and for which covered services. Should a consumer be

denied access to a covered service, for whatever reason, the Commissioner encourages the consumer to file a complaint with this office.

While the Commissioner is aware of the concerns prompting this request, the Commissioner believes that the rule as drafted will provide the transparent and timely access to covered services required by RCW 48.43.065. However, the Commissioner will continue to monitor this issue, to determine if additional clarification or processes are needed to ensure all enrollees can access all covered services in an expeditious manner.

Comment*: There should be defined penalties for inadequate networks and for violation of the rule.*

Response: The Commissioner agrees that there should be penalties for violation of these rules. The Commissioner has general enforcement authority and a broad range of enforcement tools that may be used for this purpose. It is important that appropriate penalties be determined on a case-by-case basis when evaluating all the facts and circumstances. Therefore, the rule does not define enforcement specifically for this violation for two reasons. First, the Commissioner does not believe this to be necessary since his regulatory authority already exists. Second, the Commissioner did not want to create any misunderstanding or inadvertently limit the range of potential enforcement actions that may be taken for violation of the network access rule.

Comment*: The rule appears to generally apply to dental plans when dental plans would not have the same network as a traditional medical plan. Additionally, some sections should be applicable to all oral health services and not just pediatric oral health.*

Response: The Commissioner took these comments into consideration and clarified, where appropriate, that dental plans only have to meet certain requirements in the rule. Additionally, the Commissioner included a specific section on oral health in the general standards section of the rule to provide clarity; WAC 284-43-200(14).

Comment*: Standards regarding continuity of care must be included in the rule including the movement of enrollees from Medicaid and commercial coverage. Associated with this, analyze the combined networks for commercial coverage and Medicaid plans, including managed care Medicaid plans.*

Response: While the Commissioner agrees that continuity of care is an important issue facing enrollees that are moving between commercial coverage and Medicaid, this would be outside the

scope of the rulemaking and therefore will not be addressed. This comment also asks the Commissioner to "analyze the combined networks," presumably to determine whether providers contracted with multiple plans (both Medicaid and commercial) have capacity to serve all enrollees for whom they have contracted. The Commissioner shares the concern that providers may over commit themselves through contracting with multiple plans, and have insufficient capacity to provide services to all those plans' enrollees. However, the Commissioner does not regulate providers and does not have authority to address this issue. There is not one single state agency that has the regulatory authority to address and evaluate capacity across the full spectrum of plans. This will need to be addressed as part of a larger coalition of state agencies.

Comment*: Comments received requesting clarification on when zip codes may be used for a service area and also requesting the Commissioner allow zip codes to define service area.*

Response: The Commissioner declines to adopt a definition for service area that relies upon zip codes. Federal guidelines require issuers to satisfy county integrity requirements in 45 CFR 155.1055. Additionally, the Washington State Health Benefit Exchange has stated in its "Guidance for Participation in the Washington Health Benefit Exchange" document, Section 2.2.17, that a qualified health plan service area must meet 2705(a) of the PHS Act and 45 CFR 155.1055(b) which sets service areas by county. Washington State does not have any counties that would qualify to meet the federal examples of when zip code service areas would be allowed. Federal guidance is clear that the only reason a zip code service area is approved is due to specific issues such as water or land barriers.

Comment*: Strike "within the state" from the definition of service area. It limits the consideration of networks to in-state providers only and does not consider existing delivery systems, provider networks, and natural referral patterns that cross state boundaries. It would disrupt existing delivery systems and limit consumer choice.*

Response: The Commissioner took this comment into consideration and struck "within the state" from the definition of service area.

Comment*: Received comments critical of, and supportive of, the standard of substantial evidence of good faith efforts of contracting and comments inquiring as to what evidence will be considered in the determination of good faith efforts at contracting. Comments received urging the retention of the clear and convincing evidence standard while other comments urged the deletion of this standard as overstepping the Commissioner's authority. Comments received that*

an issuer would meet this standard by making minimal efforts, such as simply emailing a proposed contract to a provider with a very short turn-around time.

Response: The Commissioner noted that both providers and issuers requested that the rules require the other party to submit to certain limits on its contract terms. Per RCW 48.43.730, the Commissioner has authority to review provider contracts. This includes reviewing all the terms in a provider contract, including compensation amounts, to ensure there is no violation of state or federal law. However, the Commissioner's remedy when a violation is found is disapproval of the provider agreement, network, or an alternate access delivery request. This statute does not give the Commissioner authority to impose specific provider reimbursement amounts. RCW 48.43.730(3).

Based upon this limitation, and the limited instances in which review is appropriate under the statute, it would be inappropriate for the Commissioner to review substantive contract terms in every case. Given these parameters and the intent of the rule, good faith efforts to contract is the appropriate standard to include as a threshold requirement.

The Commissioner also received comments indicating that both providers and issuers have, at times, refused to engage in efforts to contract. As stated above, the Commissioner has no authority to require providers to contract with issuers. However, the Commissioner does have authority to require a showing of good faith efforts to contract in order to meet the network requirements. Under this requirement, the Commissioner will evaluate exactly what efforts an issuer made to include a provider in its network. The rules go to the extent of the Commissioner's authority, and can go no further.

Evidence of the issuer's good faith efforts to contract will include, at a minimum:

- Provider information identifying the provider organization name and affiliates name(s), business address, mailing address, telephone number(s), email address, organizations representative name and title;
- Issuer's information identifying the issuer representative's name and title, mailing address, telephone number, and email address;
- If a contract was offered, a list that identifies contract offer dates and a record of the communication between the issuer and provider. For example, the issuer should indicate whether contract negotiations are still in progress or the extent to which it is are not able to agree on contract terms. "Extent to which you are not able to agree," means quantification by some means of the distance between the parties' positions. For example, "After working together for two weeks, the parties still had several contract provisions upon which they were unable to come to agreement, and neither party was able to compromise further," or "The parties exchanged draft contract provisions and met

in person, but their positions were widely divergent and we were unable to come to agreement;"

- If a contract was not offered, explain why the issuer did not offer to contract. Documentation must be as specific as possible.

Comment: *Comments received requesting an opportunity to submit rebuttal evidence by providers and facilities when an issuer claims an inability to contract.*

Response: The rules are not intended to arbitrate whether a particular provider or facility should be included in a network. The rule is intended to ensure enrollees have access to sufficient numbers and types of providers for covered services. The only time the Commissioner will closely examine contract terms is when a compensation agreement causes the underlying health benefit plan to otherwise be in violation of state or federal law pursuant to RCW 48.43.730. In that case, the Commissioner may well request such information from the relevant provider(s) in order to evaluate whether an issuer contracted in good faith. But the Commissioner believes that it would be inappropriate to require him to evaluate such information in every case. Accordingly, the Commissioner declines to require an opportunity for rebuttal from the providers and/or facilities when an issuer indicates an inability to contract.

Comment*: Require that providers meet or exceed the National Culturally and Linguistically Appropriate Services Standards.*

Response: The Commissioner declines to include this requirement in the rule. The Commissioner has no regulatory authority over providers therefore it would be inappropriate for the rule to require this standard.

Comment: *Require confidential access to services, particularly for adolescents.*

Response: Currently, WAC 284-04-510 limits the disclosure of health information. Specifically, the rule provides that an issuer cannot disclose any nonpublic personal health information related to a service the minor has accessed without the express authorization of the minor. This includes mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or other covered person. Additionally, the issuer cannot require the minor to obtain the policyholder's or other covered person's authorization to receive health care services which the minor may obtain without parental consent under state or federal law. Accordingly, these provisions will not be restated in this rule and would be outside of the scope of this rulemaking.

***Comment**: Concerns raised about the effect of the rule on rural health delivery systems.*

Response: The Commissioner took this comment into consideration and also is concerned about access to enrollees in rural areas of the state. The rule addresses this issue in a few ways.
First, the rule provides general standards that networks must meet. Specifically, networks must have sufficient numbers and types of providers to ensure that all covered services are provided in a timely manner and appropriate to the enrollee's needs. However, in recognition that there are some areas in the state that are geographically difficult in which to build a network either due to a lack of providers and/or enrollees, the rule allows for the filing of an alternate access delivery system if the county has a population that is 50,000 or fewer. This would affect Garfield, Wahkiakum, Columbia, Ferry, Lincoln, Skamania, Pend Oreille, San Juan, Adams, Klickitat, Pacific, Asotin, Jefferson, Douglas, Kittitas, Okanogan, Stevens, and Whitman counties. This will incentivize contracting in rural areas and provide more choices for rural consumers.

Second, qualified health plans must include sufficient number and types of Essential Community Providers to provide reasonable access to the medically underserved or low-income in the service area. Although Essential Community Providers are determined by the Centers for Medicare & Medicaid Services (CMS), there are certain categories on the list in the rule that will directly involve providers in rural areas. In fact, 37 of the 39 designated critical access hospitals are on CMS' non-exhaustive list of Essential Community Providers. Additionally, the rule specifically requires inclusion of 50% of rural health clinics, 90% percent of federally qualified health centers and look-a-likes, at least one essential community hospital per county, and 75% of school-based health centers in issuers' networks.

Finally, part of the network evaluation is the geographic mapping reports. The geographic network maps are just one tool in the network evaluation that the Office of the Insurance Commissioner will be conducting. The mapping reports are a minimum requirement and will be evaluated in conjunction with the general standards outlined in the rule for network access and adequacy. In order to encourage the building of networks in rural areas, the 60 mile/minute requirement was adopted. Also in this section of the rule, the rule defines urban. It is important to note that the definition of urban in the network access rule covers approximately 88% of the population of Washington State. Accordingly the 30 mile/minute minimum requirement for providers will affect the significant majority of the enrollees.

***Comment:** The definition of "women's health care" should include abortion care for those plans that cover it.*

Response: The current definition in RCW 48.42.100 includes maternity care, reproductive health services, gynecological care, general examination, and preventative care. While the statute

allows issuers to include additional services as "women's health care," it does not provide the authority to require inclusion of additional services. This rule cannot exceed the statutorily mandated definition. However, issuers must provide sufficient number and type of providers and facilities to provide covered services for enrollees. Should a plan cover termination of pregnancy, either voluntary or involuntary, then an enrollee must be able to access those services in a timely manner appropriate for the enrollee's condition. Additionally, RCW 48.42.100(2) requires issuers to include providers acting within the scope of their license as in-network providers in compliance with Chapter 9.02 RCW.

Comment: *Only those providers who offer a full range of health care options should be counted towards fulfilling network standards for reproductive health providers.*

Response: To the extent that the comment regards the contracting process, this rule is not intended to address that issue. This rule does address consumer access to covered services. It is the role of the issuers to build a network that will provide sufficient numbers and types of providers to ensure access to enrollees for all covered services. The Commissioner has no authority to require any party to contract with another party, or to set provider contract terms.

Comment: *Add cancer care and hematologic disorders to list for which standing referrals to specialists are permitted.*

Response: The section, currently WAC 284-43-200(13)(d), regarding standing referrals, is meant to cover a broad range of conditions. It would be burdensome to specifically list these conditions. Accordingly, cancer care and hematologic disorders are subsumed in chronic conditions in this section of the rule. Additionally, RCW 48.43.515(3) provides that an enrollee with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time.

Comment: *Change the term "gender preference" to "sexual orientation."*

Response: The Commissioner took this comment into consideration when drafting the rule. Based upon this comment, language was changed to align with RCW 49.60.030, 45 CFR 156.200(e), 42 U.S.C. §18116.

Comment: *Use of terms related to behavioral health is inconsistent and unclear; the term should be defined by WAC 388-877-020 and consistent with DSHS rules. Substance use disorder and chemical dependency need to be addressed as part of network adequacy.*

Response: To the extent this comment relates to behavioral health treatment as part of the Essential Health Benefit of mental health and substance use disorder services, including behavioral health treatment, the diagnoses and required benefits are set forth in detail in WAC 284-43-878(5). To the extent these terms are referenced in this rule, the intent is to ensure access to covered services. The Commissioner declines to adopt the DSHS definition, as those are rules of a sister agency and if changed, may be changed to the detriment of the network access evaluation process. The Commissioner will, however, look to the definitions in WAC 388-877-020, WAC 284-53, federal laws and rules, and applicable case law. Substance use disorder and chemical dependency are specifically contemplated as part of the network access determination in WAC 284-43-200(11), as well as the Essential Health Benefit requirements in WAC 284-43-88(5).

Comment: *Changing terminology to "network access" as opposed to "network adequacy" implies a per member and per service review. Adequacy describes a baseline quality of a network while access can vary in quality. An adequate network is one in which patients receive proper care and emphasis should be placed on that.*

Response: The Commissioner respectfully disagrees. Network access is larger than network adequacy; network adequacy is part of network access. For example, where an issuer has contracts with a host of providers, but enrollees are unable to access care by those providers due to geographic location or closed practices, network adequacy may be adequate, while network access is not. The language was changed to more accurately reflect the intent of the rule and the actual process undertaken by the Commissioner. Networks are dynamic and evolving systems that constrict and expand over time and throughout plan years. The Commissioner is not undertaking a singular or audit review of the network; rather the Commissioner will be evaluating the networks early for access to covered services and monitoring issuer network maintenance throughout time.

Comment: *Define "issuer".*

Response: The prior version of the rule included issuer in the definition of "health carrier." For consistency with the remainder of the chapter, the term issuer will be as defined in WAC 284-43-130(14).

Comment: *A concern was raised that the rule would apply to the Health Care Authority's self insured plans, such as Uniform Medical Plan.*

Response: As a general matter, self insured plans are not subject to the insurance code or the rules promulgated by the Commissioner. RCW 41.05.140 gives the Commissioner limited authority over the self insured plans administered by the Health Care Authority (HCA), for the purpose of conducting financial examinations and determining the adequacy of reserves. The Commissioner does not have broad authority to enforce other provisions of the insurance code and insurance rules against HCA's self insured plans. Further, nothing appears to require that HCA apply this rule to its self insured plans. Under RCW 41.05.017, the plans HCA offers must satisfy a number of statutes, including several sections of the insurance code. RCW 41.05.017 does not, on its face, require HCA's self insured plans to also comply with the Commissioner's rules concerning the enumerated statutes. One of the insurance statutes applicable to HCA's self insured plans under RCW 41.05.017, provides that every "carrier" must meet the standards set forth in the statue "and any rules adopted by the Commissioner in implementation of this provision of the code." RCW 48.43.515(8). "Carriers" are defined as a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020. Self insured plans, such as Uniform Medical Plan, are not carriers as defined in RCW 48.43.005(25) and WAC 284-43-130 (14). Therefore neither the plain language of RCW 41.05.017, RCW 48.43.515(8), nor this rule, appear to make this rule applicable to HCA's self insured plans. However, the Commissioner must defer to the HCA's interpretation of the statutes it is compelled to enforce.

Comment: *Many comments received requesting changes in definitions in WAC 284-43-130.*

Response: The Commissioner declines to change definitions except to the extent the definition directly pertains to the rule section being amended at this time.

Comment: *Comments received that certain network formations will be in violation of the rule.*

Response: The Commissioner declines to comment on hypothetical network formations. It is impossible to evaluate whether a network will violate the rule based on a hypothetical. In order to evaluate a network formation the Commissioner would need to review all required documentation for the network model.

Comment: *Comments received asking about implementation of the rule.*

Response: The Commissioner has received multiple comments regarding the filing instructions, required document formats, and other submission requirement for issuers to comply with this rule. The OIC Rates and Forms division maintains a dedicated Network Access website page for interested parties available at: http://www.insurance.wa.gov/for-insurers/filing-instructions/file-network-access/
Filing instructions, form templates, analyst checklist, etc., will be posted on this webpage.

Comment: *The rules as they currently exist are sufficient and "have teeth," and should not be changed.*

Response: The Commissioner disagrees that the existing rules are sufficiently clear and enforceable to adequately protect consumers, especially in the era of network innovation. Additionally, the Commissioner must harmonize Washington State's rules with the ACA and federal rules implementing it.

Comment: *Comment that the Commissioner should have prepared and provided a Small Business Economic Impact Statement (SBEIS) as part of the CR102 filings for this proposed rule. The specifically expressed concern was that the access standards in proposed WAC 284-43-200 for time to appointment for primary care and specialty care will impose performance requirements on health care providers as agents of the issuers in meeting these access standards.*

Response: WAC 284-43-200, as proposed in the rule filing, requires that each issuer maintain a provider network that is sufficient in numbers and types of providers and facilities to assure that all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. This section puts the responsibility on the issuers to "demonstrate that services are readily available without unreasonable delay to all enrollees" and "each enrollee must have adequate choice among health care providers". WAC 284-43-200(13) provides the issuers with some standards for adequate access—one of which is that enrollees have access to a non-preventive care appointment with their primary care provider within ten business days of request and within 15 business days for specialists (for non-urgent services).

The network adequacy rules, as proposed, then allow for the filing of alternate access delivery requests when sufficient providers cannot be contracted to meet these standards or a provider becomes unavailable or a county has less than 50,000 people and the county is the sole service area for the plan.

Taken as a whole, none of these rule provisions establish a performance standard that must be embedded in contracts between issuers and providers. They instead set access standards that

issuers must meet by contracting with sufficient primary care and specialty care providers to handle the needs of their plan enrollees. The Commissioner believes the only likely cost to primary and specialty care providers is the very minimal cost of informing the issuers (that they contract with) that their panels are full, which in this case would be when they cannot add additional enrollees and stay within the appointment standard. The proposed rules, by also providing a standard for the ratio of primary care providers to enrollees, further emphasize that the access issue is one of contracting with a sufficient number of providers. That being said, issuers may choose to add to their provider contracts performance guarantees regarding patient access as a means of expanding the capacity of their existing provider networks, but such a contract addition is not required by this proposed rule.

Comment: *Require issuers to collect clear and unambiguous statements of referral practices in their contracts with network providers.*

Response: Provider contracts, which this language refers to, will be addressed in phase two of this rulemaking, WAC 284-43 Subchapter C.

Comment: *Add "covered service" after "provider and facility" in the rule to be consistent.*

Response: The Commissioner took this comment into consideration and, where appropriate, included the suggested language.

Comment: *Concern that under the rules, enrollees cannot independently pursue their rights to access covered services through private causes of action against issuers, but must instead rely only on regulatory enforcement by OIC.*

Response: Nothing in the rules is intended to alter the ability of enrollees to pursue their rights to access covered services against issuers under any cause of action to which the enrollee may be entitled under federal or state law

Comment: *General comments made correcting grammar usage or typographical errors.*

Response: The Commissioner took these comments into consideration and, where appropriate, corrected grammar and typographical errors.

Comment: *Issuers should be required to notify enrollees when a provider wouldn't perform a particular covered services.*

Response: The Commissioner declines to include such the requirement. To require this would be administratively burdensome. The rule requires that enrollees have access to covered services and that issuers notify enrollees how to access covered services. The rule is not intended to do the converse.

WAC 284-43-200: Network access-general standards

Comment: *The general standards section is confusing when read with the section on assessment of access section, WAC 284-43-230, because it appears there are general standards in both sections of the rule.*

Response: The Commissioner took these comments into consideration when drafting the rule. Based upon this comment, the Commissioner undertook a broad restructuring of these two sections. The organization of the general standards section was reworked and many pieces of the assessment of access section were moved into general standards. Accordingly, assessment of access is a much smaller subsection and is targeted to what the Commissioner will be reviewing when evaluating whether the general standards and other requirements of the rule have been met.

Comment: *In regard to prior authorization, the qualified staff should be a licensed healthcare professional within the same profession as for what the prior authorization is made. Timely prior authorization should be two hours for emergent and four hours for non-emergent. Additional comment that staffing requirements are inappropriate in these rules.*

Response: The Commissioner declines to adopt this suggestion. This would be an incredible administrative burden to require one of each provider type available to make prior authorization decisions. To the extent that this comment deals with utilization review and prior authorization, including timeliness of decisions, WAC 284-43-410 and WAC 284-43-860, would govern as those issues are outside the scope of this rulemaking. The Commissioner respectfully disagrees this is a staffing requirement; rather it is a requirement that the issuer be prepared to give timely prior authorization and ensure access to provider and facilities that provide the covered service.

Comment: *Maintain the 30-mile reasonable proximity example in the general standards, eliminate the 30-mile example in general standards, or change the 30-mile example in standards to a stricter standard.*

Response: The Commissioner took these comments into consideration when drafting the rule. Because the geographic network reports specifically designate time and/or distance criteria to be used in evaluating provider networks, the Commissioner determined that the distance example in

general standards was no longer useful or necessary and indeed may confuse the issue as this was just an example, not a requirement. Instead, general standards are focused on the requirements that the Commissioner will be measuring all provider networks on a case-by-case, fact-specific, basis. Dependent upon the factual circumstance, reasonable proximity may be more or less than the 30-mile example that was used prior. In the general standards section, WAC 284-43-200, the Commissioner included that eighty percent of enrollees must be within 30 miles of a primary care provider in an urban area and within 60 miles of a primary care provider in a rural area.

Comment: *Do not delete section WAC 284-43-200(3) which pertains to situations when there is an absence of, or insufficient number of, providers and yet the issuer must provide covered services within a reasonable proximity at no greater cost than if provided by an in-network provider. Ensure this requirement is met even if there is a pending alternate access delivery request pending.*

Response: The Commissioner agrees these are important requirements and maintained these requirements in the rule. The section referenced above is now WAC 284-43-200(5). The Commissioner considered the comment regarding pending alternate access delivery requests and included language that the requirement to provide covered services at no greater cost is required even if an alternate access delivery request is pending.

Comment: *Specific pediatric adequacy standards should be developed and monitored to ensure that children enrolled in qualified health plans have access to needed services in a timely manner. Include requirements for sufficient pediatric oral, dental, and mental health providers.*

Response: The Commissioner agrees that networks need to have sufficient numbers and types of providers for enrollees to access covered service, including pediatric services. The rule is intended to address that issue. The rule addresses access to covered services for enrollees generally, which would contemplate the needs of pediatric enrollees. Additionally, the rule requires that providers be accessible in a timely manner appropriate for enrollees' conditions and that there is adequate choice among providers. There are also sections of the rule which pertain specifically to pediatric providers, including specialists and oral health providers. The rule requires sufficient access for enrollees of qualified health plans as well as those who purchase health insurance outside of the Health Benefits Exchange.

Comment: *There should be no greater cost to enrollee for out-of-network providers when there is not sufficient in-network providers.*

Response: The Commissioner agrees. The rule requires, in situations where there is an absence or insufficient number of a type of provider, that the enrollee may obtain the covered service at no greater cost to the enrollee than if the covered service were obtained from a network provider.

Comment: *Shorten the wait times for enrollees requiring an urgent appointment to 24 hours regardless of prior authorization.*

Response: The Commissioner took this comment under consideration and retained the 48-hour access to urgent appointment without prior authorization. Should an enrollee need care prior to this, the rule requires emergency services be available 24 hours a day.

Comment: *In regard to urgent appointments, the referring physician should not be required to document whether a longer wait time for an appointment is permissible or not detrimental to the enrollees' health.*

Response: These comments were taken into consideration in drafting the rule. Accordingly, this requirement was removed from the rule.

