OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Mike Kreidler- Insurance commissioner

As required by

The Washington State Administrative Procedures Act

Chapter 34.05 RCW

Matter No. **R 2021-16**

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

Relating to the adoption of

Implementation of E2SHB 1477 and Consolidated Health Care Rulemaking

April 8, 2022

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

Section 2: Reasons for Adopting the Rule

The Commissioner is adopting rules to implement the portions of E2SHB 1477 concerning access to next day appointments, as 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. These rules will facilitate implementation of recent laws by ensuring that all affected health care entities understand their rights and obligations.

Section 3: Rule Development Process

On July 7, 2021, the OIC filed a preproposal statement of inquiry (CR-101) to begin formal rulemaking. The CR-101 comment period was open until September 15, 2021.

The OIC released the first draft of the revised rule text on July 13, 2021, and held a meeting for interested parties on August 5, 2021.

On October 4, 2021, the OIC filed a CR-102, and the first public hearing was scheduled for November 10, 2021.

The OIC held the first public hearing on November 10, 2021. Comments on the CR-102 were also due on November 10, 2021.

The OIC released the second draft of the revised rule text on January 7, 2022.

On February 8, 2022, the OIC filed a supplemental CR-102, and the second public hearing was scheduled for March 24, 2022.

The OIC held the second public hearing on March 24, 2022. Comments on the supplemental CR-102 were also due on March 24, 2022.

Section 4: Differences Between Proposed and Final Rule

There are no differences between the proposed version that was submitted with the supplemental CR-102 and the adopted version.

Section 5: Responsiveness Summary

The OIC received comments and suggestions regarding this rule. The following information contains a summary of the comments, the OIC's response to the comments, and information about whether the OIC incorporated changes based on the comments.

Some comments were received under the proposed rule for R2021-14 (Health Insurance Discrimination and Gender Affirming Treatment) relating to proposed amendments to WAC 284-170-280. However, proposed amendments to WAC 284-170-280 were filed with the proposed rule for R2021-16 (Implementation of E2SHB 1477 and consolidated health care rulemaking) in order to consolidate rulemaking efforts. Therefore, comments and responses relating to all amendments to WAC 284-170-280 are addressed in this CES for R2021-16.

The OIC received comments from:

- Association of Washington Healthcare Plans
- Asuris Northwest Health
- BridgeSpan Health Company
- Cambia Health Solutions
- Coordinated Care Corporation
- Health Alliance
- Kaiser Permanente
- National Alliance on Mental Illness
- PacificSource Health Plans
- Premera Blue Cross
- Providence Health Plan
- Regence BlueShield
- Washington State Medical Association

Comments to the CR-101, draft rule text, CR-102 and supplemental CR-102

We urge the OIC omit the reporting requirement at this time, and to convene carriers and providers in a workgroup to arrive at a solution on how to address the requirements of RCW 48.43.790. The requirement doesn't apply until January 1, 2023. There is time to work on this collaboratively. We recommend that the OIC start with a limited scope of rulemaking that	The Commissioner appreciates the comments but declines the request to omit the reporting requirement. Due to the urgent nature of these appointments, carriers must sufficiently monitor access and report to the OIC that they are meeting this requirement.

