Washington
State
Hospital
Association

April 21, 2014

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

Submitted by e-mail 4/21/2014

Dear Commissioner Kreidler:

On behalf of our 98 member hospitals, the Washington State Hospital Association (WSHA) appreciates the opportunity to comment on the draft rules on network adequacy filed on March 19, 2014 (WSR 14-07-102). WSHA believes network adequacy regulations should be governed by the following principles:

- Washington residents should be assured reasonable access to care, regardless of whether they live in an urban or a rural area.
- While we understand that hospitals exist in competitive markets and do not expect all hospitals to be included in all networks, exceptions to the rule's minimum requirements should be limited.
- "Spot contracting" is no substitute for an adequate network.
- Standards for access should be clear and measurable; and
- Consumers need information that helps them make informed choices about insurance based on provider and facility participation.

Given these principles, we have major concerns with the draft rule. The most important are summarized below; others are included in an attachment.

1. ***Rural access. We are concerned that the rule has lower standards for access for rural consumers than urban consumers by requiring a hospital within 30 minutes of enrollees in urban areas, but within 60 minutes of enrollees in rural areas.***

   We believe the minimum standard should be the same across the state. If a carrier cannot meet the standard for rural access, they can file an "alternate access delivery request," but we should not start out with a lower expectation of access in rural areas. We should be encouraging access, not discouraging it. Staff at the Office of the Insurance Commission (OIC) have tried to reassure us that these are the minimum standards, and that carriers are free to go beyond them. But why is the OIC establishing such a low bar? A previous version of the rule required hospital access within 30 miles for enrollees across the state. We request the OIC return to this standard, or use existing standards such as the Medicaid contract standard.

   We are similarly concerned about access to primary care and mental health care. The first stakeholder draft required access within 30 minutes for enrollees in both

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rural areas. The new draft requires access within 30 miles in urban areas and 60 miles in rural areas. Again, we see no reason for this distinction, assuming there are available providers. We request the primary care and mental health care access requirements, along with the hospital access requirements, be 30 miles in both urban and rural areas.

While our prime concern relates to the variation between areas, we also believe the access standard should be measured in miles, not minutes, for clarity purposes.

2. *Network adequacy exceptions. We do not believe the rule imposes sufficient restrictions on carriers seeking an exemption from its requirements.*

   The rule allows carriers to avoid its network adequacy requirements and file an "alternate access delivery request" if they can present "substantial evidence" of a good faith effort to contract. In a previous version of the rule, the OIC required carriers to submit "clear and convincing evidence" of a good faith effort to contract, and we request a return to that standard.

   In order to avoid the specific access requirements contained in this 27-page draft rule, carriers should bear the burden of persuading the OIC that they did, in fact, make a good faith effort to contract. "Substantial evidence" is enough evidence merely to support a conclusion, but not necessarily enough evidence to persuade a finder of fact that an assertion is true. The evidence of a good faith effort should be highly persuasive in order for carriers to be exempt from the access requirements of this rule.

3. *Rate information and contract terms need to be considered as evidence, for an exemption to be granted.*

   We believe the OIC needs to consider rate information and contract terms, as proof of a good faith effort to contract, when it determines whether a carrier can be granted permission to file an alternate access delivery request. The current draft does not allow the OIC to consider evidence of "substantive contract terms offered by either the issuer or the provider" in this analysis. This gives the carrier the ability to assert there was a failure to contract without presenting any proof about whether they offered reasonable rates.

   As we understand it, the OIC has considered proposed payment rates in the past when determining whether there was a good faith effort. We think the authority to do so still exits and should be used. If the OIC has the ability to evaluate rates to determine if there has been a discriminative benefit design,[1] we believe it also should be able to consider payment rates when determining whether a carrier has undertaken a good faith effort. We do not know what other type of evidence would inform determinations of whether the carrier has made a sufficient effort to allow it to be granted an exception to the standard rules.

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[1] RCW 48.43.730 requires carriers to file all provider contracts and provider compensation agreements with the commissioner thirty calendar days before use.

