PROPOSED RULE MAKING

CR-102 (October 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: October 04, 2021
TIME: 2:30 PM

WSR 21-20-108

Agency: Office of the Insurance Commissioner

☒ **Original Notice**
☐ **Supplemental Notice to WSR _____**
☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR** 21-14-094 **; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**
☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or**
☐ **Proposal is exempt under RCW _____.**

Title of rule and other identifying information: (describe subject) Implementation of E2SHB 1477 and Consolidated Health Care Rulemaking

Insurance Commissioner Matter R 2021-16

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
Wednesday, November 10, 2021	3:30 PM	Zoom Meeting: Detailed information for attending the Zoom meeting posted on the OIC website here: https://www.insurance.wa.gov/implementation-e2shb-1477-and-consolidated-health-care-rulemaking-r-2021-16	Due to the COVID-19 public health emergency, this meeting will be held via Zoom platform.

Date of intended adoption: 11/12/21 (Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: Jane Beyer
Address: PO Box 40260, Olympia, WA 98504-0260
Email: rulescoordinator@oic.wa.gov
Fax: 360-586-3109
Other:
By (date) 11/10/21

Assistance for persons with disabilities:
Contact Melanie Watness
Phone: 360-725-7013
Fax: 360-586-2023
TTY: 360-586-0241
Email: MelanieW@oic.wa.gov
Other:
By (date) 11/10/21

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The Commissioner is adopting rules to implement E2SHB 1477 concerning access to next day appointments required in the legislation. This rule is also being used to consolidate rulemaking to ensure that rules related to recently enacted legislation that also amend WAC 284-170-280 are adopted by the OIC prior to Jan. 1, 2022. These rules will facilitate implementation of recent laws by ensuring that all affected health care entities understand their rights and obligations.

Reasons supporting proposal: The rule is amending WAC 284-170-280 to be consistent with changes in legislative requirements, to adopt reporting requirements regarding access to the next day services to ensure that enrollees are receiving these vital services for the prevention of suicide, and to address network access plan standards specific to gender affirming treatment.

Statutory authority for adoption: RCW 48.02.060, RCW 48.43.515, RCW 48.44.050, RCW 48.46.200, Chapter 302, Laws of 2021, and Chapter 280, Laws of 2021

Statute being implemented: RCW 48.43.790 and RCW 48.43.0128

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Name of proponent: (person or organization) Mike Kreidler, Insurance Commissioner

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Jane Beyer	PO Box 40260, Olympia, WA 98504-0260	360-725-7043
Implementation:	Molly Nollette	PO Box 40260, Olympia, WA 98504-0260	360-725-7000
Enforcement:	Charles Malone	PO Box 40260, Olympia, WA 98504-0260	360-725-7000

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:
Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Is a cost-benefit analysis required under RCW 34.05.328?

☐ Yes: A preliminary cost-benefit analysis may be obtained by contacting:
Name:
Address:
Phone:
Fax:

TTY:
Email:
Other:

☒ No: Please explain:

The Washington Administrative Procedure Act (APA)[1] requires that "significant legislative rules" be evaluated to determine if the probable benefits of a proposed rulemaking exceed its probable costs. Considering both quantitative and qualitative information and analysis[2]. A draft of this determination must be available at the time the filing for the rule's preproposal or CR-102. The final version of this document must be completed prior to final rule adoption and included in the rulemaking file.

Determination of exemption

The Office of the Insurance commissioner has determined that under **RCW 34.05.328(5)(b)(iii),** this rule will adopt or incorporate, one or more of the following without change; federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or items as referenced by Washington state law, national consensus codes that generally establish industry standards. The material adopted or incorporated

Rationale

E2SHB 1477 was signed into law after this most recent session. Among various requirements assigned to other agencies such as implementing the national 988 suicide prevention hotline in Washington, the bill also add a section to Title 48 that requires carriers to ensure that enrollees experiencing urgent, symptomatic behavioral health conditions have access to next day appointment. Additionally, the team is utilizing this rulemaking as the consolidate rulemaking to ensure that rules related to recently enacted legislation are adopted by the OIC prior to Jan. 1, 2022. The rule is amending WAC 284-170-280 to be consistent with these requirements and to adopt reporting requirements regarding access to the next day services to ensure that enrollees are receiving these vital services for the prevention of suicide.

Determination

OIC determines that this rule is exempt from cost benefit analysis requirements.

