Washington State
Office of the
Insurance Commissioner

Mike Kreidler-*Insurance Commissioner*

As required by

The Washington State Administrative Procedures Act

Chapter 34.05 RCW

Matter No. **R 2014-08**

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

Relating to the adoption of

Network access maintenance standards

November 25, 2015

TABLE OF CONTENTS

Section 1: Introduction

Revised Code of Washington (RCW) 34.05.325 (6) requires the Office of Insurance Commissioner (OIC) to prepare a “concise explanatory statement” (CES) prior to filing a rule for permanent adoption. The CES shall:

1. Identify the Commissioner's reason’s for adopting the rule;
2. Describe differences between the proposed rule and the final rule (other than editing changes) and the reasons for the differences; and
3. Summarize and respond to all comments received regarding the proposed rule during the official public comment period, indicating whether or not the comment resulted in a change to the final rule, or the Commissioner's reasoning in not incorporating the change requested by the comment; and
4. Be distributed to all persons who commented on the rule during the official public comment period and to any person who requests it.

Section 2: Reasons for Adopting the Rule

Based on the significant changes in health care delivery occurring after January 1, 2014 due to health care reform, the Commissioner determined that updating the network access rules was necessary to protect consumers. The Commissioner started rulemaking related to network access rules (Matter R. 2013-22) in September 2013 and adopted rules in April 2014 updating network access standards. For purposes of discussion in this document, Matter R. 2013-22 is referred to as Phase 1 of network access rulemaking. The rules currently being adopted are referred to as Phase 2.

During the rulemaking of Matter R. 2013-22, the Commissioner decided to delay adoption of the rules relating to maintenance and contracting of networks because of the significant complexity of the rulemaking and the short time frame. The delayed rules are now being adopted.

The Commissioner first publicly shared the rules now being released during Phase 1 of network access rulemaking in the first exposure draft, released October 22, 2013. The delay of these rules was communicated to stakeholders when the second exposure draft was released on February 14, 2014.

These rules clarify standards for provider network maintenance and contracting. Issuers will benefit from written guidance regarding the Commissioner’s review standards for network maintenance and contracting. Specific maintenance standards are necessary so that issuers are aware of ongoing requirements to maintain their networks and provide notification to the Commissioner when networks change between regular reporting periods.

Consumers will also benefit because issuers will be held to clear standards that can be enforced, if necessary. The purpose of these standards is to ensure that consumers are able to access the benefits allowed pursuant to the plan and that network-related processes do not serve as a barrier to access.

Consumers will benefit from timely notice of changes to their networks resulting from provider contract terminations. Consumers need to know when a provider is leaving the network in time to be able to make alternative arrangements for scheduled care, and to plan for emergencies.

Finally, consumers with chronic conditions will benefit in two ways from issuers' monitoring of their networks as they relate to care for chronic conditions. These enrollees will benefit from enhanced coordination between their providers, and from timely notice when care for their chronic conditions may be disrupted.

Section 3: Rule Development Process

The CR 101 was filed on: July 18, 2014. The CR 101 was distributed to the OIC Health insurance rules list serve. A list serve of parties interested in network access was also utilized to distribute drafts and solicit comments.

• The comment period was open until: August 22, 2014.
- An exposure draft was released online and to interested parties on October 15, 2014. Comments were accepted until October 31, 2014.
- A second exposure draft was released online and to interested parties on March 3, 2015. Comments were accepted until March 20, 2015.
- Stakeholder meetings were held December 11, 2014 and March 12, 2015.

• The CR 102 was filed on: June 16, 2015. The comment period was open until: July 21, 2015.

• The rule-making hearing was held on: July 21, 2015.

Background Information Considered

The following documents were considered to develop the rules:
- Rulemaking file, R-2013-22, regarding Essential Health Benefits
- CMS Chronic Conditions Data Warehouse
- California Medicaid managed care network rules
- Section 2706 of the Patient Protection and Affordable Care Act of 2010
- Section 2717 of the Public Health Service Act
- Various state and federal statutes and regulations regarding network access.
- Federal bulletins and guidance
- RCW 48.43.730/SB 5434 and existing Chapter 284.43 WAC, subchapter B.
- Network access research documents prepared by Georgetown University

Section 4: Differences Between Proposed and Final Rule

Only insignificant changes were made to the proposed rule. They were made to add clarity to our intent.

- WAC 284-43-202 (3)(a) Added specificity to the timeframe for reporting changes to a network.
- WAC 284-43-225(2) Added “These records must be retained for a period of ten years:”
- WAC 284-43-300 Deleted “Provider networks must include and maintain every provider category and type necessary to deliver covered services.”
- WAC 284-43-310 Deleted “selection” and add “selecting” to clarify intent.
- WAC 284-43-310 (1)(b) Deleted “practitioners”
- WAC 284-43-320 (1) Changed “shall” to “must.”
- WAC 284-43-320 (14) Added effective date and safe harbor.

Section 5: Responsiveness Summary

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

Comments were received from:

- Aetna
- American Academy of Dermatology
- America’s Health Insurance Plans
- Association of Washington Healthcare Plans
- Cambia Health Solutions
- Cathy Bolt-Jones
- Department of Early Learning
- Early Childhood Development Association of Washington
- First Choice Health Network
- Group Health Cooperative
- Kaiser Permanente
- National Hemophilia Foundation
- Northwest Health Law Advocates
- Physical Therapy Association of Washington
- Premera Blue Cross
- Providence Health & Services
- Remony Henry
- Seattle Cancer Care Alliance
- Seattle Children’s Hospital

- United Concordia Companies
- Washington Association of Naturopathic Physicians
- Washington Association of Nurse Anesthetists
- Washington Chapter of the American College of Emergency Physicians
- Washington Community Mental Health Council
- Washington East Asian Medicine Association
- Washington State Chiropractic Association
- Washington State Department of Health
- Washington State Hospital Association
- Washington State Medical Association
- Washington State Podiatric Medical Association
- Washington State Psychological Association

General comments and/or comments relating to multiple sections

Comment: *The Commissioner received requests to engage in a collaborative stakeholder process that allows for dialogue among all interested parties. Stakeholders requested information regarding the intent and rationale for the proposed rules. Stakeholders also requested that verbal comments be allowed in the rulemaking process.*
Response: The Commissioner appreciates the requests and held additional dialogues with stakeholders in response to these comments. The Commissioner held two stakeholder meetings prior to the release of the CR-102 to review proposed changes to the rules. Staff answered stakeholder questions and considered all comments received at the meetings. The Commissioner also released documents with the second stakeholder draft explaining the intent of specific provisions of the rules.

Comment: *A stakeholder expressed concern that the (concise explanatory statement) CES should not be used to interpret or modify the rule as adopted.*
Response:
The CES offers information and responds to stakeholders about the reasoning and sources that the rule-making team utilized in deciding to accept or reject proposed changes to the rule. The OIC carefully considers all comments voiced by stakeholders and issues the CES to be as responsive as possible to issues presented by stakeholders during the rulemaking process. The CES does not modify or clarify the rules.

Comment: *The Commissioner received several requests related to issues addressed in Phase 1 of network access rulemaking. These included requests to:*

- *Set specific network access standards for certain providers and facilities including neurodevelopmental centers, East Asian medicine practitioners, comprehensive cancer treatment centers designated by the National Cancer Institutes, substance use disorder services, early intervention providers, and community-based emergency services/inpatient care for psychiatric emergencies;*
- *Adjust standards regarding access to care in rural areas, clarify geographic mapping requirements and clarify how access is defined in terms of distance the patient is required to travel to receive services;*
- *Adjust essential community provider (ECP) standards, including by separating the ECP category of "hospitals" into "types" of hospitals (e.g. orthopedic hospitals), and requiring issuers to contract with each hospital type;*
- *Clarify that additional providers who meet the definition of an ECP may meet the ECP standard as the CMS list is non-exhaustive;*
- *Allow additional providers such as community mental health agencies to be classified as ECPs;*
- *Require issuers to contract with specific providers; and*
- *Add coinsurance to the cost-sharing requirements under WAC 284-43-201 so that coinsurance is the same for enrollees accessing covered services from out-of-network providers.*

Response: The Commissioner is committed to ongoing evaluation and monitoring of the network rules in entirety. The rules adopted under the first rulemaking have been utilized repeatedly and have functioned as designed to ensure access. The Commissioner recognizes that Washington is an innovator in this area and we are continually analyzing the impact of these rules to ensure that consumers are guaranteed access to covered services. These particular requests are outside the scope of this rulemaking and were addressed in the previous rulemaking. Please refer to the CES of Phase 1 of the network access rulemaking for discussion.

Comment: *Stakeholders requested that the Commissioner work with stakeholders to understand the work being done to develop ACOs.*

Response: This rule does not address the subject matter of Accountable Care Organizations. An ACO is a specific entity that is so designated by CMS, and is relevant only to Medicare plans. As ACOs are being developed, the Commissioner is working with stakeholders and other agencies. ACOs are an innovative and new access model currently in the beginning of development. The Commissioner supports innovation but wants to develop the proper relationship of regulation to such bodies. ACOs are a strategic interplay between the provider, purchaser, and issuer – unlike any model we have seen previously. We are very carefully monitoring how ACOs are developed and the issues that are raised by that interplay.

Comment: *Stakeholders asked if there should be requirements for notifying consumers of network changes.*
Response: Washington state law requires issuers to provide notification to enrollees when specific network changes occur (RCW 48.43.515(7)). Such notification requirements were clarified during phase 1 of network access rulemaking in WAC 284-43-204, WAC 284-43-229, and WAC 284-43-252. In phase 2 of network access rule making, the Commissioner amended WAC 284-43-251 providing expanded notification time period to enrollees when network changes occur.

Comment: *A consumer expressed concern for the needs of individuals who live on islands and the low number of behavioral health providers in these areas who are accepting new patients. She encouraged additional attention to the time and cost of ferry travel.*
Response: This request is outside the scope of this rulemaking. Such requirements were addressed during Phase 1 of network access rulemaking. Please refer to the CES for Phase 1 and WAC 284-43-200(6) & (11) that address access and travel requirements.

