ORIGINAL

HEARING
IN THE MATTER OF
RULE 106
"NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS"

BEFORE THE HONORABLE LENITA BLASINGAME
CHIEF DEPUTY COMMISSIONER AND HEARING OFFICER
ARKANSAS INSURANCE DEPARTMENT

HEARING PROCEEDINGS

OCTOBER 29, 2014

10:41 a.m.

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I N D E X

E X H I B I T S

(ALL EXHIBITS BOUND SEPARATELY & ATTACHED HERETO.)

HEARING OFFICER: Today is October 29th, 2014 and we're here in the matter of the proposed Rule 106, "Network Adequacy requirements for Heath Benefit Plans."

I'm Lenita Blasingame, Chief Deputy Commissioner for the Insurance Department and Commissioner Bradford has appointed me to be the Hearing Officer this morning.

Present at the table is Mr. Booth Rand, the Managing Attorney for the Insurance Department, Ms. Zane Chrisman and Dr. Joe Thompson.

Mr. Rand, are you ready?

MR. RAND: We are. Ms. Hearing Officer, I'd like to go ahead and admit, into the administrative record, a series of Exhibits, and then after that I will describe the basics of the rule that we've got proposed, and I would like to do what we did previously with 106, and give you a general overview of the comments that we've had, without having to read every letter and e-mail. I know that some of them have showed up, so they can certainly recite their letters or communicate specifics, if that's okay with you.

HEARING OFFICER: That's fine.

MR. RAND: We've provided the Hearing Officer with a notebook that has our proposed

administrative exhibits. Exhibit No. 1 is the designation of Hearing officer, which the Commissioner appointed you to hear Rule 106 this morning.

Exhibit No. 2 is our Notice of Public Hearing, which set out the public notice for today's hearing for October 29th, 2014, at 10 a.m. for review of proposed Rule 106 on Network Adequacy.

Exhibit 3 is the proposed rule itself. Exhibit 4 are the communications or e-mails and letters that we send to the Arkansas Democrat Gazette to run the notice of the hearing in the newspaper for three days, which is required by the Administrative Procedures Act.

Exhibit 4A has the receipts and shows the public notices and the dates that ran in the paper. I believe the notice -- that the public notice for today's hearing for 106 ran for three days, September 14th, September 15th and September 16th, which are the three days that comply with the APA.

Exhibit 5, Ms. Hearing Officer, as you know we are required by the APA, also, to send copies of our proposed rules to interested persons and members in the industry who have agreed to the e-mail notice system and Exhibit 5 is evidence of a record that the Legal Division keep whenever we send out e-mails of proposed rules by Ms. LoRraine Rowland.

Exhibit 6, as you know, Ms. Hearing Officer, when the Department does a rule we have to correspond with and file the proposed rule with the Arkansas Legislative Council. They require the filing of a questionnaire, which is a series of questions about the benefits of the rule, the impact of the rules, the main purposes of the rule and so on. They require filing of the financial impact, discussion about what impact the rule may have to businesses and to the industry itself. They also require us to summarize the rule and they also require us to file an economic impact segment. All of those items are in Exhibit 6, which we have followed for publication of this rule.

Exhibit 7 is a copy of a letter that we sent to the Governor's Office. We do give notice to other agencies about our rulemaking activities. The Governor's Office, obviously, is one of those.

Exhibit 8 is -- we also notify the AG's Office when we're doing rules. We sent them a copy of the proposed rule.

Exhibit 9 is distribution of the rule to the Secretary of State's Office.

Exhibit 10, I believe, are the comments that were made by the public in response to the rule.

HEARING OFFICER: That's Exhibit 11; 10 was

the notice to the economic development --

MR. RAND: Oh, I'm sorry, I forgot the AEDC. Exhibit 10 is the cover letter and attachment of the rule that was sent to AEDC, and I have Exhibit No. 11 being the comments, Ms. Hearing Officer, in my notebook.

HEARING OFFICER: Yes. Let's go ahead and admit those into the record.

(Exhibits 1-11 were admitted into the record and attached hereto.)

MR. RAND: And let me give a description of the rule for it to make better sense, and then I will talk about the comments in a second.

The Arkansas Insurance Department -- this proposed rule is needed for a variety of important reasons. One is it's required by federal law that qualified health plans, under the Affordable Care Act, have to have an adequate network for QHPs.

Outside of that requirement, the Insurance Department has no network adequacy requirements for anything outside of health maintenance organizations. The only part of our regulatory responsibility that addressed network adequacy was in the HMO code. And HMOs used to have to get certification network adequacy through the Department of Health. We felt like it would be better for us to review network adequacy instead of DOH and so we

repealed the section in the HMO code that required DOH to review network adequacy. I believe they did it county by county.

And so we wanted to assume jurisdiction over that because we were going to have to have qualified health plans in the marketplace under federal law. So we don't have a network adequacy rules that establishes any standards for medical provider networks, geometrics, ratios or just access, so this rule is incredibly needed by the Department for standards.

We have never adopted the NAIC earlier model act on network adequacy and I do know that they're working on a current, new, improved version, but we just don't simply have the time to wait for the NAIC to finish up with that. We've got too much pressing needs to develop standards.

So the whole purpose of this rule is to provide network adequacy standards for not just federally mandated QHPs, but also health plans in the marketplace that have managed care networks. We simply don't have any standards on that, and we have, over the years, had to take issues about providers not being in network or not -- losing a hospital and plans not having enough on a case-by-case basis. As Ms. Hearing Officer knows, it's some of the most frustrating compliance issues that we've

had over the last four or five years in health insurance regulation. We just simply have not had standards.

And what we've had to do, what Zane has had to do in the Health Connector Division, we've had to issue bulletins adopting, basically, a lot of these geometrics. And we felt like it was important to promulgate an actual rule, to have public comment on it to get a rule out that discusses this. So that's driving a lot of this.

The proposed rule is -- I'll just go through it. The proposed rule initially was drafted in the spring of 2014. Zane and I and staff used the original, rather archaic NAIC Network Adequacy Model Act as a basis to start our work. We started working on developing a network adequacy model before the NAIC new group started working back some time in the spring or early -- late part of winter last year. So a lot of what we're reading today in our proposed rule are what we've developed and designed ourselves.

So let's talk a little about this as I go through it. The way the rule is structured -- I just want to point out the basics. The network adequacy requirements will comply to the health plans that we have defined in the rule. We are not trying to impose network adequacy plans on workers' compensation or auto med pay or disability income. We have restricted this to apply to

healthcare plans in the marketplace we can regulate on a fully insured basis that use managed care networks.

So accident policies, med pay, workers' comp, accidental death, dismemberment, we've accepted those out, including Medicare. So we want to make sure that we're not encroaching into areas where there are other network adequacy requirements under Medicaid or Medicare. We're strictly dealing with fully insured plans that we can regulate.

The way the rule is structured, is it comes from Section 5 where the guts and the meat of the requirements are. The requirement under 5A is that a health carrier has to maintain a network that's sufficient in numbers and types of providers to assure that all health care services to cover persons will be accessible without unreasonable delay.

