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October 31, 2014

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

Dear Commissioner Kreidler:

Thank you for distributing the draft rule (R2014 08 Provider Network Rules, phase 2) in advance of filing the CR-102 documents.

While we are pleased to have the opportunity to comment on the impact the rules have on our members, we are extremely concerned that the general distribution e-mail message stated that the OIC may move immediately to the formal rulemaking as early as mid-November. Once again the WSMA, along with other stakeholders including insurers, consumers, providers and facilities, asks that the that the OIC use a stakeholder process and schedule that will allow for an open and transparent rulemaking process. As we have now entered into the second phase of rulemaking for the 2016 benefit year, the OIC must provide an opportunity for public discussion and dialogue.

The WSMA wishes to emphasize the need for the OIC to carefully consider and address stakeholder input at these meetings, and to engage in meaningful dialogue with participating parties. Furthermore we ask that the OIC include verbal comments in its rulemaking process, and ask that the OIC not rely solely upon written comments.

By way of example, we ask that you consider the process by which you conducted the OIC's 2012 Essential Health Benefits rulemaking. During that rulemaking OIC staff actively engaged in the discussion by asking and responding to questions, and explaining the intent or what they were trying to accomplish with each of the rule's provisions. We urge the OIC to return to this more open and transparent process in this and other rulemaking processes.

The WSMA also asks that you use this second phase of rulemaking to address errors and problems that resulted from the rushed first phase of rule making for R 2013-22. Undoubtedly, the OIC and stakeholders have identified problems with the most recently adopted rule that should be corrected during this second phase of rulemaking. For example, WAC 284-43-201(b)(i) states that in-network deductibles and copayments will apply to out-of-network referrals. The clear language of the rule implies that the co-insurance amount may remain at the out-of-network benefit level. It is only through reviewing the language in the CES that the OIC elaborates on their expectation that there be no co-insurance applied in these instances. If that is the intent, then the rule and not the CES should make that requirement clear.

The proposed new rule should also clarify and correct the inadequate language defining an Essential Community Provider (ECP). The rule itself indicates that a provider must be on the Non-Exhaustive List of

Providers to be considered an ECP. In contrast, the concise explanatory statement does not impose that restriction.

We recommend the adoption in rule of the inclusion of the broader, non-exhaustive list referred to in the concise explanatory statement. A simple change to the rule's language stating that the list of ECPs is not exhaustive and thus, a provider or facility excluded from the list may still qualify as an ECP, could resolve this confusion.

Generally, we strongly recommend revising and reviewing the 'triggers' and benchmarks that the OIC is proposing to establish for issuers and the situations under which issuers need to provide notice regarding any changes to the network.

Some of the metrics identified below do not make sense when looking at access to care for certain types of service delivery, geographic regions, or patient populations.

- **WAC 284-43-202(1)(a) and (1)(2) – Maintenance of networks; notices and triggers for notice.** This subsection requires notice to the Commissioner of a reduction of ten percent in the number of specialty providers. This provision makes no distinction for geographic region nor for service delivery or provider type. We recommend the agency define the trigger of a loss of a provider to a network specific to those categories. For example, for a metropolitan region such as Seattle, there would be a need for far more than two (2) of a particular type of specialty provider to serve that area. Therefore, a trigger requiring notice in a situation where there are fewer than two (2) such providers in such a region is insufficient to address the need for an adequate supply of providers.

- **WAC 284-43-202(1)(e) –Maintenance of Networks.** This provision requires notice be made in situations where a 15 percent reduction occurs in the number of providers that typically treat a specific chronic condition or disease where the condition affects more than five percent of the issuer's enrollees in the service area. Here, too, we question the relevance of the five percent or 15 percent designation. We therefore recommend a reexamination of the proposed metrics for assessing appropriate triggers for issuers to give notice of material changes in the network. For example, does the OIC differentiate between a primary care provider and a specialist when both may have the capability to care for an enrollee with a chronic condition? What is the significance of a 15 percent reduction in the number of providers when far more than 5 percent of the issuer's enrollees are being treated with chronic conditions?

- **WAC 284-43-202(1)(e) –Maintenance of Networks**. This section requires notice for termination of expiration of a contract with a hospital or an associated medical group within a particular service area. We agree that notice of this material change to a network should trigger notice to the OIC and as such, support this provision.

- **WAC 284-43-202(5) – Maintenance of Networks**. This section requires an issuer to assure continuity and coordination of care in a manner consistent with professionally recognized evidence-based standards of practice, across the health plan network. Here, too, we question the development of this standard and request more information about how the OIC would enforce such a provision. For example, please consider the following questions raised by the section: How could an issuer assure continuity and coordination for these standards? Is the insurer citing certain professionally recognized standards of practice? What are those standards? How would an insurer monitor for those standards that are *not* evidence-based? We urge caution and a significant amount of stakeholder input before adopting this type of standard as it may significantly increase the administrative burden on providers (who must file reports and data with the issuers) and the issuers which must report to the OIC.

- **WAC 284-43-310 –Selection of Providers – credentialing and unfair discrimination.** A narrow network should be crafted in such a way as to assure that patients are able to have true access to care. For example, the narrow network should include an appropriate complement of specialists whose clinical expertise is needed to provide appropriate levels of care to a patient/enrollee population with chronic illnesses, such as oncologists caring for cancer patients. We argue that a poorly crafted narrow network could result in steering of the sickest patients to those products that cover a broad number of providers and thus allow an issuer with a narrow network to select – "cherry pick" - for a healthier and lower cost population. We do, however, support language in this provision that prevents network creation and provider or facility selection to serve as a substitute for prohibited risk avoidance or prohibited discrimination.

- **WAC 284-43-320 - Provider contracts standards – hold harmless provisions**. Noticeably absent from this amendatory section addressing provider contracts are the standards established in RCW 48.39.005 and RCW 48.39.010. The standards in these sections of the Revised Code require that notice be given no less than 60 days prior to changes made that are unrelated to compensation. Moreover, this section also requires that:

  > *(1)*[1]*A third-party payer shall provide no less than sixty days' notice to the health care provider of any proposed material amendments to a health care provider's contract with the third-party payer.*
  >
  > And that,
  >
  > *(2)Any material amendment to a contract must be clearly defined in a notice to the provider from the third-party payer as being a material change*[2] *to the contract before the provider's notice period begins. The notice must also inform the providers that they may choose to reject the terms of the proposed material amendment through written or electronic means at any time during the notice period and that such rejection may not affect the terms of the health care provider's existing contract with the third-party payer.*

These standards, which were established for contracts and material amendments made to subsequent contracts (if those contracts are renewed), could have significant impact on the establishment of a network.

Please consider these comments as an opportunity to address certain elements of the previous rule and rulemaking process that are not working for physicians. We welcome the opportunity to discuss our points further in person, and again urge you to not move forward with formal rulemaking until all stakeholders have an opportunity for public discussion and dialogue.

Sincerely,

*Kathryn Kolan*
Kathryn Kolan, JD
Director of Legislative and Regulatory Affairs

cc: Jennifer Hanscom, Executive Director/CEO
WSMA Executive Committee

[1] RCW 48.39.010
[2] Defined in RCW 48.39.005(2)