Comment: *Stakeholders expressed belief that narrow networks should contain appropriate levels of specialists and that narrow networks could result in steering the sickest patients to those products with the broadest networks. Another stakeholder expressed concern that sufficient safeguards against discrimination must be included in the rule to protect patients with chronic conditions.*
Response: Network access standards are clearly defined in 284-43 WAC Subchapter B and include a requirement for appropriate levels of providers to ensure access to all covered services, regardless of the network model. Current network access rules also prohibit issuers from designing networks which discriminates against individuals with chronic conditions, and have built in protections to prevent this from occurring.

Comment: *Clarify the relationship between provisions in this draft and the previous round of network access rulemaking. Re-open sections from the previous rule, or at least reference back to the original rule as necessary.*
Response: This round of rule-making includes sections that were originally proposed in Phase 1 but were not included due to time constraints. The rulemaking was divided Phase 1) and provisions to become effective for plan year 2016 (this rulemaking). The Phase 1 rules were standards for creating and reporting provider networks. This set of rules (Phase 2) is standards for maintaining provider networks and reporting changes.

The previous round of rule-making is not within the scope of this rule-making but, as necessary, the Commissioner has referenced previous standards to clarify intent.

Comment: *Stakeholders shared concerns that the rules perpetuate an underlying assumption that only large, broad networks that include all specialists provide adequate access to care. They opined that existing standards are already sufficient to protect consumers and that tracking changes to a network will not demonstrate changes in the adequacy of that network. They believe that the proposed new monitoring and reporting requirements are excessive and flexibility is needed to allow issuers to create networks as they see fit. Some stakeholders urged caution against intrusive rulemaking that will stifle health plan innovation and encouraged the OIC not to proceed with new rules. Stakeholders requested that the regulations be postponed until the NAIC model act discussions are completed as adding additional state specific requirements are administratively burdensome.*

Response: The Commissioner respectfully disagrees with this comment. The intent of this rule is to ensure enrollee access to covered services. It is the role of the issuer to build networks with sufficient number and types of providers to provide enrollees access. The rule in no means promotes one network model over another. The Commissioner recognizes and agrees that the choice of a network model 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. The requirements in the rule simply establish reporting requirements for issuers to demonstrate network access standards, regardless of the network model. The rule provides flexibility to issuers to create innovative networks. Finally, the Commissioner is actively involved in, and participates on the Network Adequacy Model Review (B) Subgroup that is redrafting the NAIC Managed Care Plan Network Adequacy Model Act.

Comment: *Some commenters argued that the proposed rules would create a more active role for the Commissioner in provider negotiations and should not be adopted. Alternatively, other stakeholders requested changes to the rules specifically to create a more active role for the Commissioner in provider negotiations.*

Response: The rule does not create a new role for this office to participate in the provider negotiation process. The rule establishes reporting requirements for issuers to demonstrate that network access standards are maintained throughout the plan year and guarantee enrollee protections in the provider/issuer contracting arrangement.

Comment: *Psychologists are unable to join networks.*

Response: It is the role of the issuer to build networks with sufficient numbers and types of providers to provide enrollees access. Issuers may close provider panels when they meet these requirements.

Comment: *Issuers are inappropriately restricting reimbursement for certain CPT codes used by psychologists.*
Response*:* This issue is not related to these rules.

Comment: *Access to hemophilia treatment centers is limited by at least one issuer. Stronger oversight is encouraged to ensure access to care for individuals with hemophilia and related bleeding disorders.*
Response: The Commissioner agrees that stronger oversight is needed to ensure access to care for all covered health conditions. The purpose of these rules and the previous network access rules is to provide that stronger oversight. All plans must meet the general standards of the network access rule as set forth in WAC 284-43-200. When it is determined that a plan does not meet access requirements the Commissioner has an array of regulatory tools to address the situation. If a stakeholder believes that a plan does not meet these standards, they may notify the OIC's Consumer Protection division to file a complaint.

Comment: *A stakeholder requested that the Commissioner be provided with reasons for closed panels and the denial of providers who would like to participate in a network.*
Response: The Commissioner's authority extends to ensuring that all enrollees are provided with all covered services in a timely manner appropriate to the enrollee's condition. Within that authority, the Commissioner explicitly declines to require any issuer to contract with any specific provider. See WAC 284-43-205(4). To do so would intrude upon the right of issuers to design their networks as they see fit, and to include only those providers with whom they choose to contract. It would also interfere with market forces that support quality, efficient medical care and, in turn, a healthy insurance market.

As a result, so long as the issuer's network meets the access standards under these rules and the rules promulgated under Phase 1 of the network access rulemaking, there is nothing to be gained by including the requested requirements in these rules.

Comment: *OIC rules should be more consistent with DSHS rules and amend the definition of mental health services in WAC 284-43-130 to include substance use disorder services.*
Response: This is outside the scope of this rulemaking. The definitions in this rule are unique to provider networks and access to covered services.

Comment: *Stakeholders expressed concern that a significant waiting period for prior approval of contracts would slow progress in developing networks.*
Response: Washington state law, RCW 48.43.730, specifically provides a 30 day review period for this office to approve or disapprove a provider agreement. This rule provides guidance to issuers regarding implementation of the statute, but does not change the statutory waiting period.

Comment: *The rules should address cost-sharing assistance and prior authorizations for early intervention services.*
Response: Cost-sharing assistance and prior authorization for covered services are outside the scope of this rulemaking. These rules only reference provider networks and access to covered services.

Comment: *Stakeholders asked that all sections clearly reference facilities in addition to providers when appropriate.*
Response: The definition of provider in WAC 284-43-130, which applies to this section, includes facilities. Therefore, where the word "provider" is used in a provision, that provision includes facilities unless the context requires otherwise.

Comment: *Stakeholders expressed concerns that requiring amendments to all contracts in WAC 284-43-300, WAC 284-43-310, WAC 284-43-320, and WAC 284-43-330 would be burdensome and likely to cause confusion between contracting parties, especially if inserted into negotiations currently under way. Amendments should only apply to new contracts or those renewed, renegotiated or otherwise amended on or after January 1, 2016 (or the effective date of the rule). Stakeholders also requested a safe harbor period and significant lead time to make the changes.*
Response: The Commissioner appreciates the comment but expects that all changes will be made to existing contracts. The Commissioner will incorporate a safe harbor to allow time for such changes to be made to comply with WAC 284-43-320. After the expiration of the safe harbor, the Commissioner will not allow deviations from the rule. These rules relate to significant consumer protections, which must not be delayed. In addition, see the below discussion regarding the disarray surrounding provider contracts that has come to light as issuers come into compliance with ACA provisions that require them to know, retain documentation of, and make transparent which providers are included in their networks. Delay will prolong an unacceptable situation that is depriving consumers and providers of rights they have secured through contracts with issuers.

WAC 284-43-202 – Maintenance of sufficient networks (new section)

Comment: *Change the caption of WAC 284-43-202 to "Sufficient network providers" as the original caption suggests a need for multiple networks.*
Response: The Commissioner took this comment into consideration and changed the language as appropriate.

Comment: *A stakeholder requested that the Commissioner consider evaluating network adequacy consistent with other regulators. In doing so, the OIC should consider measuring network adequacy on a county-level basis, rather than service area. The analysis should consider the number of physicians by specialty that should be included in-network to meet anticipated patient need.*
Response: The Commissioner declines to make these changes. Issuers have the latitude to define their service areas by a county, multiple counties, or statewide. The tests for network adequacy are based upon accessibility to enrollees, not numbers per geographic area. That ensures that each enrollee has reasonable access, regardless of their location. For example, networks must be sufficient such that covered services are accessible to each enrollee in a timely manner appropriate to his or her condition. All covered services must be readily available without unreasonable delay to all enrollees, including access to emergency services at all times. WAC 284-43-200(1). The test would be the same whether applied to one county or an entire service area, because it is based on access available to each enrollee.

The same logic applies to the requirement for inclusion of specialists in networks. Tests that simply require a specific number of specialists be included in a network would be less favorable to enrollees because a network could then include the requisite number, all of whom are located in one area. That network would satisfy the numerical requirement but would not be providing reasonable access to enrollees who live far from that area.

Specialty services require unique standards for monitoring due to the nature of medical specialties. For example, there are many providers in some specialist categories, yet very few in others. These numbers also change over time as specialists enter and leave practice, and as the number of patients fluctuates. The test for reasonable access must be based upon reality – the number of providers who are available and willing to contract with issuers. Thus, setting a number of specialists in a particular category, in addition to having the problem explained above, would also create a rigid ideal that would not always be achievable. Alternatively, the number could become inadequate if patient need increased. Therefore, the Commissioner believes that the standard must necessarily be flexible as to numbers, instead being based upon enrollee access.

Comment: *Please share the source and basis for metrics proposed in the rule, especially the metrics in WAC 284-43-202.*
Response: The metrics come from the State of California's standards for Medicaid managed care and Medicare Advantage. The metrics were proposed so that there is a clear standard by which issuers are required to provide notification to the OIC, rather than allowing them to only notify the OIC when they believe network access requirements are no longer being met.

Comment*: Stakeholders supported requiring issuers to monitor their networks and notifying the OIC when networks no longer meet the standards in WAC 284-43-200. Alternatively, there were requests this section not be adopted or delayed for future rulemaking.*
Response: The variety and scope of the comments received in this matter illustrate the need for the Commissioner's office to clearly set forth for all stakeholders specific reporting requirements. All interested parties should have clear guidelines to understand what, when, and how requirements in WAC 284-43-200 are met and reported during the plan year.