addresses the access plan and does not include a Form D reporting requirement. It is unclear what purpose the next-day appointment data will serve. How will the OIC determine the number of next-day appointments each carrier needs to demonstrate compliance? We strongly believe carriers should be afforded the opportunity to demonstrate their plan to comply with ESHB 1477's next-day appointment availability requirement (RCW 48.43.790) before the OIC mandates an onerous and potentially costly reporting process.	The Commissioner notes that the development process for Form D will involve the opportunity for feedback from interested parties, which may include carriers and providers. The Commissioner appreciates your support of the draft rule's requirements regarding access plans. However, that requirement is in addition, rather than an alternative, to the reporting requirement. The Commissioner has revised the proposed rules so that the reporting timeframes will be set each calendar year and will be no more frequent than weekly and no less often than twice yearly. The OIC reviewed prior comments and weighed the need to receive information with the ability for carriers to produce it. Setting the filing frequency each year provides a balance between these two needs, allowing adjustment of the reporting time frame based on multiple factors, including performance in respect to making these appointments available.
Consider an annual instead of weekly reporting requirement. • We believe it is more useful to report in a way that shows trends in network access over a longer period. • While carriers and providers would still be keeping documentation on a daily basis, this would help ensure data is accurate and allow providers and carriers to work through any technical issues in the data prior to submitting it to the OIC. • This would also help to alleviate the need to hire additional staff solely for the purpose of weekly reporting to the OIC. Change the reporting frequency from weekly to quarterly. • This will ensure the OIC still obtains data necessary to ensure compliance with the underlying requirement from E2SHB 1477 but helps reduce the administrative burden on carriers and providers. • In order to provide the OIC with accurate and meaningful data on same day appointment utilization and availability, we'll need to include claims data and information received from provider and member calls and other communications. A quarterly report will allow appropriate time for claims-processing and outreach, while still balancing the need to confirm compliance. • It is unlikely that there will be enough data to provide a meaningful report every week.	The Commissioner appreciates the comments and has revised the proposed rules so that the reporting timeframes will be set each calendar year and will be no more frequent than weekly and no less often than twice yearly. This will allow the OIC to adjust the reporting time frame as appropriate, considering factors such as carrier performance in respect to making these critical appointments available. The Commissioner notes that this rulemaking is not about trending data. Rather, the Legislature required that carriers ensure appointments are obtained within 24 hours for urgent symptomatic behavioral health condition requiring immediate attention.
Without clear guidance as to the frequency in advance of the reporting period, it will be untenable to configure the report and required data streams that will need to be incorporated. We suggest OIC consider a frequency range of no more frequent than monthly, similar to reporting for Network Form A.	The Commissioner appreciates the comment but declines the request to change the frequency range to less often than weekly. The OIC reviewed prior comments and weighed the need to receive information with the ability for issuers to produce it. Setting the filing frequency each year provides a balance between these two needs, allowing adjustment of the reporting time frame based on multiple factors, including performance in respect to making these appointments available.

We are supportive of the draft rule for WAC 284-170-280. The reporting requirements included in the draft rule are an important part of promoting access to next day appointments for urgent behavioral health care and identifying any gaps to care that exist. Too often we hear from our members that they were unable to find a behavioral health care appointment in the appropriate timeframe for their needs, especially with a provider within their network and particularly in times of needing urgent care. Transparent, weekly updated reports from health plans detailing compliance with next day appointment access is a vital component to accountability and improving access to behavioral health care for the people in our state. Within these reports, it is critical to know when and why a next day appointment was not possible. Weekly reports are an appropriate cadence to monitor health plan compliance especially as inability to access an appointment quickly for urgent behavioral health can lead to devastating and harmful consequences for an individual. We also support the inclusion of establishing a process for ensuring access to next day appointment for urgent, symptomatic behavioral health in an issuer's access plan as a part of promoting network adequacy. Additionally, as implementation moves forward, we suggest that rulemaking also take appropriate steps to ensure that an individual does not get balanced billed for an urgent behavioral health appointment. It is vital that individuals who experience urgent and symptomatic behavioral health conditions have access to timely, next-day appointments that meet the needs of the individual. Connecting people to these services, especially in times of crisis, will be a critical component with the implementation of the 988 hotline and a tremendous step forward for behavioral health care for Washingtonians.	The Commissioner appreciates your support of the proposed rules. E2SHB 1688 (Chapter 263, Laws of 2022) addresses balance billing and emergency behavioral health services. This issue is not addressed in this rulemaking. The OIC will be engaging in separate rulemaking to implement E2SHB 1688.
We find the weekly reporting unattainable. Requiring a weekly report places a significant administrative burden on both providers and carriers to create new data collection, storage, and sharing processes to comply with the proposed reporting requirements. For example, health plans will need to receive timely, regular or daily reports from providers of their appointment availability and how many of those appointment openings were accessed due to an urgent, symptomatic behavioral health care crisis. Currently, providers are not reliably providing data to us that inform health plans if their panel is open. It also presents a high potential for inaccurate data submission. For carriers to provide weekly reports, behavioral health providers must provide reports of who they see that fits into the next day appointment definition, when they were contacted and when they were seen. Carriers will each have different ways to approach compliance and obtain data, so providers will be confused. This adds a material administrative burden on providers that may result in them leaving the network or limiting their practices, restricting access to services for enrollees. Many will not comply – resulting in a difficult decision for carriers: terminate the provider and further limit member access to behavioral health or be out of compliance with the insurance regulation. Neither outcome serves our enrollees, or our network providers. Conduct an additional stakeholder meeting to discuss the challenges of the proposed reporting requirement. The administrative burden placed not only on carriers, but behavioral health providers who will need to report their appointment availability to potentially multiple parties will be extremely	The Commissioner notes that RCW 48.43.790, by its terms, may impose a new burden on both providers and carriers to create new data collection, storage and sharing processes to comply with the proposed reporting requirements. The proposed rules define the mechanism for OIC to monitor compliance. Given that the next day appointment requirement is not effective until January 1, 2023, there is an opportunity for carriers to work with their contracted behavioral health providers to establish these processes. In addition, the Commissioner has revised the proposed rules to remove the specific data points to be included in the reporting. These will instead be determined during the development of Form D, which will involve the opportunity for feedback from interested parties, which may include carriers and providers. And the Commissioner has revised the proposed rules so that the reporting timeframes will be set each calendar year and will be no more frequent than weekly and no less often than twice yearly. The OIC reviewed prior comments and weighed the need to receive

