AWHP
ASSOCIATION OF WASHINGTON
HEALTHCARE PLANS

August 12, 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 pre-publication draft 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 participate in a stakeholder process regarding implementation of E2SHB 1688. We appreciate your consideration of our previous comments on the CR-101 for this rulemaking, and we would like to offer the following additional comments for your consideration on the pre-publication draft of the rules.

Out-of-Network Claims Payment and Dispute Resolution

WAC 284-43B-030 and WAC 284-43B-032 in the draft stipulate that until July 1, 2023, or a later date determined by the Commissioner, the commercially reasonable amount payment standard and state arbitration process remain in effect. Like the rules governing individual and small group health plan filings, we strongly recommend the OIC set a deadline in rule by which the Commissioner will announce and post if a new date is determined for transitioning over to the federal No Surprises Act (NSA) out-of-network payment standard and independent dispute resolution (IDR) process. Carriers will need time to prepare filings, systems, and processes to switch from the state requirements to the federal requirements. We request a deadline of March 31, 2023, for the Commissioner to communicate the new date or affirm July 1, 2023.

WAC 284-43B-035(1)(b) states that "…the commissioner's review does not include a review of whether particular claims included in the request are subject to chapter 48.49 RCW or whether claims are appropriately bundled under subsection (3) of this section. A party seeking to challenge whether a claim is subject to chapter 48.49 RCW or whether claims are appropriately bundled may raise those issues during arbitration." We understand this is generally the OIC's current practice, however, we recommend the OIC consider the impact this approach may have to the cost of healthcare. We anticipate charges from arbitrators to decide whether arbitration requests are within the scope of the state's balance billing protections and/or following claim bundling requirements. Arbitration is costly and time consuming, therefore, we believe the dispute resolution process would greatly benefit from the OIC conducting this preliminary review of arbitration requests.

WAC 284-43B-035(5)(a) requires the OIC to provide both parties a list of four individual arbitrators and one arbitration entity to review as part of the arbitrator selection process. We recommend that all arbitrators be listed individually and not at the entity-level. A single arbitration entity may have many individual arbitrators. This approach will help ensure all potential arbitrators are equally considered during the selection process.

Alternate Access Delivery Requests

WAC 284-170-210(2)(b) outlines the requirements for carriers to submit evidence of good faith efforts to contract with providers. Those requirements include confirmation from a carrier that "appropriate staff" of the provider were contacted. We are concerned "appropriate staff" is vague and recommend that either further detail is provided surrounding this requirement or the requirement is removed from the rules.

WAC 284-170-210 (2)(c) states that an alternate access delivery request (AADR) may be approved for the earlier of: one health plan year, one calendar year, or until a provider contract is executed. Subsection (5) states that an approved AADR expires on the earlier of: December 31 of the year the request was approved, or the date a provider contract is executed. As currently written, WAC 284-170-210(2)(c) and WAC 284-170-210(5) appear to conflict. We recommend revising the language in those subsections to clarify the termination date for approved AADRs.

WAC 284-170-220(1)(d) states that an amended AADR terminates on December 31st of the plan year. Not all health plans use the calendar year for plan years. It is common in the large group market to use plan years that begin and end mid-year. For that reason, we recommend the language in this subsection be revised as follows:

> "(d) The Amended Alternate Access Delivery Request terminates on ~~December 31~~ **the last day** of the plan year."

We appreciate your consideration of our comments and the continued stakeholder process as this rulemaking evolves. Please do not hesitate to contact me with any questions or to discuss.

Sincerely,

Chris Bandoli
Executive Director