Comment: *Please clarify the Commissioner's intent to be notified of particular network changes as it is unclear when the Commissioner expects an alternative access delivery request (AADR) to be filed. Notification of network changes is unnecessary because monthly Provider Network Form A submissions would ensure the Commissioner is aware of changes. As originally written, it appears that the standards do not require notification in all instances where a network no longer meets network access standards. Would an AADR be required if changes in a network occurred, but the network is otherwise adequate? An AADR should only be filed if a reduction in the number of providers causes a network to no longer be in compliance with WAC 284-43-200, if an issuer and provider/facility are no longer in active contract negotiations, or it is apparent that contracts will actually be terminated. Alternatively, the Commissioner should establish a baseline adequacy standard that if maintained, despite a percentage change in the network, would not require a notification. Either eliminate WAC 284-43-202 or eliminate the monthly Provider Network Form A submission requirement.*
Response: This section of the rule was edited significantly during the course of the rulemaking process to address stakeholder comments about what is required to be filed and when it must be filed. The intent of this section is to ensure significant changes to network access are reported timely to the OIC and when those changes cause a network to fail to meet standards in WAC 284-43-200; clearly notifying all parties that an AADR must be filed.

The requirement to file a monthly Provider Network Form A is statutory (RCW 48.44.080 and RCW 48.46.030) and cannot be changed through rule-making.

Comment: *Stakeholders expressed concern regarding the requirements related to notification upon provider contract termination. Providing notification within five days of receipt of a provider's termination notice is problematic because sending a termination notice is a common practice that often starts the negotiation process. Submitting notification to the Commissioner of termination notices would be burdensome and unnecessary because most negotiations end in a contract agreement. Stakeholders shared alternative triggers for OIC notification including the end of negotiations or an actual contract termination, or 30 days post-termination notice.*
Response: The Commissioner believes that the requirement is reasonable. The issuer must ensure that enrollees have appropriate access to providers at all times. Therefore, when a notice of termination is issued, the issuer must prepare for the possibility of that termination in order to ensure that such access will not be compromised. Taking a "wait and see" attitude toward such notices risks such compromise of the networks and has two negative consequences which timely planning would have avoided: the need for crisis stopgap measures to ensure access, and consumer confusion. Consumers are entitled to reasonable advance notification of potential terminations so that they can plan accordingly.

Issuers and providers are encouraged to begin the re-negotiating process early if they are concerned about hitting these triggers.

Comment: *Stakeholders expressed concern regarding the tight timeframe for submission of an AADR and requested additional time for submission. They noted in particular that a one day turnaround to provide an AADR when requested by the OIC is unrealistic. Alternatively, the OIC could be notified upon a termination notice, but more formal steps like submission of an AADR would not be triggered until a later date if negotiations are not successful. A submission deadline of 15 days would be consistent with WAC 284-43-3650. (Editor's note – this WAC does not exist – we are unsure what WAC the commenter is trying to cite.) Stakeholders also asked the Commissioner to clarify that all time limits begin to run after an issuer submits its preliminary determination of whether an AADR needs to be filed. Stakeholders requested that further work be done to come up with reasonable timelines for submission of an AADR.*
Response: Please see exhibit "X" for additional information about the state implementation plan in this matter.

These rules provide for longer turnaround times in almost all situations. The one-day turnaround to submit an AADR only arises when a provider termination has occurred and the issuer has failed to notify the OIC about it. In these situations, it is critical that the OIC be advised how enrollees are accessing service and being protected. It is the OIC's expectation this will occur only in rare circumstances.

Comment: *The provision requiring OIC notification when a single hospital terminates is too broad and will end up requiring notifications that are unrelated to network adequacy. For example, sometimes there are multiple hospital contracts in a service area to provide overflow capacity, but the contracts are not necessary to meet network adequacy requirements. Specific language was suggested that would clarify that the only hospital terminations needed to be reported are those that are essential for meeting network adequacy requirements. A stakeholder also expressed opposition to mandatory reporting for a single termination, as is proposed for hospitals.*
Response: The Commissioner declines to change this requirement because when a hospital or hospital-based medical groups leaves a network it has the potential to significantly disrupt enrollee care. The termination of a single hospital does not necessarily mean an issuer no longer complies with WAC 284-43-200; however, it could mean an entire network no longer has providers if the network design is based upon a single hospital delivery system. Based upon the complexity of new network designs and innovation in the marketplace this requirement is necessary to understand network impacts when a hospital termination occurs.

Comment: *Providers and facilities should also be notified of changes to networks if they make regular referrals to the dropped provider/facility and/or have admitting privileges to a facility. The OIC should be notified of the impact of the loss of a key player in a delivery system that is interdependent upon a variety of providers and facilities.*
Response: Communication surrounding changes that affect a network's compliance with the standards in WAC 284-43-200 routinely involves discussion and analysis of the impact of the change. However, tracking of referral patterns and admitting privileges would be a significant administrative burden to require of issuers and the OIC. If such a requirement were to be put in place, it is unclear how a "key player" should be defined.

Comment: *Additional time is requested to submit an AADR to the Commissioner for carriers who may need to cross state lines to contract to complete networks.*
Response: The Commissioner finds the timeframes are sufficient for an issuer to notify the Commissioner. While contracting across state lines may require additional time, that should not impact the timeframe for notifying the Commissioner or preparing an AADR.

Comment: *Please clarify the expectations for reporting a change to a network with respect to small and large groups because they have different filing requirements.*
Response: Thank you for your comment. The Commissioner has modified the language to address the concern that small and large group markets have

different filing requirements. Large group filings are not necessarily filed every year. The review timeframe has been synchronized for all lines of business.

Comment: *A stakeholder expressed a desire to see a requirement that issuers report changes in the number of providers accepting new patients reported to the OIC.*
Response: The Commissioner declines to make this requested change. We understand your concerns; however, a closed practice is still accessible to enrollees previously enrolled in a plan.

Comment: *Stakeholders expressed support for the requirement that enrollees receive 30 day notice upon possible termination of their provider from a network. There was also opposition to this requirement and a suggestion that it only apply to situations where there will be an actual contract termination.*
Response: The Commissioner recognizes the competing interests of enrollees (who need sufficient warning to change possible appointments if their provider is no longer in-network) and issuers (who do not want to send notices of terminations that do not actually end up occurring). He agrees that the ideal situation would be that notices will be both timely and sent only when terminations will actually occur. The issue here is that issuers cannot know which terminations will actually occur until either a contract expires or a new contract is signed. The request to take a status quo approach is unfair to consumers who are directly affected and potentially harmed by the termination. Providing 30-day advance notice to affected parties is reasonable and fair.

Comment: *Add an additional subsection requiring that issuers report a reduction in ECPs in their network because the ACA requires that networks include a certain percentage of ECPS.*
Response: Taken together, WAC 284-43-200 and WAC 284-43-202 address this ACA requirement. A reduction in ECPs that results in a network no longer meeting the standards in WAC 284-43-200 would trigger OIC notification and filing of an AADR.

Comment: *Please clearly state the responsibility of issuers to provide covered services in a culturally competent and accessible manner.*
Response: Per WAC 284-43-220 (3)(f)(i)(H), issuers are required to establish an access plan that addresses “specific procedures and materials used to address the needs of enrollees with limited-English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities.” Issuers are also required to comply the standards in WAC 284-43-200.

Comment: *Please clarify the specialties that are referred to in WAC 284-43-202 (3)(b).*
Response: The comment was taken into consideration in drafting the rule and changes were made to clarify the Commissioner's intent.

Comment: *The practicality of monitoring network access in terms of specific chronic conditions is very difficult. This section should be removed and/or clarified because there is no broadly applicable list of top chronic conditions nor agreed upon monitoring mechanisms. Stakeholders recommended that the triggers in WAC 284-43-202(3) be based on best practices, as issuers do not currently have processes in place to track the data that is requested. Adding these processes will create additional costs and require additional burden on providers to track new data. It is unclear how an issuer would identify these providers. A stakeholder suggested this section be left for future rulemaking when more specific requirements could be set.*
Response:
The purpose of WAC 284-43-202(3) is to monitor that enrollees have continued access to all providers through the plan year. The purpose of monitoring changes to providers for enrollees with chronic conditions is that those populations have specific and unique needs for access. An issuer could use polling, billing, or other identifiers to identify providers of services required for treatment of particular chronic diseases. For example, enrollees with chronic conditions would tend to generate repeat visits with repeat diagnostic codes.

Comment: *Stakeholders expressed concern that the triggers to monitor changes in WAC 284-43-202(3) are inadequate to monitor the impact of network changes on enrollees with chronic conditions, especially those that are rare or most commonly found in children. Specifically, the monitoring of specialists is inadequate in WAC 284-43-202 (3)(g) because the size of service areas, enrollment, and the capacity of the delivery system to serve all patients in a given area are not being considered. The triggers also do not address the concentrated nature of the delivery system for patients with complex medical needs. As an alternative, stakeholders recommended that a metric be developed that requires notification if a network loses a certain percentage of any one type of specialty or subspecialty and consideration be given for the above factors. There was a concern that the triggers in WAC 284-43-202(3) would not be sufficient to require a notification if a pediatric specialty hospital were to be removed from a network. There was also concern that issuers would be unable to determine if there has been a 15% reduction in the number of cancer care providers because patients are treated by several providers. A stakeholder asked to explain the significance of a 15% reduction in the number of providers when far more than 5% of an issuer's enrollees are being treated with chronic conditions. How will providers treating specific chronic conditions be weighted to ensure adequate access for the most prevalent conditions? The Commissioner should consider a metric that*

requires notification if a network loses a certain percentage (much less than 10%) of any one type of specialty or subspecialty. Please meet with interested parties to discuss the impact of these metrics.
Response: The Commissioner declines to make the requested adjustments to the triggers at this time. The rules impact will be carefully monitored and assessed for effectiveness. Monitoring changes to a network that specifically could impact individuals requiring specialty care is challenging and an issue that may need to be addressed in the future with additional clarification or new rulemaking. The complexity of the issue is illustrated by the range of stakeholder comments about this section, which in most instances are opposing viewpoints and requests. One commenter seeks more monitoring and reporting, the other argues that the requirements in the proposed rule are too onerous. The Commissioner has sought, through these rules, to balance competing stakeholder interests while imposing only reasonable and necessary regulatory requirements.

