Washington
State
Hospital
Association

December 20, 2013

The Honorable Mike Kreidler, Commissioner
Washington State Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255

Submitted by e-mail 12/20/13

Dear Commissioner Kreidler:

Thank you for sharing with us the stakeholder exposure draft of the updated network adequacy rules. We very much appreciate the opportunity to comment on how these draft rules would affect access to health care in the 98 hospitals across the state of Washington. Our comments in the attached document represent our preliminary analysis of the stakeholder draft. We are continuing to review the draft and consult with our members, and we may have additional comments in the future.

We are very pleased the OIC is updating the network adequacy standards. We know this is an enormous undertaking, and we applaud your commitment to this task. In order to make commercial insurance meaningful, consumers need reasonable access to care. We are very pleased the OIC included provisions on spot contracting, tiered provider networks, balance billing, subcontracted networks, essential community providers, and mental health. Although we were also very pleased to see specific distance requirements and appointment standards for access to primary care and specialty care, there appears to be no requirement for access to acute care. We are requesting this problem be remedied by the inclusion of the Medicaid managed care standard for access to acute care. We are also requesting this standard apply regardless of the population of the county, as it does for Medicaid.

We are also concerned that the stakeholder draft makes it far too easy for an issuer to avoid the rule's network adequacy requirements, including the essential community provider requirements, by claiming the facility or provider refused to contract. The issuer should bear the burden of proving, by clear and convincing evidence, that the facility or provider refused to contract, and the facility or provider should be given the opportunity to present its own evidence to the OIC about the contract negotiation process. This way, an issuer will not be able to avoid the network adequacy standards by making the unilateral claim the provider or facility refused to contract. If an issuer satisfies its burden and is allowed to present an alternate network standard, there should also be specific criteria in the rule with which to judge whether the network is adequate.

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Again, thank you for your commitment to this effort. We look forward to continuing to work together to ensure reasonable access to care. If you have any questions about our suggestions, please contact Barbara Gorham at 206-216-2512 or BarbaraG@wsha.org.

Sincerely,

Claudia Sanders

Barbara Gorham

Claudia Sanders
Senior Vice President
Policy Development

Barbara Gorham
Policy Director, Access

Attachment

Outline of Issues in the OIC Stakeholder Draft of Network Adequacy Rules
Washington State Hospital Association – December 20, 2013

We present our comments in two categories: 1) a list of the significant issues we see in the stakeholder draft with comments and, where warranted, some suggested solutions; and 2) a list of smaller changes we believe will improve the stakeholder draft.

Significant Issues:

Standards for Network Adequacy (pages 42-49): The rule lists the factors the Office of the Insurance Commissioner (OIC) will consider when determining whether an issuer's network is adequate. We applaud the OIC for including specific distance requirements and appointment standards for access to primary care and specialty care. Unfortunately, the stakeholder draft does not contain similar requirements for access to acute care. On page 28, the rule states issuers are required to submit a map to the OIC every year showing there is a hospital within 30 miles for every enrollee, but this requirement does not appear in the "assessment of adequacy" section. Therefore, it appears there is no substantive requirement that an issuer contract with a hospital. *The Medicaid managed care contract requires plans to contract with at least one acute care hospital within 25 miles for 90 percent of enrollees in both rural and urban areas. We request the OIC adopt this same standard for the commercial market.*

The rule also allows issuers to use facilities in a neighboring service area to satisfy the network adequacy requirement if "the hospital in the service area refuses to contract with the issuer at reasonably proximate reimbursement levels to those the issuer entered into in other service areas with similar provider or facility types" (page 45). Assuming the stakeholder draft is changed to require a hospital within 25 miles for 90 percent of enrollees, this access requirement could be easily obviated by the issuer by claiming the hospital "refused to contract." Rates in other markets are not relevant; it would make much more sense to use rates in the relevant service area for comparison. *We would therefore request this provision either be deleted or changed to "if the hospital in the service area refuses to contract with the issuer at reasonably proximate reimbursement levels to those negotiated by other issuers with other facilities and providers in the same service area." In any case, we would suggest that, if an issuer claims the hospital "refuse[d] to contract," the rules should require the issuer to establish this by "clear and convincing evidence," and the provider or facility should be given the opportunity to rebut the issuer's claim by presenting its own evidence regarding the contract negotiation process.*