burdensome. Many behavioral health providers are solo practices with little or no administrative staff. Adding this additional burden on providers to procure data needed for reporting will worsen the workforce shortage issues that remain a barrier since the pandemic. We believe a meeting that included at least the two entities responsible for providing and reporting the data would assist in the work of pre-empting confusing definitions, operational constraints and help inform development of the 988 Crisis Hotline Appointment Form D. We are concerned about the administrative burden for small practices to set up the data sharing for this reporting. Even provider network information is difficult for carriers to keep updated, since that information is also provider-owned data. There are lots of difficulties and resources needed for this, especially with shorter reporting periods. We are confused about how often carriers must report and concerned about pass-through of administrative burden on practices that may or may not be impacted. Would appreciate if these rules could be made as least administratively burdensome as possible.	information with the ability for issuers to produce it. Setting the filing frequency each year provides a balance between these two needs, allowing adjustment of the reporting time frame based on multiple factors, including performance in respect to making these appointments available.
It is important to note that, regardless of the reporting frequency, carriers are still required to meet the next day appointment requirement. Carriers are also still obligated to file an alternate access delivery request if their networks are not able to meet the access requirements.	The Commissioner appreciates your comment but notes there is no alternative access delivery request (AADR) process available to meet the requirements of this bill/statute.
We note that the underlying legislation does not actually require the OIC to receive reports from health carriers on access to appointments after a patient calls the crisis line.	The Commissioner notes that, during the legislative process, the OIC provided details to the Legislature about how the OIC would ensure these requirements were met, including the requirements of this rulemaking, and submitted a fiscal note, which identified the monitoring to be conducted by the OIC.
Most behavioral health provider practices are not set up for next day appointment availability. The regulation appears to assume that carriers will require providers to have next day availability. Holding appointments open is expensive to a practice, and unless the carrier sets up a referral service for crisis appointments with select providers who we compensate for those open appointments, we cannot ask that of providers. In addition, that solution would create a tier in the network just for these behavioral health next day providers, which isn't currently allowed under the OIC network regulations. If providers block time for potential visits and no patients utilize that time, an available appointment has been taken away from patients. This reduces access, which is not the legislative goal. The aspirational design of the legislation does not align with workforce realities. Even if national telehealth service vendors are available to provide enhanced access for next day services, the continuity of care an enrollee with urgent symptomatic behavioral health needs will not be well served by defaulting to that as a solution even if it is compliant.	The Commissioner appreciates the comments. However, the legislative goals and content of the statutory requirements are outside the scope of this rulemaking, which is instead focused on ensuring compliance with the statutory requirements.
We would appreciate clarification regarding to whom these rules apply.	The Commissioner appreciates the comment. These rules apply to issuers of health plans, who must demonstrate their compliance in making these appointments available to their enrollees. However, issuers may need to work with their contracted behavioral health providers to establish processes for obtaining data for these reports.