Lastly, the standards in WAC 284-43-202 are not meant to indicate a change in an issuer's ability to provide access to particular segments of an enrollee population. They are meant to be triggers to notify OIC of, and begin planning to address, potential network changes that may serve as the basis for consumer complaints and/or may cause a network to be out of compliance.

Comment: *Stakeholders expressed concern that because primary care providers and specialists both have the capacity to care for an enrollee with a chronic condition and more conditions should be managed at a primary care level ,the triggers in WAC 284-43-202(3) are inadequate. They asked to clarify what it means to be a "provider for a specific chronic condition or disease" in WAC 284-43-202 (3)(f). They also asked if a 15% reduction in psychologists who treat depression secondary to diabetes would require OIC notification. Stakeholders also expressed concern that distinct specialists are often lumped into a single category of medical provider. Finally, they asked how this rule would support the management of chronic conditions at the primary care provider level rather than at a specialist level? To allow for more detailed oversight, it was suggested that "for a specific chronic condition or disease" be added to WAC 284-43-202 (3)(b).*
Response: Current RCWs/WACs rely on the issuers to define a specialist. The Commissioner's current best reference identifying specific specialists is the CMS Chronic Conditions Data Warehouse, but stakeholders were asked to provide a better list if possible. Triggers in WAC 284-43-202(3) are not meant to capture every change in a network, only those most significant changes that would allow the Commissioner to be aware of network changes before network disruption and consumer complaints arise. Mechanisms to monitor primary care providers are sufficient, but additional standards are proposed in this rule for specialists so that the Commissioner is aware of changes to a network that may impact access.

Comment: *No specific time is listed as the date from which such changes in network and enrollment size are to be measured. Please state an explicit start time from which changes will be measured, especially for new networks.*
Response: Networks are required to be currently reported monthly via submission of a Provider Network Form A. Any changes from the network as reported to OIC in the latest Provider Network Form A must be reported if they rise to the levels set forth in these rules.

Comment: *Mental health providers and specialty providers should be in two separate subsections to govern reductions in access. Having them together with an "or" could allow an issuer to reduce only mental health providers because they are too costly.*
Response: This is a misreading of the proposed rule. The percentages of these two providers groups are not blended together. The 10% reduction standard applies to each group separately. However, to clarify the purpose and intent, the word "either' has been added to the section.

Comment: *Add to end of WAC 284-43-202 (3)(a) "in a service area" to be consistent with other reduction language.*
Response: This requirement ensures that issuers report reductions in numbers of specialists, including recognizing and reporting which enrollees will be affected. The purpose of leaving the requested phrase out of the language is to address the reality that specialty providers and some mental health providers are concentrated in certain areas of the state, primarily metropolitan areas. Thus, a reduction in the number of specialty providers in a particular service area might also be a reduction of specialty providers in a wider area, or even a reduction overall. To limit the reporting requirement only to the service area where those specialists are concentrated would miss this important piece of the situation. For example, a reduction in the number of providers in Spokane who provide a particular pediatric specialty service could affect half the state. To add the requested phrase would serve to present the issue as affecting only the Spokane area when, in fact, its effect was much more widespread.

Comment: *The AADR requirement in WAC 284-43-202 (3)(g) is redundant because an issuer will have to provide an AADR under WAC 284-43-202(2) if a network change results in a network no longer meeting that standard in WAC 284-43-200.*
Response: Section 284-43-202 (3)(g) explicitly set forth specific changes which must be reported to OIC. It further requires that the report include an AADR if a change results in the network no longer meeting the network access standards (including WAC 284-43-200), or an explanation of why it does not. So it is a mechanism for ensuring that networks continue to meet the standard set forth in WAC 284-43-200 despite certain changes, rather than a mere restatement of that standard.

Comment: *The rule should clarify that issuers are required to have "and maintain" adequate networks.*
Response: The Commissioner appreciates this clarification and changes were made as necessary.

Comment: *Why did the OIC choose to add "qualified" to describe certain stand-alone dental plans? It seems to be unnecessary.*
Response: A "qualified" stand-alone dental plan is one that provides the pediatric oral services essential health benefit (WAC 284-43-879). Stand-alone dental plans that do not provide this essential health benefit are not "qualified" stand-alone dental plans and exempt from 284-43 WAC Subchapter B. The terms were used in order to clearly state which stand-alone dental plans are subject to the requirements. A change was made to clarify the Commissioner's intent and to be consistent throughout all network rules.

Comment: *The application of proposed network access rules to dental plans is confusing because of very different provider networks and business models in dental care.*
Response: The Commissioner recognizes the unique composition of dental plans' provider networks, and has made changes to clarify which requirements do and do not apply to those networks.

Comment: *WAC 284-43-202 (5)(a) is out of place and not within the scope of this particular section of the rule. It should be included in the various rules dealing with rate filings.*
Response: This provision is not about the rates filings but instead about the network upon which rate factors are based. That network must be identified and valid for the coverage area in order to be an appropriate basis for actuarial projections of health care costs that are used to calculate rates.

Comment: *Define "actual network" in WAC 284-43-202 (5)(a).*
Response: "Actual network" refers to a network which has been filed with the Commissioner, detailing the providers included in the network. Filings must not be based on hypothetical networks.

Comment: *A stakeholder expressed concern regarding the timing proposed for WAC 284-43-202 (5)(a) because networks change on a daily basis. They suggested that allowances be made to reflect that proposed networks also include any anticipated changes to the network by adding "…on the network it*

proposes for the health plan's service areas and any anticipated changes to such network."

Response:

The Commissioner declines to change the language to include "…and anticipated changes to such network." We believe there may be a misunderstanding about the intent of this language. The providers in a network can change on a daily basis. This provision does not restrict this natural network behavior. The provision requires that issuers rate must be based upon the actual network to be utilized, as filed with OIC at the time of the rate filing. Rates are filed once for a plan coverage period (and as rate changes are requested). There is no requirement to update rates every time the network changes.

Comment: *Stakeholders asked to clarify the requirement regarding closed practices in WAC 284-43-202 (5)(c). What is a closed practice? Can a closed practice be included to determine network access for current enrollees? Or to maintain the current level of enrollees? If it means that a practice is no longer accepting new patients, how does this satisfy patient needs? It was suggested that an additional sentence be added to this section: "Closed network status must be shared with current enrollees at time of approval and available to new consumers prior to enrollment."*

Response: A "closed practice" is one that is actively providing covered services to patients, but has no further capacity to take on new patients. A closed practice is satisfying patient needs since the providers are actively providing covered services to current enrollees who are their patients. As a result, closed practices necessarily count toward the fulfillment of network access requirements. Requirements for provider directories were addressed in network access rulemaking phase 1 and is outside scope of this rulemaking. Please see WAC 284-43-204 for provider directory requirements in the rule.

Comment: *A stakeholder expressed a desire that closed practices in WAC 284-43-202 (5)(b) be prohibited from fulfilling any type of network access requirement, not just prohibited from use in meeting anticipated enrollment growth projections.*

Response: Though closed to new patients, a "closed practice" is still actively providing covered services to current enrollees who are its patients. Therefore, closed practices necessarily count toward the fulfillment of network access requirements. The rule appropriately accounts for current enrollees' access while also reflecting the fact that a closed practice does not provide access for new enrollees.

Comment: *WAC 284-43-202 (5)(c) should be expanded to require issuers to ensure that there is a sufficient number of each such provider type to make their*

services accessible to enrollees, whether or not an issuer requires a referral to obtain a particular provider type's service.
Response: Issuers are required to ensure that there is a sufficient number of each provider type in its network to provide services to enrollees, whether or not referral is required, under WAC 284-43-200 and WAC 284-43-202(1). WAC 284-43-202(5)(c) makes clear this requirement applies to direct access providers. This is necessary because, where a referral is necessary, either the referring provider or the issuer ensures that the enrollee is referred to a specific provider who is taking new patients. The patient is not necessarily a part of that process, whereby he or she is able to request the provider type of his or her choice. However, with direct access providers, the whole purpose is that the enrollee may access those providers without having to go through another provider or the issuer. Thus, in this situation, there is a heightened responsibility on the issuer to ensure enrollee access to these providers, including the provider type of their choice.

Comment: *Regarding WAC 284-43-202(5)(d), a stakeholder opined that these rules propose monitoring of a "best practice", and expressed concern that it is inappropriate to include best practices in regulations because best practices may change over time and thus the regulations may become outdated.*
Response: This rule requires maintenance of the continuity and coordination of care that enrollees receive from care models that include "gatekeepers" to control access to care. The gatekeepers may be medical homes / medical management services, or the enrollees' primary care providers. The use of these models is entirely appropriate and may change over time, but if not monitored properly, gatekeepers have the potential to inappropriately deny access to services. Therefore, this requirement is not a "best practice" but a requirement to monitor enrollees' access to services. The rule balances fostering of innovative care models with ensuring access under all models by requiring the issuer to maintain responsibility for access when control of access has been delegated to gatekeepers.

Comment: *Please clarify the type of network models described in WAC 284-43-202 (5)(d).*
Response: The Commissioner believes that the rule defines the models that are expected to be monitored with sufficient clarity, and declines to adopt this suggestion. Issuers are welcome to contact the OIC if they are unable to determine how this rule applies to a specific, unique network model.

Comment: *Stakeholders expressed both support and opposition for the requirement that health plans demonstrate that they have adopted professionally recognized standards to monitor and ensure continuity of care in WAC 284-43-202 (5)(d). Stakeholders asked whether the issuer must cite particular*

professionally recognized standards of practice and, if so, what those standards are. They recommended that the rule include examples of standards and/or the organizations that promote them. They also requested that OIC establish a "baseline standard", mandating substantive requirements for the delivery of care coordination services, either by issuers or their contracted providers. On the other hand, other stakeholders expressed concern that the requirements could potentially interfere with the clinical judgment of healthcare professionals and asked that they do not disrupt innovations in health care delivery. These stakeholders expressed concern that the monitoring of specified networks are outside the scope of health insurance, difficult to implement, and intrude into to the provider-patient relationship. They opined that such requirements may fall more within the scope of the state medical board, Department of Health, or NCQA's HEDIS. Stakeholders requested additional dialogue before adopting this type of standard or consideration of the issue as part of the administrative simplification process.