Comment: *Do not limit single case agreements or "spot contracting." These types of agreements allow an enrollee to obtain services when needed. Comments were also received that the rule precludes the use of single case provider reimbursement agreements where appropriate.*

Response: The Commissioner agrees that single case provider reimbursement agreements can be an important tool to provide services to an enrollee when there is a unique situation where an enrollee's care necessitates a provider that is out-of-network or out-of-service area. However, single case provider reimbursement agreements should be the exception and not the rule. If these types of agreements are being used on a regular basis there may be a broader issue with the provider network and the ability to provide access to covered services. However, the rule allows the use of single-case agreements where appropriate.

Comment: *Strengthen the section on pediatric dental to include adult dental and further define "normal utilization."*

Response: The Commissioner agreed with this comment and changed the language regarding utilization. In regard to the pediatric and adult oral services comment, pediatric dental is required

under the Affordable Care Act as an Essential Health Benefit, which this section is intended to address.

Comment: *Clarify what will result in discrimination.*

Response: The rule is intended to set out the general legal principle against discrimination consistent with state and federal law. It is not intended to provide examples of what would be a discriminatory service area as this is a fact-specific analysis that should be determined on a case-by-case basis. Additionally, there is a whole body of case law dealing with this particular issue and it would be outside the scope of the rulemaking to provide further clarification.

Comment: *Change reference to "cancer care center" to "NCI-designated comprehensive cancer care centers" in the section dealing with when an issuer may use facilities and providers in neighboring service areas to satisfy a network access standard if that type of facility is not in the service area.*

Response: The Commissioner has been informed that there are only four NCI-designated comprehensive cancer centers in the Pacific Northwest. Should the Commissioner require thaht networks include only cancer centers with this designation in the rule, the Commissioner would essentially be requiring issuers to contract with only specific providers for coverage of a specific condition. This would run contrary to the intent of the rule which is to ensure access to covered services. It is the role of the issuers to build networks with sufficient numbers and types of providers to provide enrollees access to covered services.

Comment: *Include solid organ, bone marrow, and stem cell transplants in the list of facilities providing transplant service in the section dealing with when an issuer may use facilities and providers in neighboring service areas is to satisfy a network access standard if that type of facility is not in the service area.*

Response: The Commissioner took this comment into consideration and included these three transplant services in WAC 284-43-200(5)(e).

Comment: *Remove language regarding the ratio of primary care providers to enrollees for the state because the ratio for a particular area may be significantly different than the state average, and, even if an issuer includes every provider in the county, it would result in less provider availability because the formula is exceeding the average of enrollees to providers.*

Response: The primary care provider ratio required under subsection WAC 284-43-200(13)(b)(i) is a standard for determining whether a network meets the Essential Health Benefits category of ambulatory patient services. It is not a determination of whether the network is sufficient in its number of primary care providers to assure that, to the extent feasible based on the number of primary care providers in the service area, primary care will be accessible in a timely manner, as required under WAC 284-43-200(1). This is an illustration of how the various aspects of analysis set forth in the rule work together, and satisfaction of a particular requirement is only one part of the analysis. The focus of the provider network rule is on access to covered services within a reasonable time and networks need to be created accordingly.

Comment: *Define "wellness." An associated comment indicated that this should be removed as it is outside the scope of rulemaking.*

Response: The Commissioner took this comment into consideration and included a reference back to the statute and the rule regarding Essential Health Benefits, RCW 48.43.005(37) and WAC 284-43-878(9). Additionally, as issuers are required to provide coverage for Essential Health Benefits, this information is important for the Commissioner to have in order to evaluate the network.

Comment: *Include language in WAC 284-43-200(12) that the provider network "or the summary of benefits and explanation of coverage for the health plan" must include preventive and wellness services.*

Response: The Commissioner declines to include this language as this section pertains to the network and access to these services which are required under RCW 48.43.005(37) and WAC 284-43-878(9), not information to be included in the summary of benefits and explanation of coverage for a particular plan.

Comment: *Requiring smoking cessation "quit lines" or "help lines" is excessive, not within "provider services," and does not involve licensed providers.*

Response: This benefit is highly encouraged both by the Commissioner and the U.S. Department of Health and Human Services and is consistent with the ACA's goals of promoting wellness and decreasing health care costs. Quitting smoking is advantageous to wellness and smokers as a group incur higher health care costs than nonsmokers.

Wellness, as defined in RCW 48.43.005(37), includes smoking cessation. WAC 284-43-878(9) requires that certain Essential Health Benefits are provided, including wellness. The rule requires that, to the extent services for smoking cessation are provided, the follow- up services, which may include providers or facilities, are medically necessary and the enrollees have access to sufficient information to access those services. This provision ensures that, where smoking cessation programs are a covered benefit, the benefit is not illusory.

Comment: *Expand list of mental health providers authorized to provide mental health and chemical dependency care operating in the scope of their practice. Consider adding language describing services beyond inpatient psychiatric to include outreach, stabilization, and outpatient therapy. Include crisis intervention as well as stabilization.*

Response: The Commissioner took these comments into consideration when drafting the rule. While the Commissioner cannot mandate coverage, the intent of the rule is to ensure there are sufficient numbers and types of providers for enrollees to access covered services. This section of the rule includes services from licensed mental health providers. Based upon this comment, stabilization was added where appropriate and the language in this section was clarified. Additionally, every category of provider, WAC 284-43-205, needs to be read in conjunction with this section.

Comment: *Information on mental health and substance use disorder treatment should be available 24 hours a day and by providing information on the website. Conversely, comment urged the deletion of the section ensuring an enrollee can identify information about mental health and substance use disorder treatments by calling a customer service representative because it follows a section that discusses network access for those providers and facilities which is sufficient.*

Response: The Commissioner took these comments into consideration when drafting the rule. The Commissioner declines to delete this section because this information is important for the enrollee to access providers and facilities that offer covered services specific to mental health and substance use disorder treatment. However, the Commissioner also declines to require issuer's provide a customer service representative be available 24 hours a day. The Commissioner leaves it to the issuers to determine if posting such information on a website is the most efficient means. Additionally, issuers are required to include pertinent information in the Access Plan, WAC 284-43-220(3)(f)(i)(E), including standard hours of operation, and after hours, for prior authorization, consumer and provider assistance and claims adjudications.

Once reports are submitted by issuers the reports can be accessed on the Office of the Insurance Commissioner's website. One must search by company at: http://www.insurance.wa.gov/consumertoolkit/search.aspx and then click on "View Access Reports" under the Network Access Reports heading.

***Comment**: Request to define behavioral therapy and habilitative therapy and a requirement to use only licensed categories of providers.*

Response: Currently, these services are specifically addressed in WAC 284-43-878, Essential Health Benefit categories. The Commissioner declines to define these services in this particular rulemaking as it would be outside the scope of the rulemaking.

***Comment:** Requirement that a preventative visit occur within 10 days is unrealistic as providers cannot meet this requirement. An appointment within 10 days should only be for routine visits.*

Response: The Commissioner took these comments into consideration when drafting the rule. Accordingly, WAC 284-43-200(13)(b)(iii) requires that enrollees have access to an appointment, for other than preventative services, with 10 business days of requesting an appointment.

***Comment:** When listing facilities in neighboring service areas that may be used to satisfy a network access standard, need clarity around the pediatric community hospitals pursuant to Department of Health as there are only four in the state.*

Response: The Commissioner took these comments into consideration when drafting the rule. Accordingly, WAC 284-43-200(5)(b) references pediatric community hospitals only. The reference to the Department of Health was deleted.

***Comment:** Define "reasonable proximity" as used in WAC 284-43-200(5), when an issuer has an absence or insufficient number or type of provider to provide a particular service.*

Response: The Commissioner declines to define reasonable proximity as this will be determined on a case-by-case basis taking into account all the facts and circumstances in that particular situation.

***Comment:** Requirement that issuer ensure an appointment within a certain amount of time is unreasonable as issuers do not have access to provider's calendars nor do the providers supply*

issuers with turnaround times for enrollees. Related comment that appointment criteria is not part of network adequacy or provider network formation.

Response: The intent of the rule is to ensure that enrollees have reasonable access to providers. This is an example of what would be considered reasonable in the context of appointments. It is the issuer's responsibility to understand who its providers are and the ability of those providers to treat enrollees. Without this information it is unclear how issuers can determine whether their network(s) are "sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition," and that "for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees."

Comment: *Removal of sections allowing the issuer to set the standards to determine network access creates ambiguity because what is necessary is not defined.*

Response: The Commissioner respectfully disagrees, as the rule now specifically defines what is necessary to have network access and adequacy as opposed to allowing different issuers create "reasonable criteria" for themselves. The benefit for having clearly defined criteria is a level playing field where everyone is held to the same specific standards resulting in no ambiguity.

Comment: *Define "commercial network provider."*

Response: The Commissioner took these comments into consideration and deleted the reference to "commercial network provider." This subsection has been modified and is now WAC 284-43-200(15)(a).

Comment: *Add a section to WAC 284-43-200 that specifically requires adequate networks for chemical dependency treatment.*

Response: The Commissioner declines to add the requested section. Consistent with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the definition of substance use disorder in WAC 284-43-005(7), the phrase "substance use disorder," as used in rule, includes those conditions meeting the definition of chemical dependency. WAC 284-53-010(7) requires that issuers that provide such benefits through a defined network must meet the network adequacy requirements set forth in WAC 284-43-200 and also requires that

health benefit plans that allow for out-of-network benefits must apply them to chemical dependency services consistent with medical and surgical benefits. Since WAC 284-53-010(7) already requires issuers to meet network adequacy requirements for substance use disorder, which includes chemical dependency by definition, it would be redundant to restate this in this rule. Additionally, the Essential Health Benefits under WAC 284-43-878(5) require "mental health and substance use disorder services, including behavioral health treatment." This language is mirrored in WAC 284-43-200(11).

Comment: *Include in WAC 284-43-200(2) a reference to WAC 284-43-222 so that Essential Community Providers are included for qualified health plans and issuers are required to have adequate choice among health care providers.*

Response: The Commissioner took this comment into consideration and included a reference to WAC 284-43-222 in WAC 284-43-200(2).

Comment: *Change language in WAC 284-43-200(11)(a) to list all mental health providers or change language to "licensed mental health providers."*

Response: The Commissioner took this comment into consideration and changed the language in WAC 284-43-200(11)(a) to "mental health providers."

Comment: *The rule inadvertently excludes categories of providers that are needed to appropriately provide Applied Behavioral Analysis services, specifically providers that are certified rather than licensed.*

Response: The Commissioner recognizes the issues around coverage for certified providers of applied behavioral analysis (ABA) therapy for autism spectrum disorders. However, he must decline to make the suggested change because it would broaden the requirements. The "Every Category of Provider" statute, RCW 48.43.045, and the definition of "health care provider" under RCW 48.43.005, limit the providers that must be permitted to provide covered health services to those licensed under Title 18 or Chapter 70.127 RCW. In addition, although ABA providers are certified by a responsible state agency, the suggested change would open the requirement to include providers certified by any entity, potentially leading to unintended results.

The rule provides general standards that networks must meet. Specifically, networks must have sufficient numbers and types of providers to ensure that all covered services are provided in a timely manner and appropriate to the enrollee's needs. However, the standards are meant to be a

minimum that the issuer must meet, and, to the extent that a licensed provider is referenced, the issuer is not limited to the inclusion of licensed providers.

Comment: *Change the language in WAC 284-43-200(5) from "hospital" to "services" or "care services."*

Response: The Commissioner declines to change the language as requested as it may inadvertently limit the types of facilities and changes the intent of the section.

Comment: *Restore the words "each type of" and "types of providers who" to WAC 284-43-200(2) to provide clarity and consistency with other sections.*

Response: The Commissioner declines to change the language as requested as those phrases were specifically deleted to clarify the Commissioner's expectations for access to covered services.

Comment: *Delete WAC 284-43-200(5) because this subsection negates consumer access requirements, will be disruptive to established hospital/provider relationships, and will disrupt continuity of care.*

Response: The Commissioner took this comment into consideration and declines to delete this subsection. Current WAC 284-43-200(5) was originally in WAC 284-43-230(3) and moved as part of a multiple section reorganization to clarify general standards required for network access. The subsection has no effect on consumer access requirements, however, WAC 284-43-229(7) adds a requirement that issuers give notice to certain enrollees when their providers are moved to a different tier.

Comment: *Subsection (c)(ii) should be changed to "(ii) The issuer establishes that when an enrollee is referred to a specialist, the enrollee has access to an appointment with a specialist within fifteen business days for nonurgent services."*

Response: The Commissioner declines to make this change, as this would not require access to the category of specialist to which the enrollee has been referred, but instead to *any* specialist. This would lead to absurd results and would not require that issuers provide covered services the enrollee needs in a manner that meets the standards. The Commissioner has received comments from providers and consumer groups which raised concerns about issuers requiring enrollees to

see specialists who, even on the surface, are not an appropriate provider. For example, pediatric enrollees being sent by issuers to specialists who do not treat pediatric patients.

Comment: *The addition of the phrase "to the extent feasible based on the number and type of providers and facilities in the service area" weakens the rules.*

Response: The Commissioner disagrees with this interpretation. This phrase does not change the rule, but simply refers to the fact that there remains flexibility in the rule to deal with the realities of provider location and willingness to contract.

Comment: *The following language should not be deleted from WAC 284-43-200: "A health carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to covered persons (enrollees)."*

Response: Updates to the requirements for maintenance of networks, which this language refers to, will be addressed in phase two of this rulemaking.

Comment: *"Crisis intervention and stabilization" should be removed or clarified as this refers to services, not providers and "crisis" is an undefined term.*

Response: The Commissioner declines to remove the referenced language. This language is consistent with the U.S. Department of Health and Human Services' final regulation regarding Essential Health Benefits which requires QHP's and non-grandfathered health insurance plans in the individual and small group markets to provide mental health and substance use disorder services in a manner that complies with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Additionally, the rules regarding Essential Health Benefits, WAC 284-43-878(2) and (5), require coverage for emergency and mental health services.

Comment: *Change "condition" to "mental health condition" in WAC 284-43-200(11)(a).*

Response: The Commissioner declines to make the suggested change. To do so would change the intent of the section and could exclude certain conditions, such as substance use disorders, that are found in the Diagnostic and Statistical Manual of Mental Disorders.

WAC 284-43-201: Alternate access delivery request

Comment: *Rule ignores that issuers have a major interest in addressing issues with the networks and dealing with them as a business matter, that there is unavailability of certain providers in less populated areas of the state, and there is an unwillingness of some providers to contract with issuers.*

Response: The Commissioner took these comments into consideration when drafting the rule. The Commissioner recognizes and agrees that dealing with the adequacy of the network is a business decision that issuers must make, but this needs to be balanced with the promise issuers made to enrollees that the networks will provide access to covered services. Taking into consideration that there are areas of the state where it is a challenge to build adequate networks, due to the inability to contract or the lack of provider or facility types in less populated areas, the Commissioner specifically included these circumstances as situations where an alternate access delivery request is appropriate.

Comment: *Rule does not allow for the issuer to review and cure any perceived deficiencies in the network. Comments also received that issuers should be held accountable for identifying issues with the network, report the issues to the Commissioner, and mitigate potential gaps in coverage.*

Response: The Commissioner took these comments into consideration and clarified when an alternate access delivery request would be appropriate. The Commissioner understands the fluid and changing nature of networks and that there are situations when a loss of a provider or facility has the potential to negatively affect delivery of care to enrollees. In recognition of this, the rule allows the issuer to review the network, report any deficiencies to the Commissioner, and propose an alternate access delivery system in order to assure access to covered services. This allows enrollees to access necessary care while the issuer addresses any issues with the network.

Comment: *Having an alternate access delivery system creates two different standards for network adequacy and access.*

Response: This section of the rule was edited significantly during the course of rulemaking taking into consideration the concern that the rule was creating two network standards. The intention is not to have different standards, but to have a reasonable option available to issuers to account for the unavoidable situations that occur when building and maintaining networks. The intention is to limit alternate access delivery requests to unfortunate circumstances where there was an approved network, something happened to the network that affects access to providers, and the necessity to maintain access to enrollees while issues with a network are addressed.

The rule also provides flexibility for issuers where it has been traditionally difficult to build strong networks by allowing for an alternate access delivery in counties with population of 50,000 or less and the county is the sole service area for the plan. This will incentivize contracting in rural areas and provide more choices for rural consumers.

***Comment**: Clarify what are consistent patterns of practice for obtaining health care. Additional comment that what is a pattern and practice may not be the most convenient, quality, or cost effective option to the member.*

Response: Commissioner took this comment into consideration, struck this language, and added language that was consistent with the intent of the section.

***Comment**: Strike language "for that portion of its service area for a plan" and use "for that county" in WAC 284-43-201(2).*

Response: This particular section is now WAC 284-43-200(15)(c). When redrafting this section, the Commissioner took this comment into consideration and changed the language to include county.

***Comment**: Clarify that the receipt of an approval for an alternate access delivery request is a precondition for the issuer to offer coverage in applicable service areas in WAC 284-43-201(3).*

Response: This particular section is now WAC 284-43-200(15)(b), and contemplates a situation when a previously approved network has a loss of a provider or facility. In this situation, the issuer is already providing coverage in the service area.

***Comment**: Ensure that co-payment, co-insurance, and deductibles apply to an alternate access delivery system at the same level as in-network. Comments also received urging the inclusion of co-insurance in this section of the rule or refer generally to cost-sharing in this section.*

Response: The Commissioner took this comment into consideration when drafting the rule. The rule specifically mentions co-payment and deductibles, but does not specifically mention co-insurance. This is because coinsurance is not a fixed dollar amount similar to a deductible or copayment. Rather it is based upon a percentage of an allowable charge, negotiated charge, billed charge, or similar charge. Coinsurance should not be assessed at a higher percentage or higher out-of-pocket charge because that would violate the requirement that the issuer must

ensure that the enrollee obtains all covered services in the alternate access delivery system at no greater cost to the enrollee than if the service was obtained from network providers or facilities. For example, suppose an enrollee has a 20% coinsurance for in-network providers. She needs a service that has a $200 allowable charge when received from an in-network provider. The enrollee coinsurance is $40. No in-network provider is available within a reasonable distance. The issuer makes arrangements for the enrollee to obtain the service from an out-of-network provider who charges $1000. The enrollee's obligation in this scenario will be $200. In order to meet the standard of WAC 284-43-201(1)(b), the most the enrollee's cost share obligation in this situation for this service is $40. Since coinsurance is expressed in terms of a percentage of charges, the $40 in this situation is less than the coinsurance percentage for in-network providers (20% in this hypothetical). However, that is necessary in order to keep the enrollee's costs no more than they would be if she could obtain the service from an in-network provider.

Comment*: Add language that issuers must specify which portions of the network standards it cannot meet when submitting an alternate access delivery request.*

Response: Issuers are required do so when an Alternate Access Delivery Request Form C is submitted for the Commissioner's review and approval.

Comment: *There should be an inclusion criteria related to costs because, while an alternate access delivery request may not be detrimental to an enrollee' s health, the enrollee may have to travel a longer distance for a specialist and it will cost more.*

Response: The rule is intended to ensure access to covered services. Should an issuer submit an alternate access delivery request based upon an inability to contract with a provider, there is a general requirement that the enrollee be able to access the covered service. However, it may be reasonable to require the enrollee to travel a longer distance to access the service, depending upon the factual scenario at hand. While the Commissioner cannot contemplate every scenario and the effect on the enrollee, including costs associated with travel, as it will vary depending upon the situation, the Commissioner can require certain standards of access and the rule does so. To this end, the rule specifically requires that an alternate access delivery system ensures that the enrollee must be able to obtain the health care services from a provider or facility within the closest reasonable proximity of the enrollee.

Comment: *"Alternate" should be changed to "alternative."*

Response: The Commissioner took this comment into consideration and declines to make the requested change. To change the language as requested implies that an issuer requesting an alternate access delivery system is held to a different, and possibly sub par standard. That is not the intent and may result in enrollees being unable to access providers and covered services. The rule is clear; the issuer must demonstrate that the alternate access delivery system must provide an enrollee access to sufficient number and type of providers or facilities.

Comment: *Clarify intent with practice referral patterns as issuers need to be able to move away from referral patterns that are cemented based on past practice.*

Response: The Commissioner took this comment into consideration and changed the language of the section to more accurately reflect the intent of the alternate access delivery request and the need to demonstrate a method to assist enrollees in the location of providers and facilities in neighboring service areas.

Comment: *Delete reference to limitations on authority to refer enrollees to specialty care in the alternate access delivery request section as it would allow broad, undefined, and possibly discriminatory opportunity for issuers to restrict access to necessary specialty care referrals at the sole discretion of the Office of the Insurance Commissioner.*

Response: The Commissioner took this comment into consideration and deleted the language as requested.

Comment: *Allowing other arrangements acceptable to the Commissioner gives too much flexibility to issuers to pass on higher costs to enrollee when the issuers are unable to build an adequate network.*

Response: An alternate access delivery request is to be used only in an extraordinary circumstance as delineated in the rule. It is not meant as a tool to avoid the general standards of the rule. Additionally, the rule specifically puts parameters on costs to enrollees should an alternate access delivery request be granted by the Commissioner. The Commissioner needs some latitude to be able to consider circumstances that are not contemplated by the rule to ensure that enrollees have access to covered services even if the issuer is experiencing issues with the network.

Comment: *Clarify requirement to seek reasonable proximate reimbursement rate when an alternate access delivery request is submitted.*

Response: The Commissioner took this comment into consideration and deleted the language.

Comment: *Define "reasonable basis" when evaluating whether the alternate access delivery system ensures access to covered service to enrollees.*

Response: The Commissioner declines to define "reasonable basis" as this will be determined on a case-by-case basis taking into account all the facts and circumstances in that particular situation and request for an alternate access delivery request.

Comment: *Need affirmative statement that, should an issuer file an alternative access delivery request, the reasonable travel time standard in WAC 284-43-200(6) will be enforced.*

Response: The alternate access delivery request is made when the issuer is unable to meet one or more requirements in WAC 284-43-200. Inclusion of any one of those requirements in the alternate access delivery request is inconsistent with the intent of the new section. Having said that, the alternate access delivery request requires reasonable "availability and accessibility" and clarifies that enrollees be able to obtain health care services from a provider or facility within the closest reasonable proximity of the enrollee in a timely manner appropriate for the enrollee's health needs (WAC 284-43-201(1)(d)). That is the reason it is a request submitted to the Commissioner for approval. The issuer must demonstrate that, not only is an AADR necessary as a result of the occurrence of one of the four unavoidable situations that allow submission of an alternate access delivery request, but that the proposed alternate access delivery system provides reasonable access despite this unavoidable situation.

Comment: *Unclear what is meant by "limitation on authority to refer enrollees to specialty care" in former WAC 284-43-201(1)(b)(i). Delete or clarify.*

Response: The Commissioner took this comment into consideration and deleted the language. This section is now WAC 284-43-201(1)(d).

Comment: *Delete reference to whole population of enrollees in section on single case provider reimbursement agreements as it is likely to undermine the ability to minimize this practice as an issuer could offer a single enrollee access to a needed provider type within the plan's network and require all other enrollees to seek services from providers of that type out-of-network through single case rate agreements without violating the rule.*

Response: Single case provider reimbursement agreements are not intended to provide continuous and ongoing general access to covered services in-network. Instead, the agreements should be used when there is a unique provider or service that an enrollee needs and the provider or facility is not in-network. If there is a gap in the network in which multiple enrollees cannot get access to the covered service, then there is a larger issue with the network and the issuer needs to consider filing an alternate access delivery request until the issue with the network is addressed.