Everything in this rule are tests for that particular sentence. We will always come back to that sentence as our mandate or our requirement. The geometrics, the ratios, the referral patterns, and all these specifics that we have further elaborated on are ways to get to show that that first sentence is met. So we don't want to get locked in with technical geometrics distances. The Department has to have enough flexibility and freedom to review whether a plan is adequate or not

under that general sentence. That is the only sentence in this rule that has a "shall" that we're going to look at as the basics of the general rule that we will always come back to.

As you notice on Section 5A we talk about the sufficiency being demonstrated by all these ratios, referral patterns, waiting times, geographical accessibility. So carriers can show us all of these things to show that they are meeting the substance of that first sentence.

Section B is our primary geometric rules or requirements. It is setting out geometric accessibility tests and we decided to use a distance test, not a driving test. I believe our general counsel and myself felt like weighing whether or not it takes you two hours to drive from Fort Smith to Fayetteville, it was too argumentative, how fast you drive. So we felt like it was a little bit more objective to use the distance between the listed provider type and their residence.

The typical distances were 30 miles from emergency room service, 30 miles to a PCP, 60 miles to specialty care professionals, between the specialty care professional and the residents, and for qualified health plans PCPs, 30 miles between residents to the PCP.

We were looking at, I believe, what is

generally what we see in other states in terms of mile radiuses, 30 for emergency rooms, 30 for primary care professionals, 60 for specialty care. These are, by and large, kind of what you see around in the other states, although I know Colorado and Washington have more much elaborate rules than ours, but that's kind of what we decided.

One of the issues is why are you not listing hospitals here? Well, our problem with listing hospitals in terms of mileage, is that we want to encourage health plans to participate in counties or markets or areas or quadrants of Arkansas that do not have a hospital within 30 miles or 60 miles. We want the health care plans to be able to go into a county and sell the plan without being regimented into how far they are away from a hospital. So we want to encourage participation into the market by the carriers into these rural counties without restricting them to hospital distances.

Not every county in Arkansas has a hospital, it's my understanding, so we -- on hospitals, we're going to come back to the general test under A, where we have to look at the reasonable accessibility of your member to a hospital, looking at it on a case-by-case basis. We are afraid to put in a numerical, geometric

distance for a hospital that might block a plan's ability to participate to provide health insurance in that county.

So we are aware of the hospitals not being listed here, but we are afraid of the consequences if we put some mileage issue on it, and we wanted providers to participate or actually sell policies in these counties.

The requirement for network adequacy under Section 5 is ongoing. You just don't meet it one time each year. We are going to expect the carriers to meet these geometrics and adequacy requirements throughout the year, to provide us notice when you don't, so that you can correct issues that occur.

The other major section of the rule gets into the provision of geometric access mapping and that starts in Section 5F, 1 through 4, and Ms. Chrisman can talk about this if there are questions, but we have listed a panorama of a variety of specialists in provider types that we want you to send -- you being the insurance company -- geometric access maps by county to us showing your ratios and covered percentages of compliance percentages, about how many of those you've got and what percentage of those you have to cover members. That has to be submitted with performance metrics, again, showing your compliance percentages.

One of the comments has been, what are your

compliance percentages? We do need to talk about, and possibly consider addressing threshold or compliance percentage requirements as to these geometrical covered percentages that we reference in G, up in these listed providers.

So I would propose to the Hearing Officer as to the issue -- some of the insurance companies need clarification that if they're going to have to submit geometric access maps for all these providers on a county basis, that they need to be told are you expecting 100-percent compliance with that, or are you expecting 80 percent; what is your compliance percentage that you refer to in 5G? That is something that we need to take up as we deliberate what the rule needs to be.

I don't think any change would be significant that would require re-notice if we do thresholds or compliance percentage. As it is right now it seems to suggest 100-percent requirement to these distance ratios that are required in the rule to these specialists and PCPs and ECPs.

The carriers, again, want us to say whether it's 100 percent or 80 percent. In addition, the comments also have noted that they are approved or accredited -- the issuers can speak to this when they make their comments -- I believe based on the region. The rule

proposes the geometric percentages to be sent in by county, so they want us to be clear about this. Are we -- we're approved per region, but these requirements are by county, so I would deliberate on the need for making more clarification if we need to on that.

The rest of the section on Section H, essentially community providers for qualified health plans, under federal law they have to cover ECPs. The status of who is an ECP is very broad.

Some of the comments that we've gotten are it really makes no meaningful difference to me that I have an ECP within 30 miles because just about anything can be an ECP. We need to be more clear and focused on network adequacy issues for ECPs because they're so broad. They include schools and other ECP providers, but the rule does require ECP providers to be within 30 miles of the residence of the person. We may need to discuss with the Commissioner and with the Hearing Officer maybe tightening that up in response to some of the comments.

Section 5I, we -- in addition to requiring the health insurance company to show us that it's meeting the geometric percentages, requirements and network adequacy, would require them to also file with us an access plan. The access plan, without reading every one of these listed 12 items, is basically describing to a

policyholder who is in the provider directory, what you need to do if you want to switch providers. It describes your continuation of coverage issues.

A lot of these requirements are already statutory, that may already be in members' materials, but we do want to have the carriers to submit us access plans the way we have it, or at least make it available.

One of the comments is -- well, when I get to Section K, is that all the geometrics, all the requirements in 5B related to distance ratios and the insurance company's need to comply with those can be met if they are accredited by an accrediting organization such as NCQA or an ACA-certified accrediting organization for networks.

If the insurance company has an accreditation from one of these approved organizations under Section K, the insurance company, itself, does not have to submit all these geometrics. They can have NCQA or URAC or whoever is doing it that they've paid to do that to us.

Well, the question has been asked if you're going to let NCQA or our accrediting organization to submit a certification that we have an adequate network, showing and giving you copies of materials and data support that they meet these geometrics, why don't you let

us do that for access plans because this is a separate, additional requirement that we're going to have to file as well. And I've advised the carriers that I would propose that to the Commissioner and to the Hearing Officer, that if NCQA or the accrediting organization can also do a certification of these access plans, I would ask the Commissioner and the Hearing Officer to agree to allow certification of that, however, we do want to have them available, we do want to have them on file to be able to look at those.

Section 5J, provider directories

essentially requiring healthcare providers to update healthcare provider directories after 14 days after a provider leaves a network, we've had some comments by providers who -- and we've had this issue, as the Hearing Officer knows herself, where hospitals are not in network anymore, or the doctor is not in the network anymore, and when the consumer goes up to the insurance company's website, the provider directories are not updated, the provider is still in network, the insurance company has not done a timely job of updating who's in the network, or who's free to take more patients and those sort of things. This requires a 14-day update. It's got some specifics on advanced activities that need -- I mean, activities that need to take place in case you do lose a provider in the

directory.

Section 6, I would let, when Mr. Couch from Delta Dental gets up to talk, explain this issue a little bit better, but it's my understanding we want to have network adequacy on -- we have to have network adequacy on dental plans that are offered through the marketplace or offered outside the marketplace, but have to have EHB for pediatrics.