Response: This section is a recognition that issuers and providers are creating many new, innovative models of care. In fact, fostering and encouraging such innovation is one of the main goals of the ACA and, in turn, these rules.

Where an enrollee's primary care provider guides the enrollee's care through the gatekeeping function, that primary care provider coordinates and assures continuity of that care through referrals. While ubiquitous at one time, today that model is only one of many currently in use, and innovation is occurring every day. This section is designed to require that, regardless of the care model they use to provide covered services, issuers ensure that the enrollee still has someone responsible for coordination and continuity of their care. The rule was intentionally written to accomplish that purpose while fostering innovation. There is currently no "gold standard" to require for use that is applicable across all models. Thus, the Commissioner declines to mandate a particular system or set of standards to accomplish the requirement. Instead, the rule simply requires issuers to report the system and standard that they are using. The Commissioner will use the tools he has available to monitor the market and will continually evaluate the need for further rulemaking.

Comment: *Stakeholders requested that the Commissioner amend his frequency standard for the monitoring of care coordination to monthly under certain circumstances, at least quarterly, or at least once a year (by striking "as often as necessary"). As written, the compliance standard is unclear.*
Response: The Commissioner agrees that frequent monitoring is valuable and may be necessary in order to ensure that enrollees receive coordination and continuity of care. However, as stated above, he believes that best practices, including the most effective monitoring practices, will likely be developed by issuers and providers as they develop their processes around these

requirements. Thus, he declines to set more specific parameters around monitoring requirement at this time. The Commissioner will use the tools he has available to monitor the market and will continually evaluate the need for further rulemaking.

Comment: *Stakeholders asked a number of questions related to the implementation of WAC 284-43-202 (5)(d), including: How can an issuer assure continuity and coordination in order to meet these standards? How will issuers evaluate whether the care is being delivered in a "manner consistent with professionally recognized evidence-based standards of practice?" How would an issuer monitor for those standards that are not evidence-based?*
Response: Please see above. At this time, the Commissioner believes that development of these processes should be left to those with expertise in developing and implementing care models: issuers and providers.

Comment: *How will the Commissioner enforce the provision? What corrective action will the Commissioner take if the OIC views medical homes or medical management models as out of compliance?*
Response: The Insurance Code authorizes a range of market examination and enforcement tools which may be employed. The OIC will evaluate each situation and take action appropriate to the circumstances.

Comment: *WAC 284-43-202(5)(d)(ii) should be revised to include a reference to mental and behavioral health providers.*
Response: The Commissioner declines to add a reference to mental and behavioral health providers in this section because "primary and specialty providers" includes both mental and behavioral health providers.

WAC 284-43-225 Issuer recordkeeping – provider networks (new section)

Comment: *Stakeholders expressed concern that filing requirements do not address confidentiality of provider contracts and negotiated agreements, as much of the information is confidential and proprietary. Others requested that carriers be required to submit only documentation about efforts to contract, not the actual contracts.*
Response: This section is not related to filing requirements of contracts with the OIC, but instead clarifies the Commissioner's expectations regarding recordkeeping of these contracts by issuers. The requirement to file provider agreements is set forth in RCW 48.43.730 and WAC 284-43-330. RCW 48.43.730(4) specifically protects the proprietary content of compensation exhibits. Records that are requested as part of a market conduct continuum are

protected by RCW 48.37.080. This rule does not change these filing requirements or protections.

Allowing issuers to only provide documentation about "efforts" to contract and not the actual contracts conflicts with statutory requirements. Only an executed contract ensures providers are in-network providers. It is an unreasonable expectation that the OIC can review network access if it were to only have access to contracting efforts and could not review the actual contracts that determine who comprises those networks.

Comment: *The recordkeeping requirements for contracting efforts are unnecessarily broad and vague. There may instances where no records exist because no negotiations were called for. Record keeping and record submission provisions should be focused on exceptional situations not already addressed elsewhere. This could be, for example, an instance where a particular access standard is not met as a result of an issuer and a provider not being able to reach agreement. Further, please clarify the term "associated accounting records."*
Response: The previously-promulgated network access rules, for example WAC 284-43-201(2)(a) and (b), require issuers to document good faith efforts to contract in order to request an AADR based on an inability to contract with sufficient providers to meet the network standards. This section simply requires issuers to keep that documentation and be able to provide it upon request. The situation suggested by the commenter – where an AADR is requested due to inability to contract - is exactly the situation in which such records must be created and kept. "Associated accounting records" means records related to payment under a provider contract. For example, if an issuer has filed a Provider Network Form A that includes a particular provider as part of its network, the issuer is required to keep records of its contract with that provider and the issuer will also have accounting records showing any payments made to that provider pursuant to that contract.

Comment: *A stakeholder requested clarification regarding the measurement of timeframes for retention in WAC 284-43-225(1). Does the ten year requirement for retention begin at the beginning or the end of the contract? Many issuers have long-standing provider contracts in place which may span longer than the ten year time period laid out in this section.*
Response: The Commissioner has clarified this time period in response to this comment.

Comment: *Please specify that contracting records include contracts offered, rejected, and the reasons for rejection.*
Response: The proposed amendment is a misunderstanding of the requirements, and is outside the scope of this rule. The requirement to

document good faith efforts to contract was part of Phase 1 of the network access rules (for example, WAC 284-43-201(2)(a) and (b)). Those rules do not require that terms or reasons for rejection be documented. In fact, those rules (and the AADR instructions) specifically state that information regarding contract terms should not be provided.

Comment: *Stakeholders expressed both support and concern regarding the requirement to track prior authorization data. Commenters believed that the data will be used to determine trends across health plans. Some stakeholders urged removal of this requirement (instead using existing methods as put forth in RCW 48.43.530 or traditional data call/survey requests) while others urged strong utilization of the data to evaluate market performance. Supporters of collecting prior authorization data also asked that issuers maintain records of actions that result in a reduction of the amount, duration, or scope of services provided to enrollees.*

Response: This is a recordkeeping rule. It puts in place no new requirements or standards for prior authorization. WAC 284-43-225 (2) was developed to ensure that prior authorization processes are not used a barrier to covered services. Thus, commenters are correct that the data is expected to be subject to statistical and trend analysis for that purpose. The data collected will be part of the market monitoring of the effect of these rules, as discussed previously in this Concise Explanatory Statement. As such, it may be used in various ways.

Comment: *Please clarify the intention of a "given period of time" in WAC 284-43-225(2). A retention period of seven years would be reasonable. Please add additional specificity to the collection of prior authorization data, such as whether or not prior authorizations requests include instances where a prior authorization was requested by a provider but not required by an issuer.*

Response: The Commissioner took these comments into consideration and clarified the expected length of time. A specific request from the OIC to an issuer to provide prior authorization data will include specific and detailed information regarding the scope of the request. Issuers will also have the opportunity to ask questions regarding that specific request.

WAC 284-43-251 Enrollees access to providers

Comment: *Stakeholders expressed general agreement with WAC 284-43-251. However, they requested that the rule emphasize the responsibility of providers to proactively communicate with carriers regarding changes to a practice that affect access, such as a change of address.*

Response: The Commissioner appreciates the support for the section. The Commissioner declines to modify the rule to require providers to proactively

communicate with carriers on any specific topic. Issuers and providers have well established communication protocols with each other and specify them in the provider contracting process.

Comment: *Stakeholders asked to clarify the intention of this section.*
Response: WAC 284-43-251 has been a rule since 2001. It was adopted as part of rulemaking for the Patient's Bill of Rights (PBOR) enacted 2000 (RCW 48.43.500). The PBOR provides important protections for consumers and enrollees to get information about how their health plans provide access to covered services. Modifications to the rule are required to provide additional clarification for what constitutes sufficient access to particular categories of providers (such as primary care providers) and in particular situations (such as enrollees with complex medical conditions).

Comment: *It was requested that issuers have 30 days to accommodate the request of an enrollee to change primary care providers to allow for requests at the end of the month.*
Response: The requirement that coverage begins the following month is statutory by RCW 48.43.515(2).

Comment: *A stakeholder asked that individuals with chronic conditions be able to select a specialist as their primary care provider in the plan's network.*
Response: The Commissioner declines to require that a particular category of provider be designated as a primary care provider. Issuers should determine the categories of providers they will designate as primary care providers.

Comment: *Please clarify who defines a primary care provider.*
Response: The Commissioner declines to address who defines a primary care provider as it is outside the scope of this rulemaking.

Comment: *A stakeholder asked that enrollees be allowed to choose and change specialists, with a requirement that sufficient specialists be available to accommodate enrollees.*
Response: This comment is outside the scope of this rule. This rule is about access, rather than referral patterns. Both this rule and the Phase 1 rules do require that networks include sufficient specialists (or an Alternate Access Delivery Request) to provide all covered benefits to enrollees at in-network rates.

Comment: *Stakeholders expressed support for WAC 284-43-251(3) but raised concerns that issuers are circumventing the rule by imposing stringent prior*

authorization and benefit level exception requirements for patients with complex medical conditions. Please clarify this language as there is confusion about prior authorization and utilization management in the new health care environment. Please strike "such as prior authorization for services" in WAC 284-43-251(4).
Response: Prior authorization is allowed as issuers have the right to determine the medical necessity of treatments. That being true, the requirement for reporting of prior authorization information under WAC 284-43-225(2) is designed to ensure that issuers are not using prior authorization to inappropriately deny access.

Comment: *Stakeholders expressed concern over different enrollee notification standards when a provider's contract is being terminated, depending on the provider type. They requested 60 day notice for all provider types.*
Response: RCW 48.43.515(7) requires enrollees to receive 60 days notice if a primary care provider's contract is terminated. Other protections exist for individuals with chronic conditions who see a specialist on an ongoing basis, such as continuity of care through the course of treatment. The Commissioner believes that a notice requirement for all providers would be unduly burdensome on issuers while providing minimal benefit to enrollees.