Carriers may not be able to comply with the data elements required in the weekly reporting. Specifically, we do not have access to the number of available appointments, the number of appointments where the scheduling timeframe was met within one day, and the number of appointments where the scheduling timeframe was not met within one day. We would be completely reliant on providers to share this data with us and to do so in a timely manner. A health plan will not know if a member calls a provider directly to request a next-day appointment, and we will not know when a member was unable to get an appointment within one day unless the member contacts us with that information. The draft regulation has a detailed list of data elements. These data elements are not the most meaningful data elements to understand access to services. Instead of the data elements called out in the draft regulation, we recommend the following data elements: - Masked patient identifier. - Date of outreach to patient. - Follow-up visit within one day (Y/N) - A category field to cover "If 'N', why?". This could be a free text comment field or include categories to select from, such as "patient did not return call." How will the OIC use the report? A network report is typically used to monitor networks, but this report includes a requirement to make and justify not meeting the next day standard. There is not a safe harbor for best efforts, workforce refusal, or other mitigating circumstances. If the reporting requirement remains in the rule, we urge the OIC to remove the required reporting field mandating an explanation of why the next day appointment standard wasn't met, and instead to rely on market conduct review to identify non-compliance. Chapter 284 WAC is replete with examples of the Commissioner's right to request and receive information from carriers; a similar standard could be applied here that is less burdensome administratively and achieves the same result. OIC's proposed addition of subsection (3)(c)(iii) reflects the importance of ensuring a robust Stakeholder process as you develop the 988 Crisis Hotline Appointment Form D. We look forward to participating in a process to ensure data elements requested in the report can be collected in a manner that best serves all the parties who will use the data to assess efficacy and needed improvements to our behavioral health system. To that end, we recommend limiting the potential scope of inputs to sources that can be externally validated by the OIC.	The Commissioner appreciates the comments and concerns. The Commissioner understands that carriers have not tracked this data to date, as this is a new statutory requirement. The Commissioner has revised the proposed rules to remove the specific data points to be included in the reporting. The OIC will engage with interested parties, which may include carriers and providers, to identify the data elements that are needed on Form D for regulatory purposes in order to demonstrate compliance with RCW 48.43.790. As this report will be available to the public, it will be designed to ensure enrollee privacy protections are met.
We appreciate the approach in the regulation to move specific data components out of the regulation so that the reporting can align with the data elements that will be available to carriers after the program has been implemented.	The Commissioner appreciates the comment.
Limit the reporting to instances when a member directly contacts their health plan for help scheduling a next-day appointment. We support ensuring there is a process to help members who are struggling to find a behavioral health service appointment; however, carriers do not have visibility when a member calls the 988 crisis hotline or when they contact a health care provider about an appointment.	The Commissioner expects carriers to use information available to them from any sources in order to complete the reporting. The rules have been revised to reflect this expectation.
Suggested revision to WAC 284-170-280 (3)(c)(iii): "The report must reflect information from ~~any~~ sources available at the time the reporting is completed including, but not limited to:"	The Commissioner appreciates the comment but declines the requested revision. This item was added to help address prior comments indicating concerns regarding carriers' access to the data needed to complete reporting. The intention is for carriers to use whatever sources of this information are available to them at the