4. *The rule does not require access to clinical trials for cancer treatment.* As we have mentioned in previous comments, this rule should require carriers to include National Cancer Institute-designated cancer care centers in their networks. This is the only way consumers can be guaranteed access to clinical trials for cancer treatment. To ensure access to clinical trials, we request "cancer care hospitals" be changed to, "National Cancer Institute-designated comprehensive cancer care centers."

We respectfully request you to withdraw this proposed rule so the OIC can take more time with the stakeholder process. We think it is important for Washington consumers and providers to get these rules right. We look forward to continuing to work together to ensure reasonable access to care.

If you have any questions, please contact Barbara Gorham at 206-216-2512 or BarbaraG@wsha.org.

Sincerely,

Claudia Sanders
Senior Vice President
Policy Development

Barbara Gorham
Policy Director, Access

Attachment

Outline of Additional Issues in the Draft Network Adequacy Rules
Washington State Hospital Association – April 21, 2014

Essential Community Providers: We remain concerned about the fact that the rule limits the list of essential community providers to those that are on the "CMS non-exhaustive list of community providers." We are confused about why the rule outlines criteria for essential community providers, but then also explicitly requires providers to be on the "non-exhaustive list." Given that this list is non-exhaustive, it would make sense to apply these criteria to providers not on the CMS list so they can be considered essential community providers if they qualify.

Lack of criteria for what constitutes a minimally acceptable "alternate access delivery request": There seem to be no criteria for what constitutes a minimally acceptable alternate access delivery request, and therefore there is a lack of transparency around which requests the OIC will grant and which it will deny.

Definition of "clear and convincing evidence of a good faith effort to contract": As stated in our cover letter, carriers should not be allowed to file an alternate access delivery request unless they can present "clear and convincing evidence of a good faith effort to contract." If the OIC returns to this standard, the term needs to be defined. We would suggest the following definition:

> "'Clear and convincing evidence of a good faith effort to contract' means the issuer has demonstrated that they have attempted to contract with the provider or facility at the same or reasonably proximate terms, payment structure, and rates structure as those it has negotiated with other providers of the same provider or facility type in the county, or negotiated with other similar provider types in its network if no other similar provider or facility exists in the county."

Data and Transparency: Although we are requesting you withdraw this rule, we would also request that, if the rule is adopted, the OIC carefully monitor the actual proximity to care for enrollees, especially in rural areas to evaluate the impact of the carriers' networks on small rural providers and facilities. As stated in our cover letter, we are very concerned that access in rural areas will decline under these rules. It is important that we measure the effect of the 60-minute or 60-mile access standard in rural areas. If the data show that available providers who are closer to enrollees are being left out of networks because the carrier has contracted with larger facilities farther away, this is important information to have. We believe you have the data necessary now and the authority currently to do this monitoring.

Prior Authorization: The rule requires that issuers have processes in place to obtain prior authorization in a timely manner. These processes 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: The rule says an issuer must make a good faith attempt to contract with provider groups in the Emergency Department 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 believe rule should reflect federal law and explicitly contain this requirement.

Mental Health: Overall, we are very pleased with the OIC's inclusion of mental health providers in the Geographic Network Reports and Assessment of Access sections. We believe the draft could be further improved in two ways: First, so that the map shows which providers have prescribing authority, we believe the maps should show this. Second, although the draft rule recognizes the need for enrollee access to substance use disorder treatment, the rule does not require the issuer to include chemical dependency treatment providers or facilities in their networks. We believe it is absolutely essential that this be a requirement.

Cost-sharing limits in alternate access delivery systems: All out-of-pocket cost limits should apply in an alternate access delivery system. We believe the rule should spell out that copayments and deductibles, coinsurance, and out-of-pocket maximum requirements must apply to alternate network standards at the same level they are applied to in-network services.

Access to Dialysis Services: The access to care requirements should include access to kidney dialysis. The Northwest Kidney Centers is submitting a number of recommendations to improve the draft rule in this respect.

Provider directories: We believe that, throughout this section, "provider directories" should be changed to "provider and facility directories." Enrollees need to be able to see which facilities are included in-network in the issuer's online directory. We also believe the rule should state that, "where tiered networks are offered, the provider directory shall identify which providers and facilities are in which tiers."

For more information, please contact:
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