Comment: *Some stakeholders expressed support for the provisions in WAC 284-43-251 that clarifies the requirements for primary care providers, pediatricians, and standing referrals. They also asked for specific provisions relating to an adequate number of specialists and sub-specialists as well. Other stakeholders suggested that existing rules are sufficient and the section appears to unnecessarily restate previous rules.*
Response: The Commissioner declines to require an arbitrary number of specialists and sub-specialists in a network. The network access rules require issuers to provide access to a sufficient number of providers (specialists and sub-specialists) based upon multiple different factors set forth through 284-43 SubChapter B, including but not limited to time/distance standards, appointment standards, and population condition standards.

Comment: *Stakeholders asked to clarify the intent of singling out pediatricians in WAC 284-43-251(2) as there are many family practitioners who see children. It is unclear if a certain number of pediatricians accepting new patients is required to comply with this section.*
Response: The provision was added to the rule to ensure enrollees have access to open-panel practices that include pediatricians. While it is correct that many family practitioners care for children, there are specific other factors that require access to these specific providers such as medical conditions, age needs, and enrollee preference.

Comment: *A stakeholder requested additional provisions to ensure minors have access to services in accordance with laws related to minors' rights in health care.*
Response: In this rulemaking, the Commissioner's goal is to ensure access for all enrollees and protect their rights to health care. Minors' rights to health care are addressed elsewhere in the law.

Comment: *Concern was expressed that the rule's focus on requirements for primary care providers and pediatricians could be read as undermining the broader requirements to maintain accessible networks.*
Response: The Commissioner respectfully disagrees with this comment that clarifying requirements for primary care providers and pediatricians undermines the broader requirements to maintain accessible networks. 48.43 RCW, 48.44 RCW, 48.46 RCW, and 284-43 WAC Subchapter B provide a regulatory framework for network access to all providers.
WAC 284-43-251 builds upon the general requirements under WAC 284-43-200 by providing additional clarity regarding what constitutes sufficient access to particular categories of providers (such as primary care providers) and in particular situations (such as enrollees with complex medical conditions). Rather than undermining the broader requirements, it adds to them.

The general rule in WAC 284-43-200 clearly states the standard for specialists, and needs no clarification. In contrast, there is additional information necessary to clarify the application of the general standard to the providers and situations to which it applies, which is provided by this section.

Comment: *How is an "extended period of time" defined in WAC 284-43-251(3)? Is this at the discretion of the issuer or provider?*
Response: The rule specifies that the notice must be given consistent with the *enrollee's* needs and the plan benefits. The rule goes on to give an example illustrating the reality that the amount of time for which a standing referral is appropriate will depend, in each case, upon those factors. The provision is not about who has discretion but rather is an *enrollee notification and protection* requirement. The enactment of the Patient's Bill of Rights (PBOR) in 2000 (RCW 48.43.500) provides important protections for consumers and enrollees to get information about how their health plans provide access to covered services.

Comment: *A stakeholder expressed concern regarding the change from the term "psychiatric condition" and recommended that the reference in WAC 284-43-251 (3) include neurodevelopmental disabilities. It was also recommended that substance use disorder treatment be referenced in WAC 284-43-251(3).*

Response: The Commissioner made changes to this section which address these comments.

Comment: *Please allow direct access to East Asian medicine practitioners in WAC 284-43-251.*
Response: The Commissioner declines to add direct access for any provider in the rule. The requirement that enrollees have direct access to certain categories of providers is a statutory requirement set by the Legislature.

There are a very large number of provider types, any of whom may desire that enrollees have the ability to self-refer to them. Requiring direct access for the many types of providers in the marketplace conflicts with the consumer protections provided in a managed care network model. This rulemaking encompasses standards for provider networks; it does not encompass new requirements for direct access to particular types of providers.

Comment: *Remove WAC 284-43-251(4) as singling out a provider type for favorable treatment is inappropriate.*
Response: Direct access to chiropractors is required by RCW 48.43.515(5).

Comment: *Please amend WAC 284-43-251(7) to align with the changes in WAC 284-43-320(10) clarifying termination for cause or without cause.*
Response: The Commissioner took this comment into consideration and modified the language as appropriate.

WAC 284-43-300 Provider and facility contracts with issuers- generally

Comment: *Please clarify the intent of this section because it is confusing when read with WAC 284-43-205. Please amend the section to include "consistent with the requirements of WAC 284-43-205." Please remove the second sentence in WAC 284-43-300 (2) as it appears to be confusing and inapplicable.*
Response: Thank you for your comment. We removed the sentence as we agree that it is unnecessary.

Comment: *Please add "at all times during the contract period" to the end of the second sentence in WAC 284-43-300(2) to prevent one-time preventive services offerings, such as HIV tests and screenings.*

Response: The Commissioner declines to make this change because this section is about provider contracting and subcontracting general requirements. This section is not about benefit limitations.

WAC 284-43-310 Selection of participating providers – credentialing and unfair discrimination

Comment: *Stakeholders expressed support for the changes in WAC 284-43-310, including the explicit prohibition on discrimination based on provider type or category where the provider is acting within the scope of their license. Some stakeholders indicated they believe that issuers have failed to meet this requirement, so expressed a desire for strong enforcement. Alternatively, other stakeholders expressed opposition to this section as they opined it would intrude on an issuer's ability to make decisions about the number of providers within its network.*
Response: The changes to this section are not substantive; they are wording changes and the importation of the existing requirement from RCW 48.43.045. The Commissioner felt it was important to clarify existing law as it pertains to network creation, but these changes do not change the requirements and therefore would not affect an issuer's ability to make decisions about the number of providers in its network.

Comment: *Please clarify the intention of referencing practitioners in WAC 284-43-310.*
Response: Thank you for your comments. We agree that it should be deleted and have made the change.

Comment: *Please amend WAC 284-43-310 (1)(c) to bar discrimination of any type based in part on provider type, not just on the sole criteria of provider type.*
Response: The Commissioner declines to make this change. The changes to this rule are not intended to broaden the scope of RCW 48.43.045, nor would that be encompassed within this rulemaking.

Comment: *Please clarify the intent of WAC 284-43-310 (1)(c) so that it is understood that an issuer could make a determination that a particular provider type is sufficiently represented in a network and that no additional contracts would be offered to those provider types. Language was suggested that would clarify this intention.*
Response: The Commissioner declines to make this change. The Commissioner agrees that the law does not require issuers to contract with more providers of a particular type than are necessary to meet this standard, but believes that no additional clarity is needed on this point.

Comment: *Please consider how the removal of "facilities" from WAC 284-43-310(1) would apply to narrow or tiered networks as they may be discriminatory if they require patients to overcome administrative hurdles to receive specialty care, or result in adverse selection.*
Response: The wording changes to WAC 284-43-310(1) have not eliminated the requirement that issuers develop standards for selecting facilities. Rather, it eliminated the duplicate mention of facilities in the requirement. Issuers remain required to develop standards for selecting facilities of each licensure type (for example, hospitals, inpatient rehabilitation facilities, and skilled nursing facilities).

Comment: *Please change "scope of their license" to "lawful scope of their practice" to include provider types that are not required by law to have a license to deliver health care services.*
Response: The Commissioner declines to make this change to extend the rule beyond practitioners regulated by Titles 18 and 70 RCW.

Comment: *A stakeholder expressed concern that WAC 284-43-310 puts the burden on providers to prove that they were excluded in a discriminatory manner, rather than putting the burden on the issuer to prove that plans are inclusive of all provider types.*
Response: The burden of proof is not changed by the changes proposed in WAC 284-43-310. The rule continues to place the responsibility explicitly and exclusively on the issuer to demonstrate that its standards for selection and credentialing of providers are non-discriminatory.

Comment: *Please clarify the intent of WAC 284-43-310 and whether or not it requires a specific process for all specialties listed with the American Board of Medical Specialties or some other basis, or would a more general process meet the requirement.*
Response: The rule does not specify any specialty list but rather requires an issuer have selection standards for *all providers*. An issuer is not required to have a unique standard for every specialty unless that specialty requires a unique standard. A more general process may suffice, if it adequately addresses all specialties.

Comment: *Please require issuers to give providers an explanation for termination of a contract, including the standards that were evaluated to determining contract termination.*
Response: This is outside the scope of the rulemaking. The Commissioner's requirements for inclusion in a contract are those necessary to accomplish the

Commissioner's regulatory responsibilities as assigned by the Legislature. Additional provisions are subject to negotiation between the provider and the issuer.

Comment: *A stakeholder asked that issuers provide standards for provider contract termination to the Commissioner and provide data to the Commissioner to determine if contracts were terminated specifically to avoid risk. They also asked that terminated providers be given the right to appeal a termination before it occurs and disclose to the providers the standards used to terminate the contract.*
Response: The Commissioner declines to include these requirements, which are already set forth in RCW 48.43.055.

WAC 284-43-320 Provider contracts- standards – hold harmless

Comment: *Changes to WAC 284-43-320(2) were suggested to incorporate utilization management service agreements.*
Response: The requested change is outside the scope of this rulemaking.

Comment: *The change to WAC 284-43-320(3) is unnecessary as it will have an administrative burden on administrative staff.*
Response: The Commissioner respectfully disagrees. The hold harmless provisions are a significant consumer protection and it should be clearly stated and understood by both parties. There should be no reason for deviations from this language.