	time of the reporting in order to help ensure that the reported data is as complete as possible.
We respectfully urge the OIC to share the 988 Crisis Hotline Appointment Form D referenced in WAC 284-43-270(3)(c)(ii) with carriers as soon as possible to allow time to implement a supporting data process and infrastructure to comply with the reporting requirements. As the OIC works to develop these technical reporting requirements, we encourage the OIC to circulate stakeholder drafts for feedback, as well as hold stakeholder meetings to allow technical data experts from the carriers to discuss the instructions and raise any questions.	The Commissioner appreciates the comments. The Rates, Forms and Provider Networks division of the OIC will implement Form D and will use their standard process to engage interested parties for their feedback.
988 has yet to be operationalized. Therefore, reporting should only occur 6 months post "go-live" in any region—giving the providers and carriers time to monitor the new process of 988 without any undue burden of data reporting. To properly configure the report and required data streams, carriers will need at a minimum six months to configure once the template is received. For context, Network Form A reporting infrastructure has taken over one year to configure and requires continual monthly validation. Suggested revisions to WAC 284-170-280 (3)(c): "Beginning ~~January 7, 2023~~, no sooner than six months following the effective date of this rule and finalization of the reporting data elements.~~,~~ issuers must submit a report that will document their health plans' compliance with next day appointment access~~. including a count of enrollee appointments available for urgent, symptomatic behavioral health care services.~~"	The Commissioner appreciates the comment but declines the request to postpone the reporting effective date. Due to the urgent and critical nature of these appointments, carriers must start monitoring access as of the 1/1/23 effective date for plan compliance, as per RCW 48.43.790, and report to the OIC that they are meeting this requirement.
Remove "a count of enrollee appointments available for urgent, symptomatic behavioral health services." This data element of number of available appointments does not align with how services are currently provided and would therefore be a challenging data element for medical practices to report on to health carriers. Physicians and medical practices will often use the technique of scheduling patients with urgent needs into time slots that otherwise look booked and then see those patients on top of their normally scheduled caseload for the day. They do not actually hold appointment time slots open on the off chance that patients will ask to book those times. We recommend instead focusing on how carriers handled the requests they received. Remove the requirement to report the number of next-day appointments available. We believe compliance with the next-day appointment availability requirement can be demonstrated by reporting the number of member requests a carrier receives for next-day appointments and how many of those requests resulted in appointments scheduled within the required timeframe. Reporting the number of next-day appointments available across our networks will not demonstrate whether members are struggling to access appointments. It would be difficult for the OIC to determine what number of open appointments are required to demonstrate adequate access. If a carrier is not meeting the next-day timeframe when a member contacts them for assistance scheduling an appointment, further investigation into network adequacy could be conducted. Carriers will be wholly reliant on providers to share their appointment availability, without guarantee that providers are capable of fulfilling the request. This requirement will place a significant administrative burden on carriers as well as behavioral health providers who will need to report their appointment availability to multiple carriers. Washington, like the entire country, is experiencing a shortage of behavioral health providers, and many behavioral health providers are solo practices with little or no	The Commissioner appreciates the comments but declines the request. The Commissioner understands collecting this information may be challenging, but the number of available appointments is a key element to understanding if enrollees can actually receive services when they need urgent care in compliance with the law.

administrative staff. Placing this responsibility on behavioral health providers could worsen the burden on an already strained workforce.	
We believe the draft rule implies a carrier requirement to schedule these next day appointments for our members, which is not how we interpret E2SHB 1477. E2SHB 1477 does not require health plans to schedule the appointments, for good cause. We do not have access to provider scheduling systems and provider appointment availability is not shared with health plans on a real-time basis. We believe it is the role of the health plan to create robust provider networks and provide access to covered services for our members, and it is the role of the provider to manage and schedule the appointments.	The Commissioner appreciates the comments but notes that the proposed rule does not reference a requirement for health plans or carriers to schedule these appointments. The Commissioner utilized the statutory language of the bill when detailing carrier requirements, such as "Health plans issued or renewed on or after January 1, 2023, must make next-day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions to receive covered behavioral health services." The Commissioner agrees that carriers must have robust networks that ensure that enrollees with urgent symptomatic behavioral health conditions have access to next day appointments. While the requirement to create robust provider networks has been in place since 2015, E2SHB 1477 includes a new requirement unique to access to behavioral health services that is in addition to long held requirements related to network access.
Is the member or provider required to make a next day appointment?	Either the member or provider may make next day appointments. This rulemaking addresses the issuer's obligation to make next day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions.
Ensure there are exceptions to carrier responsibility to meet the next-day appointment timeframe. For instance, carriers cannot control whether a member follows through and goes to a scheduled appointment; carriers cannot control whether a member agrees to see a provider who has next-day appointment availability; and carriers should not be penalized if a provider cancels a scheduled appointment. Carriers may not know if a member attended an appointment until after they receive the claim.	The Commissioner notes that the carrier's obligation is to make next day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions, and that availability is what will be reflected in the reporting. The rules do not indicate that carriers are responsible to ensure that a member actually goes to a scheduled appointment or agrees to see a provider who has next-day appointment availability, or that a provider does not cancel a scheduled appointment.
Can the next day appointment be virtual?	Yes, the statute allows for telemedicine appointments, consistent with RCW 48.43.735.
Please define urgent and symptomatic.	The term "urgent symptomatic behavioral health condition" is now defined under WAC 284-170-280(3)(c)(iv).