Comment: *Delete language that an alternate access delivery system may result in issuer payment of billed charges. While this may result, inclusion of this in the rule may cause confusion.*

Response: The Commissioner declines to delete this language. Health Care Service Contractors and Health Maintenance Organizations have a statutory obligation to provide services through a contracted network of providers. When an issuer is unable to meet this requirement the Commissioner must act to ensure consumer protection is not compromised including the requirement for enrollees to be held harmless and not balanced billed due to a network disruption. Like insurance regulators across the country as well as many consumer advocacy groups, the Commissioner is very concerned about the effect of poorly built networks. Billed charges may, in fact, have to be paid in order for enrollees to obtain the coverage they paid for when a network does not include a provider of a covered service in order to avoid that consumer being balanced billed. The Commissioner does not believe that stating this fact is confusing.

Comment: *Use of alternate access delivery systems should be limited and only under very unusual and extraordinary circumstances and issuers should bear the burden of developing adequate networks through contracting efforts. Only allow an alternate access delivery request if providers and facilities are not available for inclusion in the network.*

Response: The Commissioner agrees that the use of alternate access delivery systems should be limited. Accordingly, the rule only allows the submission of an alternate access delivery request in four circumstances: there are sufficient numbers and types of providers in the service area but the issuer is unable to contract with these providers and facilities, the network has been previously approved and a provider or facility type becomes unavailable, in a county that has a population of 50,000 or fewer, and a qualified health plan that cannot meet the Essential Community Providers inclusion standards. The Commissioner declines to require that the issuers show that providers and facilities are not available for inclusion in the network, as this appears to require issuers to contract with any provider or facility merely because the provider or facility is

in the service area. As stated above, the Commissioner has no authority to require any party to contract with another party or to set provider contract terms such as reimbursement rates.

Comment: *Use of the phrase "contracted" should be deleted because some issuers use contracted and in-network as different agreements when building a network.*

Response: The Commissioner took this comment into consideration and deleted the references to contracted in this section of the rule.

Comment: *Allow an alternate access delivery request for network that includes integrated health systems, primary care medical homes, accountable care organizations, and designated providers for specialized treatments such as cancer care or transplant services.*

Response: The Commissioner declines to make the requested change because these rules do not necessarily prohibit an integrated delivery system, ACO look-alike, or any other innovative care delivery system, as long as the networks are structured in accordance with applicable regulations. The rule allows for tiered networks which foster innovation and flexibility for issuers to structure their providers and facilities in a manner that meets the business goals of the issuer, as long as enrollees have access to covered services.

There appears to be two concerns. First, a sense that the rules require "broad networks" and second, the sense that innovative delivery systems would require an alternate access delivery request. The first is a misconception which may be rooted in the confusion caused by casual use of the term "ACO." An ACO is a specific type of shared savings program for Medicare regulated by CMS. Commercial innovative delivery systems such as those contemplated are referred to in the proposed rules as "tiered networks." Such a system is expressly allowed under WAC 284-43-229, and may be designed however issuers and providers desire. An alternate access delivery request is not required in order to utilize such network structures. These tiered networks, however, will still be held to the standards set forth in the rules. This balances the Commissioner's expectation to ensure enrollee access to covered services and fostering innovation.

Comment: *The phrase "[a]n issuer must satisfy this obligation even if an alternate access delivery request is filed and pending commissioner approval" means that, under an AADR, an issuer is not required to "provide covered services at no greater cost to the covered person than if the service were obtained from network providers and facilities."*

Response: The Commissioner disagrees with this interpretation. WAC 284-43-201 states the requirements of an alternate access delivery system, which expressly include this requirement, or other arrangements acceptable to the Commissioner, in subsection (1)(b). In contrast to the current rules, the proposed rules include explicit statements of the requirements for an alternate access delivery request and the issuer's proposed alternate access delivery system, which affords the Commissioner greater ability to enforce the network access standards even where a network has experienced one of the situations set forth in WAC 284-43-220 (15)(a) through (d). The statement that these obligations continue even while an alternate access delivery request is pending is meant to ensure that no gap in access occurs as a result of one of these situations.

Comment: *Single case agreements should not be prohibited, but should be considered as part of an alternate access delivery request.*

Response: The Commissioner agrees that single case provider reimbursement agreements can be an important tool to provide services to an enrollee when there is a unique situation where an enrollee's care necessitates a provider that is out-of-network or out-of-service area. Single case agreements are not prohibited by these rules. However, single case provider reimbursement agreements should be the exception and not the rule. If these types of agreements are being used on a regular basis there may be a broader issue with the provider network and the ability to provide access to covered services. Where appropriate and necessary, single case agreements may be used under the proposed rules.

Comment: *Where a covered service is not available in a service area the issuer must proposes an alternate access delivery request.*

Response: The Commissioner declines to require an alternate access delivery request anytime a covered service is not available because situations where this happens may be dealt with under other provision in the rule, as appropriate.

WAC 284-43-203: Use of subcontracted networks

Comment*: Use of the entire network undermines the issuers' efforts to develop networks that best meet the needs of the enrollees.*

Response: There is a mistaken impression that the rules preclude issuers from subcontracting only for specific providers. The Commissioner disagrees with this conclusion as issuers may still subcontract. The Commissioner has always required issuers to clearly identify specifically those providers with whom they contract. The rule is intended to clarify that, where issuers subcontract for providers, it is inaccurate to file a report indicating that they have subcontracted

for all providers in a particular network if they have not. If the issuer has subcontracted only for certain providers in a network, the issuer must specifically identify those providers for whom it has subcontracted by using a unique network name that includes only those providers. The intent of the rule is to allow flexibility to create networks that are innovative and cost effective, balanced with the need for transparency in the process and access by the enrollee. For example, if an issuer wants to rent only Providers A, B, and C from a leasing organization, it may do so. In order to provide transparency and avoid market confusion, the leasing organization must identify this set of providers as a network, and must have contracts with providers A, B, and C that support the creation of that specific network.

Comment: *Add language that, as a condition or requirement to gain participation in a subcontracted network, the issuer shall not require a provider to participate in another medical plan or contract offered by the issuer.*

Response: The Commissioner has no authority to require any party to contract with another party, or to set provider contract terms. These limits do not allow the Commissioner either to require providers and issuers to contract with one another or to require the parties to agree to certain contract terms.

Comment*: Add language that prohibits issuers from requiring certain types of providers and facilities to use out-of-network vendors for services when such requirements would negatively impact care.*

Response: The intent of the rule is to allow enough flexibility to create networks that are innovative and cost effective. It is the role of the issuers to structure the networks in accordance with the rule and in a manner in which networks are sufficient in number and choice of providers and facilities to provide enrollees access to covered services in a timely manner appropriate for the enrollee's condition.

Comment: *Requirement to retain contracting documents with the subcontractor and providing access to any pertinent information related to the contract for up to ten years is out of line with current business practices. If necessary, do the documents need to be maintained in electronic or hard copy?*

Response: Where an issuer permits a facility or provider to delegate functions, the issuer must require the facility or provider to maintain these records for the duration of the contact or up to

ten years. This is in line with the retention requirements for Medicaid. It is the role of the issuer to determine the method of retention based upon current business practices.

Comment: *Add language that a provider or facility must approve their inclusion in a subcontracted network in writing.*

Response: This would be a term negotiated as part of the contract between an issuer and provider/facility. The Commissioner has no authority to require any party to set provider contract terms. These limits do not allow the Commissioner either to require the parties to agree to certain contract terms.

Comment*: Sets up a requirement that issuers that choose to contract on their own paper will be double contracting as they will have rented an entire network and also have contracts on their own paper. This is illogical and will increase costs.*

Response: This comment actually illustrates one of the problems the requirements of WAC 284-43-203 are designed to avoid. There is no requirement to "double contract." In fact, having more than one active contract with a provider to provide the same services for an issuer may violate WAC 284-43-320(3). Each issuer is required to have a single contract with each provider in its networks.

The requirements of WAC 284-43-203 are designed to clarify which providers are contracted for which issuer networks and how. Where a provider is directly contracted with an issuer for a particular issuer network or networks, that direct contract is the only contract that will be submitted for that provider in that issuer network or networks. Where a provider is contracted by virtue of a subcontracted network for a particular issuer network or network, that is the only contract through which the provider may be contracted with the issuer for that issuer network or networks. The issuer must submit both the contract between itself and the network administrator and the contract between the network administrator and the provider. The latter is often called a "downstream contract."

For example, an issuer contracts with a network administrator. The network administrator has contracts with a complete network of all categories of providers, who provide all sorts of covered services. The issuer contracts with the network administrator to include in the issuer's network "all providers contracted with the network administrator." The issuer would submit that contract, as well as the downstream contracts with each provider. All providers contracted with that network administrator would be in-network for that issuer.

Suppose the issuer subcontracts with the network administrator, but only to include three of the network administrator's contracted hospitals in the issuer's network. Under the rule, the issuer may do so. However, this group of three hospitals would have to be identified by a unique network name, which distinguishes the group of three hospitals from the total group of providers contracted with that network administrator, and from some other subset of the network administrator's contracted providers. By identifying the group of three hospitals using a unique network name, the issuer clearly identifies exactly which providers (the three hospitals) are in the issuer's network by virtue of its contract with the network administrator. The issuer would be required to submit the contract with the network administrator to "rent" this unique network that includes only these three hospitals. The issuer would also be required to submit the "downstream" contracts between the network administrator and the three hospitals. Only the three hospitals would be in-network for that issuer.

When an issuer submits a generic contract between itself and a network administrator, in the which contract says that the issuer is contracting to include "all providers contracted with the network administrator" in the issuer's network, the Commissioner takes at face value that it includes "all providers." However, when an issuer subsequently begins direct-contracting with some of the providers who have contracts with the network administrator, and perhaps even also reports that it is only contracted with that network administrator for some subset of its contracted providers, neither the Commissioner, nor the network administrator, nor the providers themselves know their network status. There is also no way for an enrollee to know the provider's network status in this situation.

Comment: *Requiring the issuer to not use less than one hundred percent of a subcontracted network does not allow issuers to exclude providers consistent with RCW 48.43.045 and WAC 284-43-203(2) which permits issuers to require providers to abide by certain standards.*

Response: The Commissioner disagrees with this interpretation. An issuer may contract with a network administrator to include precisely those providers the issuer chooses for inclusion in its network. There is no requirement to contract with any provider, whether directly or as part of a pre-existing network "rented" from a network administrator. The requirement in this rule is simply to **identify** exactly which providers an issuer has in its network. If the issuer has subcontracted only for certain providers in a network, and has excluded certain providers consistent with RCW 48.43.045 or other applicable statute or regulations, the issuer must merely identify those providers for whom it has subcontracted by using a unique network name that includes only those providers. For example, if an issuer wants to rent only Providers A, B, and C from a leasing organization, but not Provider D, it may do so. In order to provide transparency and avoid market confusion, the leasing organization must identify this set of providers as a

network, and must have contracts with providers A, B, and C that support the creation of that specific network.

WAC 284-43-204: Provider directories

Comment: *Standardize provider directory updates so that updates are done in a timely manner and include how often the directories must be updated. Concerns raised that the rule requires paper copies.*

Response: The Commissioner took this comment into consideration when drafting the rule. The provider directory must be updated at least on a monthly basis and available online. Printed copies must be made available upon request. Up-to-date and accurate provider directories are important so that consumers will know which providers are included in the plans so they can make more informed decisions about which plan to select. The Commissioner believes this will help consumers who are concerned about having access to specific providers/facilities as they will have the information they need to choose a plan that best meets their health care and financial needs. However, this requirement does not require paper copies to be printed unless and until requested. It is up to the issuer to determine how best to structure its business processes to provide up-to-date paper copies on request.

Comment*: Require issuers to demonstrate capacity to accept new patients. Address capacity in the rule by including patient/provider ratios.*

Response: The Commissioner is mindful of the interplay and tension of capacity of providers and facilities with an adequate and accessible network. However, the Commissioner cannot assess capacity because providers are outside of the Commissioner's regulatory authority. The rule attempts to balance this issue within the regulatory authority of the Commissioner.

Comment*: Conduct an assessment of the information in the provider directory and if a certain percentage of the information reviewed is not accurate, assess penalties.*

Response: The Commissioner agrees that it is imperative that the information in the provider directory be accurate and that there be penalties for violation of these rules. The Commissioner has general enforcement authority and a broad range of enforcement tools that may be used for this purpose. It is important that appropriate penalties be determined on a case-by-case basis when evaluating all the facts and circumstances. Therefore, the rule does not define enforcement specifically for this violation for two reasons. First, the Commissioner does not believe this is necessary since his regulatory authority already exists. Second, the Commissioner does not want

to create any misunderstanding or to inadvertently limit the range of potential enforcement actions that may be taken for violation of the network access rule.

Comment: *Many comments were received requesting certain information be required in the provider directory. The information requested included: accessible equipment for individuals with disabilities, location of providers, how to obtain services from out-of-network providers, language/cultural information, interpreter services, list of outpatient services affiliated with a facility or institution, relevant experience treating specific populations, health education services, transportation services, financial and eligibility services, among other items. The provider directory should also address the needs of those with limited English proficiency and literacy and with diverse cultural and ethnic backgrounds and physical and mental disabilities.*

Response: The Commissioner considered these comments when drafting the section on provider directories. Where appropriate, the requests were included as required information in the provider directories. The Commissioner recognizes that provider directories provide much needed information for consumers so that they can make more informed decisions about which plan to select and how to access services. It is important to balance the important need for information with the administrative burden on issuers to collect and maintain this information. Particularly when the issuers are dependent upon providers and facilities with whom they contract to provide accurate and up-to-date information.

When determining which information to require in the provider directories, the Commissioner considered federal standards. The standards adopted by the Commissioner are comparable to the federal standards encouraged in the final 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM) issued on March 14, 2014 which expects the directory to include location, contact information, specialty, and medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients. CMS' guidance also encourages issuers to include languages spoken and provider credentials, and whether the provider is an Indian health provider.

Comment: *Requiring the provider directory to include information on whether a provider may be accessed without a referral is onerous and confuses network requirements with benefit and/or product design.*

Response: The Commissioner recognizes that provider directories provide much needed information for consumers so that they can make more informed decisions about which plan to select and how to access services. However, since this information is already required by statute,

as there are certain types of providers that must be accessed without a referral, it is important for enrollees to be able to easily access this information. RCW 48.43.515.

Comment: *Do not require a notation of any closed practices for primary care providers, chiropractors, women's health care providers, or pediatrician as this is reported by the provider and is subject to provider submitting that information to the issuer. Also received comments urging the list be expanded to include other provider types.*

Response: The provider directory is intended to give enrollees readily available information on providers. The providers listed are considered direct access providers and/or providers of Essential Health Benefits. Enrollees need to be able to easily find such a provider who is accepting patients and issuers are required to report this information. RCW 48.43.515, 48.42.100, WAC 284-43-865.

Comment: *Require mechanisms for providers to correct or update provider information, require issuers to include input from providers when describing services, include a requirement that the issuers make the directories available to providers as means of confirming information is accurate.*

Response: This is a contract provision to be negotiated between the provider and the issuer. The Commissioner has no authority to require specific provider contract terms. It would be administratively burdensome to require the issuers to provide a monthly updated directory to every provider and facility in the issuers' networks and solicit provider input. However, the rule requires that provider directories are updated at least monthly and available online. Providers can access the provider directory online, similar to consumers, to verify accuracy, and there is nothing to prevent them from seeking corrections or changes to improve accuracy.

Comment: *Enrollees should not be required to request printed directories; issuers should send the directories unless enrollees opt-out.*

Response: The Commissioner recognizes that provider directories provide much needed information for consumers so that they can make more informed decisions about which plan to select and how to access services. However, it is important to balance the access to information with the costs and administrative burden, especially a contemplated monthly mailing of the provider directory for each plan. Accordingly, the rule requires the provider directory to be updated at least monthly online and be available in printed form upon request.

***Comment**: Do not include telemedicine information in the provider directory because the issuers do not have this information and it is a new area of medical delivery.*

Response: The Commissioner took this comment into consideration when drafting the rule. The Affordable Care Act promotes the use of telemedicine in both Medicare and Medicaid. Telemedicine is considered a cost-effective alternative to the more traditional face-to-face delivery system of providing care. It can also be utilized to provide care to rural areas or areas with provider shortages. However, information on telemedicine services is required only if available.

***Comment:** Information on prior authorization and referral should be in plain talk and translated into primary languages spoken by members. Comments also received that information on prior authorization and referral should be included in provider directory and summary of benefits and available prior to purchase.*

Response: The Commissioner agrees that this information is important for enrollees to access and understand. However, it also needs to be placed in the appropriate form. Information on prior authorization and referrals is a contractual obligation between the parties and is required to be in the plan documents: policy, certificate of coverage, and summary of benefits. However, the rule does require that the referral and authorization practices, including how to access those services, be included as an introduction or preamble to the provider directory or may be described in the summary of benefits. WAC 284-43-200(8). This information is also required under RCW 48.43.510(2) to prospective enrollees. Additionally, currently issuers provide plan documents in multiple languages.

***Comment:** Delete reference to "provider groups with which a provider is a member" as provider directories do not need to include whether providers are members of their local, state or national organizations. Comment also received that listing all hospital affiliations will cause confusion if a provider is affiliated with in-network and out-of-network hospitals.*

Response: The Commissioner agrees with this comment, but declines to delete the referenced phrase. The Commissioner took this comment into consideration and clarified the language to require only information on in-network affiliations or provider groups. The intent of this section is for the issuers to include information about provider groups the provider is a member of, not organizations. The section where this language is included pertains to only in-network institutional affiliations and provider groups in order to give the consumer important information on how and where to access covered services with a particular provider or group.

Comment: *Allow issuers to include a link in the provider directories to providers' websites where information can be found.*

Response: The Commissioner took this comment into consideration and has no objection to issuers providing a link to the providers' websites for information.

Comment: *Include requirement for tag lines in English or other languages spoken by the issuer's population which describe how the enrollee can access interpreter services and other enabling services as well as requirement that directories include information for TTY services and other means of communication for hearing impaired enrollees.*

Response: The Commissioner took this comment into consideration when drafting this section. The section specifically requires that the directories be offered to accommodate individuals with limited-English proficiency or disabilities. Additionally, the provider directory must include information about any available interpreter services, communication, and language assistance services and the mechanism by which the enrollee can access the services.

Comment: *Requirements are not required by statute and online directories are only required for qualified health plans.*

Response: The Commissioner disagrees with this interpretation. RCW 48.43.510(1)(g) specifically requires issuers to provide "a convenient means of obtaining lists of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network." This requirement is not limited to qualified health plans. Additionally, subsection (8) of the statute encourages issuers to communicate this information by implementing alternative, efficient methods of communication, including electronic communication. Subsection (9) grants the Commissioner specific rulemaking authority to implement this section and requires him to consider opportunities to reduce administrative costs to health plans.

The Commissioner received comments expressing concerns about the cost and administrative burden of requiring printed provider directories. The Commissioner shares these concerns and believes that an online directory is much more efficient, both in resources used and in ease of editing to keep the directory current. While a printed directory must still be available for those who request it, the Commissioner believes that an online directory is the best method of providing enrollees and consumers current, detailed network information.

Comment: *Allow HMOs to make a notation in the provider directory next to providers that "limited services apply" for providers that are used for a limited range of services through referral.*

Response: The Commissioner would have no objection to including such a notation and nothing in the rule restricts the issuer from doing so. The intent of this section of the rule is to provide information to the consumer that is useful in accessing services. Such a notation would aid in this goal.

WAC 284-43-205: Every category of health care providers

Comment: *Define "unreasonable limits" and recommend limits be based upon enrollees' needs and medical conditions and provide more clarity in terms.*

Response: The Commissioner took this comment into consideration when drafting the rule. Language was included to clarify that this section is reliant upon the benchmark plan for large groups and the Essential Health Benefits for small group and individual plans. This section is intended to ensure that every category of provider is in the network and accessible to enrollees.

Comment: *Expand scope to include a list of specific categories of facilities that must not be excluded, such as an NCI-designated comprehensive cancer care center and transplant Centers of Excellence.*

Response: The Commissioner declines to extend the scope of this section as requested. This section of the rule is intended to be generally applicable. It is not intended to require specific categories of providers or facilities to be in a network.

Comment: *Clarify the definition of "medical home."*

Response: The Commissioner took this comment into consideration and refined the definition of "medical home" using guidance from the Agency for Healthcare Research and Quality as well as the U.S. Department of Health and Human Services.

Comment: *Underlying statutes refer to Basic Health Plan and it is premature to write rules for the large group market that require compliance with the Essential Health Benefit requirements which do not apply. Make this section consistent with current law.*

Response: The Commissioner took this comment into consideration and changed language where appropriate and necessary.

Comment: *Should not prevent plans from innovating by forbidding issuers to offer riders, as specified in WAC 284-43-205(5). This limits product design.*

Response: The Commissioner disagrees that this section inhibits innovation or prohibits riders. Rather, this section prohibits a plan design that would require the purchase of a rider in order to obtain services from a particular category of provider. If allowed, such a practice could result in a design that may be illusory or discriminatory and may violate the intent of the Every Category of Provider statute. Additionally, this language is from the NAIC model rule and has not been modified. Finally, it should be noted that HIOS definition of product/plan and the requirement to provide data in the SERFF Plan Management binder restricts the ability to file riders.

WAC 284-43-220: Network Reports

Comment: *Concerns were raised about the administrative burden the new reporting requirements will create. Also, comments that the Commissioner already requires some of these reports, such as access plans, so why put them in the rule.*

Response: To the extent that there are new reporting requirements, the Commissioner built certain exemptions and extensions into the rule to recognize the need for issuers to modify their business practices. However, the Commissioner notes that the rule is intended to codify what was already submitted for review and part of the existing process, in order to make the process more transparent. For example, issuers have been required to submit the Provider Network Form A and Network Enrollment Form B regularly and submit the geographic network maps and access plans upon request.

Comment: *Concerns about how to file certain items, that filing instructions are not updated or online that give sufficient instructions to issuers on how to report certain items (i.e. Essential Community Providers).*

Response: Filing instructions and necessary forms and templates will be updated for the issuers' use when submitting the required forms and documents.

Comment: *Do not require certain brand of software for the geographic network maps, such as GeoAccess.*

Response: This comment was taken into consideration and the reference to GeoAccess was changed to a generic term to allow flexibility for the issuers to choose the software program that works best within their business practices.

Comment: *Submitted reports should be posted on the Office of the Insurance Commissioner's website.*

Response: The Commissioner took this comment into consideration when drafting the rule. Once reports are submitted by issuers the reports can be accessed on the Office of the Insurance Commissioner's website. One must search by company at http://www.insurance.wa.gov/consumertoolkit/search.aspx and then click on "View Access Reports" under the Network Access Reports heading.

Comment: *The rule requires annual filing when filing the rates, but not all rate filings happen together once a year.*

Response: The comments were taken into consideration in drafting the rule and the rule was changed to make the regulation consistent with how and when filings are received.

