June 3, 2022

Jane Beyer, Senior Health Policy Advisor
Washington Office of the Insurance Commissioner
P.O. Box 40258
Olympia, WA 98504-0258
Submitted via email to: rulescoordinator@oic.wa.gov

Re: Comments on CR-101 for the Implementation of E2SHB 1688 (R 2022-02)

Dear Ms. Beyer,

On behalf of the Association of Washington Healthcare Plans (AWHP), thank you for the opportunity to provide input regarding the notice to start rulemaking to implement E2SHB 1688. We understand the intent of this rulemaking is to revise the Balance Billing Protection Act rules and OIC network access rules to be consistent with the new law. With that in mind, we would like to offer the following comments for your consideration as you draft regulations.

E2SHB 1688 Section 18 –

Sec. 18(2)(b)(i) states that a carrier may ask the Commissioner to amend an existing alternate access delivery request (AADR) "at least three months after the effective date" of the AADR. We suggest the OIC's regulations clearly define the effective date of an AADR after it is submitted the OIC. It is important for both carriers and providers to understand when the three month time-period officially begins.

Sec. 18(2)(a)(ii) and Sec. 18(2)(b)(i) requires carriers to provide substantial evidence of good faith efforts on its part to contract with providers or facilities. We recommend the regulation define "substantial good faith contracting efforts" or further clarify what the OIC will expect as evidence when a carrier initially submits an AADR for approval or when a carrier submits a request to amend an AADR to use the dispute resolution process.

Sec. 18(3) states the OIC will require provider networks include a "sufficient number" of behavioral health emergency services providers "beginning January 1, 2023." First, we recommend the OIC clarify what constitutes a "sufficient number" of contracted behavioral health emergency services providers. The statutory language is ambiguous, and carriers and providers would benefit from understanding what standard the OIC will expect health plans to meet. Second, it is unclear from the bill language whether the OIC will expect plan year 2023 provider networks to be compliant with this requirement, or whether the OIC will apply this requirement to filings received after January 1, 2023. We believe the intent of this provision was to provide carriers additional time to add behavioral health emergency service providers to their

networks. Therefore, the rule language should clarify that the requirement in Sec. 18(3) will be applied to provider network filings received by the OIC on or after January 1, 2023.

WAC 284-170 Network Access Rules –

Recently, there has been confusion in the industry around referencing coinsurance in an AADR. Many carriers were told coinsurance may not be applied for any services that are subject to an AADR. Unfortunately, the current rule language in WAC 284-170-210 is silent regarding co-insurance and only states the copayments and deductibles must apply to alternate access delivery systems at the same level they are applied to in-network services. We understand carriers have an obligation to meet network adequacy and when that is not possible, to ensure members have access to covered services at no greater cost than if they received those services from a network provider or facility though an AADR. However, we do not believe that means coinsurance should be prohibited in an AADR. If a carrier does pay billed charges to a provider under an AADR, we agree coinsurance cannot be based on that out-of-network rate. However, if a carrier can negotiate a single case agreement (SCA) with a provider, that is considered a participating contract that must be filed with the OIC. In that instance, we believe it is appropriate to apply any in-network cost-sharing, which may include coinsurance. Additionally, changes to RCW 48.49.030 in Sec. (8) of E2SHB 1688 appear to anticipate and allow application of all in-network cost sharing, and that the calculation of the cost sharing must be based on the qualified payment amount (NSA calculation method). This protects the member from being subjected to a coinsurance based on a provider's billed charge reimbursement. It is detrimental to the cost of health care if carriers are required to waive coinsurance for all service and circumstances under an AADR. We believe the OIC should take this rulemaking opportunity to clarify the requirements for coinsurance in AADRs.

Additionally, WAC 284-170-210 would benefit from clarification regarding the use of SCAs in relation to AADRs. SCAs help contain health care costs and are an important tool to facilitate ongoing negotiations between a provider and a carrier toward a network agreement. AWHP has received feedback from some member plans that SCAs cannot be mentioned or referenced in an AADR. However, we believe the OIC should encourage continued good faith negotiations throughout the process, regardless of whether an AADR is in place. We agree a SCA cannot be used to demonstrate network adequacy or be relied on solely in an AADR, however, we request the OIC clarify in regulation that a carrier is not prohibited from negotiating an SCA with a provider for services under an AADR.

Post-Emergency Stabilization Services and Reimbursement

We request that the OIC provide guidance regarding the criteria for determining when a patient has transitioned from pre-stabilization due to a medical or behavioral health emergency to a point when they are stabilized but remain hospitalized at a non-network facility for medically necessary post-stabilization treatment. This transition is complicated by the fact that the facility and provider reimbursement post-stabilization will be determined under the federal standards instead of the state standards.

Because of the difference in the reimbursement methodology, it will be necessary to determine when the point of stabilization has occurred to trigger the change. It is anticipated that without clear guidance, this could result in confusion and disputes between providers/facilities and carriers.

It is also requested that the rules clarify whether an issuer would be permitted to transfer the stabilized patient from a non-participating facility to a participating facility post-stabilization, and what would happen if the patient refused the transfer.

We appreciate your consideration of our comments and our continued collaboration with the OIC as this effort continues to evolve. Please do not hesitate to contact me with any questions or to discuss.

Sincerely,

Chris Bandoli
Executive Director
AWHP