The rules do not clarify the statute. They do not specify how a carrier is to make an appointment available, or even what constitutes 'next-day' (business day or calendar day, within 24 hours? Within business hours?). What does 'available' mean for purposes of compliance? Is a carrier required to act affirmatively to make the appointment available, or is making telehealth services, their network providers and referrals to local crisis stabilization centers sufficient to comply? The rules do not answer these questions. Instead, the OIC proposes weekly reporting of the number of 'requests' received, and when members were seen. Nothing requires a carrier to set up a 'request' based system for making next day appointments available.	The Commissioner appreciates the comments. However, defining these terms is outside the scope of this rulemaking. The data points for the reporting will be determined during the development of Form D, which will involve the opportunity for feedback from interested parties. Carriers may have access to the behavioral health crisis call center system platform and/or the behavioral health integrated client referral system once those are established as required by the bill.
We thank the OIC for recognizing that work is still being done to establish the behavioral health crisis call center system platform and the behavioral health integrated client referral system and removing components in the regulation of unknown data fields until more information is known. We recognize that as the state program is more fully implemented, the types of data available may change. For future updates to reporting requirements, we recommend that the OIC allow ample time for all parties to make the necessary changes and report the new components.	The Commissioner appreciates the comments.
Revise or remove the network access requirements related to gender affirming treatment. • Significant barriers exist that will prevent carriers from complying with the proposed geographic network report and access plan requirements. • There is a lack of providers who offer gender affirming treatment in Washington. Neither the underlying legislation nor this draft regulation address the provider shortages, and placing network access requirements on carriers will not create new providers willing to perform these services. • This reporting is not feasible for gender affirming treatment, since it is not a provider type, specialty type or license, and carriers do not contract with providers at this service-level. • Some providers may not want to publicly disclose that they provide these services, and they don't have an affirmative duty to do so. • Carriers do not have complete data to meet these requirements. • Carriers are already required to comply with network adequacy requirements, and 2SSB 5313 did not mandate or contemplate new network access standards specific to gender affirming treatment. • No other subset of medical services is currently required to have separate network access standards described in the access plan. • The list of map criteria contains more points of information than can be displayed on a single map. • Section 3 of the law authorizes the Commissioner's rulemaking to implement sections (3), (4) and (5) of (3) of the bill, but those sections do not authorize a new geographic mapping requirement specifically for gender affirming treatment. • Sec. [(3)] requires carriers to comply with network access requirements in general but does not state the Commissioner must develop new network reporting or access standards for gender affirming treatment and services. Without a specific definition of the provider types or programs to map, this requirement is difficult to implement and will result in wildly differing submissions as each carrier interprets this differently without more specific guidance. Recommendations: ○ The information be gathered through a data call. ○ Carriers should be able to use their claims history to provide information regarding which contract providers have performed gender affirming health care services. ○ Carriers may be able to create a map with provider types that could offer	The Commissioner has removed the proposed addition to the geographic network reports requirements. However, the Commissioner expects that carriers should be able to meet the appropriate standards of accessibility for gender affirming treatment that are required in WAC 284-170-200 and demonstrate this through reporting requirements in WAC 284-170-280. Thus, the rule has retained the proposed addition to the access plan requirements. As indicated under RCW 48.43.515 and reflected in Sec. 3 (3)(d) of 2SSB 5313, the Commissioner has authority to adopt rules regarding access to health services. The Commissioner notes that the access plan does not include information about any specific provider, and there is no public disclosure within it. Rather, it is solely for the carrier to describe what they are going to do and how they are going to monitor access. The carrier has a duty to provide access to these services in-network and does need to have a plan for that.