Comment: *Uncouple product review and approval from network review and approval. Suggest requiring submissions of network materials by a minimum time period, such as 30 days, from the date the new product will be offered to the public.*

Response: The Commissioner declines to make the suggested change. The Affordable Care Act has changed how the Commissioner must review networks. To be a qualified health plan, the plan must meet the criteria for certification described in the Affordable Care Act. One of the criteria that such a plan must meet is network adequacy. This criterion includes, but is not limited to, the requirements in 45 CFR § 156.23, 2702(c) of the PHSA Act (45 CFR § 156.230(a)) and the Washington State Insurance Code. The Commissioner must be able to review the networks with the form, rate, and binder submissions so that he can approve the products for the Exchange to certify. This is a time consuming and ongoing process that should not be on such an accelerated timeline or outside the product submission review process. Also, submitting materials so close to the date the plan will be offered to consumers does not give the Commissioner enough time to adequately review the network or address any issues with the network.

Comment: *Concern that the rule references networks being defined and reported at the plan level instead of the unique provider network level.*

Response: The landscape of the marketplace is changing as a result of the ACA. Accordingly, the analysis needs to be done at the plan level as well as the network level.

Comment: *Provider Network Form A should not be filed monthly.*

Response: Pursuant to RCW 48.44.080 and 48.46.030 this provision was retained and this report must be submitted monthly.

Comment: *Panel status should be added to the required data fields on the Provider Network Form A.*

Response: This is a content issue with the Provider Network Form A which is outside of the scope of the rulemaking and is more appropriately dealt with in filing instructions.

Comment: *Issuers should be required to file notices of reimbursement to providers and include justification for changes in reimbursement.*

Response: The Commissioner has no authority to require any party to contract with another party, or to set provider contract terms (such as reimbursement rates). Pursuant to RCW 48.43.730, while the Commissioner may review compensation agreements, the ability to regulate reimbursement amounts is prohibited.

Comment: *Comments were received urging time/distance requirements for access to providers and conversely, urging the Office of the Insurance Commissioner to not use any time/distance standards for access to providers. Also comments were received with suggested time/distance standards for access to providers. In related comments, a different standard for urban and rural areas was requested as well as making the standards its own separate section.*

Response: The geographic network map evaluation tool allows the Commissioner to have a visual representation of the network. In order to evaluate networks, it is essential for the Commissioner and the issuers to have evaluation parameters for the location of providers in relation to the enrollees. However, distance criteria were not included for all providers because some of the providers are either unique in the services provided, are geographically spread out,

or are sparse in certain areas of the state. As it is vital that the map provide a meaningful representation of the network, if distance criteria were included for these providers, the map would not be a valuable evaluation tool.

In determining which time/distance criteria to use, the Commissioner considered what other states were using in their network evaluation; for example, California, Texas, and Vermont. The criteria used by other states were mixed. Sometimes the criteria were time and distance, time, or distance when evaluating location of providers in relation to enrollees. After consulting Washington State maps about primary care providers and hospitals in the state and identifying where there may be provider shortages, a distance standard of 30 miles for urban and 60 miles for rural as the base criteria was determined to be the most appropriate for Washington State for primary care, mental health, and pediatric services. For hospitals and emergency services a time criteria was used.

After considering the issuers comments regarding concerns in building networks in certain areas of the state and the inability to identify providers in certain areas of the state, the urban rural split in criteria was included. This is important to promote innovation and flexibility in building networks and also to provide access to services to consumers in rural areas.

Comment: *Comments were received criticizing the different distance standard for pediatric specialists and that it was less stringent than adult specialists.*

Response: The Commissioner agrees that the distance standard is different for pediatric specialists and general pediatric providers in WAC 284-43-220(3)(e)(i)(D). This is based upon feedback received from issuers regarding concerns in building networks in certain areas of the state and the inability to identify providers in certain areas of the state, particularly specialists and pediatric specialists.

However, the Commissioner disagrees that the standard for pediatric specialists is less stringent than adult specialists. First, there is no specific evaluation of adult-only specialists. Second, the geographic network map is for specialists generally, not solely adult specialists, and requires issuers to map the specialists listed on the American Board of Medical Specialties to show that 80% of enrollees have access to adequate numbers of provider and facilities in each specialty. Third, the American Board of Medical Specialties list comprises 38 specialty types, including pediatrics. The pediatric subspecialties, which are subsumed on the map, include adolescent medicine, child abuse pediatrics, developmental-behavioral pediatrics, hospice and palliative medicine, medical toxicology, neonatal-perinatal medicine, neurodevelopmental disabilities, pediatric cardiology, pediatric critical care medicine, pediatric emergency medicine, pediatric endocrinology, pediatric gastroenterology, pediatric hematology-oncology, pediatric infectious

diseases, pediatric nephrology, pediatric pulmonology, pediatric rheumatology, pediatric transplant hepatology, sleep medicine, and sports medicine.

This results in pediatric specialists, in particular, being evaluated in at least four different ways: under general standards that require, among other things, sufficient numbers and types of providers to provide services in a timely manner, in the submission of the Provider Network Form A which lists all providers in a network, in the submission of the geographic map, which includes a specific pediatric specialty call-out, and in the submission of the geographic map for specialists.

Comment*: Definition of "urban" is not accurate.*

Response: The Commissioner wanted a definition that was clear and easy to use for evaluation purposes, but which also took into consideration the measures being used by various state and federal agencies. The Commissioner started from the baseline definition used by the state Office of Financial Management, where rural is defined as a county with a population density of less than 100 persons per square mile, and adjusted that definition to better mirror the availability of health providers in Washington State.

The density threshold was reduced slightly for an "urban" county to 90 persons per square mile. In Washington State, there are three counties with a density of 90-100 persons per square mile and then a significant drop in county density levels down to 68 persons per square mile. Additionally, the use of incorporated cities with populations of more than 30,000 was introduced as another indicator of urban density. This combined approach allowed the Commissioner to identify as "urban" all but one of the urbanized areas in the state identified by the US Census Bureau; the only additions in the list were Pullman and San Juan County and the only area missed was Lewiston-Clarkston.

Finally, the Commissioner proposed a 25 mile radius, in otherwise rural counties, around "urban" cities (more than 30,000 population) to reflect a reasonable commuting distance of approximately 30 minutes to those cities. This is a slightly smaller radius than the 30 miles used by California, Minnesota and Texas for primary care accessibility. This addition to the definition mimics the urban and suburban areas plotted on Four-Level Consolidation of RUCA (Rural Urban Commuting Areas) Codes maps by the Census Bureau for the state without requiring Office of the Insurance Commissioner's staff, insurers and providers to do the highly detailed analysis of each census tract in which the Census Bureau engages. The resulting population considered to be urban (88%) is at the high end of most such urban/rural classification systems, where the urban population typically comprises 73% to 87% of the overall state population.

***Comment**: Concerns were raised about the rural hospitals and clinics in regard to the mapping requirement that issuer must document that enrollees are within 30 minutes in urban areas and 60 minutes for rural areas to hospitals services, including emergency services. The concerns included not only access to care for those in the rural areas, but also the economic effect on the rural hospitals and clinics if the standard is 60 minutes. Urged to have a 30-mile standard for the hospitals.*

Response: The geographic network maps are just one tool in the network evaluation that the Commissioner will be conducting. To emphasize this, language was added to the rule to clarify that the mapping reports are a minimum requirement and will be evaluated in conjunction with the general standards outlined in the rule for network access and adequacy.

In order to encourage the building of networks in rural areas, the 60-minute standard was implemented. The intention is not for the issuers to immediately only include those hospitals on the outer limit of 60 minutes, but instead to set a minimum and allow flexibility when building the network. In determining the 60-minute mapping standard, the Commissioner consulted maps on the Washington State Department of Health's (DOH) website as well as a DOH white paper on trauma and emergency cardiac and stroke systems in Washington State which indicated that all Washington residents live within an hour of a level I or II trauma center by air or ground ambulance. Additionally, this standard supports the Healthy People 2020 target.

The Commissioner recognizes that rapid response is a challenge in rural areas and addressed this by using a minute standard rather than a mile standard as road conditions and weather can complicate a strict mile standard. It is important to note that the definition of urban in the network access rule covers approximately 88% of the population of Washington State; accordingly the 30 minute standard will affect the majority of the enrollees. There are also other standards in the rule that effect the rural health system, particularly for qualified health plans, including the inclusion of 50% of rural health clinics located outside an area defined as urban, one Essential Community Provider hospital per county in the service area, 90% percent of federally qualified health centers and look-a-likes, and 75% of school-based health centers.

***Comment:** Concerns were raised by numerous specific groups that the geographic network maps would not include or should include physical therapists, podiatrists, acupuncture and East Asian medicine providers, NCI-designated comprehensive care centers, transplant Centers of Excellence, and dialysis services, among others, and that their inclusion or exclusion in a network would not be evaluated unless they were specifically included on one of the geographic network maps.*

Response: The geographic mapping reports are just one tool in the network evaluation that Commissioner will be conducting. To emphasize this, and based upon comments received from provider groups, language was added to the rule to clarify that the geographic network maps are a minimum criteria and will be evaluated in conjunction with the general standards for network access and adequacy.

Networks need to be evaluated using multiple reporting tools. Geographic mapping is one tool to demonstrate a visual representation of a network. This visual representation will still need to be evaluated in conjunction with the Form A which lists all providers as well as the general standards of reasonable proximity and sufficient numbers and types of providers for enrollees to access covered services.

Specialty services, which would include some of the provider groups that commented about this issue, are a unique category of provider. Because of the numerous types of specialists, a map that included every single specialty type or a map for each specialty type would be meaningless for network evaluation purposes and would create a tremendous administrative burden for the issuers. This would potentially slow down filings and the review process. Accordingly, the Commissioner chose a list of specialists for the issuers to include on the geographic network map that was generally accepted and would give the Commissioner a starting place to evaluate where the broad types of specialists are located in relation to enrollees. The Commissioner will be evaluating specialties within the categories listed on the American Board of Medical Specialties as a single population of providers and subcategories will be subsumed on the map.

In regard to physical therapists, there is a geographic network map specifically for therapy services that will show whether eighty percent of the enrollees have access to therapy services within 30 miles in an urban area and within 60 miles in a rural area.

Comment: *Concerns were raised that the categories listed on the American Board of Medical Specialties includes some specialists of which there are none in the state and may also leave out common specialists such as cardiologists. Related comment that some specialists are so limited in number the time/distance standards are unrealistic and maps will not capture location in relation to enrollees.*

Response: The geographic mapping reports are just one tool in the network evaluation that the Commissioner will be conducting. To emphasize this, and based upon comments received from provider groups, language was added to the rule to clarify that the geographic network maps are a minimum criteria and will be evaluated in conjunction with the general standards for network access and adequacy.

That being said, if the specialist is so rare that there are none in the service area, the issuer may submit a written narrative explaining the absence of the specialist as part of the Access Plan, the Geographic Network Report, or as part of the Alternate Access Delivery Request. Instructions on how to include this information will be on the Rates and Forms Network Access webpage. Subspecialties, such as cardiologists which are listed as a subspecialty of internal medicine, are subsumed on the map.

Comment: *Comments that the geographic network report requirement will result in administratively burdensome numbers of maps to be submitted.*

Response: The Commissioner disagrees that this reporting requirement will result in an administratively burdensome number of maps. The rule requires 11 maps for each network: hospital and emergency services; primary care providers; mental health providers (two maps required, one for general mental health providers and one for specialty mental health providers); pediatric services (two maps required, one for general mental pediatric services and one for specialty pediatric services); specialists; therapy services; home health, hospice, vision, and dental providers; pharmacy dispensing services; and Essential Community Providers.

Each map must include the network identification on it. If the map applies to more than one network, issuers may list all the applicable network identifiers on the map and submit it once.
For example, Acme Insurance Company has one network named "Acme Health." Acme will file 11 maps for plan year 2015 for the Acme Health network.

Comment: *WAC 284-43-220(3)(e)(i)(C) lists types of service providers that may not be accurate.*

Response: The Commissioner took this comment into consideration and based upon feedback from consumer groups and issuers, changed the list of types of services to more accurately reflect the types of services and facilities in Washington State. This list includes, evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment, and behavioral therapy.

Comment: *Delete references to corrective action plan because it is a specific Washington State Department of Health enforcement tool.*
Response: The Commissioner took this comment into consideration and, where appropriate, deleted the reference or changed the language to more accurately reflect the Commissioner's intent.

Comment: *Delete references to workplace and just use the distance from enrollee's residence. Issuers do not capture this information.*

Response: The Commissioner maintained the reference to workplace for two reasons; first, it gives the issuers the option to either use residence or workplace of enrollees when determining the location of enrollees in relation to providers, and second, it allows for innovation as more enrollees become interested in finding providers that are close to their workplaces.

Comment: *Section on geographic network mapping appears to require that 100% of enrollees must have access to providers within 30 miles or 60 miles in order for network to be adequate.*

Response: The Commissioner took this comment into consideration and, where appropriate, changed the percentage of enrollees in the service which must be within the specific mile minimum requirement to eighty percent.

Comment: *Filing a separate access plan for each health plan will result in duplicative filings. Should require issuers to file an access plan for each network instead of plan and note on the access plan to which plan is applies.*

Response: The Commissioner took this comment into consideration and, where appropriate, changed language.

Comment: *Requirement to submit a timeline to bring the network into compliance when there is an issue should not be exclusively for new entrants into the market. This should be general requirement of an alternate access delivery request.*

Response: The Commissioner took this comment into consideration and changed the language in WAC 284-43-220(2)(d)(iii) to clarify when a timeline would be required.

Comment: *Assessment of health status should not be included as part of the access plan. This is an onerous requirement that is specific to issuers filing an alternate access delivery request. Suggestion that this requirement be clarified so that the issuer outlines how the provider network is assessed as part of the issuer's overall quality assurance and quality improvement plan.*

Response: Networks must be sufficient in numbers and types of providers and facilities to assure that all health plan services provided to enrollees will be accessible in a timely manner

appropriate for the enrollee's condition. In order to determine whether their networks include sufficient providers and facilities to cover their enrollees or expected enrollees, issuers must know who those enrollees are, and what their health care needs are expected to be. WAC 284-43-220(2)(f)(i)(I) is a requirement that issuers demonstrate to the Commissioner that issuers have considered this in forming their networks and have reason to believe that the networks meet the general standard for enrollees.

Comment: *Issuers do not have the financial status of the enrollees or the financial status of people in a given community, so cannot map the Essential Community Providers in relation to the number of predominantly low income and medically underserved individuals in the service area as required in WAC 284-43-220(3)(e)(i)(H).*

Response: The Commissioner took this comment into consideration and changed the language to require one map that demonstrates the geographic distribution of Essential Community Providers within the service area.

Comment: *The provider directory certification requires a notation in the provider directory for Essential Community Providers. The section on provider directories does not require identification of Essential Community Providers. Clarify or change the language to be consistent.*

Response: The Commissioner took this comment into consideration and deleted the reference to Essential Community Providers in the provider directory certification subsection, WAC 284-43-220(3)(d).

Comment: *What makes a plan newly offered?*

Response: Any changes to the rates, forms, binder, benefit additions, benefit exclusions, and submission for certification or recertification could lead to a plan triggering a reporting requirement as the plan would then be considered newly offered.

Comment: *A network may be used by more than one plan, so to file the Form A for each plan by network and indicating which network applies to each plan needs to be modified.*

Response: The Commissioner took this comment into consideration and changed the language to indicate that, when submitting a Form A, an issuer must submit the report by network.

Comment: *Allow the Alternate Access Delivery Request Form C to include a range of cost-sharing requirements as opposed to a schedule of cost-sharing requirements.*

Response: The Commissioner took this comment into consideration and declines to change the requested information on cost-sharing to a range as it would not provide the Commissioner with the data needed to be able to adequately evaluate the cost-sharing element of the Alternate Access Delivery Request.

Comment: *Do not require information in the Access Plan as to the methods and processes for documentation confirming that access did not result in delay detrimental to health of enrollees.*

Response: The intent of the rule is to ensure access to covered services. It is the role of the issuer to build networks with sufficient numbers and types of providers to provide enrollees this access. In order for an issuer to determine, and the Commissioner to evaluate, that its networks meet the standards, the issuer must necessarily have a basis for making that determination. It is that basis that is required to be disclosed under WAC 284-43-220(4)(f)(i)(c). This is the crux of network evaluation and cannot be eliminated. It is asking issuers to demonstrate *how issuers know* that the network(s) are adequate and provide sufficient access to enrollees.

Comment: *Information requested in Access Plan regarding prior authorization and utilization are repetitive and may be in conflict with WAC 284-43-410 and 284-43-860. Replace with "Monitoring policies and procedures regarding the availability and timeliness of the prior authorization process in relation to the availability and accessibility of providers in the network."*

Response: The Commissioner took this comment into consideration and declines to change the requested information to general information as it is important more specific information is provided and reviewed to ensure that barriers to access are not created by processes and procedures, inability of the enrollee to access staff, and the like.

Comment: *Change the monthly submission date for the Form A from the 5th back to the 10th of each month.*

Response: The Commissioner changed the monthly submission date from the 10th of each month to the 5th of each month in 2005 to streamline filing requirements with the Health Care Authority and Department of Social and Health Services as part of administrative simplification at the issuers' request. The change in the rule text is consistent with that change.

Comment: *Include facilities providing renal dialysis services in WAC 284-43-220(3)(f)(i)(C), in regard to information included in the Access Plan.*

Response: The Commissioner declines to extend the scope of this section as requested. This section of the rule is intended to be generally applicable to the issuer's strategy, policies, and procedures necessary to maintaining a network.

Comment: *WAC 284-43-220 does not clearly state when access plans must be filed, and subsection (3)(f)(i) conflicts with (3)(f)(ii) because one refers to access plans filed in connection with a "plan" and one refers to access plans filed in connection with a "product." Access plans should be filed for networks, not plans or products.*

Response: The Commissioner took this comment into consideration and changed the language in WAC 284-43-220(3)(f)(i) and (ii) to product for consistency and clarity. An access plan must be filed when a newly offered health plan is submitted, WAC 284-43-220(1) and when one of the situations set forth in WAC 284-43-220(3)(f)(i) and (ii) occurs. Additionally, the Commissioner declines to adopt the recommendation that access plans be filed only for networks. The Commissioner's job is to evaluate whether networks provide appropriate access to all enrollees in a plan for all covered services. The connection between the plan and the network is the crux of this evaluation. An access plan filed only for a network would be missing half of the equation: the covered services.

Comment: *Delete "method and process for documentation confirming that access did not result in delay detrimental to the health of enrollees" and add "and a process for monitoring that access is maintained" to WAC 284-43-220(3)(f)(i)(C).*

Response: The Commissioner declines to make the suggested changes as it would change the intent and purpose of the section. Transparency as to how the issuer is able to evaluate whether enrollees have sufficient access is reported in the Access Plan. The issuer is expected to develop networks and monitor access.

Comment: *When submitting an Alternate Access Delivery Request Form C the issuers should identify a time period in which it will be in effect, but also allow for it to be in place indefinitely or until notification that it is no longer valid. Discourage any annual reporting requirements if the system is working and no changes have been made.*

Response: The Commissioner declines to incorporate the suggested changes. An Alternate Access Delivery Request Form C should only be submitted in limited circumstances and is not meant to be a permanent network arrangement. It is imperative in these situations that reporting requirements are adhered to so the Commissioner can monitor the status and effect of the alternate access delivery system on enrollees.

***Comment**: Issuers should notify enrollees under WAC 284-43-220(3)(f)(i)(J) of transfer of ownership or control of providers and facilities, and discontinuation of covered services.*

Response: The Commissioner declines to include this requirement. This requirement would be administratively burdensome and is not the responsibility of the issuer.

WAC 284-43-221 & WAC 284-43-222: Essential Community Providers

***Comment**: Comments requested that certain provider types should be included as Essential Community Providers, including: Indian health care providers, emergency room departments, pediatric subspecialties, public health departments, children's specialty hospitals,*

Response: The concept and definition of Essential Community Providers were formulated by CMS. CMS has in place a working process to determine which facilities meet that definition: application for inclusion on CMS's Non-Exhaustive List of Essential Community Providers. Use of this process will have two beneficial effects for Washington State. First, it will ensure that the CMS standard is used to identify ECPs in Washington, thus guaranteeing a level playing field for all issuers and providers, especially those participating in multi-state plans. Second, it avoids duplication of efforts between the State and Federal governments. The non-exhaustive list is an important starting point to identify ECPs that is changing and growing as more providers and facilities are added. Any facility that believes it is an ECP may request to be on the non-exhaustive list. It would simply need to satisfy CMS that it meets the ECP requirements.
Qualified health plans must include sufficient number and types of Essential Community Providers to provide reasonable access to the medically underserved or low-income in the service area. In fact, CMS's Non-Exhaustive List of Essential Community Providers currently includes 37 of the 39 designated critical access hospitals in Washington.

The list can be found at https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq.

However, it should be noted that according to the federal guidance, an issuer may identify and include providers that meet the federal regulatory criteria. For more information consult the final

2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM) issued on March 14, 2014, which can be accessed at:
http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf

***Comment**: The percentage of ECPs required in WAC 284-43-222 is above the 30% threshold required by federal guidance for 2015.*

Response: The 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM) issued on February 14, 2014 and the final 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM) issued on March 14, 2014 indicate an intention to have a general Essential Community Provider inclusion standard. The standard would be at least 30% of available Essential Community Providers in each plan's service area. In addition to the 30% threshold, the issuer must offer contracts in good faith to all Indian health care providers that request a contract and at least one Essential Community Provider in each Essential Community Provider category in each county in the service area where an Essential Community Provider category is available. The ACA allows the states to develop standards that meet the state's unique healthcare market. Accordingly, while the Commissioner is not required to adopt the federal threshold, the federal guidance is a floor that the Commissioner's rules cannot go below. The Commissioner adopted a 30% threshold for primary care providers, pediatric oral services, pediatricians, and hospitals that meet the definition of an Essential Community Provider. When considering the threshold at which to set Essential Community Provider standards of inclusion for the other categories, the Commissioner reviewed standards set by other states with state based-exchanges including Connecticut, California, and Colorado.

***Comment**: There is no exception for not being able to meet the Essential Community Provider standards.*

Response: The Commissioner took this comment into consideration and included language in WAC 284-43-200(15)(d) regarding submitting an alternate access delivery request when a qualified health plan is unable to meet the standards regarding inclusion of Essential Community Providers in WAC 284-43-222. An issuer will need to provide substantial evidence of good faith efforts to contract with provider or facilities in the service area.

***Comment**: Definition of service area will not allow service areas to vary by issuer and needs to be read in conjunction with the standards for Essential Community Providers as one Essential Community Provider for a large provider with a statewide service area will not allow for level or*

access to care that patients expect. The definition should be defined by urban, rural, suburban and broken down by the needs of a particular population.

Response: Issuers have the latitude to define a service area either by a county, multiple counties, or statewide. After the service area is defined by the issuer, the issuer must then meet the standards of inclusion for Essential Community Providers within that service area for qualified health plans. The definition of service area does not require issuers to all have the same service area or be statewide. Additionally, as stated above, both the federal rules and the Washington State Health Benefit Exchange define service area by county.

***Comment**: Include language that an issuer must have sufficient number and geographic distribution of Essential Community Providers to ensure reasonable and timely access to a broad range of providers for low-income medically underserved individuals in the service area.*

Response: The Commissioner took this comment into consideration and included language in WAC 284-43-222(2) to ensure that there is sufficient number and type of Essential Community Providers to provide reasonable access to the medically underserved and low income population. This language is also consistent with the general standard language in WAC 284-43-200.

