America's Health Insurance Plans

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Jim Freeburg
Special Assistant to the Commissioner
Washington Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255

Re: Network Access Exposure Draft (R 2014-08)

Dear Mr. Freeburg,

I write today on behalf of America's Health Insurance Plans (AHIP) to provide comments on the Washington Office of the Insurance Commissioner's (OIC) second exposure draft of the network access rules.

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs. Health plans have been committed to providing consumers with affordable products that offer robust networks of quality, cost-efficient providers. With this goal in mind, we offer the following comments.

Washington has had established network adequacy regulations for over a decade. In addition, the Affordable Care Act (ACA) Exchange Rule establishes network adequacy requirements to ensure all consumers have access to a broad array of physicians and hospitals in health plans' provider networks; and requires qualified health plans to maintain a network that is sufficient in number and types of providers. The Centers for Medicare and Medicaid (CMS) determined that Washington's network adequacy standards and reviews met ACA requirements[1], even before the 2013 amendments were made. Finally, in addition to state and federal standards, there are network adequacy standards required in order to meet National Committee for Quality Assurance (NCQA) and URAC accreditation.

AHIP and its members are very committed to ensuring that consumers have access to the best networks of providers available and believe standards already in existence by the state, the ACA, and accrediting organizations create beneficial consumer protections while allowing health plans

[1] Centers for Medicare and Medicaid Services. *Completing the Network Adequacy Portion of the QHP Application*. Available at: http://www.tdi.texas.gov/health/documents/QHPnetworkadqcy.pdf.

flexibility to create quality, efficient networks. We are concerned that the exposure draft as issued by the OIC would create a more active role for the department in provider contracting that would be intrusive and could be detrimental to the process of provider negotiations and confidential discussions.

As the OIC knows from its participation in the discussions at the NAIC in the development of a new network adequacy model, we strongly urge any additional state action be postponed on this issue until the discussions and activities at the NAIC have been completed. This allows for states to weigh in on and promote additional thought as to best practices and alignment of network adequacy review. To continue to create state specific models is administratively burdensome and costly to a system that is already in a great state of flux and complexity.

Here are AHIP's comments and concerns on specific areas of the exposure draft:

WAC 284-43-202 Maintenance of sufficient networks

We appreciate the OIC's efforts to incorporate our suggestion that issuers monitor their networks for compliance with existing adequacy standards and only be required to file an alternate access delivery request (AADR) when their networks no longer meet those standards. However, we do ask that the AADR process in section (2) be limited only to actual contract terminations and not potential terminations. Completing an AADR for all potential terminations is an onerous requirement. At the very least, we ask that the OIC include a provision stating that an AADR is not required if and while the issuer and provider or facility are in active contract negotiations.

We are also concerned with the timing requirement for an AADR in sections (2), (3)(g), and (4)(d). The five-day and one business day deadlines to complete an AADR and gather all supporting documentation are virtually impossible to meet. We ask that this deadline be changed to ten business days, to be consistent with the timing requirement when an issuer determines that an AADR is necessary; this will give plans adequate time to thoroughly complete their AADR and gather necessary documentation. We also request clarification that all time limits begin to run after an issuer submits its preliminary determination of whether an AADR needs to be filed.

We also remain concerned that the new exposure draft still includes troubling provisions in section (3) that incorporate the underlying assumption that a change in the network demonstrates there is no longer adequacy in the network. We maintain that change does not necessarily jeopardize access. For this reason, we believe that including an AADR requirement in section 3(g) is unnecessary and overreaching; an AADR should only be required for contract terminations that affect the network's ability to meet adequacy standards. In section (2) the OIC already proposes that an issuer must notify the OIC in writing within 5 business days of receiving or issuing written notice of a potential termination that would affect the network's ability to meet the standards set forth in WAC 284-43-200. In order to meet that standard, issuers will have already made the determination of whether a termination will affect network

access or sufficiency in those cases. Thus, section 3(g) is a redundant and unnecessary provision that should be removed.

Finally, we ask the OIC to provide clarification for its application of these requirements to "stand-alone qualified dental plans." The proposed regulations point to the network access standards in WAC 284-43-200(14), which apply to "stand-alone dental plans," which includes stand-alone dental plans offered through the Exchange and stand-alone dental plans offered outside of the Exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. It would be helpful to understand why the OIC chose to include the word "qualified" in these proposed regulations when it is not present in any other network access regulation. We believe it is unnecessary for these network adequacy rules and can be removed from the language in this section.

WAC 284-43-225 Issuer recordkeeping – Provider networks

We understand the need for adequate recordkeeping, but the timeframes laid out in section (1) should clarify when the timeframes for retention begin to run, specifically whether it is measured at the beginning or the end of the contract. Many issuers have long-standing provider contracts in place which may span longer than the ten year time period laid out in this section.

We understand that the intent of the provision that requires the tracking of the number of prior authorization requests and denials by benefit year is not related to network access, but is intended to help determine trends across health plans in this area. However, we note the classification of services requiring a prior authorization varies from issuer to issuer. Some may identify specific services; some may not require it at all. Thus, the OIC would be unable to glean trends from this data without an adequate baseline, and would have to adjust for differences in the requirements across all plans. We suggest this is an invalid measurement of trends, and thus that requirement should be removed from the rule.

Instead, we point the OIC to the existing methods of oversight of trends already collected by issuers and made available to the OIC per RCW 48.43.530, where in 10(a) each issuer must track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

WAC 284-43-320 Provider contracts – Standards – Hold harmless provisions

The requirement in section (8) that issuers require providers and facilities to cooperate with audit reviews of encounter data in relation to the administration of health plan risk adjustment and reinsurance programs is unnecessary and could provide complications with existing provider contracts. Provider contracts usually contain a provision requiring providers to comply with all audits. Such blanket audit provisions have been used to encompass necessary audits. A

requirement to specify audits for the risk adjustment and reinsurance programs could cause complications because these programs are very new and long-standing provider contracts might not currently specify those programs. Provider contracts are incredibly complex and long-negotiated and, therefore, very difficult to re-open and amend. We recommend that maintaining current language regarding cooperation with audits is sufficient to address this concern.

Additionally, we ask that section (10) be amended to further align with the proposed changes in WAC 284-43-251(7) so that both sections contain the same language regarding which enrollees must be provided notice and the classification of a patient seen on a regular basis.

WAC 284-43-330 Participating provider – Filing and approval

We appreciate that the OIC has incorporated our suggestion to amend the filing deadline for provider and facility agreements to be 30 days prior to use. We note two editorial changes required in WAC 284-43-330(2)(b)(i) – one is the change of "contact" to be "contract," and the other is the insertion of the word "change" in the that provision:

> "(i) If the negotiated contract change is only to the compensation exhibit or terms related to compensation it must be filed and is deemed approved upon filing."

The requirement in (6) that issuers file reimbursement agreements that are tied to health outcomes, utilization of specific services, patient volume, or other performance standards is duplicative with the already-existing requirement that issuers file all reimbursement agreements. If these are the specific types of agreements that the OIC seeks, then the other blanket filing requirements should be repealed. We are also concerned with the requirement that issuers identify the number of enrollees in the agreement's service area. For new agreements, this number would be unknown and for existing agreements, enrollment would be at a given point in time and it is unclear what would happen if an issuer's actual enrollment was different at the time the OIC reviewed the report.

We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue. If you have any questions, please do not hesitate to contact me at gcampbell@ahip.org (971-599-5379).

Sincerely,

Grace Campbell

Grace Campbell
Regional Director