January 15, 2015

Mr. J.P. Weiske, Chairman
Network Adequacy Model Review (B) Subgroup
National Association of Insurance Commissioners
ATTN: Jolie Matthews, NAIC Senior Health and Life Policy Counsel
701 Hall of the States
444 North Capital Street NW
Washington DC 20001-1509

Dear Mr. Wieske:

The Washington State Office of the Insurance Commissioner (OIC) appreciates the opportunity to comment on changes to the NAIC Network Adequacy Model. In 2013, Commissioner Kreidler undertook rule-making to update and revise the current network access rules. The Washington State Code was largely based upon NAIC’s model law from 1974. Staff was directed to clearly understand the concerns of stakeholders and to address them in a reasonable, meaningful manner. The Commissioner’s office engaged in extensive rule-making; receiving comments from over 80 organizations from across the country. Effective May 26, 2014, the OIC adopted extensive new rules to implement network access requirements in the marketplace. The OIC’s development of these new network access rules has effectively made Washington a national leader in network access regulation.

As the Subgroup continues its work, we share with you areas that required in-depth review of network access standards and information that helped guide our work on the network access rules in Washington.

**Enrollee Transparency (Provider Directories)**

The NAIC Model should be modified to include standards for all issuers to make their provider directories available online and to potential enrollees upon request. Implementation of Exchange final rules in 45 CFR § 156.230(b) requires QHP issuers to meet minimum provider directory standards. Such standards should be uniform across the market. Provider directories should be required to be accurate, current, and presented in a manner that is effective for the user to ascertain key requirements to access medically necessary care at in-network cost share. It is through the provider directory that enrollees make access decisions that affect their care.

When determining which information to require in the provider directories, it is important to use a universal standard to encourage uniformity for both issuers and purchasers. We encourage the
subgroup to look to federal standards that have been set forth in both the CMS Letters to Issuers and the 2016 Payment Parameters rule, which expect the directory to include, at a minimum: location, contact information, specialty, medical group, institutional affiliations for each provider, whether the provider is accepting new patients, languages spoken and provider credentials, and whether the provider is an Indian health provider.

**Tiered Networks, Accountable Care Organizations and “Look-a-Likes”**

Washington State has for many years seen the development and expansion of tiered networks in the marketplace. When created correctly, a tiered network provides appropriate network access. However, when networks are created poorly, such networks can have devastating effects on individuals and families in terms of access to care.

The NAIC Model should be updated to include standards to address innovative network designs. Specifically, the model should require that the lowest cost-sharing tier provide enrollees with access to all the Essential Health Benefits. General standards should require that sufficient numbers and types of providers are available in-network to assure that medically covered services are accessible in a timely manner appropriate for the enrollee’s condition. Tiered networks can be beneficial to all involved in the health care delivery system and the marketplace as long as the tiering process is transparent to all parties involved.

The Affordable Care Act (ACA) has similarly fostered a new type of network design identified in Washington State as a “shared risk arrangement”. These shared risk arrangements mimic many of the standards for Accountable Care Organizations (ACOs) specifically set forth in the ACA. However, it is important to recognize these shared risk arrangements are not subject to the same licensure and regulatory requirements as ACOs. We strongly encourage the subgroup to continue its work to identify appropriate network guidance in the Model law for these new entities.

**Network Access Reports**

The ACA has changed how states must review networks and raised the public’s interest in this process. States must be able to define the evaluation parameters and tools that are appropriate for them to make these determinations. Network access reports that are to be submitted to the state should be recognized as regulatory tools subject to public review.

During the subgroup’s first comment period, we heard several different parties’ interpretations of how the tools should be developed, reporting functionality, and the need for trade secret protections.

We encourage the subgroup to focus on the regulatory reason for these reports. Networks must be sufficient in numbers and types of providers and facilities to assure that all health plans
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provide enrollees with timely and appropriate access to care for the enrollee’s condition. In order to determine whether an issuer’s network includes sufficient providers and facilities to cover its enrollees or expected enrollees, issuers must know who those enrollees are, what their health care needs are expected to be, and who will provide those services. Network access reports should provide this information to the regulator to ensure these standards are and will continue to be met.

Provider Terminations

Networks are fluid entities that expand and contract by market cyclical needs such as benefit design, economics, demographics, population health, etc. One of the ACA’s purposes is to create flexibility and encourage innovation to address these factors over time.

Several organizations have commented about the need for states to allow special enrollment periods to address the situation where an enrollee purchases a plan because a provider was in-network, but that provider agreement was later terminated. While we recognize the consumer impact when a patient-provider relationship is lost due to an issuer-provider termination, it is a natural consequence of the network life cycle. Allowing a special enrollment period for a single provider termination defines a network as inadequate simply because of normal fluctuations in the network’s size. There are many implementation questions to address if the NAIC model incorporates such a standard. For example, most terminations are subsequently addressed through new contract negotiations within a few days or weeks of the original termination. Will an enrollee that changed issuers because of the termination, choosing a less desirable plan design but with access to the provider, be allowed a subsequent special enrollment right because the provider signed a new contract and is again in-network on the original plan?

We request the subgroup consider the implementation requirements and provide appropriate guidance to states if this recommendation is adopted.

Thank you for this opportunity to comment and we look forward to working with you as the NAIC revises the Network Adequacy Model. Please contact me at JasonS@oic.wa.gov or 360-725-7037 with questions.

Sincerely,

Jason Siems  
Deputy Insurance Commissioner  
Policy and Legislative Affairs Division