***Comment**: Essential Community Providers may have to charge issuers higher rates to compensate for the fact that so many of their patients are covered by Medicaid or uninsured.*

Response: As stated above, the Commissioner has no authority to set provider contract terms (such as reimbursement rates).

***Comment**: Include QHP contracting requirements for Indian health care providers, including that contracts must be offered to all tribal Indian health care providers. Include federal statutory language from 25 USC 1621(a) Section 206(a) and (e). Require use of the Washington State Indian Health Plan addendum and post the addendum on the Office of the Insurance Commissioner's website.*

Response: The comments were taken into consideration in drafting the rule and were incorporated in this section. The Commissioner declines to require the use of the addendum, however, the use of the addendum is encouraged. Additionally, an issuer is required to offer a contract if requested by an Indian health care provider. The Commissioner was urged to include language that issuers were expected to use the addendum consistent with federal guidance; however, the specific language from the March 14, 2014 2015 Letter to Issuers in the Federally-

facilitated Marketplaces states that "To promote contracting between issuers and Indian health care providers, CMS expects issuers to offer contracts to Indian health care providers and use the recommended Model QHP Addendum (Addendum) as described in the 2014 Letter to Issuers." The expectation is for issuers to offer a contract, which is consistent with the rule language.

While the Commissioner declines to post the addendum on the Office of the Insurance Commissioner's website, the rule directs issuers to use the most current version as posted on AIHC's website.

Finally, the Commissioner also declines to restate federal law as issuers are already required to comply with applicable federal law. Also, to the extent that the federal regulation pertains to reimbursements rates and contracting terms, the Commissioner has no authority to require any party to contract with another party or to set provider contract terms such as reimbursement rates.

Comment*: Require all plans, health homes, coordinated care organizations, and integrated delivery systems to contract with all reproductive health and Medicaid eligible providers that have been identified as Essential Community Providers.*

Response: As stated above, the Commissioner has no authority to require any party to contract with another party. These limits do not allow the Commissioner either to require providers and issuers to contract with one another. However, the rulemaking is important to ensure that issuers have a network sufficient in number and choice of providers and facilities to provide enrollees access to covered services.

Comment*: Integrated health care delivery systems are not required to meet Essential Community Provider standards and the rule should include this exemption.*

Response: The Commissioner included an exemption for integrated delivery systems pursuant to RCW 43.71.065(1)(c).

Comment*: Concern was raised that qualified health plans are not required to meet general access standards which would result in inadequate networks if only held to the standards specified in WAC 284-43-222.*

Response: All plans must meet the general standards of the rule as set forth in WAC 284-43-200. The first section of WAC 284-43-222 states that an issuer must include Essential Community Providers in its network for qualified health plans and the section specifically states that these are minimum standards for the inclusion of Essential Community Providers. In other

words, these standards go only to whether a network meets the ACA requirements for inclusion of Essential Community Providers. That is only one of the standards the network must meet.

***Comment**: Requirement that Essential Community Providers must comprise 30% of the provider network will result in fewer providers being included in the network. If there are only 3 Essential Community Providers in the service area but 100 other providers, your total network could be restricted to 10 providers.*

Response: The Commissioner took this comment into consideration and changed the language of this section, WAC 284-43-222(3)(a) to more accurately reflect the intent. The section reads that each issuer must demonstrate that at least 30% of available primary care providers, pediatricians, and hospitals that meet the definition of Essential Community Provider in each plan's service area participate in the provider network.

***Comment**: Remove wording that requires contracting with 100% of the Indian health care providers as that requires contracting and is based on the belief that all health centers will contract on terms actuarially acceptable.*

Response: The Commissioner took this comment into consideration and changed the language of this section, WAC 284-43-222(3)(b) to more accurately reflect the intent.

***Comment**: Mandating that issuers offer to contract with school-based health centers and Indian Health Providers is not supported by any state or federal statutory requirement.*

Response: The final 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM) issued on March 14, 2014 states an expectation that the issuers offer contracts to all available Indian health providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations.

The ACA made funds available to support school-based health centers. In addition, the Commissioner reviewed the network requirements implemented by other states, such as Connecticut, as school-based health centers are an effective way to deliver primary healthcare and mental health services to children and adolescents. According to Washington School-Based Health Alliance, there are approximately 29 school-based health centers state-wide. However, this is a requirement to offer the opportunity to contract, not a mandate that a contract must be entered into by the parties.

***Comment**: Suggestions were made to more accurately define "rural health clinics" and "federally qualified health centers."*

Response: The Commissioner took this comment into consideration and modified the definitions in WAC 284-43-221(12) and (13).

***Comment**: WAC 284-43-222(2) includes language about when an Essential Community Provider "refuses to contract at the same or reasonable proximate reimbursement rates to those negotiated with other providers in the service area." This appears to exceed the Commissioner's authority.*

Response: The Commissioner took this comment into consideration and deleted the language.

***Comment**: WAC 284-43-222(3)(g) requires one Essential Community Provider hospital per service area." One community hospital may be adequate if the service area in only one or two counties, but not if the service area is statewide. Comment received that one Essential Community Provider per county is not adequate. This should instead be based on standards that reflect the population and location of patients and hospitals in the county.*

Response: The Commissioner took this comment into consideration and changed the language in WAC 284-43-222(3)(g) to require one Essential Community Provider hospital per county. This language is consistent with the federal guidelines in the final 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM) issued on March 14, 2014, which states that issuers must include at least one Essential Community Provider in each Essential Community Provider category in each county.

***Comment**: There is no minimum standard for Title X Family Planning Clinics and Title X look alikes, to ensure access there should be a requirement that issuers make a good faith effort to contract with 100% of these clinics. Similar comment regarding Ryan White HIV/AIDS Program Providers and requesting a 90% inclusion threshold.*

Response: In accordance with federal guidelines as stated in the final 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM) issued on March 14, 2014, issuers must include at least one Essential Community Provider in each Essential Community Provider category, which includes Title X Family Planning Clinics and Title X look alikes and Ryan White Program Providers, in each county in the service area, where an Essential Community Provider in that category is available. Additionally, consistent with federal guidance, an issuer must demonstrate

that at least 30 percent of available Essential Community Providers in each plan's service area participate in the provider network.

WAC 284-43-229: Tiered provider networks

***Comment**: Concerns were raised about limited or narrow networks creating barriers to care that can be catastrophic to individuals and families.*

Response: The Commissioner shares the concern that poorly created narrow networks can have devastating effects on individuals and families in regard to access to care. Taking into consideration the concerns of consumer groups and providers, the lowest cost-sharing tier in a tiered provider network must cover all Essential Health Benefits. Additionally, the rule provides greater transparency to both the Office of the Insurance Commissioner and providers as to how tiered networks are formed. The rule also provides that the issuer must disclose to enrollees the cost difference and the basis for placement of providers and facilities in tiers. Providers must also be given a 60-day notice when the issuer amends, or revises its tiering program. For certain categories of patients, including primary care, second or third trimester of pregnancy, terminally ill, and those under active treatment for cancer or hematological disorder, 60 days notice must be provided when their provider is reassigned to a higher cost-sharing tier.

***Comment**: Add language that use of tiers must not delay treatment or interfere with or compromise a provider's medical judgment.*

Response: The Commissioner took this comment into consideration when drafting the rule. To the extent that this issue can be addressed within the Commissioner's regulatory authority, the rule requires the lowest cost-sharing tier to provide enrollees adequate access to all the Essential Health Benefits. Additionally, the general standards in the rule require sufficient numbers and types of providers to assure that covered services are accessible in a timely manner appropriate for enrollees' conditions. WAC 284-43-200(1). This rule should eliminate a situation where an enrollee cannot access care. The Commissioner also believes that tiered networks can be beneficial to all involved in the health care delivery system and the marketplace as long as the tiering process is transparent to all parties involved.

***Comment**: Include language requiring plans to have sufficient numbers of open practices in the lowest tier of cost-sharing.*

Response: The intent of the rule is to ensure there are sufficient numbers and types of providers that an enrollee has access to covered services. To this end, the rule requires that the lowest cost-

sharing tier must provide adequate access and choice among providers for Essential Health Benefits.

***Comment**: Comments were received about the notice requirement to providers when the quality, cost-efficiency, or tiering program is changed. Some comments urged a more generous notice timeline and other comments urged a shorter timeline.*

Response: The comments were taken into consideration in drafting the rule and the minimum notice requirement is 60 days. However, this is the minimum notice requirement and the provider contract can be negotiated to include additional notice.

***Comment**: Comments were received about the notice requirement to enrollees when a provider has been reassigned to a higher cost tier. Additionally, comments were received requesting the inclusion of certain enrollees to the list that notification is required to be given.*

Response: The comments were taken into consideration in drafting the rule. Accordingly, the minimum notice requirement is sixty days. Additionally, the Commissioner included patients undergoing active treatment for cancer or hematological disorders to the list of those patients that must receive notice.

***Comment**: Ensure that if the sole facility required to deliver a covered service is not available in the base tier then no cost differentials will be imposed.*

Response: The Commissioner took this comment into consideration when drafting the rule. The rule requires that cost-sharing differentials between tiers must not be imposed if the sole provider or facility required to deliver a covered service is not in the lowest cost-sharing tier of the network.

***Comment**: Issuer must not be able to use tiered networks to discriminate or limit access to certain types of providers.*

Response: The Commissioner took this comment into consideration when drafting the rule. The section on tiered networks is intended to balance the ability of issuers to innovate when building networks and ensuring that enrollees have access to covered services.

***Comment**: Tiering is outside the scope of the rulemaking and is a benefit determination and not always included in provider contracts. Additional comment received that the Commissioner should not interfere with contract and payment arrangements when an issuer rents a network.*

Response: The Commissioner respectfully disagrees that tiering is outside of the scope of rulemaking. How networks are designed, including tiering, can affect access to covered services. Additionally, it is important for all parties involved and affected by a tiered network to understand how the network has been tiered and how, within a tiered network, they can access providers and services. This section of the rule provides necessary transparency to the process.

***Comment**: Metrics and methodology used to assign providers and facilities to a tier is proprietary and a trade secret. Additional comment received that the last sentence in this section in the first exposure draft be deleted as the required explanations interfere with issuer's business decisions to manage its networks and assumes data and methodologies where there may be none.*

Response: The Commissioner took these comments into consideration. The last sentence in the section was deleted. The language was also changed to anticipate that there may be situations were there are no metrics or methodology to report. The rule now requires that this information be submitted with Provider Compensation Agreements which are afforded certain protections against disclosure under RCW 48.43.730(5).

***Comment**: Selection criteria are proprietary and are a trade secret.*

Response: The Commissioner took this comment into consideration; accordingly, the language was clarified to avoid disclosure of information that may be proprietary or trade secret.

***Comment**: Economic profile is unclear and undefined and suggests proprietary information will be disclosed.*

Response: The Commissioner took this comment into consideration; accordingly, the term was changed to "physician cost profile" to more accurately convey the intent of the submission for review.

***Comment**: Section seems to allow tiering as a utilization management tool, quality or outcome incentive, or a combination of the two. Suggests that networks could be constrained only to those*

providers who accept reduced reimbursement, financial risk incentives, and certain undefined outcome measurements.

Response: Issuers can tier based on utilization as well as quality, outcome, or incentives for quality care at a lower cost. This rule will provide the Commissioner with a mechanism to examine the criteria used by issuers in assignment of a provider to a particular tier, especially to ensure whether access is restricted. To the extent that this issue also pertains to contracting issues between an issuer and providers, the Commissioner has no authority to require any party to contract with another party, or to set provider contract terms.

Comment: *Important to be clear about the distinctions between in-network and out-of-network as well as contracted versus non-contracted providers. An issuer using a tiered network may have a contractual agreement with a provider to the effect that they are contracted with the issuer on behalf of enrollees. However, when the issuer applies tiering standards to manage networks of different sizes and composition, some of the contracted providers can be in-network for some plans and out-of-network for others.*

Response: The Commissioner took this comment into consideration and recognizes that "contracted provider" can mean many things when creating networks and tiering networks. Accordingly, the language of this section was changed to more accurately reflect this reality.

Comment: *Clarify that this section only applies to those networks where there is a different treatment of coverage for different providers within the network and does not apply to networks where tiering is used to determine which providers are in-network.*

Response: The intent of this section is to encompass all types of tiered networks and to give parameters for innovation in this area of network creation considering current and future markets.

Comment: *Appears to limit issuers' decisions about tiered networks to a restrictive, scientific methodology based on objective criteria and metrics. Tiering of networks may include more subjective and nuanced criteria. Change language to account for if there are any applicable criteria, rating, or data used to tier providers.*

Response: The Commissioner took this comment into consideration and changed the language as requested. The rule is intended to ensure flexibility while maintaining the integrity of the marketplace. It is important for transparency in the process and to the extent that issuers are

using criteria or metrics in tiering, the Commissioner needs to be able to evaluate this information to determine if there are barriers to access.

Comment: *Add language that tiered provider networks in this section do not include centers for excellence, and integrated delivery systems that do not include provider types for all services covered under the health plan, or health plans, that are developed as narrow networks.*

Response: The Commissioner took this comment into consideration and declines to add the suggested language. To include this language would be contrary to the purpose and intent of the rule as it would unreasonably restrict access and limit transparency where both are sorely needed.

Comment*: Concerns were raised that the lowest cost-sharing tier would not contain a full range of providers or allow adequate access to care. Urged the Commissioner to require that all tiers of providers include a full range of providers including Essential Community Providers and that all tiers include coverage of EHBs. Urged to also include specific facilities in the lowest cost-sharing tier.*

Response: The Commissioner took this comment into consideration; however, making this suggested requirement would stifle innovation and could potentially increase costs to consumers. Tiered networks can be an effective cost management tool and should not restrict access if the networks are built appropriately. This section of the rule is essential for transparency in the tiering process so the Commissioner can ensure that tiering of networks does not result in limited access or barriers to access to covered services for enrollees. The rule requires that the lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among providers and facilities for Essential Health Benefits. If the Commissioner allowed one specific facility or provider group to be required in the lowest cost-sharing tier, then all facilities or provider groups that wanted to be listed would need to be listed. This would run contrary to the purpose of tiered networks and the rule itself.

Comment*: Any changes to tiered network should only be allowed at the beginning of the plan year.*

Response: The Commissioner declines to adopt the suggested requirement. The reality of the marketplace is that networks are constantly changing. To allow changes to occur only at the beginning of the plan year would effectively stifle innovation, create situations where access to covered services is limited or exhausted, and would likely harm consumers in the process.

***Comment**: Broaden the class of enrollees that are notified if a tiered network changes to include those with a chronic condition.*

Response: The Commissioner took this comment into consideration and declines to make the suggested change. Chronic conditions can cover a broad range of diseases and conditions and it would be administratively burdensome to require the issuers to do so. However, the rule does require issuers to make a good faith effort to notify affected enrollees of provider reassignment within tiers.

***Comment**: Clarify distinction between a network and a tier.*

Response: The Commissioner believes the language of the rule is sufficient. Tiers make up the network.

***Comment**: Add language to indicate that tiering will be done to offer enrollees access to higher value providers, control costs, utilization, quality, or otherwise incentivize enrollee or provider behavior. Also include that an individual tier is not required to provide an enrollee with access to the full range of services and supplies covered by the health plan.*

Response: The Commissioner declines to include the requested language for a few reasons. First, the intent of the rule is to provide transparency to the tiering process as issuers develop and innovate new market strategies for the delivery of services. To the extent that an issuer may use tiering, the rule is not meant to state those reasons that may not necessarily be true for every issuer and its tiering process and methods. Second, tiering cannot result in barriers to access and listing out rationales for tiering appears to approve the stated rationale even if the tiering results in barriers to access. Third, even if tiering of a network is utilized by an issuer, for whatever reason, the lowest cost-sharing tier must still provide enrollees with adequate access and choice among providers and facilities for Essential Health Benefits. Finally, this rule is intended to address access to providers and facilities, not services.

***Comment**: Section refers to "base tier" but does not define base tier.*

Response: The Commissioner took this comment into consideration and changed the language to "lowest cost-sharing tier."

***Comment**: Continuity of care concern if a mid-year provider reclassification prevents a patient from being able to afford care with the same provider.*

Response: The Commissioner understands and shares the continuity of care concern. For that reason, the Commissioner expanded the notice requirements under the rule for additional categories of patients to provide transparency to the process and important information about access to providers and facilities. The Commissioner balanced consumer protection with the needs of the insurance market and the goals of the ACA. The Commissioner must foster innovation and measures designed to increase health care quality while decreasing costs, which are the main objectives of the ACA.

***Comment**: The requirements for tiered provider networks should include a requirement that issuers demonstrate that they engaged in good faith efforts in placement of providers into tiers.*

Response: The Commissioner declines to adopt this suggestion for a few reasons. First, the Commissioner has authority only to ensure that tiering does not result in barriers to access or other violations of the Washington State Insurance Code, not to dictate which providers must be included in specific tiers, specific tiering processes, or the application of the process to particular providers. Second, the placement of providers into particular network tiers is a contracting issue between the provider and the issuer. Third, the rules are designed to foster innovation. Finally, "good faith efforts" would be very difficult to define in this context.

WAC 284-43-230: Assessment of access

***Comment**: Assessment of capacity should be addressed. Capacity should be evaluated across full spectrum of plans including Medicaid, Medicare, managed care, fully insured, and self insured.*

Response: The Commissioner cannot assess capacity as suggested. Not only are providers outside of the Commissioner's regulatory authority but Medicare, Medicaid, and self-insured plans are also. Because of this, there is not one single state agency that has the regulatory authority to address and evaluate capacity across the full spectrum of plans. This will need to be addressed as part of a larger coalition of state agencies. However, the Commissioner is mindful of the interplay and tension of capacity of providers and facilities with an adequate and accessible network. The rule attempts to balance this issue within the regulatory authority of the Commissioner.

***Comment**: Add URAC and the Accreditation Association for Ambulatory Health Care (AAAHC) as national accrediting organizations.*

Response: The Commissioner took this comment into consideration and included URAC and AAAHC in the list of national accrediting organizations.

***Comment**: Delete "including, but not limited to." Alternatively, include factors including provider location, available services and specialties, hours of operation, breadth of services in a single location, 24/7 access with clinical call center or advice line, quality performance, member satisfaction, results from surveys etc.*

Response: The Commissioner declines to delete the references phrase, "including but not limited to", as doing so would significantly limit the Commissioner's authority and ability to review and evaluate other factors including those listed in the comment.

***Comment**: Add subsection that, if a network meets the factors in this section then the network shall be deemed adequate.*

Response: The Commissioner declines to deem access adequate if the factors in this section are met for two reasons. First, the rule needs to be read as a whole and the network must meet the requirements applicable to that specific network that are delineated in the rule. Second, this section is intended to illustrate *factors* that the Commissioner will *consider* when determining network access to give issuers guidance, but are not the entirety of evaluation.

***Comment**: Move subsection regarding school-based health centers and Indian health care providers to section on Essential Community Providers, WAC 284-43-222, as this only pertains to qualified health plans.*

Response: The Commissioner took this comment into consideration and moved the two subsections to WAC 284-43-222: Essential Community Providers for exchange plans.

***Comment:** Requiring an issuer to report the number of enrollees in the service area living in certain institutions or who have chronic, severe, or disabling medical conditions is too vague a standard.*

Response: The Commissioner took this comment into consideration and changed the language to clarify the intent and what is required in WAC 284-43-230(1)(e).

Comment: *WAC 284-43-230 should state that the Commissioner's approval or disapproval of a network will be based upon whether the issuer demonstrated by a preponderance of the evidence that it has engaged in good faith efforts to meet the network access requirements.*

Response: This section sets forth factors the Commissioner will consider when determining network access for enrollees and not the legal standards to be applied when a challenge to that decision is brought. Therefore, the Commissioner declines to adopt this suggestion.

Comment: *WAC 284-43-230(2) is weighted toward issuers and inappropriately incorporates the standards of another state agency.*

Response: The Commissioner has considered the comments from provider groups, consumer groups and issuers. The resulting proposed rule reflects a balanced approach between interested stakeholders and the regulatory responsibilities of the agency. Subsection (2) does not defer to the standards of any other agency, but allows an issuer to show that it meets the standards of another agency in support of its representation that its network is adequate. This alone is not conclusive of the issue. The Commissioner will still thoroughly review the network for compliance with the standards of the rule.

WAC 284-43-250: Issuer standards for women's right to directly access certain health care practitioners for women's health care services

Comment*: Ensure that enrollees can access full range of reproductive providers in a network and require that any plans that cover termination of pregnancy ensure there are sufficient providers in the network. Additional comments urging coverage of mammography and breast cancer detection.*

Response: The Commissioner believes the rule does this, because the rule requires issuers to maintain a network that includes provider sufficient in number and type to assure that all health plan services are provided in a timely manner appropriate for the enrollee's condition.

WAC 284-43-252: Hospital emergency service departments and practice groups

Comment*: The Commissioner was encouraged to retain $50 limit on cost-sharing for emergency room services and expand that requirement to QHPs.*

Response: The $50 limit on cost-sharing in relation to emergency services is pursuant to RCW 49.43.093(c).

***Comment**: Concern that if a hospital is deemed as being in an enrollee's network, yet the emergency physicians in that department are not, access to emergency services 24/7 is illusory.*

Response: The Commissioner agrees that this situation, which is all too common in Washington, is of great concern. For that reason, WAC 284-43-252 requires issuers to make good faith attempts to contract with all provider groups offering services within the emergency departments of in-network hospitals. That is also why the Commissioner has included the requirement in WAC 284-43-204(7) that issuers include information about the network status of emergency providers in their provider directories. Because the Commissioner does not have the authority to require emergency physicians to contract with issuers, this is the extent to which these rules can go.

Despite this limitation, even where the emergency physicians staffing the emergency department are not in-network, OIC can and does ensure that access to emergency services 24/7 is not illusory. The issuers are, in fact, required to ensure that their enrollees have access to emergency services at all times. Also, the services of the emergency department itself (equipment charges, nursing and other staff, etc.) must, in fact, be covered under the terms of the health plan contract.

DIFFERENCES BETWEEN PROPOSED AND FINAL RULE (NON-GRAMMATICAL)

- WAC 284-43-130(15): Stand alone definition of "issuer" was stricken as it created an internal discrepancy in the definitional section. Maintained as part of the definition of "health carrier," WAC 284-43-130(14). Renumbered section.
- WAC 284-43-130(30): Struck "within the state" from definition. Stricken to more accurately reflect the marketplace as issuers offer plans in border counties which utilize providers and facilities in neighboring states to provide sufficient number and choice of providers to enrollees in a manner that limits the amount of travel.
- WAC 284-43-130(30): Changed "health plan" to "product" for consistency.
- WAC 284-43-200(11)(a): Changed "Medical" to "Mental" to accurately reflect the name of the publication.
- WAC 284-43-200(12): Changed "preventative" to "preventive" for consistency with WAC 284-43-878(9).
- WAC 284-43-200(13)(b)(i): Ratio of "enrollee to primary care provider" was changed to "primary care provider to enrollee" to accurately reflect the ratio.
- WAC 284-43-200(13)(b)(iii): Changed "their" to "a" in reference to a primary care provider for consistency.
- WAC 284-43-200(15)(d): Struck reference to subsection (d) of (3) and section (4) as these are no longer valid cross references.