The rule states an issuer may also use providers and facilities in a neighboring service area to satisfy the network adequacy requirements for certain other types of facilities, including tertiary hospitals, pediatric community hospitals, specialty hospitals (e.g. cancer care hospitals, orthopedic hospitals, etc.), neonatal intensive care units, and transplant centers of excellence, in the event there are none of these facilities in the service area (page 45). Although this language

seems reasonable, the stakeholder draft fails to actually require the issuer to include these facilities in their network. *For the requirement on page 45 to be meaningful, we would request the regulations require issuers to include all of the types of facilities listed on page 45 in their networks. In addition, to ensure access to clinical trials, we request "cancer care hospitals" be changed to "National Cancer Institute-designated comprehensive cancer care centers" on page 45, and anywhere else the rules address access to cancer care hospitals.*

Alternate Network Standards (pages 7-11): Our members are very concerned about the fact that the stakeholder draft includes broad exemptions from the network adequacy standards. If the issuer is operating in a county with fewer than 50,000 people (page 9), if the issuer is "unable to contract" with the provider or facility (page 9), or if the issuer can claim a "reasonable basis" for not meeting the standards in the rules (page 8), it can propose an alternate network standard to the OIC. Almost half of Washington's counties have fewer than 50,000 people, so issuers would automatically be exempt from the network adequacy requirements outlined in the rules in those counties. Certain access to care standards, such as the access to acute care hospital requirement, should be required without exception. *We would therefore request, at a minimum, that the requirement that an issuer contract with a hospital within 25 miles for 90 percent of enrollees (requested above) apply without exception. In addition, if an issuer claims it is "unable to contract" with a provider or facility, the rules should require the issuer to establish this by "clear and convincing evidence," and the provider or facility should be given the opportunity to rebut the issuer's claim by presenting its own evidence regarding the contract negotiation process.*

In addition, there seem to be no criteria for what constitutes an alternate network standard in the stakeholder draft. *We request there be specific criteria in the rule with which to judge whether an alternate network standard proposed by an issuer is adequate.*

Essential Community Providers (pages 32-37): The rule requires that essential community providers comprise at least 30 percent of the network to provide reasonable access to medically underserved and low income enrollees in the service area. As far as we can tell, this requirement can be met by lumping all providers together so that there is no minimum requirement per type. This "lumping together" of all types of essential community providers makes it possible for entire categories of providers who serve the medically underserved to be left out of the network. *To ensure access to the full range of providers, we suggest the rule include the following language from the NAIC Model Law, "A[n] . . . issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income medically underserved individuals in the issuer's service area."*

More important, the regulations contain broad exemptions to the essential community provider requirements. For example, an issuer is exempt from the requirements if it demonstrates a provider "refuses to contract at the same or reasonably proximate reimbursement rates to those negotiated with other providers in the service area" (page 34, with similar language on page 76). The problem with this provision is twofold. First, like the "unable to contract" and "refuses to contract" language referenced above, this language is far too vague. There are many factors that come into play in rate negotiations, such as volume, gain share, and per member/per month factors. Second, essential community providers, by definition, may need to

charge commercial insurers higher rates to compensate for the fact that so many of their patients are on Medicaid or are uninsured. These providers are therefore not comparable to other providers in the service area. In addition, it is troubling that an issuer whose network "does not" meet the essential community provider requirements is allowed to simply submit an alternate network adequacy standard to the OIC for approval (pages 36). This seems to give the issuer every reason to not make a good faith attempt to contract with essential community providers. The exemption seems to swallow the rule. *We would request there be no exemption from the essential community provider requirements. In the alternative, if an issuer claims the hospital "refuse[d] to contract," the rules should require the issuer to establish this by "clear and convincing evidence," and the provider or facility should be given the opportunity to rebut the issuer's claim by presenting its own evidence regarding the contract negotiation process.*

Finally, the rule needs to be clearer about the definition of Disproportionate Share Hospital (DSH). The rule includes DSH hospitals as essential community providers, but does not define what constitutes a DSH hospital (page 32). *We would suggest that a DSH hospital be defined as any hospital that is receiving either Medicaid or Medicare DSH payments.*

Prior Authorization (pages 65-66): The rule requires that issuers have processes in place to obtain prior authorization in a timely manner. *At a minimum, the plan should conform to the requirements of WAC 284-43-410, which spells out reasonable response times for prior authorization requests. Although these regulations should already apply, it would be helpful for the network adequacy rules to include, or at least cross-reference, these provisions.*