Comment: *One stakeholder asked that the following changes be made to this section:*

1. *Add this phrase to the end of WAC 284-43-320 (3)(a): "nor does it prevent an enrollee from choosing not to use their insurance benefits so long as the enrollee has agreed in writing prior to service or by withholding enrollment information from a provider."*
2. *Please add this phrase to the end of WAC 284-43-320 (3)(d) "unless insurance information has been withheld from the provider or waived in writing prior to treatment."*
3. *Please add this phrase to the end of WAC 284-43-320(4) "except when waived by the enrollee prior to treatment or withheld from the provider."*

Response: The Commissioner declines to make these changes as making the change would negate an important consumer protection. Providers under contract with a carrier are not allowed to bill consumers other than pursuant to their contract with the carrier. Even though it may be cheaper for the consumer to

cash pay rather than pay down their deductible, providers must honor the terms of their contract if the consumer has disclosed their insurance coverage to them.

Comment: *Please amend WAC 284-43-320 (6)(a) to include "direct or indirect" compensation and require affirmative agreement before they take effect. If affirmative action is not obtained, the issuer should follow due process for contract termination including its notification process.*
Response: The Commissioner declines to add "direct or indirect" as it would be redundant. The rule addresses provider and facility compensation, without limiting it to direct compensation, and also includes notice of any changes "that affect health care service delivery."

Comment: *Stakeholders expressed a desire for adequate time be given to providers in WAC 284-43-320(6) to review changes once notice is received in order to determine whether or not to accept the change or terminate the contract. Stakeholders asked that RCW 48.39.005 and RCW 48.39.010 be included in WAC 284-43-320 to require that notice be given no less than 60 days prior to changes that are unrelated to compensation. They suggested that issuers be prohibited from implementing the change if the provider sends a notice of termination.*
Response: The Commissioner declines to extend the minimum review time beyond 60 days because he believes that 60 days is a reasonable time for providers to review, analyze, and respond to proposed contract changes. However, the notice period is a minimum. Parties are free to negotiate longer notice periods.

The Commissioner declines to repeat the provisions of RCW 48.39.005 and RCW 48.39.010 in this rule, as he believes such repetition to be unnecessary. He also declines to make the final suggested change. Under RCW 48.39.010, the provider's rejection of a material amendment does not affect the terms of the contract, meaning that a provider may prevent the issuer from implementing the change simply by rejecting the change. If a provider chooses to terminate a contract due to a proposed contract change, the provider is not prohibited by the Insurance Code from doing so. Such a prohibition only exists if it is a term of that contract.

Comment: *The current proposed timelines in WAC 284-43-320 (6)(a) and (6)(b) need to be clarified to avoid the unintended consequence of providers being forced to accept changes in administrative policies or procedures impacting compensation for a period of time if the 60-day notice periods do not line up correctly. There is a potential timing issue between the receipt of the proposed change and the right for the provider/facility to exercise its right to terminate the*

contract because the provision is made subject to the 60 days' notice of WAC 284-43-320(9).
Response: This is a misreading of the Insurance Code provisions affecting the provider's rights in this situation. There is no period of time in which this minimum notice period requires a provider to accept changed contract terms. Please see the response to the preceding comment. Under RCW 48.39.010, if the provider rejects the proposed change, the contract terms remain unchanged. Therefore, if the provider chooses also to terminate the contract, the terms will remain unchanged until the contract termination date. If a provider contract, by its terms, is terminated by a provider's rejection of a material change, then that is a matter that has been negotiated between the provider and the issuer and does not conflict with RCW 48.39.010 so long as the terms of the contract remain the same until the termination date.

Comment: *Please add a provision in WAC 284-43-320 (6)(c) to restrict retroactive changes without written consent only to comply with regulatory requirements that are applied to issuers and providers retroactively.*
Response: WAC 284-43-320 (6)(c) prohibits *any* retroactive changes without written consent. Such a provision would therefore allow retroactive changes without written consent in some situations where the current rule does not. This would appear to be the opposite of the commenter's intent.

Comment: *Commenters raised concern that providing an enrollee's entire policy to a provider is onerous and unnecessary. Are issuers required to grant providers full access to an enrollee's benefit contract or would just a benefits summary suffice? An explanation for this provision was requested. Please clarify this requirement extends only to contracted/participating providers and facilities.*
Response: Issuers are already required to provide this information, and much more, upon the request of any person per RCW 48.43.510(2). This proposed provision adds no additional requirements. This information is needed for providers to file grievances on behalf of patients and to know what services they will be compensated for. The Commissioner expects issuers to grant providers full access to an enrollee's benefit contract, not just a summary.

Comment: *A stakeholder requested clarification regarding WAC 284-43-320(7). Is this contract language required to be added to all provider and participating facility contracts verbatim as written in the proposed rule or will carriers have some flexibility with their individual contracts?*
Response: The Commissioner expects issuers to amend their contracts to reflect the new requirements, including the verbatim language.

Comment: *Stakeholders expressed concern that requiring providers and facilities to cooperate with audit reviews of encounter data is unnecessary as current language regarding cooperation with audits is sufficient to address this issue. Stakeholders also were concerned that the section mandates that carrier contracts require subcontractors to participate in audit reviews. Stakeholders asked for clarification regarding the type of data that is necessary to be collected under WAC 284-43-320(8) and who is responsible for the cost of such audits. Stakeholders requested it be clarified that audit review may not be performed to discriminate against enrollees or to retaliate against providers. They also asked that issuers be restricted to auditing only for specific data and that providers and facilities be compensated for the expense of complying with audit data.*
Response: This section is intended to reflect and make transparent to providers the new and additional requirements applicable to issuers who participate in risk adjustment and reinsurance programs. The risk adjustment and reinsurance audits look at different information than that required under WAC 284-43-324 – encounter data versus claims data. RCW 48.43.730 requires intermediaries to comply with state law. Audit review data cannot be used to discriminate against enrollees or retaliate against providers under RCW 48.18.480, RCW 48.44.220, and RCW 48.46.110. The Commissioner believes it is unnecessary to reiterate this protection in this section.

Comment: *Please require that issuers provide a 120 day notice before terminating a contract without cause.*
Response: The Commissioner declines to make this change. The 60 day notice period is a balance between providers' and enrollees' need to have advance notice, and issuers' right to contract freely. The Commissioner also notes that sixty days is a minimum standard in existing contracts. Parties to the contract may negotiate a longer notice period.

Comment: *WAC 284-43-320(6)(a) extends the 60 day notice requirement to changes affecting health care service delivery. We suggest the term "health care service delivery" be clarified so as to only include changes that directly affect the provision of health care services to enrollees. Changes that have an administrative impact on a provider's practice should not fall within this 60 day notice requirement.*
Response: The Commissioner declines to make this change to the 60 day notice requirement. The timeframe to notify parties about changes that affect health care service delivery is an important protection for all parties to the contract.

Comment: *A stakeholder expressed support for a providers ability to reject a material amendment to a contract without affecting the terms of the existing contract in WAC 284-43-320 (6)(b). Issuers should be required to pay for the cost of providers complying with state and federal law.*

Response: The cost of complying with state and federal regulations is outside the scope of this rule.

Comment: *A stakeholder asked that enrollees be given the names of providers who are still available in-network if their original provider is terminated from the network.*
Response: The Commissioner agrees that enrollees must be able to locate in-network providers if one of their providers is terminated from their network. That need is met through enrollees' access to the issuer's Provider Directory, which must be kept current and which must indicate closed practices.

Comment: *Why was the restatement of RCW 48.43.085 struck from the subsection? What protections will there be for consumers to go out of network if needed?*
Response: The Commissioner struck the section to align with RCW 48.43.085 which prohibits the Commissioner from adopting rules to implement the section. The same protections will still apply.

WAC 284-43-330 Participating provider – filing and approval

Comment: *Please prohibit incentives to specific provider types if the incentive is not offered to other providers in WAC 284-43-330.*
Response: The Commissioner declines to set contract terms or compensation rates.

Comment: *Please ensure that filing instructions are clear and detailed. The proposal establishes excessive monitoring and reporting requirements. There are redundant filing requirements in WAC 284-43-330 (1) and (2)(b).*
Response: Thank you for your comment. General filing instructions are a separate document which is not a part of this rule making. The OIC intends to use its standard practice to send revised general filing instructions to issuers to review and comment upon. Concerns about the clarity or detail of the instructions should be addressed through that process.

Comment: *Please amend the filing deadline for provider and facility agreements to be 30 days prior to use.*
Response: The Commissioner made this change to clarify expectations.

Comment: *If an issuer must file for prior approval, what will be the criteria for approval? Are levels of providers in the network included?*

Response: The approval criteria are set forth in Chapter 48 RCW and Chapter 284 WAC. The Commissioner also provides a checklist to the public that sets forth in detail the criteria and provisions of law that are used in review of provider agreements.

Comment: *Add to the end of WAC 284-43-330(1) "the filing process shall not prevent the insurer and provider from negotiating a contract and its terms in good faith."*
Response: The Commissioner declines to make this change. Issuers and providers may negotiate a contract. The revisions to regulation do not add, remove, or modify this right. Further, it is the expectation of this office that all parties negotiate in good faith their contracts. Therefore the basis and intent to add this language is unclear.

Comment: *Stakeholders expressed concern regarding the capacity of OIC staff to manage the increase in volume if the rules were to be adopted as drafted, especially the requirement that a filing must contain "all contract documents between the parties."*
Response: The rule clarifies the OIC's filing expectation. The requirement to file all contract documents is statutory and has been a requirement for many years.

Comment: *A stakeholder asked that negotiated contracts be allowed to take effect thirty calendar days after filing with the Commissioner.*
Response: The Commissioner declines to make this change.

Comment: *A stakeholder asked for clarification as to when carriers can move forward with executing a contract. If the Commissioner approves a contract prior to the full thirty day time period, can a carrier move forward with executing the contract?*
Response: Provider agreement submissions are prior approval. Once an approval occurs, an issuer may execute the contract. The "implementation date" for notifying the Commissioner of the execution date may be addressed through multiple different filing options. For example: if a carrier has selected the "upon approval" field in SERFF and the Commissioner approves a contract prior to the thirty day time period, then the contract can be used upon approval. For specific filing instructions please see the Washington State SERFF Health and Disability Form Filing General Instructions, SERFF Industry manual, or contact the Rates and Forms helpdesk at: RFHelpdesk@oic.wa.gov

Response: *It is unclear how "good faith" is defined here so it would be difficult for an issuer or network to determine what documents to retain.*

Response: Please see the CES related to Rulemaking 2013-22 for further discussion on the Commissioner's expectations regarding "good faith" negotiations.