- WAC 284-43-220(3)(e)(i)(E): Struck “each area” and made specialty plural. Also struck “each” and included “the.” Both changes made to accurately reflect the intent of the section.
- WAC 284-43-220(3)(e)(iii): Struck “this” for readability.
- WAC 284-43-220(3)(f): Changed “health plan” to “product” for consistency.
- WAC 284-43-220(3)(f)(i)(K): Changed “Processes” to “Issuer’s process” to differentiate from the Department of Health’s corrective actions.
- WAC 284-43-220(4)(b): Corrected “An area with” to “An area within” to accurately reflect the definition.
- WAC 284-43-220(3)(d)(i)(A): Added “and facilities” for consistency.
- WAC 284-43-220(3)(e)(i)(C): Included “substance use disorder” in title of map and also included “substance use disorder” where specialty mental health providers are referenced. Amended language for consistency with other areas of the rule that reference mental health and substance use disorder providers.
- WAC 284-43-222(5)(a): Name of addendum was corrected.
- WAC 284-43-229(4): Amended language to make consistent with the section, changed “lowest cost tier of the network” to read “lowest cost-sharing tier of the network.”
- Throughout rule text any reference to “file” or “filing” was changed to “submit” or submitted” to make the rule consistent in word usage.

IMPLEMENTATION PLAN

See attached Exhibit A.

HEARING SUMMARY

The Commissioner delegated the responsibility to preside over the hearing to staff. Kate Reynolds, Special Assistant to the Commissioner, presided. The hearing began at 9 a.m. on April 22, 2014. Because testimony did not differ from the written comments received, the applicable Commissioner’s response for the written comment on the subject applies to the comments received at hearing. The following testimony was offered:

Shalom Sands, Washington State Nurses Association: Submitted written comments. Testified that while WSNA approves the use of provider neutral language they are concerned that the geographic mapping will omit data to determine if consumers have access to specialty services and in compliance with every category of health care providers. Particularly in reference to relevant information which may exclude ARNPs from plans. And also women’s right to access health care providers, particularly birthing centers and nurse midwives. Cannot determine whether there are adequate women’s health care providers.

Chris Bandoli, Regence: Submitted written comments. Testified that Regence is still concerned but the concerns are in written comments. Implementation is on a short timeframe to implement

the new requirements and hope there will be a willingness to be flexible on both sides. Innovation is important and best way to do so is move beyond traditional way that medicine is reimbursed and need to work collaboratively to do so.

Mark DelBecco, Seattle Children's Hospital: Submitted written comments. Requested that the draft rule be withdrawn because of effect on consumers and children in the state. Testified that Seattle Children's Hospital has significant concerns including the erosion of OIC's regulatory authority in good faith efforts of contracting. Wanted to bring the issue to a personal level and testified to a personal story and the story of children that are receiving care at Seattle Children's Hospital. Narrow networks are threatening access to care. Seattle Children's Hospital has added four staff members to submit requests for befit level exceptions and review denials.

Sydney Smith Zvara, Association of Washington Healthcare Plans: Submitted written comments. Testified that core concerns remain. Requested that draft rule be withdrawn until federal guidelines come out. This rule is extensive and complex, burdensome and cumbersome with thousands of maps required and multiple reports. Insures and providers are negatively impacted because of the need to ask more questions more frequently. Asked whether small business impact statement applies. Important and we need to get it right. Asked for OIC to maintain current regulations.

Leanne Gassaway, America's Health Insurance Plans: Submitted written comments. Testified that America's Health Insurance Plans shares Association of Washington Healthcare Plans' comments. The effective date of the rule may make information more incomplete because of need to amend provider contracts. Subcontracted network changes will also require necessary filing changes. Will not bring greater transparency and will be in same situation as last year. Issuers will be scrambling to file accurate information under a distressed timeline. Need more flexibility in working with the OIC to create innovative networks as the one size fits all does not work. Massive healthcare reform should not squash those, including Accountable Care Organizations, and the alternate access delivery request must allow innovation. Need choice and competition and not focus on location. The provider tools are severely limited in these regulations; subcontracted networks, any willing provider, and single case reimbursement agreements.

Mel Sorenson, Washington Association of Health Underwriters: Request that draft rule is withdrawn. Testified that the Association is concerned that the unintentional effect of the rule will be to collapse choices in health plan options. Completion ought to provide for widest array of market options. Adverse to the idea of competing options as the rule will create flatter more common network. Concerned that a principle cost management tool, competition, including price competition will be negatively affected among providers and issuers. This is impaired when regulation or policy seeks to protect economic interests of those providers that may be unhappy they are not included in networks. Competitive bidding will accrue to the benefit of those paying the bills.

Katie Rogers, Coordinated Care: Submitted written comments. Testified that rule adds unnecessary barriers and restrictions that will increase costs with negligible increase to access and does not ensure highest quality of care at lowest cost. Rule does not encourage innovation and runs contrary to the ACA. Rule exceeds federal guidelines by requiring contracting with certain Essential Community Providers. State regulations should be consistent with federal rules as this will increase costs and limit affordable choices offered in the Exchange. Will need to modify networks and will take significant time and resources. Coordinated Care has sent emails with questions about 2015 filings, due in seven days, and await a response from the OIC. Adopting such a rule seven days before filing is untenable.

Mary McHale, American Cancer Society Cancer Action Network, Inc.: Submitted written comments. Testified that the stronger tools to gather data on provider access gaps are positive. This rule has positive steps toward greater transparency. Several areas can be improved; revisit with data driven changes. Alternate access delivery request requires disclosure of important information. Summary of filing will be made to public which is important. Concerned with the American Board of Medical Specialties tie for specialties because subspecialties, such as oncology subspecialists, will be subsumed on the geographic maps so there is no way to require certain subspecialties will be adequately included in networks. Continuity of care concerns for cancer care patients that cannot afford provider when they change tiers but pleased that cancer patients will be given notice when provider changes tiers. Want to be able to evaluate how often providers change tiers during the plan year. 60 mile access in rural area may negatively impact smaller rural providers as they are passed over by issuers. This is not the case in the current regulation which includes a 30 mile example that is important to consumers that are taking legal action.

Linda Gainer, Seattle Cancer Care Alliance: Submitted written comments. Testified that there is a need to access life saving cancer care and clinical trials. People travel great distances to get treatment at SCCA; cutting edge and new drugs are available. Testified to programs, procedures, and clinical trials that the SCCA offers and the survival rates of the patients. SCCA has specific expertise in the field. Many people with Exchange plans do not have access to in-network care at SCCA. SCCA supports limits on single case reimbursement agreements in determination of network adequacy, the coverage of out of network services without additional costs, and the notice requirement for cancer patients when their provider changes tiers during the plan year. Concerned that the coverage offered through the Exchange will not provide access to individuals that need it with SCCA. Patients need access to an NCI-designated cancer center.

Waltraut Lehmann, Premera Blue Cross: Submitted written comments. Joined comments made by AWHP. Testified that while Premera understands the OIC's need for clarity, Premera is concerned about the great number of reports, filings, and record keeping items that are required by the rules. Monumental implementation tasks are required and we need further definition and clarification. Burden imposed inequitably on narrower networks that do not include every provider available in the marketplace. Urged the OIC to rely on the federal standard in drafting

the rule. In some areas of state, with the mileage requirement, there may not be providers available at all and no map will capture them. Concerned also about the tiering regulations and although have spoken with the OIC, believes the rule does not reflect these conversations. More work is needed on the rules.

Barbara Gorham, Washington State Hospital Association: Submitted written comments. Requested that draft rule is withdrawn. Testified that rules were drafted under an unreasonable timeline. Need to address the minimal access requirements. The rule affords less access in rural areas than urban areas. First draft that included 30-miles was correct; the new 60-minute requirement will negatively affect access. Allow issuers to file an alternate access delivery request if they cannot meet the 30-mile standard. Exemptions appear easy to get because the standard went from clear and convincing to substantial evidence. Issuers should bear a heavy burden for an exemption from the rule. Need to be able to review rates and substantive contract terms. Know that the OIC has looked at this in the past and has this information. Not sure what OIC is going to look at to ensure issuers met this requirement. Every consumer should have access to clinical trials for cancer treatment and rules should require this. Both sides are asking for more time in drafting this rule.

Jim Freeberg, National Multiple Sclerosis Society: Submitted written comments. Testified that smaller networks pose a risk to someone with Multiple Sclerosis. Have seen in other states issuers exclude Multiple Sclerosis specialists because of high costs and concerned that this may happen in Washington State. Appreciate efforts to provide consumer with information about whether plan has smaller network and want more protection around administrative changes and tiering changes. Urge strong oversight so consumers are not left out in the cold. Consumers should not navigate unreasonable barriers to care.

EXHIBIT A

State Implementation Plan

Healthcare Networks

Chapter 284-43 Subchapter B of the Washington Administrative Code (revised)

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Purpose

The Washington State Office of the Insurance Commissioner (OIC) provides the information in this implementation plan to meet agency and Administrative Procedure Act (RCW 34.05.328) requirements related to rule adoptions.

Introduction

On September 18, 2013, the Insurance Commissioner's Office filed a CR-101 to begin the rule making process for health coverage issuer provider network formation, access, and filing and approval standards. The current network adequacy and related provider contracting regulations were adopted prior to the passage of the Affordable Care Act. Based on the significant changes in health care delivery and access to care that occurred after January 1, 2014 due to health care reform, the commissioner determines that updating these regulations is reasonable and necessary. Clarification of state network access criteria in these areas is needed to support issuer filings. The purpose of this rule implementation plan is to inform those who must comply with 284-43 WAC Subchapter B about how the OIC intends to:

- Implement and enforce the rule.
- Inform and educate persons affected by the rule.
- Evaluate the rule.
- Train and inform staff about the new or amended rule.

Also included in this plan is information about:

- Supporting documents that may need to be written or revised because of the amended rule.
- Other resources where more information about the rule is available.
- Contact information for OIC employees who can answer questions about the rule implementation.

Implementation and Enforcement

The OIC will implement and enforce this rule. Using existing resources, OIC staff will continue to work with issuers, providers, and interested parties in complying with the requirements of the Healthcare Network rules. As the standards in the rule contain current and new sections we anticipate existing resources will need to be reallocated and/or retooled to implement and enforce this rule.

Interested Party Filers and User Training

To help inform and educate affected persons; the OIC has done the following:

- Implement:
  - Network reporting portal for issuer submissions of Network Access Reports.
  - Dedicated mailbox for network access questions.
  - Rates and Forms webpage for Network Access information.
- Provide consumer direct access to network reports on the OIC website.
- Conducted Network Access Report submission training for industry users on March 26, 2014.

To facilitate implementation; the OIC continues to develop and maintain the following:

- Receive and review network access reports
- Develop issuer general filing instructions.
- A Consumer Frequently Asked Questions document on its website.

Submission Requirements and Timelines

The rule standards contain multiple reporting requirements, submission timeframes, and reporting extensions. For example, 284-43 WAC, Subchapter B contain a "safe harbor" for gradual implementation of some requirements (e.g., submission of geographic maps and Access Plans), and the rules also contain several options for working with OIC to obtain assistance and additional time to meet the requirements, which are called out below.

Immediate implementation of this rule crosses three plan year submission deadlines. Rule enforcement sets forth the following submission calendar:

Plan Year 2013:

Reporting Requirement	Due Date	Extension permissible	Extension guidelines
Network Enrollment Form B	March 31, 2014	Yes	OIC granted industry wide extension from March 31, 2014 to April 30, 2014 to allow issuers to submit reports in Network Access Report portal.

Plan Year 2014:

Reporting Requirement	Due Date	Extension permissible	Extension guidelines
Provider Network Form A	January-May 2014 due by 10th of each month	Yes	Issuer may provide written request for a filing extension or waiver. A 15 day extension will be automatically granted. Subsequent written extension requests will be granted based on cause. A carrier may request a waiver to not file for a single or multiple months.
	June 5, 2014 and each month thereafter by the 5th of that month	Yes	Issuer may provide written request for a filing extension or waiver. A 15 day extension will be automatically granted. Subsequent written extension requests will be granted based on cause. A carrier may request a waiver to not file for a single or multiple months.
Provider Directory Certification	June 5, 2014 and each month thereafter by the 5th of that month	Yes	A granted Provider Network Form A extension automatically extends Provider Directory certification submission requirement for same period. WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown.
Network Enrollment Form B	March 31, 2015	Yes	WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown.

Access Plan	New plan - Large group market	Yes	WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown.
GeoNetwork Report	New plan offering – Large group market	Yes	WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown.
Provider agreement contracting	January 1, 2015	Yes	WAC 284-43-221 – An issuer may provide written request extending the implementation of the rule in provider contracts up to one year. The additional period allows recontracting up to January 1, 2016.

Plan Year 2015:

Reporting Requirement	**Due Date**	**Extension permissible**	**Extension guidelines**
Provider Network Form A	5th of each month	Yes	Issuer may provide written request for a filing extension or waiver. A 15 day extension will be automatically granted. Subsequent written extension requests will be granted based on cause. A carrier may request a waiver to not file for a single or multiple months.
Provider Directory Certification	5th of each month	Yes	Granted Provider Network Form A extension automatically extends Provider Directory certification submission requirement for same period. WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown.
Network Enrollment Form B	March 31, 2016	Yes	WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown.
Access Plan	May 1, 2015 Individual, Small group and Pediatric Stand Alone dental plan	Yes	WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown. WAC 284-43-220(1)(c) – A safe harbor standard may be applied
	New plan offering – Large group market	Yes	WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown. WAC 284-43-220(1)(c) – A safe harbor standard may be applied

GeoNetwork Report	May 1, 2015 Individual, Small group and Pediatric Stand Alone dental plan	Yes	WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown. WAC 284-43-220(1)(c) – A safe harbor standard may be applied
	New plan offering – Large group market	Yes	WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown. WAC 284-43-220(1)(c) – A safe harbor standard may be applied
Alternative Access Delivery Request	Upon issuer notification to OIC of need	Yes	WAC 284-43-220(1)(b) – an issuer may provide written request for a filing extension or waiver. The request will be permitted for good cause shown.
Provider agreement contracting	January 1, 2015	Yes	WAC 284-43-221 – An issuer may provide written request extending the implementation of the rule in provider contracts up to one year. The additional period allows recontracting up to January 1, 2016.

Informing and Educating Persons affected by this Rule

To help inform and educate the affected persons, OIC is doing or has done the following:

- Sent out public notices
- Used a distribution list created for this rule making to send updates
- Circulated two separate rule drafts for comment prior to filing CR-102
- Posted information on OIC's agency web pages
- Emailed stakeholders who have requested to be on our distribution list for this rule making
- Educated the public when they contact OIC
- Provided issuer training as appropriate

Evaluating the Rule

The OIC will work closely with issuers, providers, and other interested parties to evaluate the effectiveness of the rule. Contingency plan reviews will occur periodically and provide opportunities to evaluate the rule for future rule-making.

Training and Informing Agency Staff

A new unit in the Rates and Form Department has been established to facilitate implementation of this rule. The unit will work with and inform staff throughout the OIC and other agencies as needed about network access reporting and maintenance requirements.

List of Supporting Documents that May Need to be Written or Revised

The rule will require the OIC to develop and post on its website the Alternative Access Delivery Request Form C [see attachment A]. OIC will need to post Network Access Portal general filing instructions for submission of network access reports.

More Information

Rule making documents are available at: http://www.insurance.wa.gov/laws-rules/legislation-rules/

Contact Information

Kate Reynolds, Special Assistant to the Commissioner
Policy & Legislative Affairs Division
PO Box 40258
Olympia, WA 98504
360-725-7170
KateR@oic.wa.gov

Attachments

Attachment A – Alternative Access Delivery Request Form C

ATTACHMENT A

<Date>

<Insert Carrier Name>
<Address>
<City><State><Zip Code>

This "Alternative Access Delivery Request Form C" and supporting documentation is submitted for consideration and approval by the Washington state Office of the Insurance Commissioner. In this submission I have filed only one Alternative Access Delivery Request.

Filing Instructions:

Step 1:
Send an email to Network Access Administrator at: OICNetworkAccess@oic.wa.gov requesting activation for an Alternative Access Delivery Request Form C submission assignment in the Network Access Portal.

Step 2:
Complete this form by checking the appropriate box for consideration of either an:

1. Alternative Access Delivery Request per WAC 284-43-200(15)(a),
2. Alternative Access Delivery Request per WAC 284-43-200 (15)(b),
3. Alternative Access delivery Request per WAC 284-43-200 (15)(c); or
4. Essential Community Provider (ECP) – Narrative Justification per WAC 284-43-200(15)(d).

Step 3:
Upload in the Network Access Portal:

1. One PDF document that includes:
   a. A properly completed Alternative Access Delivery Request Form C; and
   b. Items 1-3 for Alternative Access Delivery Request, or
   c. Items 1-4 for Essential Community Provider (ECP) – Narrative Justification.
2. Supporting reports outlined in item 4 - Alternative Access Delivery Request. A separate network access report, in the required format, per WAC 284-43-220(3)(d) and the Network Access Report Filing Instructions.

<Filer Signature>
<Title>
<Contact Information>

□ Alternative Access Delivery Request must include:

1. Cover letter specifically setting forth the issuer's request by network, action plan, and resolution.
2. The following supporting documentation per WAC 284-43-220(3)(d):
   a. Supporting data describing how the proposed plan ensures enrollees will have reasonable access to sufficient providers, by number and type for covered services;
   b. A description and schedule of cost-sharing requirements for providers subject to the request;
   c. How the provider directory will be updated so that an enrollee can access provider types that are subject to the request;
   d. The issuer's marketing plan to accommodate the time period that the alternative access delivery system is in effect, and specifically describe how it impacts current and future enrollment.
3. Certification by an Officer of the Issuer that the submission consists solely of true and accurate documentation.
4. The following off cycle reports must be submitted separately but concurrently with the Alternative Access Delivery Request Form C information.
   a. Provider Network Form A demonstrating the addition and/or deletion of providers and facilities specific to this request. A Provider Directory Certification should not be filed concurrently with the proposed Provider Network Form A report. If the Insurance Commissioner approves this request, the issuer must file an off-cycle Provider Network Form A and a Provider Directory Certification as requested in the approval letter.
   b. A Network Enrollment Form B must be submitted with current enrollment. "Current" means enrollment as of the last complete month prior to submission of this form. For example, submission of a Network Sufficiency Form C on June 10th requires a Network Enrollment Form B report for enrollment figures for January 1st – May 31st of the current year.

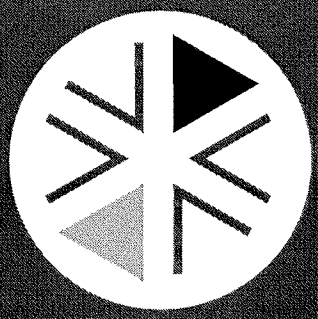
- ☐ <u>Essential Community Provider [ECP] – Narrative Justification requests must include:</u>
  1. Cover letter specifically setting forth the issuer's request by network, action plan, and resolution.
  2. Documentation fully describing and demonstrating why the issuer's plan does not meet the requirements of WAC 284-43-222:
     a. If the request is based, at least in part, upon a lack of sufficient ECPs with whom to contract, the issuer should include information demonstrating the number and location of available ECPs.
     b. If the request is based, at least in part, upon an inability to contract with certain ECPs, the request should include substantial evidence of the issuer's good faith efforts to contract with additional ECP's and state why those efforts have been unsuccessful.
     - Evidence of the issuer's good faith efforts to contract will include, at a minimum:
       i. Provider information identifying the provider organization name and affiliates name(s), business address, mailing address, telephone number(s), email address, organizations representative name and title.
       ii. Issuer's information identifying the issuer representative's name and title, mailing address, telephone number, and email address.
       iii. If a contract was offered, a list that identifies contract offer dates and a record of the communication between the issuer and provider. For example, you should indicate whether contract negotiations are still in progress or the extent to which you are not able to agree on contract terms. "Extent to which you are not able to agree" means quantification by some means of the distance between the parties' positions. For example, "After working together for two weeks, the parties still had several contract provisions upon which they were unable to come to agreement, and neither party was able to compromise further" or "The parties exchanged draft contract provisions and met in person, but their positions were widely divergent and we were unable to come to agreement."
       iv. If a contract was not offered, explain why the issuer did not offer to contract. Documentation must be as specific as possible.
     - The assessment of whether the issuer has made good faith efforts to contract is an assessment of the efforts to contract, not an assessment of the particular terms being offered by either party. Evidence regarding the parties' positions on particular terms, or the reasonableness of terms, should not be included.

3. Documentation identifying how the issuer plans to increase ECP participation in the provider network during the current plan year and subsequent Exchange filing certification request.
4. Documentation describing how the issuer's provider network(s), as currently structured, provides an adequate level of service for low-income and medically underserved individuals. Your request must specify:
    a. How the current network(s) provide adequate access to care for individuals with HIV/AIDS (including those with co-morbid behavioral health conditions).
    b. How the current network(s) provide adequate access to care for American Indians and Alaska Natives.
    c. How the current network(s) provide adequate access to care for low-income and underserved individuals seeking women's health and reproductive health services.

2016 Participation

Washington Health Benefit Exchange
810 Jefferson Street SE
Olympia, Washington 98501

GUIDANCE FOR PARTICIPATION IN THE WASHINGTON HEALTH BENEFIT EXCHANGE



March 2015

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washington healthplanfinder
click. compare. covered.

SECTION 1: INTRODUCTION

This Guidance for Participation specifies how a health insurance issuer can participate in Washington Healthplanfinder (HPF), Washington's State Health Benefit Exchange (WAHBE). An issuer may participate in the individual Exchange by offering qualified health plans (QHPs) through the open enrollment period, November 1, 2015—January 31, 2016, for coverage in plan year 2016. An issuer may also offer QHPs through the Small Business Health Options Program (SHOP) that covers small-employer groups in Washington State. A separate section in this document provides guidance to issuers who want to participate in SHOP.

The Guidance will provide information on the following:

- Certifying and recertifying a health plan to become a QHP;
- Monitoring and compliance of QHPs;
- Decertifying a QHP;
- Special guidance for coverage of American Indian/Alaska Natives.

The Patient Protection and Affordable Care Act of 2010 (ACA) authorized the creation of State-based Marketplaces also known as Exchanges. The Washington State Legislature established WAHBE by enacting Substitute Senate Bill 5445. WAHBE is governed by an eleven member Board consisting of nine voting Board members and two non-voting, ex-officio members, the Washington State Insurance Commissioner and the Director of the Washington State Health Care Authority. The WAHBE Board is authorized by the Legislature to certify QHPs offered through HPF using 19 certification criteria.

The Washington State Office of the Insurance Commissioner (OIC) regulates health insurance issuers and health plans. This document does not provide guidance on achieving regulatory approval by the OIC. Throughout this document, however, WAHBE may refer issuers to the OIC as the source of regulatory information.

1.1 Glossary

WAHBE applied the standard definitions found within the Affordable Care Act and subsequent guidance whenever possible.

"ACTUARIAL VALUE"
The percentage paid by a health plan of the total allowed costs of benefits.

"AFFORDABLE CARE ACT"
The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name Affordable Care Act (ACA) is used to refer to the final, amended version of the law.

"APPEAL"
An official request from a health insurance issuer that WAHBE reconsider a decision to decertify a QHP, deny recertification of a QHP, or not certify a health plan as a QHP.

"ENROLL"
The point at which an individual is covered for benefits under a QHP, without regard to when the individual may have completed or filed any forms that are required to become covered by the health plan.