gender affirming treatment within their license scope. ○ Revise (3)(f)(i)(J) to: "An issuer must provide one map that identifies each provider or facility to which an enrollee has access in the service area for gender affirming treatment~~, including what gender affirming treatment services are provided by each provider and facility~~." ○ Gender affirming treatment services should be subject to the same level of detail in the access plan as any other medical service. If carriers determine that a gap exists for any medical service (including gender affirming treatment), the Form C requirements for an alternate access delivery request will apply. ○ Consider the impact this rule will have on carriers and providers, and ensure the industry has more time to implement. ○ In order to identify providers, carriers could: ▪ review claims for gender affirming treatment services, but this is very time consuming and adds cost to network administration that will not provide accurate information. ▪ issue a survey of all provider types whose license has gender affirming treatment and services within scope, but survey responses are never 100%, and the information will be based on best effort, not actual accuracy in terms of assessing access.	
We question whether this addition to the network reporting requirements supports effective oversight of access to services for transgender enrollees and ask the OIC to remove the requirement or in the alternative, require carriers to note in the provider directory if a provider has identified themselves as offering gender affirming treatment or services. The OIC's decision to require network access reporting based on specific types of services rather than provider licensure is a material departure from the current structure of its network access regulations. An agency decision that is the product of "illogical" or inconsistent reasoning that fails to consider "less restrictive, yet easily administered" regulatory alternatives may be determined to be arbitrary and capricious, which is not permitted under the Administrative Procedures Act. Petroleum Commc'ns, Inc. v. FCC, 22 F.3d 1164, 1172 (D.C. Cir. 1994); RCW 34.05.570.	The Commissioner has removed the proposed addition to the geographic network reports requirements. However, the Commissioner expects that carriers should be able to meet the appropriate standards of accessibility for gender affirming treatment that are required in WAC 284-170-200 and demonstrate this through reporting requirements in WAC 284-170-280. Thus, the rule has retained the proposed addition to the access plan requirements. As indicated under RCW 48.43.515 and reflected in Sec. 3 (3)(d) of 2SSB 5313, the Commissioner has authority to adopt rules regarding access to health services. The reporting requirements do involve more than the alternative suggested here, but they are not unduly burdensome and are aligned with the goal of accessibility that the bill intended to address.
The last part of the proposed requirement for gender affirming treatment asks carriers to establish processes to ensure that delay in access is not detrimental to the health of enrollees. This asks carriers to create a process to prove a negative using an undefined standard of what is 'detrimental'. The answer to whether something is detrimental can vary depending on whose perspective is applied and the standards applied. We ask OIC to consider removing this requirement or restating it so that carriers aren't required to prove a negative.	The Commissioner appreciates the comment and expects that this requirement should be addressed similarly to the equivalently worded requirement that already exists in relation to the network access plans more generally (e.g., for primary care, specialists and hospitals), as indicated under WAC 284-170-280(3)(g)(i)(C).

Section 6: Implementation Plan

A. Implementation and enforcement of the rule.

The OIC intends to implement the rule through the Rates, Forms and Provider Networks Division and enforce the rule through the Legal Affairs Division. OIC

staff will continue to work with the carriers and interested parties with the requirements of the rule.

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

After the agency files the permanent rule and adopts it with the Office of the Code Reviser:

- Policy and Legislation Division staff will distribute the final rule and the Concise Explanatory Statement (CES) to all interested parties by posting and sharing the documents through the OIC's standard rule making listserv.
- The Rules Coordinator will post the CR-103 documents on the OIC's website.
- OIC staff will address questions as follows:

Type of Inquiry	Division
Consumer assistance	Consumer Protection
Rule content	Policy and Legislation
Authority for rules	Policy and Legislation
Enforcement of rule	Legal Affairs
Market Compliance	Rates, Forms and Provider Networks; Company Supervision

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

- Policy and Legislation Division staff will distribute the final rule and the Concise Explanatory Statement (CES) to all interested parties by posting and sharing the documents through the OIC's standard rule making listserv.
- The Rules Coordinator will post the CR-103 documents on the OIC's website.

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

The Rates, Forms and Provider Networks Division will solicit and monitor carrier submissions to ensure all carriers have met the reporting and provider directory requirements as applicable.

Appendix A

CR-102 Hearing Summary

Summarizing Memorandum

To: Mike Kreidler
Insurance Commissioner

From: Shari Maier
Presiding Official, Hearing on Rule-making

Matter No. R 2021-16

Topic of Rule-making: Implementation of E2SHB 1477 and Consolidated Health Care Rulemaking

This memorandum summarizes the hearing on the above-named rule making, held on November 10, 2021, in Olympia, Washington via a virtual meeting over which I presided in your stead. The hearing began at 3:34 p.m.

The following agency personnel were present: Jennifer Kreitler, Paul DuBois, Deanna Ogo, Jane Beyer and Savanna Cavalletto.