Balance Billing (page 59): The rule says an issuer must make a good faith attempt to contract with provider groups in the ER if the hospital is included in the issuer's network. The Affordable Care Act requires insurers in this situation to pay their median negotiated rate, their standard rate, or the Medicare rate, whichever is greater. *We would request, for clarity purposes, that the rule reflect federal law and explicitly contain this requirement.*

Provider Network Directories (pages 18-19): We want to make sure the rule ensures enrollees can easily determine which hospitals are in-network. *We would therefore request the rule require issuers to update their provider network directories on a monthly basis.*

Telemedicine (page 19): As drafted, the rule substantially limits the types of services that would be paid for through telemedicine. WSHA is advancing legislation in the 2014 legislative session that would require health plans to cover services delivered through telemedicine technology if the same service is paid for when it is delivered in person. *We therefore suggest removing the section in the stakeholder draft dealing with telemedicine until after the law is clarified in this area so these regulations align with Washington State law.*

Tiered Provider Networks (pages 39-42): The rule requires all tiers of a tiered provider network to meet minimum network adequacy requirements. *We support this provision, but we believe the following language should be inserted: "Issuers must not use tiered networks to discriminate or limit access to certain types of providers."*

Mental Health:
We are very pleased the OIC intends to establish network adequacy standards for mental health providers and facilities. To further refine these provisions, we have a few suggestions:

- First, issuers should notify the OIC when the network has a reduction of five percent or more in the number of primary care providers. Mental health providers should be treated similarly. *We would therefore request the requirement that issuers report a reduction of five percent or more in the number of primary care providers (page 12) be applied to mental health providers as well.*
- Second, we support the requirement that issuers map mental health providers (page 29), but *the maps should specify the types of providers available in a service area.* It is necessary for issuers to contract with a variety of mental health professionals (social workers, psychologists, advanced registered nurse practitioners, and psychiatrists) to ensure individuals living with a mental illness have appropriate access to counseling and medication management. For example, an issuer could have an entire network of social workers. This would be very problematic for people living with a serious mental illness who need access to a provider with prescribing authority.
- Third, the stakeholder draft states that "residential treatment facilities" must be a part of an issuer's network (page 29). *If the intent of this language is to require access to both involuntary and voluntary inpatient treatment, the correct term for an involuntary inpatient treatment facility is an "evaluation and treatment facility" not a "residential facility." We would also suggest the OIC add to this section "voluntary inpatient services."*
- Fourth, the stakeholder draft states "[a]n issuer must not impose notification or prior authorization requirements upon women's health care practitioners, providers, and facilities . . . unless such requirements are imposed upon other providers offering similar types of service (page 51). We believe issuers currently impose significant administrative burdens on mental health providers. *We therefore request the OIC include in the draft rule the following language: "[a]n issuer must not impose notification or prior authorization upon mental health practitioners, providers, and facilities unless such requirements are imposed on other providers offering similar types of service."*

Spot Contracting (page 10): The rule says single case agreements may only be used in unique situations and may not be used to fill gaps in the issuer's network. We support this provision, and we thank the OIC for including it in the stakeholder draft.

Subcontracted Networks (pages 16-17): The rule requires issuers using a subcontracted network to use the entire network. We support this provision as well.

Other Suggested Changes:

Page 8: **Edit --** (a) Copayment~~s and~~ ,deductible, coinsurance, and out of pocket maximum requirements must apply to alternate network standards at the same level they are applied to in-network services. *This makes it clear that all of the out-of-pocket costs must remain the same if an issuer is allowed to adopt an alternate network standard.*

Page 7: **Insert as the second sentence of the new section --** (2) The issuer must specify which portions of the network adequacy standards it cannot meet when it proposes its alternate network standard.

Page 31: **Edit --** (I) Essential community providers. An issuer must provide one map that demonstrates that the geographic distribution of essential community providers, by type of provider or facility, within the service area in relation to the number predominantly low income, and medically underserved individuals in the service area meets the standards of WAC 284-43-222.

Page 38: **Insert at the end of (3) –** "If the plan covers out-of-network providers, the issuer must also identify for the commissioner upon request the number of requests for out-of-network coverage that were denied."

Page 62: **Edit –** A carrier's selection standards must not discriminate regarding participation in the network solely based on the provider or facility type or category if the provider or facility is acting within the scope of their license.

Throughout the draft: **Insert --** *Where reimbursement "rates" are discussed, we suggest the rule also mention "reimbursement methods" (such as percentage of bill charged, encounter rates, per-diems, and Diagnosis-Related Groups [DRG's]). This could be done by defining reimbursement "rate" to include reimbursement methods.*

For more information, please contact
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