"ENROLLEE"
Qualified individual or qualified employee enrolled in a QHP.

"EXPIRE"
The point at whcih a QHP issuer does not elect to seek recertification of a QHP offered through Healthplanfinder. This act by the QHP issuer will constitute "non-renewal of recertification" (45 CFR §156.290).

"HEALTH BENEFIT EXCHANGE BOARD"
The governing board of the WAHBE as established in Chapter 43.71 RCW.

"HEALTH INSURANCE ISSUER" OR "ISSUER"
A "carrier," which includes a disability insurer, health care service contractor, or health maintenance organization, as defined in RCW 48.43.005 and defined in the Employee Retirement Income Security Act and used in the ACA.

(In this document, Issuer refers to a health insurance company, **Product** to a suite of plans that share, for example, a common set of health benefits, and Health Plan refers to the actual insurance coverage purchased by a consumer. The document does not refer to health insurance companies as "the plans" or "the health plans.")

"HEALTH PLAN"
Health plan means any policy, contract, or agreement as defined in RCW 48.43.005 and offered by an issuer and used in accordance with section 1301(b)(1) of the ACA. A health plan is the specific health benefit plan purchased by a subscriber, employer, or employee. Each health plan is the pairing of a product's benefits with a particular cost-sharing structure, provider network, and service area. Multiple health plans can be associated with a single product.

"NAVIGATOR"
An organization that has been awarded a grant by the Exchange to carry out activities and meet the standards described in 45 CFR §155.210. Navigator representatives are qualified, trained, and certified to engage in education, outreach and facilitation of selection of a QHP by a consumer for Healthplanfinder.

"OPEN ENROLLMENT"
The period each year during which consumers may enroll or change coverage in a QHP through Healthplanfinder.

As of publication of this Guidance, proposed federal rules provide that Open Enrollment for 2015 coverage is an extended period from October 1, 2015 through December 15, 2015.

SHOP open enrollment begins 90 days prior to the group's renewal date for the employer and 60 days prior to the group's renewal date for the employees.

1.1 Glossary
(Continued)

"PLAN YEAR"
The consecutive 12-month period during which a health plan provides coverage for health benefits. For individuals, it is the calendar year, and for SHOP it is the 12-month period beginning with the qualified employer's effective date of coverage.

"PRODUCER"
A person licensed by the OIC as an agent or solicitor to sell or service insurance policies.

"QUALIFIED HEALTH PLAN OR QHP"
A health plan that is certified by an Exchange.

"QUALIFIED HEALTH PLAN ISSUER OR QHP ISSUER"
A health insurance issuer that provides coverage through a qualified health plan offered through Healthplanfinder.

"SHOP"
The Small Business Health Options Program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

"SPECIAL ENROLLMENT"
A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through Healthplanfinder outside of the annual open enrollment period.

"WASHINGTON HEALTHPLANFINDER" OR "HEALTHPLANFINDER"
The marketplace in Washington State where qualified individuals and small employers can shop for and purchase Qualified Health Plans (QHP).

1.2 Overview of Guidance

1.2.1 Objective

The purpose of this Guidance is to provide health insurance issuers the foundational information needed to offer individual and/or SHOP QHPs through Healthplanfinder. The certification criteria set forth within this document do not supersede a QHP issuer's responsibility to provide coverage based upon state and federal laws and rules. While the Guidance specifies some, but not all, federal and state laws or regulations that apply to offering health insurance coverage through Healthplanfinder, this document does not release a QHP issuer from complying with all relevant state and federal laws. Please see Appendix I for a directory of Federal rules issued under the ACA.

The Guidance will also specify how WAHBE will apply the certification criteria to a health plan. To be certified, a QHP must:

- Be approved by the OIC;
- Satisfy the certification criteria specified by the Washington State Legislature; and
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR parts §155 and §156.

To participate in the Exchange, a QHP issuer must meet the legal requirements of offering health insurance in Washington State. A QHP issuer must also sign a Participation Agreement with WAHBE to participate in Healthplanfinder.

1.2.2 Term of Engagement

An Individual or SHOP health insurance plan certified or recertified as a QHP will be offered through Healthplanfinder. New and renewed individual plans will be available beginning November 1, 2015 with an initial effective date of coverage beginning no sooner than January 1, 2016. The date when SHOP plans will be made available for plan year 2016 will be announced in a separate communication.

Health insurance issuers, responding to this Guidance, will offer certified or recertified individual QHPs for a term of one year beginning January 1, 2016 and ending December 31, 2016. Only OIC approved health plans certified by the Board may be offered as QHPs through Healthplanfinder during this period.

1.2.3 Contact

Your contact at WAHBE for this document is Susanne Towill, Senior Plan Manager, Operations Division. Please direct all questions regarding plan management and this document to Susanne Towill at (360) 688-7789 or QHP@WAHBExchange.org.

1.2.4 Plan Management Timeline and Letter of Intent

An issuer is recommended to inform WAHBE of its intent to participate in Healthplanfinder. Submitting a letter of intent is nonmandatory and nonbinding, but will help the WAHBE prepare for the certification process and Open Enrollment. WAHBE is not requesting that an issuer indicate the specific health plans it intends to offer through Healthplanfinder. Please, however, inform WAHBE of the markets (Individual and/or SHOP) in which your organization intends to offer QHPs. WAHBE also requests that issuers include a list of counties that they intend to serve in their Letter of Intent. An issuer may submit a letter of intent to WAHBE at QHP@WAHBExchange.org.

Plan Management Timeline

Please click on the following link to access WAHBE plan management materials where you will find the most recent plan management timeline:

http://wahbexchange.org/partners/insurance-carriers/plan-management-workgroup/

1.3 Participating in Healthplanfinder

A QHP issuer may participate in WAHBE's Individual market, SHOP market, or both. An issuer is not required to participate in the same markets inside and outside of Healthplanfinder.

1.3.1 Initial Certification of Qualified Health Plans

WAHBE intends to certify QHPs annually and only those health plans certified or recertified by WAHBE may be offered as QHPs through Healthplanfinder.

An issuer must continue to comply with OIC regulatory requirements and the OIC will continue to provide regulatory review of health insurance issuers and health plans. WAHBE will determine if the issuer satisfies the non-regulatory certification criteria. Once the Board issues QHP certifications, WAHBE will inform an issuer of the decision.

An issuer will need to enter into a Participation Agreement with WAHBE before offering QHPs through Healthplanfinder. The terms of the Participation Agreement will incorporate the health plan certification criteria described in this Guidance. WAHBE, in addition to the Legislature, reserves discretion to modify and amend the terms and conditions of current QHP certification criteria and how they may be applied in the certification or decertification process, consistent with current laws and rules, at any time up to and including the execution of issuer Participation Agreements.

Prior to publishing plan offerings, an issuer will need to enter into an Electronic Data Interchange (EDI) Trading Partner Agreement and one or more EDI interfaces will need to be tested between the issuer and WAHBE. These steps will ensure that the issuer and WAHBE will be able to communicate enrollment data to and from each other. Two hardcopies of the EDI Trading Partner Agreements should be sent to WAHBE; WAHBE will sign both and return one to the issuer. EDI Trading Partner Agreements need to be submitted only by issuers new to WAHBE and have not previously offered plans through Healthplanfinder.

1.3.2 Recertification of Qualified Health Plans

WAHBE intends to recertify a QHP annually and must complete the recertification process by the ACA deadline of September 15 of the applicable calendar year (45 CFR §155.1075(b)). The recertification process will involve a review of the certification criteria reflected in this document.

1.3.3 Submitting Health Plans to Become Certified as a QHP

The WAHBE certification process begins when an issuer submits a rate and form filing to the OIC for regulatory review and approval of a health plan. Please refer to the OIC for information on how and where to submit the rate and form filing for a health plan.

SECTION 2: SPECIFICATIONS FOR PARTICIPATION

2.1 Summary of Initial Certification and Recertification Criteria

To participate in WAHBE's QHP certification process, an issuer will need to submit plans and supporting documentation as specified for each criterion. The following chart summarizes the nineteen criteria to be applied in the certification process of a QHP. Each criterion is reviewed and approved by either the OIC or WAHBE.

Table 1

Summary of Initial Certification and Recertification Criteria

No.	Criteria Level	Criteria	Reviewed by OIC or WAHBE?	Initial Certification Criteria	Recertification Criteria?
1	Issuer	Issuer must be in good standing	OIC	Yes	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	WAHBE	Yes	Yes
3	Issuer	Issuer must comply with the risk management programs	WAHBE	Yes	Yes
4	Issuer	Issuer must comply with market rules on offering plans	OIC	Yes	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	Yes	Yes
6	Issuer	Issuer must be accredited by an entity that the federal Department of Health and Human Services recognizes for accreditation of health plans within the specified timeframe	WAHBE	Yes	Yes
7	Product	QHP must meet marketing requirements	WAHBE	Yes	Yes
8	Product	QHP must meet network adequacy requirements which will include essential community providers	OIC	Yes	Yes
9	Product	Issuer must submit health care provider directory data	WAHBE	Yes	Yes
10	Product	Issuer must implement a quality improvement strategy	WAHBE	Yes	Yes
11	Product	Issuer must submit health plan data to be used in a standard format for presenting health benefit plan options	WAHBE	Yes	No
12	Product	Issuer must report quality and health performance	WAHBE	Yes	Yes
13	Product	Issuer must use a standard enrollment form	OIC	Yes	Yes
14	Product	Issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system	OIC	Yes	Yes
15	Product	Services provided under a QHP through a Direct Primary Care Medical Home must be integrated with the QHP issuer	OIC	Yes	Yes
16	Plan	A QHP must comply with benefits design standards (e.g., cost sharing limits, "metal level" (Platinum, Gold, Silver, or Bronze), essential health benefits)	OIC	Yes	Yes
17	Plan	Issuer must submit to the WAHBE a QHP's service area and rates for a plan year	OIC	Yes	Yes
18	Plan	Issuer must post justifications for QHP premium increases	WAHBE	No	Yes
19	Plan	Issuer must submit to the WAHBE QHP benefit and rate data for public disclosure	WAHBE	Yes	Yes

2.2 QHP Specifications

An issuer's health plan must satisfy the following criteria to become certified as a QHP offered through Healthplanfinder.

2.2.1 Licensed and Good Standing

An issuer must have un-restricted authority to write its authorized lines of business in Washington in order to be considered "in good standing" and to offer a QHP through the Washington Healthplanfinder.

The OIC determines if an issuer is in good standing. Please direct requests for a certificate of good standing to companysupervisionfilings@oic.wa.gov.
OIC determinations of good standing will be based on authority granted to the OIC by Title 48 RCW and Title 284 WAC. Such authority may include restricting an issuer's ability to issue new or renew existing coverage for an enrollee.

An issuer must inform WAHBE within five business days if the OIC has restricted in any way the issuer's authority to write any of its authorized lines of business. If the OIC has restricted the issuer's ability to underwrite current or new health plans, then WAHBE will determine, consistent with OIC restrictions, if the issuer can submit a health plan for certification or recertification of a QHP.

Restrictions on an issuer's ability to underwrite current or new health plans may result in QHP decertification by WAHBE.

2.2.2 User Fee Adherence

In ESHB 1947, the Washington State Legislature designated a portion of premium tax receipts and a fee assessed on QHPs as sustainable funding for WAHBE's administrative expenses beginning in 2015.

If a QHP issuer's payment of the QHP assessment is delinquent, then WAHBE may assess a penalty. WAHBE will assess a penalty equal to 1%, rounded up to the nearest whole dollar, of the issuer's delinquent amount for each 15-day period that an issuer's payment is overdue. To avoid penalties for late payment, a QHP issuer is encouraged to pay any and all assessed amounts while contesting a fee.

If WAHBE determines that a QHP issuer is not making timely and full payment of the QHP assessment, and WAHBE determines that the QHP issuer will not resume making timely and full payments, then WAHBE will decertify all of the issuer's QHPs.

2.2.3 Risk Management Programs

A QHP issuer must comply with the requirements of the reinsurance, risk corridors, and risk adjustment programs as specified in the ACA, standards set in federal rules 45 CFR part 153, state rules adopted by the OIC, and the annual Notice of Benefit and Payment Parameters published by the Department of Health and Human Services (HHS) or the OIC.

The OIC will monitor a QHP issuer's compliance with the risk management programs. If the OIC determines that a QHP issuer is no longer complying with the requirements of the risk management programs, and further determines that the QHP issuer will not resume full compliance with the requirements of the risk management programs, then WAHBE will decertify all of the QHP issuer's QHPs.

2.2.4 Market Rules for Offering QHPs

An issuer must comply with the market rules for offering Individual or SHOP QHPs set forth by the ACA or Washington State law, including the four metal levels of coverage designated in §1302 of the ACA.

Please refer to OIC regulatory specifications for information on the calculation of the actuarial value for each metal level.

Only a QHP issuer that satisfies the following market rules may offer QHPs through either market in Healthplanfinder:

- A QHP issuer must offer at least one QHP at the silver level and at least one QHP at the gold level.

- An issuer must offer a child-only plan at the same level of coverage as any QHP (which does not include catastrophic plans) offered through Healthplanfinder (45 CFR §156.200(c)(2)) to individuals who, at the start of the plan year, have not reached the age of 21.

- A health plan meeting the definition of a catastrophic plan in RCW 48.43.005 may only be sold through Healthplanfinder.

If the OIC determines that a QHP issuer is not complying with the market rules in either market within Healthplanfinder, and the OIC further determines that the QHP issuer will not resume compliance with the market rules, then WAHBE will decertify all of the issuer's QHPs in that market.

2.2.5 Non-discrimination

A QHP issuer must comply with federal and Washington State non-discrimination requirements. A QHP issuer may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR §156.200(e)). An issuer may not provide essential health benefits if its benefit design also discriminates based on an individual's degree of medical dependency or quality of life (45 CFR §156.215).

The OIC will enforce non-discrimination requirements and monitor for noncompliance. If the OIC determines that a QHP issuer is not complying with the non-discrimination requirements, and the OIC further determines that the QHP issuer will not resume compliance with the non-discrimination requirements, then WAHBE will decertify all of the issuer's QHPs affected by that noncompliance.

2.2.6 Accreditation

For a plan to become certified as a QHP, the QHP issuer must meet a minimum level of accreditation by an accrediting entity recognized by HHS. WAHBE will verify an issuer's accreditation status for certification or recertification.

A QHP issuer must achieve the AAAHC, URAC or NCQA Exchange accreditation by the first accreditation renewal date after the QHP issuer's third certification process. If a QHP issuer does not maintain accreditation of a QHP as defined by WAHBE, then WAHBE must decertify that QHP.

WAHBE may offer a QHP prior to that health plan becoming Exchange-accredited in these two circumstances:

1. Offering a health plan as an accredited QHP

WAHBE will certify a health plan as accredited if one of the following statuses is held by an issuer for commercial insurance or Medicaid products:

- NCQA: excellent, commendable, accredited, provisional, or interim (interim is a new 18-month Exchange accreditation offered by NCQA). WAHBE will not recognize these NCQA statuses: denied, appealed by issuer, in process, revoked, scheduled, suspended, or expired.

- URAC: full, conditional, provisional, or corrective action. WAHBE will not recognize this URAC status: denial.

- AAAHC: Certificate of Accreditation. WAHBE will not recognize: denial.

2. Offering a health plan as an unaccredited QHP

During a new issuer's initial and next two certification processes, WAHBE may certify a health plan as an unaccredited QHP if the issuer satisfies the following:

- When submitting a health plan for certification, an issuer must attest that it will schedule the "Exchange accreditation" in the plan types (HMO, MCO, POS, or PPO) used in offering its QHPs.

- A QHP issuer must achieve "Exchange accreditation" and make provide proof of that accreditation before the beginning of the QHP issuer's third certification process. For example, if an unaccredited issuer began offering QHP coverage in the 2014 plan year, then it would need to achieve and document "Exchange accreditation" by the beginning of the certification process to be performed by WAHBE in 2016 for offering QHP coverage in the 2017 plan year.

2.2.7 Marketing

A QHP issuer will be encouraged to actively market products available through Healthplanfinder and to participate in joint marketing efforts with WAHBE, as applicable. WAHBE has created its own logo and logo mark (or "bug") that designates the certification of a QHP. An issuer can use the Healthplanfinder bug to co-brand QHP marketing materials or web pages in accordance with guidelines developed by WAHBE Communications. The logo or bug cannot be modified, and no other logo can be used to represent Healthplanfinder or QHP certification. WAHBE will review and approve the use of the logo or bug on an issuer's marketing materials. The QHP issuer will be able to review any WAHBE marketing materials that use the QHP issuer's logo.

A QHP issuer must submit for WAHBE approval one marketing document to post on Healthplanfinder for each QHP. In these marketing materials the QHP issuer may inform consumers that the plan is certified by WAHBE as a QHP. The QHP issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP. A QHP issuer and its officials, employees, agents and representatives must not employ marketing practices or benefit designs that may discourage the enrollment of individuals with preexisting conditions or significant health needs in QHPs (45 CFR §156.225(b)). A QHP issuer must submit marketing materials in both English and Spanish in PDF form.

QHP issuers will be expected to create marketing and enrollment materials in advance of the validation of plans to be offered in production. Marketing materials will not be displayed on Healthplanfinder if they do not conform to the standards set through this criterion.

2.2.8 Network Adequacy

An issuer must ensure that a QHP's network satisfies at least the following standards:

- The network is sufficient in number and type of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay;
- Includes essential community providers in accordance with 45 CFR §156.235 or meets the alternate standard; and
- Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act (45 CFR §156.230(a)) and WAC 284-43-200, *et. seq.*, and any subsequent rules issued by the OIC.

A QHP issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system. Hospital contracts must comply with this provision by January 1, 2015. The OIC will enforce network adequacy requirements and monitor for noncompliance. If the OIC determines that a QHP issuer is not complying with the network adequacy requirements, and the OIC further determines that the QHP issuer will not resume compliance with the network adequacy requirements, then the WAHBE will decertify all of the issuer's QHPs affected by that noncompliance. Please refer to the OIC for additional regulatory guidance on network adequacy.

2.2.9 Provider Directory

A QHP issuer must contribute data on the health care providers that participate in networks associated with

a QHP. Please make sure to include your issuer name in the name of your network when submitting provider directory data to eHealth.

2.2.10 Quality Improvement Strategy

Issuers are required to submit their quality improvement strategy in both PDF and Word Formats. The PDF format will be viewed by consumers and should include the issuer's logo and be formatted for direct upload to Healthplanfinder. WAHBE will provide issuers with a form to submit your quality improvement strategy in Word.

2.2.11 Standard Format for Presenting Health Benefit Plan Options

Issuers are required to provide WAHBE with a Summary of Benefits and Coverage (SBC) for each plan variant of a QHP, in English and Spanish, for display on Healthplanfinder. Issuers will need to use the new standard SBC form developed by the Department of Health and Human Services (HHS) effective for plan year 2016.

The naming convention for SBCs is:

- Plan year
- Carrier name
- Full plan name
- Metal level (if not included in plan name)
- Any cost share variant detail (73/87/94)
- AI/AN version, if so
- English or Spanish
- Draft or Final version
- Plan ID number

A QHP that provides coverage for abortion services must provide notice of that coverage on the SBC in the "other covered services" section (45 CFR 156.280(f)). If the QHP does not include abortion services, it should be listed under the "excluded services" section.

Issuers will include direct links to a plan's drug formulary in each SBC that must be accessible to consumers as defined by HHS in the 2016 Notice of Benefit and Payment Parameters.

Issuers will submit final SBCs in English and Spanish in a PDF document with English and Spanish versions of each plan variant.

Cross Mapping Form

WAHBE will implement plan cross-mapping in order to facilitate eligibility redeterminations and coverage renewals (including automatic renewals) in the individual market for both QHPs and QDPs. This includes circumstances where an issuer non-renews coverage under a particular plan (a "plan non-renewal") or discontinues coverage under a product (a "product discontinuation").

Issuers must perform cross-mapping in accordance with applicable state law and federal requirements. WAHBE will review for compliance with federal requirements set forth in 45 CFR 155.335.

Issuers will need to use WAHBE's Plan Cross-Mapping Submission Form to provide plan cross-mapping information; WAHBE is not using the CMS Plan Crosswalk Template.

2.2.12 Quality Measures

To satisfy this criterion, a QHP issuer will need to participate in the implementation of this rating system, including the disclosure and reporting of information on health care quality and outcomes described in §1311(c)(1)(H) and §1311(c)(1)(I) of the ACA, and the

implementation of appropriate enrollee satisfaction surveys consistent with §1311(c)(4) of the ACA (45 CFR §156.200(b)(5)). During 2015, QHP issuers are required to report quality measures specified by CMS as part of the 2015 Quality Rating System beta test. WAHBE will provide more information as it becomes available.

A QHP issuer will be required to participate in any additional quality reporting requirements that may be authorized by federal regulation and specified by WAHBE.

2.2.13 Standard Enrollment Form

The standard enrollment form for Washington State is based on the HHS standard enrollment form and is housed on the Health Care Authority's website. This form and the electronic enrollment application process within Healthplanfinder satisfy this criteria for QHP Issuers.

2.2.14 Hospital Patient Safety Contracts

A QHP issuer will satisfy this criterion by establishing an adequate health care provider network as specified in section 2.2.8 and further directions provided by the OIC.

2.2.15 Direct Primary Care Medical Homes

The ACA directs that a QHP may provide coverage through a qualified direct primary care medical home plan so long as the services covered by the medical home plan are coordinated with the QHP issuer. The federal rules further establish a coordination criterion to be used if a direct primary care medical home is submitted with a QHP.

State law, Chapter 48.150 RCW, however, specifies that a direct primary care medical home must be integrated with an issuer's QHP. If a QHP filing contains a direct primary care medical home, then WAHBE will recognize the OIC's approval of the plan to confirm that the medical home is integrated with the QHP.

2.2.16 Benefit Design Standards

A QHP issuer must ensure that each QHP complies with the benefit design standards specified in the ACA, including the cost-sharing limits, actuarial value requirements for metal levels, and the essential health benefits (45 CFR §156.200(3)).

The ACA, §1302(d), requires non-grandfathered individual and small group health insurance plans, except for catastrophic plans, to be offered through one of four metal level categories (Platinum, Gold, Silver, or Bronze) in an Exchange. An actuarial value calculator, provided by HHS, can be used to produce computations of a QHP's metal level based upon benefit design features.

Please refer to the OIC for further regulatory guidance on benefit design standards.

2.2.17 Service Areas and Rating Requirements

The QHP service area must be established without regard to racial, ethnic, language, or health-status related factors specified under section 2705(a) of the Public Health Service Act, or other factors that exclude specific high utilization, high cost, or medically-underserved populations (45 CFR §155.1055(b)). A QHP service area will be set by county or counties; however, an issuer demonstrating good cause, as specified in WAC 284-43-130, may set a QHP service area by zip codes. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable. Consumers will be able to identify a service area by providing a zip code or county in Healthplanfinder.

WAHBE will display the rates on the Healthplanfinder web pages. The OIC will approve a QHP issuer's health plan rates for an entire benefit or plan year. Approval of a plan by the OIC will confirm that a QHP has met the service area standards.

2.2.18 Posting Justifications for Premium Increases

QHP issuers must provide premium increase justifications as part of the regulatory rate filing procedure. The OIC posts this justification, along with its own summary of the premium increase justification for the public. The submission of the justification to the OIC will satisfy this criterion for an issuer submitting a plan to become a certified QHP.

