Washington State Medical Association | WSMA
Physician Driven
Patient Focused

2033 Sixth Avenue, Suite 1100
Seattle, Washington 98121
206-441-9762
1-800-552-0612
Fax: 206-441-5863
e-mail: wsma@wsma.org

1800 Cooper Point Road SW
Bldg 7, Suite A
Olympia, Washington 98502
360-352-4848
1-800-562-4546
Fax: 360-352-4303

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August 19, 2014

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

Dear Commissioner Kreidler:

On behalf of the Washington State Medical Association and its physician and physician assistant members, please see the comments below in response to the CR-101 regarding network access (WSR 14-15-104).

Please consider these comments as an opportunity to "fix" the elements of the previous rule that are not working for physicians. To that end, we support your addressing these concerns for the 2016 benefit year rather than waiting until 2017 or beyond.

The WSMA requests that the OIC use a stakeholder process and schedule that will allow for an open and transparent rulemaking process. For example, the OIC's 2012 Essential Health Benefits rulemaking process was excellent and allowed for discussion and "no surprises" as to the content of the proposed rule. We urge the OIC to emulate such efforts in this and other rulemaking processes.

We support the OIC's participation in the National Association of Insurance Commissioner's workgroup updating the Network Adequacy Model Act No. 74. Assuming the NAIC meets its goal of finalizing the model by November of this year, we request that you consider the Model Act's revisions and incorporate the changes as appropriate in this rulemaking process.

Comments on the CR-101 (WSR 14-15-104): The comments below address:

- Sections removed in the first exposure draft (released on December 4, 2013), were to be addressed in the second round of rulemaking.

- Changes in law that were made for the 2015 benefit year which we recommend the OIC reconsider.

1. **Standards for negotiations between issuers and physicians.**

Failing to establish a strong standard of proof regarding evidence of good faith negotiations will result in inadequate networks for patients and an unequal playing field for negotiations between issuers and physicians, weighted in favor of issuers. We recommend the establishment of stronger standards negotiations in the proposed rule for the 2016 benefit year.

The second exposure draft for the 2015 benefit year (released on February 14, **2014)** established a stronger "clear and convincing" standard of evidence to show good faith negotiations. The final rule for the 2015 benefit year did not include a higher standard for negotiations (though it may have been addressed in supplementary carrier filing documents). The evidence presented in support of good faith efforts to negotiate should be highly persuasive to ensure that carriers establish an adequate network of providers. A higher evidentiary standard will allow the Commissioner to consider **all** of the substantive terms and conditions, offered by either the issuer or provider, so as to determine whether either party is negotiating in good faith.

2. **Negotiating standards and alternate access delivery exceptions.**

In order to maintain meaningful access to care for patients, seeking an alternate access delivery network should not become a means by which issuers attempt to avoid risk. To protect fairness to physicians and patients, the rule should place sufficient restrictions on issuers who try to avoid risk by seeking an alternate access delivery exception. In order to ensure that issuers have attempted to establish an adequate network before seeking an exemption, a higher evidentiary standard for good faith negotiations should be required. This higher standard will require that issuers *prove* that they negotiated in good faith rather than simply supporting a conclusion that they did. Said differently, the evidence of a good faith effort should be highly persuasive in order for carriers to be exempt from the access requirements laid out in the 2015 benefit year rules.

3. **Network capacity**.

Assessing provider capacity for each individual issuer yields a distorted picture of the true capacity of the marketplace. We recommend assessments of network capacity include evaluation of capacity across all commercial issuers with a relationship to a single provider that may be included in multiple issuers' insurance products. We want to reemphasize the need for the Commissioner to assess the issue of provider capacity. As we understand it, the Commissioner's assessment of provider capacity focuses on each individual issuer, rather than with consideration of capacity across all issuers in the marketplace. This false picture can lead to unrealistic expectations in access to care for consumers as well as physicians. This problem is compounded

when providers are part of networks affiliated with Medicaid in addition to networks affiliated with the commercial market.

4. **Enrollee's access to their physician.**

We support the language (appearing in the December 4, 2013 exposure draft) regarding "access" as long as it assures that an enrollee has access to their physician as a participating provider within the issuer's network. We emphasize this point as it seems that the OIC substitutes "adequacy of a participating physician network" with simple access to non-network physician at an "in-network" benefit level. Our concern is that it is impossible to guarantee that a patient is protected from additional out-of-pocket costs if that patient is treated by a non-network provider and the "hold harmless" language found in providers' contracts is therefore inapplicable as a contract would not exist out-of-network.

We would still welcome an opportunity to discuss these comments with you in person. Thank you for your urgent attention to this issue. If you have any questions, please contact Kathryn Kolan at kak@wsma.org or (206) 618-4821.

Sincerely,

Dale Reisner, MD
President

cc: Jennifer Hanscom
Executive Director/CEO
WSMA Executive Committee
Kathryn Kolan, JD, Director of Legislative and Regulatory Affairs