[1] Chapter 34.05 RCW

[2] RCW 34.05.328(1)(c)

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- ☐ RCW 34.05.310 (4)(b) (Internal government operations)
- ☐ RCW 34.05.310 (4)(c) (Incorporation by reference)
- ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
- ☐ RCW 34.05.310 (4)(e) (Dictated by statute)
- ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
- ☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☒ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(4).

Explanation of exemptions, if necessary: RCW 19.85 states that "…an agency shall prepare a small business economic impact statement: (i) If the proposed rule will impose more than minor costs on businesses in an industry …" The Small Business Economic Impact Statement (SBEIS) must include "…a brief description of the reporting, recordkeeping, and other compliance requirements of the proposed rule, and the kinds of professional services that a small business is likely to need in order to comply with such requirements… To determine whether the proposed rule will have a disproportionate cost impact on small businesses".

This rule proposal, or portions of the proposal, are exempt from requirements of the Regulatory Fairness Act under:

- **RCW 19.85.025(4)** – the businesses that must comply with the proposed rule are not small businesses, under chapter 19.85 RCW.

This rule only impacts large insurance carriers which are not classified as small business ad defined by RCW 19.85.020(2). While calculating we have applied default cost of compliance $1,000 as it is indeterminate at this time. The OIC has directly heard from stakeholders regarding questions and issues related to implementation and have revised internal processes to respond to some of these issues. OIC has determined that the compliance with the proposed rule does not put any disproportionate impact on small businesses or government agencies.

Please see below:

2019 Industry NAICS Code	Estimated Cost of Compliance	Industry Description	NAICS Code Title	Average number of employees / business	Minor Cost Estimate - 0.003% of Avg. Annual Receipts
524114	$1,000	Direct Health and Medical Insurance Carriers	Finance and insurance	**742(Not small business)**	$3,503,165

Source: United States Census Bureau, (2017). Retrieved October 24, 2021, from census.gov

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☐ No Briefly summarize the agency's analysis showing how costs were calculated. _____

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Date: October 4, 2021	**Signature:** 
Name: Mike Kreidler	
Title: Insurance Commissioner	

AMENDATORY SECTION (Amending WSR 16-14-106, filed 7/6/16, effective 8/6/16)

WAC 284-170-280 Network reports—Format. (1) An issuer must submit its provider network materials to the commissioner for approval prior to or at the time it files a newly offered health plan.

(a) For individual and small groups, the submission must occur when the issuer submits its plan under WAC 284-43-0200. For groups other than individual and small, the submission must occur when the issuer submits a new health plan and as required in this section.

(b) The commissioner may extend the time for filing for good cause shown.

(c) For plan year 2015 only, the commissioner will permit a safe harbor standard. An issuer who can not meet the submission requirements in ((~~(e) and (f) of this~~)) subsection (3)(f) and (g) of this subsection will be determined to meet the requirements of those subsections even if the submissions are incomplete, provided that the issuer:

(i) Identifies specifically each map required under subsection (3)((~~(e)~~)) (f) (i) of this section, or Access Plan component required under subsection (3)((~~(f)~~)) (g) of this section, which has not been included in whole or part;

(ii) Explains the specific reason each map or component has not been included; and

(iii) Sets forth the issuer's plan to complete the submission, including the date(s) by which each incomplete map and component will be completed and submitted.

(2) Unless indicated otherwise, the issuer's reports must be submitted electronically and completed consistent with the posted submission instructions on the commissioner's website, using the required formats.

(3) For plan years beginning January 1, 2015, an issuer must submit the following specific documents and data to the commissioner to document network access:

(a) **Provider Network Form A.** An issuer must submit a report of all participating providers by network.

(i) The Provider Network Form A must be submitted for each network being reviewed for network access. A network may be used by more than one plan.

(ii) An issuer must indicate whether a provider is an essential community provider as instructed in the commissioner's Provider Network Form A instructions.

(iii) An issuer must submit an updated, accurate Provider Network Form A on a monthly basis by the 5th of each month for each network and when a material change in the network occurs as described in subchapter B.

(iv) Filing of this data satisfies the reporting requirements of RCW 48.44.080 and the requirements of RCW 48.46.030 relating to filing of notices that describe changes in the provider network.

(b) **Provider directory certification.** An issuer must submit at the time of each Provider Network Form A submission a certification that the provider directory posted on the issuer's website is specific to each plan, accurate as of the last date of the prior month. A certification signed by an officer of the issuer must confirm that the provider directory contains only providers and facilities with which

the issuer has a signed contract that is in effect on the date of the certification.

(c) **988 Crisis Hotline Appointment Form D report.** For health plans issued or renewed on or after January 1, 2023, issuers must make next day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions to receive covered behavioral health services. Beginning on January 7, 2023, issuers must submit a weekly report that will detail their health plans' compliance with next day appointment access.