So the federal law requires those types to have a network adequacy, and without going through and reading through Section 6, like I did with 5, essentially the same parameters related to geometrics and distance ratios apply to those standalone dental plans that are offered through the marketplace or are offered because of EHB for pediatric dental.

I don't want to go through all those. One of the comments that you'll hear from Mr. Couch, and that he has made already by letter, is on ECPs, they don't have -- Delta Dental, for example, does not have an ECP everywhere, so they cannot meet the 30-mile requirement to ECPs, so they've suggested that we acknowledge some of these issues with dental carriers about ECPs. I mean, there's some issues that he may want to talk about that we want to take up with the Insurance Commissioner, as well as the Hearing Officer.

That is essentially the basics of the rule and I -- there's a lot more specifics. We propose -- and I'll just kind of go through some of the comments. One of the primary comments we've gotten is under federal law qualified health plans have to have a accredited certification from an accrediting organization. You could read the rule, though, literally to permit that the insurance company could submit the metrics without an accreditation.

It is our understanding all of our issuers in our marketplace are accredited, so it's -- we don't feel it's going to be controversial to require for qualified health plans, that they have to submit an adequate network by an accrediting organization. I will add that to this proposed rule. I don't think there's opposition to that. I do not want to extend that to the commercial marketplace to the group. I just don't see a need for large group carriers having to submit NCQA accreditation. I know many of them are already, but if there's not a need for it, I just propose that we don't do that.

I do want to make an accreditation, though, required for all QHPs where it's not optional. Many of them, if not all of them, as Zane can speak to this, are going to be sending in certifications from accrediting

organizations to meet this rule.

Some of the other comments, if we look at -- one that bothered me last night as I read the comments, and this was -- it escaped everyone's attention. If you have 50 people looking at a rule, I guarantee you people will miss things that are right in front of them. Under the geometrics for specialty care professionals, we require companies to reasonably strive to have access to at least one specialty care professional within a 60-mile radius.

I got several letters. Okay, think about what you're saying here. If I have a dermatologist 20 miles aways from me, but I've got my rheumatologist, pulmonologist, lung doctor, 300 miles away, the carrier can meet the requirements of this rule because they have one specialty care provider within the 60-mile radius.

We don't interpret the rule, which should say -- and I haven't really thought seriously about how to reword this. In the case of a specialty care provider, a covered person will have access to a needed speciality care provider; in other words, a provider that you need to go to, and the carrier is not going to be able to meet network adequacy just because there's some rheumatologist or oncologist 15 miles from you, but no other specialist within 200 miles.

So we want to reword this to make sure that insurance companies -- and I don't think they would ever interpret it this way either, but that you meet specialty care radiuses simply because you have one in your radius.

And the same for ECPs. We would want to restructure this where it's one that's needed near you, not just because you've got one that has got a status of ECP that's close by. So I don't know how to reword that. We certainly feel like it needs to be fixed as we deliberate this with the Commissioner and you.

The other comments -- quite frankly the most predominant comment from -- non-insurance company comments is related to Section 5F(2) and I've discussed this with Dr. Thompson and Zane this morning, and some of our staff that we are -- we did not put in dermatologists, and I've gotten three or four letters, why aren't we in this? I've got comments and letters from autism organizations. Why are you not putting in behavioral analysis; why are you not putting in behavioral -- or whoever.

When we start listing provider types, it's my experience with any one provider in other areas, that if you look at our Equal Reimbursement Statute and you look at AWP, when we start listing providers, every year we're going to have to add another provider who didn't

know about this who wants to be listed.

So we need to propose to the Commissioner some other language to deal with the issue of how are we going to address the need for specialty providers and subspecialists under this section to make sure they're following under the geometric radiuses for needed care. So I don't know how to reword that, but it needs to be where we don't have to keep coming back to this rule and adding dermatologist or whoever it is as we begin to do.

And I know from my experience with AWP, every session they add a new provider to AWP or equal reimbursement. Start off with just chiropractors and now they've got 26 different types. So I want to make sure we're not going down this road where I have to keep coming back to this rule and keep adding. Whether it's referencing some external list, is maybe one option, but that is another comment that we've got.

I don't want to steal the thunder of Mr. Laffoon or others, the issue about reasonable criteria companies having to reasonably strive to establish reasonable criteria for access. Why are we being so general here? Why are you not being more precise? And the reason is because we don't want to set out overly technical and objective numerical specificity that might block a plan from having to issue a policy in a county.

And it is a tightrope I have to walk. I don't want to get into making a geometric or network adequacy requirement so specific that the plan can't operate effectively in a county, where they just don't have access due to rural issues and all of that.

So the other issue is on these distances. We say reasonably strive to meet 30, reasonably strive to meet 60 miles. I don't want to get complaints from -- I don't want to enforce complaints where I get a complaint from somebody against, for example, QualChoice or Blue Cross, where somebody lives 33 miles from their residence to the PCP. We want to make sure that there is enough flexibility for us to be reasonable in reviewing adequacy without letting companies go too far away from adequacy.

So I want to give some flexibility or leeway for people who might live 34 miles or 35, so we've -- we've presented this in general terms, and the best way we can. This is a hard -- very hard regulatory issue for us that we've had to deal with over the years as we've seen hospitals drop out of networks, and we've had to deal with that, but we do need standards and this is our best attempt at doing that.

And I've gotten comments and other suggestions in the record that I would like to take up with you, and you've already read them with the

Commissioner, to tweak and improve some of these language issues that providers and insurance companies have raised.

Another one off the top of my head, on geometric map reporting, I believe Blue Cross and others have pointed out, United Healthcare, how often are we going to send these maps in? We don't address in the rule the frequency in which these maps have to be sent, in terms of when they get the plans out and market them. So we do need to address that and fix that as well.

I don't think any of these suggested edits would require re-noticing the rule. These are something I think we can deliberate on, take into consideration all of these comments and improve some of the language in the rule to address some of these issues.

That's all I have.

HEARING OFFICER: Comments, Dr. Thompson?

DR. THOMPSON: Yeah, on Rule 106 I'm here representing the interest of the Department of Human Services and the Medicaid beneficiaries that are, through premium assistance, represent over 80 percent of the covered lives in the insurance -- individual insurance marketplace. The need for network adequacy requirements through such a rule as this are an extension of the state's obligation under the Medicaid program to have minimum adequacy requirements in place for its Medicaid

program.

There's an existing memorandum agreement between the Division of Medical Services within the Department of Human Services and the Insurance Department to co-manage that program, as is in existence a three-way memorandum agreement with each of the carriers and the two agencies, DHS and AID, so I'm representing those interests here on behalf and in support of a rule such as 106.

HEARING OFFICER: Thank you. Comments, Ms. Chrisman?

MS. CHRISMAN: As Mr. Rand noted during his history of what was driving this rule, whenever the Affordable Care Act was passed, network adequacy was a part of that rule that we were required to put into place. During our first year review of those plans we were basically under operation only of the federal rule, which had a reasonableness standard, but there was not anything to define what reasonable was, so unfortunately during -- well, fortunately or unfortunately, however you choose to look at it, the reasonable standard then was -- ended up being defined by me.