2.2.19 Reporting Data

As part of the OIC regulatory filing process, a QHP issuer must use the federally supplied data templates during the SERFF filing process. The OIC will forward the data for approved plans to WAHBE after plan regulatory approval has been completed.

WAHBE will use these templates to populate Healthplanfinder with rates, benefits, service area, and provider network names. WAHBE will not alter the data within these templates without written direction from the OIC.

The discontinuation of premium aggregation through Healthplanfinder will necessitate changing the reporting between WAHBE and issuers. Issuers offering QHPs through the Exchange will provide enrollment, payment, and disenrollment data in a manner and frequency specified by the Exchange as necessary to support Exchange operations including but not limited to:

- Eligibility, enrollment, or disenrollment processes
- Reports or provision of information required by the U.S. Department of Health and Human Services, Internal Revenue Service, or the Washington State Legislature.
- Estimation or collection of assessments or fees specified in RCW 43.71.080

WAHBE will provide more information to carriers as it becomes available.

2.3 Pediatric Dental Essential Health Benefit

RCW 43.71.065 specifies that Healthplanfinder will offer stand-alone pediatric dental plans. The bill further specifies that dental benefits must be offered and priced separately to assure transparency for consumers through Healthplanfinder. Stand-alone Pediatric Dental Plans will not be offered in SHOP in 2016. Instead pediatric dental benefits are embedded in SHOP QHPs. Please refer to the OIC for further guidance on setting the rate for pediatric dental. A separate Guidance for Participation for Qualified Dental Plans offered through Healthplanfinder can be found on the WAHBE website.

2.4 Monitoring and Compliance of Qualified Health Plans

2.4.1 Summary Table 2: Monitoring and Compliance of Qualified Health Plans

The following chart summarizes the monitoring and compliance activities associated with the 19 certification criteria. Monitoring activities are applied by either the OIC or WAHBE. Any penalties associated with criteria #2 and #7 were described in the previous section. See sections 2.1 and 2.2 for further detail on the certification criteria.

No.	Criteria Level	Criteria	Monitoring Entity	Penalty?	Descertification?
1	Issuer	Issuer must be in good standing	OIC	Per OIC	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	WAHBE	Yes (see Section 2.2.2)	Yes
3	Issuer	Issuer must comply with the risk management programs	OIC	Per OIC	Yes
4	Issuer	Issuer must comply with market rules on offering plans	OIC	Per OIC	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	Per OIC	Yes
6	Issuer	Issuer must be accredited by an entity that federal HHS recognizes for accreditation of health plans within specified timeframe	WAHBE	No	Yes
7	Product	QHP must meet marketing requirements	WAHBE	Yes (see section 2.2.7)	No
8	Product	QHP must meet network adequacy requirements which will include essential community provider	OIC	Per OIC	Yes
9	Product	Issuers must submit health care provider directory data	WAHBE	No	No
10	Product	Issuers must implement a quality improvement strategy	WAHBE	No	No

2.4 Monitoring and Compliance of Qualified Health Plans (Continued)

No.	Criteria Level	Criteria	Monitoring Entity	Penalty?	Descertification?
11	Product	Issuers must submit health plan data to be used in a standard format for presenting health benefit plan options	WAHBE	No	No
12	Product	Issuers must implement quality and health performance measures made available to Healthplanfinder consumers	WAHBE	No	Not yet applicable
13	Product	Issuer must use a standard enrollment form	OIC	Per OIC	No
14	Product	Issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system	OIC	Per OIC	Yes
15	Product	Services provided under a QHP through a Direct Primary Care Medical Home must be integrated with the QHP issuer	OIC	Per OIC	Yes
16	Plan	A QHP must comply with benefits design standards (e.g., cost sharing limits, "metal level" (Platinum, Gold, Silver, or Bronze), essential health benefits)	OIC	Per OIC	Yes
17	Plan	Issuer must submit to WAHBE a QHP's service area and rates for a plan year	OIC	Per OIC	Yes
18	Plan	Issuer must post justifications for QHP premium increases	OIC	Per OIC	No
19	Plan	Issuer must submit to WAHBE QHP benefit and rate data for public disclosure	WAHBE	No	No

2.4 Monitoring and Compliance of Qualified Health Plans (Continued)

2.4.2 Summary Table 3: Key Decisions That Alter the Offering of Enrollment in a QHP

WAHBE has identified key decisions by issuers, the OIC, or WAHBE that may close QHP enrollment or result in a QHP no longer being offered through Healthplanfinder. The key decisions are summarized in the table below:

No.	Decision	Notice or Request	Open to New Enrollments?	Participate in Special Enrollments throughout Plan Year?	Decertification?	Terminate Coverage and Provide Opportunity to Enroll in Other QHPs?	Is Recertification Performed?
1	QHP Issuer discontinues a QHP from the entire individual or small group market	Annual OIC filing and WAHBE Certification process (cannot be done outside of annual event) QHP issuer provides 90-day notice to enrollees of plan discontinuation.	N/A	N/A	N/A	Yes, Coverage in Healthplanfinder will expire at end of plan year and enrollees must select another certified QHP to continue coverage through Healthplanfinder and receive tax credits.	N/A
2	A QHP Issuer Discontinues All QHPs in an Individual or SHOP Market Mid-year and Exits that Market entirely	Notification to OIC and WAHBE QHP issuer provides 180-day notice to enrollees if discontinuing all plans and withdrawing from the mark	N/A	N/A	N/A	Yes. Issuers must notify enrollees that Enrollees must select a certified QHP to continue coverage through Healthplanfinder and receive tax credits.	N/A

3	QHP Issuer elects to not seek recertification of a QHP	Annual OIC filing and WAHBE Certification process (cannot be done outside of annual event)	N/A	N/A	N/A	No. However, enrollment ends at the end of the plan year. To remain covered through Healthplanfinder, an enrollee must select a different QHP for the next plan year during open enrollment.	No. The QHP status will expire at renewal.
4	WAHBE denies recertification of a QHP	WAHBE Certification process (cannot be done outside of annual event)	N/A	N/A	Yes	Yes. Coverage terminated only after WAHBE offers special or open enrollment.	No. The QHP status will expire at renewal.
5	OIC withdraws regulatory approval of a QHP	WAHBE follows the notification requirements for Decertification of QHPs (See 45 CFR §155.1080(e)).*	No	No	Yes. The Board will decertify the QHP status.	Yes. Coverage terminated only after WAHBE offers special or open enrollment.	N/A
6	WAHBE withdraws Certification of a QHP	WAHBE follows the notification requirements for Decertification of QHPs (See 45 CFR §155.1080(e)).**	No	No	Yes. The Board will decertify the QHP status.	Yes. Coverage terminated only after WAHBE offers special or open enrollment.	N/A
7	QHP Issuer petitions the OIC to Suspend new sales for the risk pool	QHP Issuer notifies WAHBE of OIC Petition and subsequent approval of suspension.	No. New enrollees may not select the suspended QHPs for a minimum of six months. However, the current enrollees may select to retain the suspended QHPs.	Suspended QHPs will be available for specific special enrollments (such as adding a dependent) to the existing plan for current enrollees to retain the coverage as an option.	No	Yes	Yes, during the annual certification process. The QHPs must be certified to continue offering coverage to current enrollees through Healthplanfinder, whether the suspension is lifted for new sales or not.

*The issuer must terminate coverage for enrollees only after the Exchange has made notification and enrollees have an opportunity to enroll in other coverage.

**The issuer must terminate coverage for enrollees only after the Exchange has made notification and enrollees have an opportunity to enroll in other coverage.

2.5 Description of Key Decisions

2.5.1 A QHP Issuer Discontinues a QHP and Removes the QHP from the entire Individual or SHOP Market

A QHP issuer may only discontinue a plan during their annual regulatory filing event. WAHBE certification of the QHP will expire at the end of the plan year as set forth in 45 CFR §156.290 and 45 CFR §155.1080, and the QHP issuer must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after WAHBE has notified the enrollees within the same 90-day timeframe specified in RCW 48.43.035 and RCW 48.43.038 and the enrollees have had an opportunity to participate in open enrollment as set forth in §156.290. A QHP issuer may never again offer the discontinued QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.5.2 A QHP Issuer Discontinues All QHPs in an Individual or SHOP Market and Exits that Market entirely

A QHP issuer must provide formal notice to the OIC and WAHBE that all of the issuer's QHPs in a market (Individual or SHOP) will be discontinued. The QHP issuer must provide the formal notice 15 calendar days before enrollees receive the "180-day" notice required in RCW 48.43.035 for SHOP QHPs and RCW 48.43.038 for Individual market QHPs.

WAHBE must decertify the QHPs as set forth in 45 CFR §156.290 and 45 CFR §155.1080, and the QHP issuer must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after WAHBE has notified the enrollees within the same 180-day timeframe specified in RCW 48.43.035 and RCW 48.43.038 and the enrollees have had an opportunity to participate in special or open enrollment as set forth in 45 CFR §156.290. A QHP issuer may never again offer a discontinued QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.5.3 A QHP Issuer Elects Not to Seek Recertification and the QHP's Certification Expires

A QHP issuer must notify WAHBE of any QHPs for which it will not seek recertification. The QHP issuer's designated QHP or QHPs will expire at the end of the plan year and will no longer provide coverage in the next plan year through Healthplanfinder.

A QHP issuer must notify WAHBE before the beginning of the recertification process of the intent to let a QHP certification expire. The expiring QHP will not be offered in the next open enrollment period and the current enrollees may select a different QHP during open enrollment for coverage in the next plan year to continue coverage through Healthplanfinder. A QHP set to expire must fulfill the obligations set forth in 45 CFR §156.290 which include providing coverage until the end of the plan year and notice to enrollees of the non-renewal. The QHP set to expire must also be made available outside of Healthplanfinder to any current enrollees who exercise their guaranteed renewal rights as set forth in 45 CFR §147.106.

Once expired, the QHP issuer may never again offer that QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.5.4 WAHBE Denies Recertification of a QHP

WAHBE will inform a QHP issuer before the beginning of the next open enrollment period that a QHP has been denied recertification. A QHP with denied recertification must fulfill the obligations set forth in 45 CFR §156.290 which include providing coverage until the end of the plan year.

The denied QHP will not be offered in the next open enrollment period and the current enrollees may select a different QHP during open enrollment for coverage in the next plan year through Healthplanfinder. The QHP

with denied certification must also be made available outside of Healthplanfinder to any current enrollees who exercise their guaranteed renewal rights as set forth in 45 CFR §147.106. A QHP issuer may never again offer that denied QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.5.5 OIC Withdraws Regulatory Approval

The OIC will inform WAHBE that it must withdraw a QHP from the market.

WAHBE must decertify the QHPs as set forth in 45 CFR §156.290 and 45 CFR §155.1080, and the QHP issuer must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after WAHBE has notified the enrollees and the enrollees have had an opportunity to participate in special or open enrollment. A QHP issuer may never again offer a withdrawn QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.
The direction provided in this section does not alter the OIC authority in RCW 48.18.110, RCW 48.44.020, and RCW 48.46.060 to withdraw approval of a plan.

2.5.6 WAHBE Decertifies a QHP

WAHBE may determine that a QHP no longer satisfies the certification criteria of a QHP and decertify the plan. WAHBE must notify a QHP issuer when a QHP is decertified as set forth in 45 CFR §156.290 and 45 CFR §155.1080.

The QHP issuer must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after WAHBE has notified the enrollees and the enrollees have had an opportunity to participate in special or open enrollment. The decertified QHP must also be made available outside of Healthplanfinder to any current enrollees who exercise their guaranteed renewal rights as set forth in 45 CFR §147.106. A QHP issuer may never again offer a decertified QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.5.7 A QHP Issuer Petitions the OIC to Suspend New Sales for the Risk Pool

A QHP issuer must notify WAHBE of the OIC Petition and subsequent OIC approval of suspension. The QHP issuer must enroll any new enrollees "in the pipeline" with effective dates after the date of closure. WAHBE will no longer offer a suspended QHP during open enrollment and current enrollees may enroll in any other QHP during open enrollment.
A suspended QHP must continue to provide special enrollment to enrollees with qualifying events. A suspended QHP, however, will no longer participate in the special enrollment activities when enrollees of other QHPs or new enrollees experience qualifying events. To be offered through Healthplanfinder, a suspended QHP must continue to achieve annual recertification.

SECTION 3: SPECIAL GUIDANCE FOR COVERAGE OF AMERICAN INDIAN/ ALASKA NATIVES

An issuer will need to comply with all federally required laws and regulations specific to American Indians and Alaska Natives (AI/AN) in the Affordable Care Act (ACA) and other federal regulations, including but not limited to:

- Monthly enrollment periods for AI/AN people to enroll through Healthplanfinder;
- AI/AN enrollee able to change from qualified heath plan to another plan one time per month;
- No cost sharing for AI/AN enrollees with incomes under three hundred (300) percent of federal poverty level;
- No cost sharing for any item or service furnished through Indian Health Care Providers, or any other health care providers, as defined in the ACA;
- Health programs operated by Indian Health Care Providers will be the payer of last resort for services provided by such programs, notwithstanding any federal, state, or local law to the contrary; and,
- Compliance with Indian Health Care Improvement Act § 206 and § 408.

The Office of the Insurance Commissioner requires issuers to offer contracts to all Indian Health Centers in their service area. If an issuer contracts with an Indian Health Center, the issuer will notify WAHBE in a timely fashion of this relationship.

Issuers are strongly recommended to use the Centers for Medicare and Medicaid Services Model QHP Addendum for Indian Health Centers when contracting with a specified Indian Health Center.

A premium sponsorship service, provided through Healthplanfinder, will assist the enrollment of tribal members in QHPs.

SECTION 4: SHOP SPECIFICATIONS

WAHBE operates the Small Business Health Options Program (SHOP). WAHBE will certify QHPs to be offered through SHOP and determine employer eligibility, support employee open enrollment and special enrollment, and perform premium aggregation through the billing and collection of employer premium payments. To be offered through SHOP, a plan must be submitted as both an employee only and an employee plus dependent(s) plan. Beginning with plan year 2016, a SHOP plan may be offered to an employer with 100 or fewer full-time equivalent employees as defined by the ACA and federal rules.

Key elements of the Washington State SHOP include, but are not limited to, the following:

- An employer may offer a single health plan or a choice of health plans at a single metal level.
- Employer premium contribution of at least 50% for employees.
- Employee participation requirement of 100% for employer groups with three or fewer employees or 75% for employer groups with more than three employees as consistent with Title 48 RCW.

Based on federal requirements, the SHOP must:

- Offer an employee choice option (for the Washington State SHOP this will be a metal level consisting of multiple plan choices).
- Offer a way for employers to compute an estimated premium.
- Prohibit carriers from varying rates during the plan year.
- Provide electronic data to the Internal Revenue Service (IRS) for tax administration purposes.

SECTION 5: ISSUER CERTIFICATION APPEAL PROCESS

A QHP issuer may appeal a decision by the WAHBE Board to decertify a QHP. An issuer may also appeal a Board decision to deny initial certification of a health plan or recertification of a QHP. An issuer is required to fully cooperate with WAHBE during an appeal process to prepare the health plan to be offered in open enrollment.

An issuer will have up to 10 calendar days from the date of the notification of a Board decision to deny initial certification of a health plan, deny recertification of a QHP, or decertify a QHP, to submit a written appeal via electronic mail to the Director of Legal Services of WAHBE.

An issuer's appeal must:

1. Identify the specific criterion or criteria appealed;

2. Provide information that clarifies the issuer's position on each unsatisfactory criterion; and

3. Succinctly state the outcome sought by the issuer.

WAHBE must send notice to the issuer in writing within seven calendar days that the appeal was received. WAHBE will offer the issuer the opportunity to address the Board about the appeal prior to a Board decision regarding the appeal. The Board will have up to 20 calendar days from receipt of the appeal to send a final written decision that upholds or denies the issuer's appeal. The Board's written response to such an appeal will be a final decision and all appeals with respect to that health plan will be exhausted. This appeal process represents the sole remedy for an issuer with respect to a Board decision regarding initial certification of a health plan or recertification or decertification of a QHP offered through Healthplanfinder.

SECTION 6: CUSTOMER SUPPORT

The WAHBE will provide a Customer Support Center to provide assistance to consumers. The WAHBE Customer Support Center will receive inquiries and answer questions about health insurance eligibility, application and enrollment, including the availability of tax credits and cost sharing reductions. The Customer Support Center will serve customers with a simple streamlined approach to ensure ease of use and customer satisfaction. The Customer Support Center will provide a toll-free phone number to respond to inquiries regarding coverage offered through WAHBE. The Customer Support Center will facilitate the application and enrollment process by offering assistance in Web-based and paper-based applications processing. The Customer Support Center will help consumers navigate eligibility for Washington Apple Health or Advanced Premium Tax Credits (APTC) and QHPs. The Customer Support Center will also triage calls concerning eligibility for other health benefit programs available to Washington State consumers, and for more complex questions, route accordingly. The WAHBE Customer Support Center will be the first point of contact for many customers with questions about applying for and enrolling in health insurance through Healthplanfinder.

An issuer must notify WAHBE of any grievances received from enrollees with respect to the operation of the Healthplanfinder marketplace. WAHBE will work with the issuer to resolve any such grievances where the issuer is responsible for resolution.

SECTION 7: ENROLLMENT IN A QHP

7.1 Individual Enrollment Processes and Timelines

Issuers will be expected to comply with the enrollment and payment processes outlined in the WAHBE Enrollment and Payment Process Guide. The Enrollment and Payment Process Guide can be obtained on the WAHBE website.

7.2 Premium Aggregation

WAHBE is in the process of ceasing the practice of premium aggregation for individual plans.

WAHBE will aggregate the premium contributions of subscribers enrolled in a QHP in the individual market on Healthplanfinder and transmit those aggregated premium payments to the appropriate QHP issuer. WAHBE must also allow a subscriber enrolled in a QHP in the individual market on Healthplanfinder to pay a premium contribution directly to the QHP issuer.

WAHBE must aggregate premiums for a QHP offered through SHOP.

A QHP issuer must agree to comply with standards and processes established for either market by WAHBE for the collection of premiums, funds transfer, reconciliation, financial accounting, and reporting. This will include compliance with all forms of payment, managing grace periods, and accepting payments on behalf of individuals from Exchange-registered sponsors in accordance with the sponsorship policy established in RCW 43.71.030.

7.3 Producer and Navigator Specifications

7.3.1 Producer

Producers who are authorized to sell Healthplanfinder products will be able to present QHP offerings to individuals and small businesses in Washington State.

7.3.2 Navigator

WAHBE will award grants to Navigator organizations and in-person assisters to carry out activities and meet the standards described in 45 CFR §155.210. Navigator representatives will be qualified, trained, and certified to engage in education, outreach and enrollment for Healthplanfinder. Navigators must meet conflict of interest standards and are prohibited from receiving indirect or direct compensation from a health insurance issuer based on enrollment. Health insurance issuers cannot act as Navigators.

APPENDIX
FEDERAL REQUIREMENTS

This appendix is not an exhaustive list of applicable requirements. Detailed Federal guidance is available on the website of The Center for Consumer Information & Insurance Oversight (CCIIO), http://cciio.cms.gov/resources/regulations/index.html#hie.

REQUIREMENT CATEGORY	FEDERAL REQUIREMENT	REFERENCE
Licensing	State Licensure	45 CFR §156.200(b)(4)
Accreditation	General requirement	45 CFR §156.275(a)
Accreditation	Timeframe for Accreditation	45 CFR §156.275(b)
Health care quality requirements	Quality Improvement Initiative	45 CFR §156.200(b)(5), Section 1311(g) of the ACA
Health care quality requirements	Quality and Outcomes Reporting	45 CFR §156.200(b)(5), Section 1311(c)(1)(I) of the ACA
Health care quality requirements	Enrollee Satisfaction Surveys	45 CFR §156.200(b)(5), Section 1311(c)(4) of the ACA
User Fee Adherence	Requirement for Exchange user fees	45 CFR §156.50(b), 155.160
Risk Adjustment	Participation in Risk Adjustment Programs	45 CFR §156.200(b)(7)
Actuarial Value Designation	Actuarial Value Standards	45 CFR §156.140
Offering requirements	Actuarial Value Tiers	45 CFR §156.200(c)(1)
Offering requirements	Child-only plan	45 CFR §156.200(c)(2)
Rating variations	Product Pricing	45 CFR §156.255(b)
Rating variations	Allowable Variability	45 CFR §156.255(a), 147.102
Marketing	Marketing Rule Compliance	45 CFR §156.225(a)
Marketing	Non-discrimination	45 CFR §156.225(b)
Abortion Services	Compliance with State Abortion Laws	45 CFR §156.280(a)
Abortion Services	Abortion Funds Segregation	45 CFR §156.280
Premium Rate and Benefit Information	Rate Plan Year	45 CFR §156.210(a)
Premium Rate and Benefit Information	Rate submission	45 CFR §156.210 (b)

REQUIREMENT CATEGORY	FEDERAL REQUIREMENT	REFERENCE
Premium Rate and Benefit Information	Rate Increase Justification	45 CFR §156.210(c), 45 CFR §155.1020(a)
Premium Rate and Benefit Information	Rate Increase Consideration	45 CFR §155.1020 (b)
Premium Rate and Benefit Information	Benefit and Rate Information	45 CFR §155.1020(c)
Service Area	Minimum Service Area	45 CFR §155.1055(a)
Service Area	Non-Discriminatory Service Area	45 CFR §155.1055(b)
Network Adequacy	Network Adequacy Standards	45 CFR §156.230 (a)
Network Adequacy	Provider Directory	45 CFR §156.230(b)
Enrollment Processes and Periods	Individual Enrollment Periods	45 CFR §156.260
Enrollment Processes and Periods	SHOP Enrollment periods	small employer: 45 CFR §155.725
Enrollment Processes and Periods	Enrollment through the Exchange for Individuals	45 CFR §156.260(b), 45 CFR §156.260(e), 45 CFR §156.205(e)
Enrollment Processes and Periods	Acceptance of enrollment information	45 CFR §156.265(c)
Enrollment Processes and Periods	Premium Payment	45 CFR §156.265(d)
Enrollment Processes and Periods	Enrollment Reconciliation	45 CFR §156.265(f), 45 CFR §155.400 (d)
Enrollment Processes and Periods	Enrollment Acknowledgement	45 CFR §156.265(g); 45 CFR §155.400(b)(2)
Enrollment Processes and Periods	Enrollment Termination	45 CFR §156.270; 45 CFR §155.430
Enrollment Processes and Periods	Termination Notification	45 CFR §155.430(d)
Enrollment Processes and Periods	Non-payment of Premium	45 CFR §156.270; 45 CFR §155.430(b)
Enrollment Processes and Periods	Notice of Non-payment of Premiums	45 CFR §156.270(f)
Enrollment Processes and Periods	Grace period for tax credit recipients	45 CFR §156.270 (d)
Transparency in Coverage	Required Information Related to Coverage Transparency	45 CFR §156.220(a)
Transparency in Coverage	Reporting Requirement	45 CFR §156.220(b), 45 CFR §156.220(c)
Transparency in Coverage	Enrollee Cost Sharing	45 CFR §156.220(d)
Non-discrimination	Non-Discrimination	45 CFR §156.200(e)
Benefit Design Standards	Minimum Coverage	45 CFR §156.200(b)(3)