In attendance:
Amy Do
Elizabeth Abekah
Eric Lohnes
Frankie Kaiser
Gretchen Gillis
Inna Liu
Jane Douthit
Katherine Seibel
Katherine Therrien
Meg Jones
Melanie Anderson
Merlene Converse
Sarah Pettey
Shelby Wiedmann
Skyler Mahjoubian
Terri Drexler
Thalia Cronin

Contents of the presentations made at hearing:

Merlene Converse, representing Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and Kaiser Foundation Health Plan of Washington Options, Inc., testified with concerns regarding the administrative burdens to carriers, providers, and the OIC for the weekly reporting requirement and suggested reporting on a quarterly cycle instead.

Skyler Mahjoubian, representing Premera Blue Cross and LifeWise Health Plan of Washington, testified that they would like to request a change in the reporting frequency from weekly to quarterly. They indicated that carriers don't have real time access to provider schedules or visibility when a member contacts the crisis hotline and that they would want to include in their reporting claims data and information from provider and member communications.

Jane Douthit, representing Regence BlueShield, testified that they have concerns regarding the weekly reporting requirement and reporting the numbers of next day appointments available. They indicated that they would like to work with the OIC on data that is accessible to them. They indicated they would like to know what the OIC will do with the information regarding the number of next day appointments that are available and how this will be used to determine whether members are struggling to obtain these appointments. They recommend removing that data element, noting that their annual filing requires that they outline their process for access to these appointments, which they feel is reasonable and appropriate. They indicated they are concerned about the administrative time and costs associated with these requirements, with particular concerned regarding the impacts on smaller providers, and noted that this would require increased data sharing with providers.

Sarah Pettey, representing Providence Health Plan, testified that they support changing the weekly reporting requirement to quarterly, noting concern of undue burden. They noted that certain data elements will be difficult to collect, giving the example that they may not know if a patient attended an appointment until they receive a claim. They also indicated that scheduling usually is not done through issuers and requested that the reporting requirement be changed to apply only for individuals who request appointments through the issuer.

The hearing was adjourned.

SIGNED this 8th day of April 2022

s/
Shari Maier, Presiding Official

Appendix B

Supplemental CR-102 Hearing Summary

Summarizing Memorandum

To: Mike Kreidler
Insurance Commissioner

From: Shari Maier
Presiding Official, Hearing on Rule-making

Matter No. R 2021-16

Topic of Rule-making: Implementation of E2SHB 1477 and Consolidated Health Care Rulemaking

This memorandum summarizes the hearing on the above-named rule making, held on March 24, 2022, in Olympia, Washington via a virtual meeting over which I presided in your stead. The hearing began at 10:04 a.m.

The following agency personnel were present: Jennifer Kreitler, Deanna Ogo, Andy Swokowski, and Savanna Cavalletto.

In attendance:
Carolina Mata-Felix
Cassie Stokes
Colton Erickson
Debbie Johnson
Denyse Bayer
Jane Douthit
Jeb Shepard
Joanne Najdzin
Katherine Therrien
Kevin Smith
Melanie Anderson
Merlene Converse
Sara Hilliard
Sherleen Satushek
Skyler Mahjoubian
Stephanie Krier
Sven Gosnell
Terri Drexler
Zach Smith

Contents of the presentations made at hearing:

Jeb Shepard, representing the Washington State Medical Association, testified that they are confused about how often carriers must report and concerned about pass-through of administrative burden on practices that may or may not be impacted. They indicated that they would appreciate clarification regarding to whom this applies and if the OIC could make the requirements as least administratively burdensome as possible.

Jane Douthit, representing Regence Blue Shield, testified that they are still concerned about reporting regarding the number of appointments available. They noted that this data belongs to providers and they are concerned as to whether providers will have bandwidth and ability to provide this information on a regular basis. They also noted concern about the administrative burden for small practices in particular to set up this data sharing, especially given the challenges with maintaining current provider network information. They indicated that they support the access plan requirement but would prefer if the OIC allowed carriers to determine how best to work with providers to comply with the requirement and demonstrate their compliance through that filing process before implementation of additional, costly, on-going reporting. They requested that the OIC make the Form D available as soon as possible for their input, as it will take them substantial time to prepare for this reporting.

The hearing was adjourned.

SIGNED this 8th day of April 2022

s/
Shari Maier, Presiding Official