So what we ended up doing was we went -- I actually went to Mr. Rand at that point and said this is the situation that I'm running into and he had mentioned that we also had these other network adequacy issues that

were occurring within the marketplace as a whole, as opposed to just the exchange marketplaces, and we kind of started trying to work through and think about those issues at that point.

We put some standards in for plan year 2014 that ended up, I think, being adequate for our means and in getting those plans approved and established for sale for the 2014 marketplace, however, it was very time intensive in terms of what we had to do for our review and I personally had a concern that if I get hit by a bus tomorrow, that you're going to end up having this continually changing determination of what reasonableness is, which would not be in the best interest of Arkansans, either the consumer or the issuers who might want to participate in our state.

At that point we went ahead and we raised this issue with our Plan Management Advisory Committee, which we have set up as a requirement under the Affordable Care Act within the Arkansas Health Connector as part of our partnership requirements.

The Plan Management Advisory Committee, it has various stakeholders from the issuers, from the consumers, in terms of advocates and other people who are just interested in the community, as well as providers. And it was almost exactly this time last year that we

actually were in this very room and we brought up the challenges that we had faced during plan year 2014 related to network adequacy.

That committee is composed of -- there's approximately 50 people that are actually voting committee members, however, we have a notification list that goes out to even more than that, probably close to 100. We went through and we discussed all of the challenges. We said that we wanted to address that through the Plan Management Advisory Committee, which we proceeded to do and actually had conversations over this for several months.

We then actually, after that, had a subcommittee and continued to discuss these items in detail. So this is not -- this is not the first time that we have discussed this topic to date. Many of the standards that you see were put together by the issuers, the consumer advocates, and the providers who came to those subcommittee and those Plan Management Advisory Committee meetings.

Following their recommendation, the recommendation was made and accepted by the Plan Management Advisory Committee, which then went through our connector and through our process under the Arkansas Health Connector, where that recommendation was made to

our Steering Committee.

The Steering Committee heard that. They actually made some additional changes to the recommendation that came from the Plan Management Advisory Committee, and that final recommendation was given to the Commissioner.

The Commissioner ended up signing off on that, and then once we had that final signature, Booth and I got together and started trying to do this compilation that you actually see before you today.

So there has been a lot of feedback already that we have tried to go ahead and put forth in this rule in order to make sure that we have everything addressed. And in something this big, whenever you're starting without any kind of rule, of course there are things that we might have missed or that we probably could have done better.

And, in fact, one of the things that Mr. Rand was talking about a minute ago in talking about the requirement for QHPs to be accredited and putting that as a requirement of the rule, and I think yesterday I sent him an e-mail saying I'm okay with that, I think I had reservations for a different reason. And as he was saying this now, then I started thinking that under the Affordable Care Act you're not required, as a QHP, to be

accredited in your first year, you just have to be seeking accreditation.

So if we put that in there, we do need to make sure that we do have some leeway related within this rule in order to not stymie anybody who might not be accredited and might want to enter the marketplace within that first year as well.

And I believe that is it, unless you have any other questions of me.

MR. RAND: And I missed a description of other comments, Ms. Hearing Officer. If we look at 5C, another comment that we need to correct relates to what happens when a healthcare carrier doesn't have enough providers to provide the covered benefit. We require the carrier to cover the person at no greater cost than if they went to an in-network provider.

One of the letters, I believe, both from Blue Cross and United Healthcare, and I bet QCA shares the same opinion, they cannot control what an out-of-network provider charges. It could be actual billed charges, and when we talk -- they can -- we can -- they can pay the in-network rate to the provider, but the out-of-network provider can provide actual amounts, so they can't -- they can't vouch for or comply with knowing that the cost -- out-of-pocket costs are going to be the same.

So we need to change that language to make it jive a little bit better with making sure that they cover their provider rate with an in-network rate of payment to the provider. I haven't thought about how it needs to be worded, but it needs to be clarified a little bit.

And the other part of Section 5C we -- and in the working groups in discussions that Zane had with the industry, we got this list of eight reports that need to be triggered when you're in 5C, and I think we've realized that if you are in 5C as a health insurance company, you don't have a provider or an in-network provider that's going to be able to give you these waiting times, referral patterns and so on, however, those are important categories we want to have reported to us, that we sort of reference up in 5A, anyway.

We want to propose to the Hearing Officer and Commissioner as we deliberate this later, to move 1 through 8 and 5C somewhere where it's applied to just basic geometrics to all plans that are in network, not out of network. The in-network provider is not going to be able to give you these hours and the carrier is not going to have a relationship with the provider to meet those. But we do want those. Those are important geometrics.

So I just want to add that another one of

the comments that we've gotten from the carriers has been 5C just needs to be improved in terms of language.

HEARING OFFICER: All right. Anything else, Dr. Thompson?

DR. THOMPSON: I would -- separate from the role that I am here for, I would just refer the Department and insurance team back to the Workforce Report that the Center for Health Improvement did two years ago, which; mapped the location of the specialists in the state by the criteria of Level 1 and Level 2 Trauma System Designation.

Clearly there are areas of the state that do not and will not meet the 60-minute requirement in this rule, so I think the flexibility to have carrier expectations and the distribution specialists leads you not be able to have an absolute threshold. You're going to have to have interpretation of -- based upon carrier and provider contracts.

HEARING OFFICER: Anything else, Zane?

MS. CHRISMAN: And I would just like to finally add that since the Commissioner ended up adopting this rule early last year, that in our effort to be fully transparent with the issuers as to what our interpretation as to what reasonable would be, and based upon their recommendation and that acceptance by the Commissioner of what the recommendation of reasonable is in terms of this,

then this was actually a -- very similar standards were published within a bulletin this year and utilized for that of the marketplace, however, we feel that it is very important for the Insurance Department and for the state, in general, to have these vetted to go through the formal rulemaking process.

HEARING OFFICER: All right. We'll see if I do better on this witness list than I did the other one.

All right. Darlene Byrd?

Please introduce yourself and tell us who you represent.

MS. BYRD: Okay. Ms. Blasingame, I am Dr. Darlene Byrd. I am an advanced practice nurse and I represent myself.

I appreciate the opportunity to express my concerns regarding Arkansas Insurance Department's proposed Rule 106, and I'm combining my comments with 108. I understand that proposed Rule 106 will set the definition and evaluation for insurance carriers to show they have an adequate provider network. Section 5 of Rule 106 defines a network as one that is sufficient in number and type of providers to ensure that all healthcare services to cover persons will be accessible without unreasonable delay.

Currently the state's major insurance

carriers recognize APRNs as primary care providers. That being the case, we should be included as we are in the definition of adequate network, and be counted as the primary care providers that we are.

I also would point out that Arkansas Medicaid regulations recognizes APRNs as providers of primary care services, however, Proposed Rule 106 is in direct conflict with Rule 108.

First, there are conflicting definitions for patient-centered medical homes between the two rules. Second, in Rule 106, APRNs are counted as primary care providers for carriers to ensure network adequacy, however, Rule 108 ties the hands of APRNs and does not recognize APRNs as primary care providers or leaders or primary care -- or patient-centered medical homes.