(i) The report is due each Friday except on state or federal recognized holidays and in such situations the report is due the first Monday following the holiday.

(ii) The report must contain all data items shown in and conform to the format of the 988 Crisis Hotline Appointment Form D report prescribed by and available from the commissioner.

(A) If an issuer has not received any next day appointment requests, the issuer must still utilize and submit the report to attest that no requests were received during the filing time frame.

(B) If an issuer has received request for next day appointments, the issuer's report must include, but is not limited to, data to identify the issuer's name, provider network name, service area by county, available appointments, appointments accessed, number of appointments for which the scheduling time frame was met within one day, number of appointments for which the scheduling time frame was not met within one day and an explanation for not meeting the time frame.

(iii) For purposes of this report, urgent symptomatic behavioral health condition has the same meaning as described in RCW 48.43.790 or as established by the National Suicide Hotline Designation Act of 2020 and federal communications rules adopted July 16, 2020.

(d) **Network Enrollment Form B.** The Network Enrollment Form B report provides the commissioner with an issuer's count of total covered lives for the prior year, during each month of the year, for each health plan by county.

(i) The report must be submitted for each network as a separate report. The report must contain all data items shown in and conform to the format of Network Enrollment Form B prescribed by and available from the commissioner.

(ii) An issuer must submit this report by March 31st of each year.

((~~(d)~~)) (e) **Alternate Access Delivery Request Form C.** For plan years that begin on or after January 1, 2015, alternate access delivery requests must be submitted when an issuer's network meets one or more of the criteria in WAC 284-170-200 (15)(a) through (d). Alternate access delivery requests must be submitted to the commissioner using the Alternate Access Delivery Request Form C.

(i) The Alternate Access Delivery Request Form C submission must address the following areas, and may include other additional information as requested by the commissioner:

(A) A description of the specific issues the alternate access delivery system is intended to address, accompanied by supporting data describing how the alternate access delivery system ensures that enrollees have reasonable access to sufficient providers and facilities, by number and type, for covered services;

(B) A description and schedule of cost-sharing requirements for providers that fall under the alternate access delivery system;

(C) The issuer's proposed method of noting on its provider directory how an enrollee can access provider types under the alternate access delivery system;

(D) The issuer's marketing plan to accommodate the time period that the alternate access delivery system is in effect, and specifically describe how it impacts current and future enrollment and for what period of time;

(ii) Provider Network Form A and Network Enrollment Form B submissions are required in relation to an alternate access delivery system on the basis described in subsections (1) and (2) of this section.

(iii) If a network becomes unable to meet the network access standards after approval but prior to the health product's effective date, an alternate access delivery request must include a timeline to bring the network into full compliance with this subchapter.

((~~(e)~~)) (f) **Geographic Network Reports.**

(i) The geographic mapping criteria outlined below are minimum requirements and will be considered in conjunction with the standards set forth in WAC 284-170-200 and 284-170-310. One map for each of the following provider types must be submitted:

(A) Hospital and emergency services. Map must identify provider locations, and demonstrate that each enrollee in the service area has access within thirty minutes in an urban area and sixty minutes in a rural area from either their residence or workplace to general hospital facilities including emergency services.

(B) Primary care providers. Map must demonstrate that eighty percent of the enrollees in the service area have access within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace to a primary care provider with an open practice. The provider type selected must have a license under Title 18 RCW that includes primary care services in the scope of license.

(C) Mental health and substance use disorder providers. For general mental health providers, such as licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners, the map must demonstrate that eighty percent of the enrollees in the service area have access to a mental health provider within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace. For specialty mental health providers and substance use disorder providers, the map must demonstrate that eighty percent of the enrollees have access to the following types of service provider or facility: Evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment, and behavioral therapy. If one of the types of specialty providers is not available as required above, the issuer must propose an alternate access delivery system to meet this requirement.

(D) Pediatric services. For general pediatric services, the map must demonstrate that eighty percent of the covered children in the service area have access to a pediatrician or other provider whose license under Title 18 RCW includes pediatric services in the scope of license. This access must be within thirty miles in an urban area and sixty miles in a rural area of their family or placement residence. For specialty pediatric services, the map must demonstrate that eighty percent of covered children in the service area have access to pediatric specialty care within sixty miles in an urban area and ninety miles in a rural area of their family or placement residence. The pediatric specialty types include, but are not limited to, nephrology, pulmonology, rheumatology, hematology-oncology, perinatal medicine,

neurodevelopmental disabilities, cardiology, endocrinology, and gastroenterology.