Comment: *Please clarify how the modifications to a previously approved template are to be filed and subsequently issued to the provider following approval. It is unclear if the red-line version of the contract is to be issued to the provider. Please define material and non-material changes and require that only material submissions be re-filed.*
Response: The Commissioner declines to differentiate between material and non-material changes. *Any* change to a provider contract must be filed and approved before the revised contract may be used. The content of general filing instructions is outside the scope of rulemaking and is addressed in Chapter 284-44A WAC, Chapter 284-46A WAC, and Chapter 284-58 WAC. The Washington State SERFF Health and Disability Form Filing General Instructions and SERFF Industry Manual provide detailed guidance about how to file a provider agreement.

Comment: *Please clarify that electronic signature are sufficient to meet the requirement of WAC 284-43-330(5).*
Response: The rule leaves open any method of signature that is legally binding.

Comment: *Stakeholders asked to delay the filing of certain reimbursement agreements in WAC 284-43-330(6) until anticipated guidance becomes available from CMS or eliminate the requirement completely. It was also stated that requirements in WAC 284-43-330 (6) are duplicative with blanket filing requirements for all reimbursement agreements. Other blanket filing requirements should be repealed if only specific agreements are sought. The information requested is proprietary and confidential and there is no provision for maintaining confidentiality in this section. Another stakeholder expressed support for this provision as originally proposed during Phase 1 of the network access rulemaking.*
Response: CMS released guidance on March 10, 2015, indicating its interest in pursuing additional payment models tied to quality. Given this information, the Commissioner declines to delay the filing of reimbursement agreements.

All provider agreements must be filed. This general requirement is stated in subsection (1). The rule then goes on to include clarification of additional requirements for specific types of agreements. The provisions for maintaining confidentiality of compensation information are found in RCW 48.43.730.

Comment: *Stakeholders asked to clarify how the OIC will determine that a reimbursement agreement in WAC 284-43-330(6) is discriminatory, including specific examples or data elements that may be evaluated to determine compliance. They asked if investigations will be triggered by complaints and if data will be compared to that of other issuers. Another stakeholder expressed concern that the section may stifle innovative reimbursement methodologies while other stakeholders expressed support for the non-discrimination language.*
Response: A provider agreement is discriminatory if it is designed to have the effect of, or results in, unfavorable treatment of enrollees with a specific covered condition or disease. All facets of provider agreements, alone and in combination, may be evaluated to determine compliance. Complaints of discrimination involving provider agreements will be investigated, as all consumer complaints are. Data may be compared to that of other issuers, and across a single issuer's providers and services areas.

The Commissioner's intent is to foster innovative reimbursement methodologies. He also intends to fulfill his consumer protection responsibilities by utilizing OIC resources to monitor the effects of reimbursement arrangements to ensure that they do not result in consumer harm.

Comment: *The Commissioner's review of compensation agreements should prevent unlawful discrimination and reject health plan compensation agreements that will have the effect of discouraging the enrollment of individuals with significant health needs.*
Response: Thank you for your comment. The Commissioner is responsible for the protection for all insureds against unlawful discrimination in the matter of insurance as set forth throughout regulation.

Comment: *Please clarify "rationing of medically necessary services" in WAC 284-43-330(6) as such services can still be subject to limitations.*
Response: The intent is to ensure that providers are not incentivized to delay or deny necessary service to achieve a certain reimbursement.

Comment: *The requirements in WAC 384-43-330(6) are not clear enough for issuers to monitor reimbursement arrangements and for issuers and providers to negotiate compliant reimbursement agreements. Issuers and providers need clear, specific and flexible guidelines to promote the necessary innovation.*
Response: While the Commissioner believes these rules are clear, he has deliberately left flexibility in the rule to allow innovation. As stated previously, the Commissioner will monitor the market carefully to determine the effect of these rules and to ensure protection of consumers. If additional specificity is necessary, there are several methods available to him (including further rulemaking) to address it.

Comment: *Reimbursement agreements tied to health outcomes have the potential for providers to tailor patient care in a manner that is unrelated to a patient's preferences or to the most clinically appropriate care for the patient. Therefore, enrollees should be notified that certain compensation agreements may be at odds with the patient's best interests or at least create the appearance of a possible conflict of interest. Enrollees should be notified of different agreements or limit notification to when the plan network reaches a certain level of contracts with performance standards.*
Response: The Commissioner declines to require the suggested notice. The Commissioner is concerned that a notice such as the commenters recommend assumes that performance-based compensation agreements are inherently bad. To the contrary, agreements tied to performance measures are encouraged and fostered by the ACA, because they are focused on quality and efficiency of patient care, rather than the quantity of services provided. The purpose of the ACA's focus on innovative care models is to decrease the level of compensation-based overuse of medical services, and increase efficiency and quality of care. Ultimately, the goal is to curb the unsustainable rise in medical costs.

At the same time, these rules do include protections against abuses of such compensation systems and conflicts of interest. The rules require that compensation agreements not result in rationing of services or other discriminatory effects. In addition, the Insurance Code protects practitioners' right to advise patients regarding their best options, even when that is critical of the patient's health carrier. Finally, the Commissioner will use the resources of the OIC to monitor the effects of these agreements on consumers, and the insurance market.

Comment: *Please prohibit pay for play agreements, under which providers receive increased compensation from health plans for utilizing or prescribing certain services. If the Commissioner is not inclined to prohibit pay for play agreements, then he should describe the possible conflict of interest they create.*
Response: To the extent that this involves provider compensation, the Commissioner declines to set contract terms or compensation rates. If a provider contract is utilized to restrict care by bypassing medical necessity standards, utilization management, or prior authorization, the Commissioner will address this practice using existing regulatory and enforcement authority.

Comment: *Carriers are unable to identify the number of enrollees who would be within an agreement's service area. For new agreements, this number would be unknown and for existing agreements, enrollment would have to be estimated and it is unclear what would happen if an issuer estimated incorrectly.*

Response: Issuers can, and do, currently identify the number of enrollees in a service area for many reasons. They use these numbers in creating plans, setting rates, creating and maintaining networks, and even making decisions about whether to enter a market at all. When issuers enter into a new service area or introduce a new product, they use projected enrollment numbers. For existing service areas and products, determining the number of enrollees is simply a matter of checking the issuer's records. Issuers can routinely access this information.

Section 6: Implementation Plan

A. Implementation and enforcement of the rule.

The purpose of this rule implementation plan is to inform those who must comply with 284-43 WAC Subchapter B and C about how the OIC intends to:

- Implement and enforce the rule.
- Inform and educate persons affected by the rule.
- Train and inform staff about the rule.
- Create or revise supporting documents necessary for the rule.
- Evaluate the rule.

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" and "Provider Contracts and Payment" rules. The standards in this rule were anticipated in phase 1 of network access rulemaking. Resources were reallocated and/or retooled at that time to support anticipated implementation and enforcement of phase 2 rulemaking.

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 and SERFF submission requirements.
- A Consumer Frequently Asked Questions document on its website.

Submission Requirements and Timelines

The rule standards contain multiple reporting requirements, submission timeframes, and one reporting extension to allow for a gradual 18-month implementation of revised requirements in WAC 284-43-320.

Training and Informing Agency Staff

A new unit in the Rates and Form Department was established to facilitate implementation of phase 1 rulemaking. The unit will continue to work with and inform staff throughout the OIC and other agencies as needed about network access reporting and maintenance requirements adopted during phase 2 rulemaking.

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

The rule will require the OIC to update and post on its website revised Network Access Portal general filing instructions for submission of network access reports.

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

Type of Inquiry	Division
Consumer assistance	Consumer Protection
Rule content	Policy
Authority for rules	Legal
Enforcement of rule	Rates and Forms
Market Compliance	Company Supervision

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

The OIC has circulated numerous drafts of the proposed rule to issuers, sharing its intention to adopt the rules. The OIC will work issuers in promoting voluntary compliance with the rule.

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

The OIC will work closely with issuers, providers, and other interested parties to evaluate the effectiveness of the rule. The rule will be periodically evaluated for future rule-making.

Appendix A

CR-102 Hearing Summary

Summarizing Memorandum

To: Mike Kreidler
Insurance Commissioner

From: Jim Freeburg
Presiding Official, Hearing on Rule-making

Matter No. R 2014-08

Topic of Rule-making: Network access maintenance standards

This memorandum summarizes the hearing on the above-named rule making, held on July 21, 2015 in Tumwater, WA over which I presided in your stead.

The following agency personnel were present:
Jennifer Kreitler
Andrea Philhower
Jeanette Plitt
Mandy Weeks

In attendance and testifying:

Lori Grassi, Washington State Chiropractic Association
Zach Snyder, Cambia Health Solutions
Melanie Stewart, American Massage Therapy Association/ WA Podiatric Medical Association
Waltraut Lehman, Premera

Contents of the presentations made at hearing:

Commenters were appreciative of OIC efforts to work with stakeholders to understand the intent of the rules. They also appreciated the responsiveness to concerns related to the filing of the alternative access delivery request, though issuers felt that the reporting timelines were too strict. Issuers also expressed concern that consumers would receive notice of a termination prematurely as negotiations would likely not lead to a termination. They asked for lead time to incorporate changes to provider contracts and clarification that electronic signatures are sufficient if wet signatures are unavailable. They also asked that

compensation information not be made public and for clarity regarding the number of pediatricians needed in a service area.

Providers asked for additional record keeping of prior authorizations and additional enrollee notice when all provider types are terminated from a network. They also asked for clarification regarding the reference to the every category of provider law in WAC 284-43-300 and "practitioners" in WAC 284-43-310.

The hearing was adjourned.

SIGNED this _21_ day of July , 2015

_____
[Jim Freeburg], Presiding Official