Therefore on paper a carrier may have an adequate network, but in reality they do not since Rule 108 will limit access to APNs and prohibit APRNs from fully practicing their profession as licensed by the State of Arkansas.

Rule 108 has the potential to injure or restrict the profession or practices of APRNs. It further violates ACA 23-99-202 by restricting the patient's right to choose their health care provider. It will disenfranchise patients from the benefits that a

patient-centered medical home may provide when the patient chooses to see an APRN exclusively or when the APRN is the only provider in the community, therefore, a carrier cannot have an adequate network because access will be limited. This creates the potential for unreasonable delay in healthcare.

In my research I have not been able to identify any specific federal or CMS rule that would prohibit APRNs from being leaders in patient-centered medical homes. In fact, all the major PCMH-certifying agencies recognizes APRNs as leaders of medical homes.

I do not believe the legislature intended to require the free market of insurance carriers to look and operate like Arkansas Medicaid as Rule 108 dictates. It is a dangerous precedent to set the state's insurance marketplace rules to that of a limited demonstration project, be it federal or state.

Therefore I would encourage the Commissioner to clear this conflict by returning to the original proposed Rule 108 that was issued May 13th, 2014, which follows the General Assembly's intent to maximize the available healthcare services and promote healthcare efficiencies that will deliver value to the Arkansas taxpayers.

The Insurance Department should produce

rules that are consistent with the legislature -- that is consistent with the legislation and the legislature's declared intent, and let the insurance carriers continue to use APRNs in their primary care provider calculations to establish network adequacies and to determine who will be leaders of the patient-centered medical homes for their beneficiaries.

Thank you for the opportunity to share my concerns.

HEARING OFFICER: You're welcome. Thank you.

Mr. Couch?

MR. COUCH: Thank you, Ms. Hearing Officer. I'm Jim Couch. That's C-O-U-C-H. I'm Vice President and General Counsel for Delta Dental Plan of Arkansas. I appreciate the opportunity to speak this morning on Proposed Rule 108. I really have just six pretty brief comments regarding -- and I'm principally focused on Section 6 of the proposed rule that deals with standalone dental plans.

So point number one, it's our understanding, and I think Mr. Rand mentioned earlier, that the intent for Rule 106 is that it would only apply to standalone dental plans to the extent that they are offering a ACA-certified plan either on or off the

exchange or outside of the marketplace.

We think that the definition of a standalone dental carrier in the definition section would -- that made that clear, would make the rule clear that that was only -- the rule would only apply to plans providing ACA-certified products.

In other words, a standalone dental plan that is not offering a certified -- ACA-certified plan would not be required to meet the requirements of Rule 106.

The second point is, Mr. Rand noted in his opening comments that in Section 5A, which is dealing with the medical plans, that there's language that specifically says that network sufficiency will be based on reasonable criteria used by the medical carrier, and he went on to mention a number of criteria that would be used.

That definition -- or language like that does not appear in the parallel section for standalone dental plans in Section 6A, and we are of the opinion that that same latitude that would be allowed for medical plans should apply to standalone dental plans. We don't see that there would be any reason for it not to be parallel.

Point number three, Mr. Rand also mentioned this for us, mentioned it in his earlier comments. Section 6A(3) addresses the essential community provider

access, and the requirement is that -- that any member purchasing a standalone dental plan would have to have access to an ECP within 30 miles of their residence.

That's just not going to be possible today for standalone dental plans. There are only 11 locations in the state that are ECPs that offer dental services, and those are really spread out across the state, and so Delta Dental has all 11 of them contracted, and certainly if there were others, we would certainly try to contract with them, but as of today I know Delta Dental could not meet this standard and I doubt any other standalone dental plan offering products on or off the exchange could meet that standard as well, so we recommend that there be further discussion with respect to that criteria. Either eliminate it, or discuss how that might be modified.

Point number four, there's a statement in Section 6B that deals with submission of metrics. The opening sentence of that section says standalone dental carriers participating in the marketplace would be required to submit certain metrics. It would be our understanding that standalone dental plans, both offering products on the marketplace, as well as ACA-certified plans off the marketplace would also be required to meet these standards. So as currently written, it would appear to only apply to marketplace products and not plans off of

the marketplace, so we think that could be corrected and have offered some suggested language.

Point number five, the access plan requirement that Mr. Rand mentioned earlier for medical plans would also apply to standalone dental plans. One of the requirements listed is that the carrier would be required to describe its procedures for making referrals within and outside of the network. I am familiar with the fact that many medical plans require referral requirements from primary care physicians to specialists. That's typically not an element of coverage requirements for standalone dental plans, and so we would suggest a minor tweak to that language, just to indicate that if that's a part of the dental plan, that that be spelled out, otherwise that that would be not required.

And then finally, Section 6G(6) of the proposed rule indicates that a standalone dental plan would have to indicate providers -- its providers participating in the patient-centered medical home, which does not apply to standalone dental plans, and so we would recommend that that be struck from the proposed rule.

And unless you have questions, those are our comments.

HEARING OFFICER: Any questions for Mr. Couch?

MR. COUCH: Thank you.

HEARING OFFICER: Mr. Sewall?

MR. SEWALL: Good morning. My name is Frank Sewall; S-E-W-A-L-L. I am Senior Counsel for Regulatory Affairs at Arkansas Blue Cross & Blue Shield, and I have some very brief remarks, many of which are made briefer because of the comments that Mr. Rand made in his opening statement, which indicates that he read some of the comments that I put in my October 27th letter, which is already part of the record, so I'm not going to repeat them.

I do want to emphasize that Arkansas Blue Cross & Blue Shield believes that carriers which issue health insurance plans providing insureds richer benefits if the insured uses a healthcare provider in a preferred provider network has an obligation set out in federal law, as Ms. Chrisman mentioned, to include a breath of in-network providers that give insureds the ability to receive necessary healthcare, and therefore we understand the need that the Department has for adopting this rule and we appreciate the principles that are in the rule, and we also applaud the Department for actually adopting a rule in this area.

As Ms. Chrisman mentioned, the health carriers that are currently involved in the exchange

offering plans in the marketplace, and hopefully if we're all certified after the election to offer plans in 2015, submitted in-network metrics and so forth based on a bulletin that the Department issued and, therefore, from a legal, technical regulatory point of view we voluntarily complied with those requirements since there was no rule in place to actually enforce those requirements.

And I know that this rule offered -- provides for a -- an effective date of January 1st, 2015, which in normal circumstances would probably cause all of us insurers heartburn in order to get the provisions of the rule in place, but since we all had to voluntarily comply with them any way, I don't think that's a real problem, except maybe with respect to Section 5I, which I will talk about in a few minutes or very shortly.

I want to applaud the Department and appreciate the reasons that Mr. Rand mentioned Section 5B of the rule, which states that -- which provides that healthcare shall strive to meet the following guidelines related to geography, accessibility through geographical access or other information.