(E) Specialty services. An issuer must provide one map for the service area for specialties found on the American Board of Medical Specialties list of approved medical specialty boards. The map must demonstrate that eighty percent of the enrollees in the service area have access to an adequate number of providers and facilities in each specialty. Subspecialties are subsumed on the map.

(F) Therapy services. An issuer must provide one map that demonstrates that eighty percent of the enrollees have access to the following types of providers within thirty miles in an urban area and sixty miles in a rural area of their residence or workplace: Chiropractor, rehabilitative service providers and habilitative service providers.

(G) Home health, hospice, vision, and dental providers. An issuer must provide one map that identifies each provider or facility to which an enrollee has access in the service area for home health care, hospice, vision, and pediatric oral coverage, including allied dental professionals, dental therapists, dentists, and orthodontists.

(H) Covered pharmacy dispensing services. An issuer must provide one map that demonstrates the geographic distribution of the pharmacy dispensing services within the service area. If a pharmacy benefit manager is used by the issuer, the issuer must establish that the specifically contracted pharmacy locations within the service area are available to enrollees through the pharmacy benefit manager.

(I) Essential community providers. An issuer must provide one map that demonstrates the geographic distribution of essential community providers, by type of provider or facility, within the service area. This requirement applies only to qualified health plans as certified in RCW 43.71.065.

(ii) Each report must include the provider data points on each map, title the map as to the provider type or facility type it represents, include the network identification number the map applies to, and the name of each county included on the report.

(iii) For plan years beginning January 1, 2015, and every year thereafter, an issuer must submit reports as required in subsection (1) of this section to the commissioner for review and approval, or when an alternate access delivery request is submitted.

((~~(f)~~)) (g) **Access Plan.** An issuer must establish an access plan specific to each product that describes the issuer's strategy, policies, and procedures necessary to establishing, maintaining, and administering an adequate network.

(i) At a minimum, the issuer's policies and procedures referenced in the access plan must address:

(A) Referral of enrollees out-of-network, including criteria for determining when an out-of-network referral is required or appropriate;

(B) Copayment and coinsurance determination standards for enrollees accessing care out-of-network;

(C) Standards of accessibility expressed in terms of objectives and minimum levels below which corrective action will be taken, including the proximity of specialists and hospitals to primary care sources, and a method and process for documentation confirming that access will not result in delay detrimental to health of enrollees;

(D) Monitoring policies and procedures for compliance, including tracking and documenting network capacity and availability;

(E) Standard hours of operation, and after-hours, for prior authorization, consumer and provider assistance, and claims adjudication;

(F) Triage and screening arrangements for prior authorization requests;

(G) Prior authorization processes that enrollees must follow, including the responsibilities and scope of use of nonlicensed staff to handle enrollee calls about prior authorization;

(H) 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;

(I) Assessment of the health status of the population of enrollees or prospective enrollees, including incorporation of the findings of local public health community assessments, and standardized outcome measures, and use of the assessment data and findings to develop network or networks in the service area;

(J) For gender affirming treatment:

(I) Standards of accessibility expressed in terms of objectives and minimum levels below which corrective action will be taken, including the proximity of gender affirming treatment services to primary care sources, and a method and process for documentation confirming that access will not result in delay detrimental to health of enrollees;

(II) Monitoring policies and procedures for compliance, including tracking and documenting network capacity and availability;

(K) Notification to enrollees regarding personal health information privacy rights and restrictions, termination of a provider from the network, and maintaining continuity of care for enrollees when there is a material change in the provider network, insolvency of the issuer, or other cessation of operations;

((~~(K)~~)) (L) Issuer's process for corrective action for providers related to the provider's licensure, prior authorization, referral and access compliance. The process must include remedies to address insufficient access to appointments or services;

(M) The process for ensuring access to next day appointments for urgent, symptomatic behavioral health conditions.

(ii) An access plan applicable to each product must be submitted with every Geographic Network Report when the issuer seeks initial certification of the network, submits its annual rate filing to the commissioner for review and approval, or when an alternative access delivery request is required due to a material change in the network.

(iii) The current access plan, with all associated data sets, policies and procedures, must be made available to the commissioner upon request, and a summary of the access plan's associated procedures must be made available to the public upon request.

(4) For purposes of this section, "urban area" means:

(a) A county with a density of ninety persons per square mile; or

(b) An area within a twenty-five mile radius around an incorporated city with a population of more than thirty thousand.