PUBLIC COMMENT REPORT

RULE 106: NETWORK ADEQUACY REQUIREMENTS
FOR HEALTH BENEFITS PLANS

We have filed with this final rule a copy of the hearing transcript for the public hearing held on October 29, 2014, as well as written comments received on the above rule. The Department received a substantial number of comments many of which raise common or similar objections, so, rather than repeating each particular comment and our response, we will group the same objections with the Department's responses:

#1. Why isn't dermatology and the sub-specialties of care in dermatology, which are usually covered in health benefit plans, listed in Section Five (5) (F)(2) for the requirement of reporting geometric access maps? [*the Department also received similar other specialty physician and specialty medical service objections about not being listed in the "Specialty Care Provider" list in Section Five (5) (F)(2)]

RESPONSE: The Department changed Section Five (5)(F)(2) after the public hearing and removed the long list of specialty providers and instead required the geometric access reporting for ALL specialty care services covered under the health benefit plan.

#2. Section Five (5)(C) of the rule requires Health Carriers to develop criteria with out of network providers in Section Five (5)(C)(1)-(8), however, Health Carriers are not in network with that provider to obtain these arrangements and therefore have no control over that provider to achieve these requirements.

RESPONSE: We agree. We moved those requirements after the public hearing to Section Five (5) (E), and made these monitoring requirements for participating providers.

#3. For Section Five (5)(C) cases where the Health Carrier has an inadequate network of providers, the rule makes the Health Carrier "ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a participating provider." The Health Carrier cannot control or know the "cost" charged to the covered person by a provider out of network and the Health Carrier requests that this instead require the Health Carrier to "pay the out of network provider the same in-network provider rate."

RESPONSE: The Commissioner decided to keep the phrase, "at no greater cost," for the protection of the consumer.

#4. The rule is unclear whether it applies to the entire fully insured commercial dental market or whether it just applies to the stand-alone dental plans issued through the ACA Marketplace or stand-alone dental plans outside the ACA Marketplace which have to provide the essential health benefit of pediatric dental benefits.

RESPONSE: The Department made numerous edits to the rule after the public hearing to make it clear that Section Six (6) applies only to Stand-alone Dental Carriers as defined in Section Three (3)(U) of the rule which "offer plans through the ACA approved Marketplace and/or offer plans outside the ACA Marketplace for the purpose of providing EHB category of pediatric dental.

#5. Section Five (B)(4) is not a strong enough geometric requirement for Essential Community Providers (ECP) if the Rule only requires a covered person to have access to at least one ECP, given the broad definition of what an ECP is. For example, a school based ECP or a Ryan White ECP provider may be within thirty (30) miles to a covered person, however the covered person may not be a student or have the specific medical needs to qualify to access it. Also, the geometric access reporting in Section Five (5)(F)(4) should require reporting of all the listed types.

RESPONSE: We desire to keep the language in both sections the same. We interpret the verb "access" to an ECP within thirty (30) miles to infer that the covered person is able to "access" that ECP commiserate with his or her needs or qualifications. As to Section Five (5)(F)(4), we believe the current language provides sufficient geometric reporting; however, we are aware of this concern and will monitor it for needed amendments.

#6. The rule requires Health Carriers to file an "access plan" with requirements listed in Section Five (5) (I) and to make it available on its business premises. This requirement derives from an out of date section from the NAIC Network Adequacy Act. The required information is not proprietary, and the enrollees already have this information available to them in online member plan information. Also, the Health Carrier should also be given the same ability to have its accrediting organization certify it has an access plan meeting the requirements in Section Five (5)(I)(1)-(12)

RESPONSE: We agree although we see no harm in requiring the "access plan" to be filed with the Department, as well as making it "available" to its insureds. We deleted the business premises requirement and most of the proprietary provisions. We added a new Section Five (5) (L) to permit a certification of this Section by an accrediting organization.

#7. The rule needs to require more autism providers and specifically applied behavioral analysts because we have so few of these in this State, and, with reduction in reimbursement for such services by some health care insurers, the number of available autism providers will further diminish.

RESPONSE: We are aware of this issue and are monitoring and studying the best way to address this issue with the available health plans, without creating a separate and additional geometric requirement here in this rule.

#8. The rule requires Stand-alone Dental Carriers to have an ECP providing dental services, and there is not an ECP in every county in this State providing dental services, the proposed Rule will interfere with our ability to therefore provide plans in such counties.

RESPONSE: We modified Section Six (6)(A)(3) to require the subject dental carrier to use best reasonable efforts to contract with an ECP in counties where an ECP provides dental care.

#9. Federal law requires all health carriers issuing QHPs to have a certified or accredited network by an accrediting organization, the rule as originally drafted appears to permit this as an option, can you explain this, and should you not therefore just state this in this Rule?

RESPONSE: See our newly added sub-paragraph (5) to Section Five (5) (K) which recognizes or acknowledges federal pre-emption this issue. We agree that federal law requires a certification for qualified health plans by an approved accrediting organization however there are a myriad of federal exceptions including first year exceptions which we did not want to set out in detail here.