It's important that any rule that's adopted give flexibility to reflect the geography, the demographics and patterns of care and the market conditions in Arkansas. We all know that as much as we

would like it to be different, that healthcare providers, especially in certain specialties, are not equally distributed throughout the state. They seem to concentrate in urban areas in our state, in Central Arkansas and Northwest Arkansas, and, therefore, there are areas of the state in which meeting the requirements of this rule for certain specialists would just be impossible and have been impossible. If there's no provider down there to contract with, then we're not going to be able to have a provider within the mileage parameters.

Section 5C, I think Booth has commented sufficiently on that. I agree with everything he said. I look forward to seeing what the language of that section will look like in the rule that's adopted.

Turning to Section 5I, the requirement for carriers to provide a access plan, it's important to note, and Booth mentioned this, that many of the provisions of this rule come from the NAIC model Managed Care Plan Act that was adopted some eighteen years ago, prior to the time that we had the modern means of communications through Internet and electronics and so forth that we have now. Prior to the time that we had national accrediting agencies such as the NCQA or URAC.

I can speak for URAC and I have with me, in case you all have some specific questions, Ms. Karen

Black, who is the Quality and Accreditation Manager for Arkansas Blue Cross & Blue Shield. She can answer any questions that you have with respect to the provisions of 5I of the requirements.

URAC requires plans to meet each and every one of those provisions that are listed in Section 5I. And for carriers to have to develop another report -- and incidentally the way the rule reads, it's not only for the Insurance Department, but we're required to have this available at our -- on our business premises and available for insureds or consumers or anyone, actually, any interested party upon request.

You know, we provide this information upon request, either on our websites, or through our customer services, or through our case managers, and that information is provided to those people when they need it, but no one, I don't believe, would want to have -- you know, just to have a report that lists all twelve of these items just for their own reading pleasure, unless they're suffering from insomnia.

So I would urge that the Department allow plans that have the appropriate national accreditation, and who are willing to provide any of the eleven or twelve items that are listed in that section to the Department upon request of the Commissioner, that those plans not be

required to develop this network adequacy report.

Ms. Hearing Officer, that concludes my remarks.

HEARING OFFICER: Any questions for Mr. Sewall?

Thank you.

MR. SEWALL: Thank you.

HEARING OFFICER: Mr. Laffoon?

MR. LAFFOON: Yes, I'm David Laffoon from Searcy, Arkansas, and Little Rock, Arkansas. I live in both places, and I'm here to represent my grandson. That's him, and that's the only reason I'm here. I didn't want to be here, certainly, and I sent comments to Mr. Rand and I decided that even though I sent those, I needed to say a couple of things.

So, first, I want to thank the Department for developing these regulations. They're very much needed. We currently don't really have any kind of regulations that regulates the networks, so therefore in some areas we have no networks. I'm going to be speaking specifically about autism because my grandson is autistic. He's five years old, so I've developed a keen interest in autism and I'm concerned that the network adequacy rules does not include ABA therapy at the level that my grandson will be able to receive those benefits.

The CDC has determined that 1 in 64 children in Arkansas have autism. Based on 2010, that's about 12,000 kids. It's well-documented that those who do not receive ABA often face a terrible life, and the cost of taking care of an autistic child can run anywhere from 1.4 to 2.4 million. That's without ABA therapy, which has been shown to lower those costs. This number has continued to increase as the rate is increasing at about 14 percent annually.

Most of the children in Arkansas covered under private individual insurance and group health insurance do not have access to the central health benefit, ABA therapy. Currently the state's largest insurer has only four providers in network, and has none in Northwest Arkansas, and unfortunately my grandson lives in Northwest Arkansas, in Bentonville.

Arkansas' second largest insurer has seven in the network. There were more providers, but they've dropped out due to the reduction in rates for this therapy.

And to get into specific issues on the rule, in Section 5B where it talks about the distance from a -- for treatment, it uses a 30 mile and a 60-mile rule, and the way I understood it, the ABA therapy would fall under the 30-mile rule, which I think it's probably

appropriate. I hope it's under the 30 miles because these children receive 25 to 40 hours a week of ABA, which means they have to go to a clinic every day and come back, so 60 miles would be very difficult.

Under 5C, where it talks about remedies for families who do not have access to providers of covered benefits, it says that the carrier shall ensure that the covered person obtains the covered benefit at no cost greater to the covered person. Currently that's not what's happening because if there's no network, I guess you have to pay out-of-network rates or you just don't get the service.

And more specifically on the -- where you accept the accreditation bodies to document certain evidence in meeting the rule, I'm concerned because I don't think most of the accrediting bodies look at ABA therapy. I could be wrong about that, but if they don't, then we need another way to look and see if they're providing ABA therapy.

So in conclusion, Mr. Rand had already received my comments and had looked at them, and I really appreciate the effort of he and the group and the Insurance Department, and thank you.

HEARING OFFICER: Anyone have any questions for Mr. Laffoon?

Thank you.

Mr. Rand, any reason to leave the record open on this rule?

MR. RAND: I have no reason to leave the record open, but let me say that if it's going to close the record right now, I will bet you that when I go back up to my office, someone has sent in comments because people wait until the day of the hearing to send me comments.

HEARING OFFICER: How about close of business today?

MR. RAND: 4:30 would be great.

HEARING OFFICER: Okay.

MR. RAND: And let me add one more thing that I didn't talk about on fixes that are needed. There are several, unfortunately, federal citation errors in the proposed rule. As we lawyers look at this, it's amazing that out of nine lawyers we will not see wrong federal cites. So there are some CFRs that should be USC and some USC that should CFR. We are going to fix those. We know what they are, we know what they need to be, so I have nothing further.

HEARING OFFICER: Anything further, Ms. Chrisman?

MS. CHRISMAN: No.

HEARING OFFICER: Dr. Joe?

DR. THOMPSON: No.

HEARING OFFICER: All right. If nothing further, this hearing is adjourned.

(WHEREUPON, at 11:50 a.m., the above hearing concluded.)

C E R T I F I C A T E

STATE OF ARKANSAS }
}
COUNTY OF FAULKNER}

RE: IN THE MATTER OF RULE 108-"NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS"

I, Michelle R. Satterfield, CCR, a Notary Public in and for Faulkner County, Arkansas, do hereby certify that the transcript of the foregoing public hearing accurately reflects the testimony given; and that the foregoing was transcribed by me, or under my supervision, on my Eclipse computerized transcription system from my machine shorthand notes taken at the time and place set out on the caption hereto.

I FURTHER CERTIFY that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was taken; and, further that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested, or otherwise, in the outcome of this action.

GIVEN UNDER MY HAND AND SEAL OF OFFICE on this the 6th day of November 2014.

MICHELLE SATTERFIELD ARKANSAS SUPREME COURT No. 570 CERTIFIED COURT REPORTER

MICHELLE RENEE SATTERFIELD NOTARY My Comm. Expires FEB 9 2019 #12369856 PUBLIC FAULKNER COUNTY, ARK.

Michelle R. Satterfield, CCR
ITS Certificate No. 570
Notary Public in and for
Faulkner County, Arkansas
Notary License #12369856

My commission expires: February 9, 2019.

EXHIBIT LIST

DATE: **October 29, 2014**

SUBJECT: **PROPOSED RULE 106: "Network Adequacy Requirements For Health Benefit Plans"**

HEARING OFFICER: **LENITA BLASINGAME, CHIEF DEPUTY COMMISSIONER & HEARING OFFICER**

EXHIBIT # DESCRIPTION

1 Designation of Hearing Officer

2 Arkansas Insurance Department 9-11-2014 Notice of Public Hearing concerning Rule 106 "Network Adequacy Requirements For Health Benefit Plans"

3 Proposed Rule 106 "Network Adequacy Requirements For Health Benefit Plans" filed 9-11-14

4 Proof of Publication of Hearing on Proposed Rule 106 in the Arkansas Democrat-Gazette as required by Arkansas Administrative Procedures Act, Ark. Code Ann. §§ 25-15-201, *et seq.*

a) Email to Arkansas Democrat Gazette 9-15-2014
b) 9-11-2014 Cover Letter to ADG
c) Copy of ADG Notice
d) Copy of ADG Billing and Notice
e) Copy of ADG receipt

5 September 16, 2014 Evidence of Blast Mail concerning Proposed Rule 106 "Network Adequacy Requirements For Health Benefit Plans""

6 9-11-2014 ALC Cover Letter, Questionnaire and Financial Impact Statement for Proposed Rule 106 "Network Adequacy Requirements for Health Benefit Plans" Summary, and Economic Impact Statement.

a) Questionnaire
b) Financial Impact
c) Summary
d) Economic Impact

7 Copy of September 11, 2014 correspondence to James Miller, Regulatory Liaison, Office of the Governor, providing Notice of Public Hearing and Proposed Rule 106

8 Copy of September 11, 2014 correspondence to Brandon Robinson, Assistant Attorney General, Office of the Attorney General, providing Notice of Public Hearing and Proposed Rule 106

9 Copy of September 11, 2014 correspondence to Arkansas Secretary of State, providing copies of the Notice of Hearing and Proposed Rule 106

10 Copy of September 11, 2014 correspondence to Pat Brown, Arkansas Economic Development Commission, providing Notice of Hearing and a copy of Proposed Rule 106

11 Public Comments after 9-11-2014

MEMORANDUM

TO: Lenita Blasingame, Chief Deputy Commissioner

FROM: Jay Bradford, Insurance Commissioner

SUBJECT: Designation of Hearing Officer

DATE: October 28, 2014

Pursuant to Ark. Code Ann. §23-61-103(e)(1), I am delegating to you the duty of Hearing Officer in the matter of "Rule 106 Network Adequacy", on October 29, 2014 at 10:00 a.m., or any postponement thereof.

10-28-14

EXHIBIT

1

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

DATE: SEPTEMBER 11, 2014

TO: ALL ACCIDENT AND HEALTH INSURERS, HEALTH MAINTENANCE ORGANIZATIONS AND HOSPITAL AND MEDICAL SERVICE CORPORATIONS & OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: RULE 106: "NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS"

NOTICE OF PUBLIC HEARING

Please find attached or available by electronic publication by the Arkansas Insurance Department ("Department") Proposed Rule 106, "Network Adequacy Requirements For Health Benefit Plans." The Arkansas Insurance Commissioner ("Commissioner") is proposing to issue medical network requirements for health plans in the individual and group market, as defined in the Proposed Rule, which use medical provider networks for plans issued or renewed on or after January 1, 2015.

Pursuant to Ark. Code Ann. §§23-61-108(a)(1), 23-61-108(b)(1), 23-76-108(a), and 25-15-204, and other applicable laws or rules, NOTICE is hereby given that a PUBLIC HEARING will be held on October 29, 2014, at 10:00 A.M., in the First Floor Hearing Room, Arkansas Insurance Department ("Department"), 1200 West Third Street, Little Rock, Arkansas.

The purpose of the Public Hearing will be to determine whether the Commissioner should adopt Proposed Rule 106, "NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS."

All interested persons are encouraged to attend the Public Hearing and may appear and present, orally or in writing, statements, arguments or opinions on the proposed Rule. All licensees and other interested persons are responsible for notifying all their personnel, agents, and employees about this Public Hearing.

Persons wishing to testify should notify the Legal Division as soon as possible, and are requested to submit intended statements in writing in advance.

Direct your inquiries to the Legal Division at (501) 371-2820 or insurance.legal@arkansas.gov.

A copy of Proposed Rule 106 can be obtained or viewed on the Legal Division's Internet Web Site at http://insurance.arkansas.gov/Legal%20Dataservices/divpage.htm.

Sincerely,

Booth Rand
Managing Attorney
Arkansas Insurance Department
(501) 371-2820

BR/lrr

EXHIBIT
2

PROPOSED RULE 106
NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS

Table of Contents

Section 1. Authority

This Rule is issued pursuant to the authority granted the Arkansas Insurance Commissioner ("Commissioner") under Ark. Code Ann. § 23-61-108(a)(1) and by Ark. Code Ann. § 23-61-108(b)(1) to promulgate rules necessary for the effective regulation of the business of insurance and as required for this State to be in compliance with federal laws, namely Section 2702(c) of the Public Health Service Act and 45 CFR 156.230 which require that qualified health plans provide sufficiently accessible medical providers. In addition, this Rule is issued pursuant to the authority granted the Commissioner to issue regulations related to the provision of adequate health care services by health maintenance organizations under Ark. Code Ann. § 23-76-108(a).

Section 2. Purpose

The purpose of this Rule is to establish standards for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility and quality of health care services offered under health benefit plans.

Section 3. Definitions

For purposes of this Rule:

A. "Accredited health carrier" means a Health carrier which has an adequate network as certified by an approved accrediting organization under the provisions of Section 5 (K) of this Rule.

B. "Commissioner" means the Arkansas Insurance Commissioner.

C. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

D. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

E. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

F. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

G. "Essential community provider" means a provider that serves predominantly low income, medically underserved individuals as defined in 45 C.F.R. §156.235.

H. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

I. "Health benefit plan" means any individual, blanket, or group plan, policy or contract for health care services issued or renewed by a health carrier on or after January 1, 2015 which requires a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. "Health benefit plan" does not include a plan providing health care services pursuant to Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq., nor include an accident-only, specified disease, hospital indemnity, long-term care, disability income, or limited-benefit health insurance policy. The provisions of this Rule shall not apply to Medicare supplement or Medicare Advantage policies or policies offering coverage through Medicare. This Rule shall also not apply to vision or dental only plans unless such plans are subject to Section Six (6) of this Rule.

J. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform physical, behavioral, mental health or substance use disorder and health services consistent with state law.

K. "Health care provider" or "provider" means a participating health care or dental professional or a facility.

L. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

M. "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization , a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. A Health Carrier does not include an automobile insurer paying medical or hospital benefits under Ark. Code Ann. §23-89-202(1) nor shall it include a self-insured employer health benefits plan. A Health Carrier also does not include any person, company, or organization, licensed or registered to issue or who issues any insurance policy or insurance contract in this State providing medical or hospital benefits for accidental injury or accidental disability. A Health Carrier shall include a Stand-alone Dental Carrier subject to Section Six (6) of this Rule.

N. "Network" means the group of participating providers providing services to a health benefit plan.

O. "Provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

P. "Patient Centered Medical Home" ("PCMH") means a local point of access to care that proactively looks after patients' health on a "24-7" basis. A PCMH supports patients to connect with other providers to form a health services team, customized for their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care.

Q. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

R. "Primary care professional" means a participating health care professional practicing within their licensed scope of practice and designated by

the health carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

S. "Qualified Health Plan" means an insurance policy that meets the requirements of 42 C.F.R. §18021(a)(1).

T. "Specialty care professional" means a participating health care professional that is specialty qualified to practice by having attended an advanced program of study, passed an examination given by an organization of the members of the specialty, or gained experience through extensive practice in the specialty.

U. "Stand-alone Dental Carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract, or enters into an agreement to solely provide, deliver, arrange for, pay for or reimburse any of the costs of dental services.

Section 4. Applicability and Scope

This Rule applies to all health carriers that offer health benefit plans in this State which are issued or renewed on or after January 1, 2015.

Section 5. Network Adequacy

A. A Health carrier providing a Health benefit plan shall maintain a network that is sufficient in numbers and types of providers to assure that all Health care services to covered persons will be accessible without unreasonable delay. Sufficiency may be established by reference to any reasonable criteria used by the Health carrier, including but not limited to: provider to covered person ratios by specialty; Primary care professional to covered person ratios; typical referral patterns; provider's hospital admitting privileges; geographic accessibility; waiting times for appointments with Participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

B. Every Health carrier shall strive to meet the following guidelines related to geographic accessibility through geographical access maps or other information:

(1) In the case of emergency services, a covered person will have access to emergency services, twenty-four (24) hours per day, seven (7) days per week within a thirty (30) mile radius between the location of the emergency services and the residence of the covered person;

(2) In the case of a Primary care professional, a covered person will have access to at least one Primary care professional within a thirty (30) mile radius between the location of the Primary care professional and the residence of the covered person;

(3) In the case of a Specialty care professional, a covered person will have access to at least one Specialty care professional within a sixty (60) mile radius between the location of the Specialty care professional and the residence of the covered person; and

(4) For Qualified Health Plans participating in the ACA approved Marketplace, in the case of Essential Community Providers, a covered person will have access to at least one Essential Community Provider within a thirty (30) mile radius between the location of the Essential community provider and the residence of the covered person.

C. In the event that a Health carrier has an insufficient number or type of participating providers to provide a covered benefit, the Health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from Participating providers, or shall make other arrangements acceptable to the Commissioner that shall include reasonable criteria utilized by the carrier including but not limited to:

(1) provider to covered person ratios by specialty;
(2) primary care provider to covered person ratios;
(3) typical referral patterns;
(4) provider's hospital admitting privileges;
(5) geographic accessibility;
(6) waiting times for appointments with participating providers;
(7) general hours of operation, including part or full time status and weekend and after hour availability; and
(8) the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

D. In determining whether a health carrier has complied with the requirements in this Section, the Commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

E. A Health carrier shall monitor, on an ongoing basis, the ability of its Participating providers to furnish all contracted benefits to covered persons.

F. Geographical access maps and compliance percentages must be submitted for each of the categories of care referenced in Section 5(B)(1-4). Requested maps may be submitted separately or combined and distinguished by color or other method. The maps must indicate which providers are accepting new patients. The following are special requirements for each category of care:

(1) Health carriers must provide geographical access maps for Primary care professionals that include each general/family practitioner, internal medicine provider, and family practitioner/pediatrician.

(2) Health carriers must provide geographical access maps for hospitals and Specialty Care Providers according to the following categories:

(a) hospitals by Arkansas hospital licensure type;
(b) home health agencies;
(c) cardiologists;
(d) oncologists;
(e) obstetricians;
(f) pulmonologists;
(g) endocrinologists;
(h) skilled nursing Facilities;
(i) rheumatologists;
(j) ophthalmologists;
(k) urologists;
(l) psychiatrists and State licensed clinical psychologists; and
(m) behavioral health.

(3) Health carriers must provide geographical access maps for mental health, behavioral health, and substance disorder providers categorized between:

(a) psychiatric and state licensed clinical psychologists;
(b) substance use disorder providers; and
(c) other mental health, behavioral health, and substance use disorder providers with additional documentation describing the provider and facility types included within the other category.

(4) Health carriers must provide geographical access maps for Essential Community Providers with the providers grouped within the following categories:

(a) federally qualified health centers;
(b) Ryan White provider;
(c) family planning provider;
(d) Indian provider;
(e) hospital; and
(f) other Essential community providers including but not limited to school based providers.

G. Performance Metrics: Non-accredited Health carriers will be required to submit metrics demonstrating performance for each of the standards above for each county in the service area and overall service area. Accredited Health carriers will be required to submit the following metrics for reporting purposes. These include:

(1) The number of members and percentage of total members meeting the geographical requirements under Section 5 (B) of this Rule.

(2) The average distance to first, second, and third closest provider for each provider type.

These figures should be provided overall (entire state) for each category as well as stratified by county for each category. For example, the percent of enrolled members that are within 30 minutes or 30 miles of a general/family practitioner will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be submitted overall and for each county. Health carriers who do not yet have enrollees in the State of Arkansas will be exempt from this requirement and must attest to not currently having enrollees in Arkansas.

H. Essential Community Providers. Health carriers issuing Qualified Health Plans are required to meet all federal requirements for inclusion of Essential community providers in the plan network. Qualifying Essential community providers include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. In addition, the following State guidelines must be met regarding Essential community providers:

(1) Each Health carrier issuing Qualified health plans will be required to meet conditions of the Heath Care Independence Program 1115 Waiver and offer at least one Qualified health plan that has at least one federally qualified health center or rural health center in each service area of the plan network.

(2) Each Health carrier issuing Qualified health plans must submit a list of school-based providers included in the plan network.

(3) Each Health carrier issuing Qualified health plans must offer a contract to at least one school-based provider in each county in the service area, where a school-based provider is identifiable and available and meets issuer certification and credentialing standards.

I. Access plans. A Health carrier shall file with the Commissioner an access plan meeting the requirements of Section 5(I)(1)- (12) of this Rule for Health benefit plans issued or renewed in this State on or after January 1, 2015. A Health carrier may request the Commissioner to deem sections of the access plan to be proprietary or competitive information that shall not be made public. For the purposes of this subsection, information is proprietary or competitive if revealing the information would cause the Health carrier's competitors to obtain valuable business information that could place the competing carrier at a competitive advantage. The Health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to any interested party upon request. The Health carrier shall prepare an access plan prior to offering a new health benefit plan, and shall update an existing access plan whenever it makes any material change to an existing health benefit plan such as the loss of a material provider such as a hospital or multi-specialty clinic. The access plan shall describe or contain at least the following:

(1) The Health carrier's network;

(2) The Health carrier's procedures for making referrals within and outside its network and for notifying enrollees and potential enrollees regarding availability of network and out-of-network providers;

(3) The Health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans;

(4) The Health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(5) The Health carrier's methods for assessing the health care needs of covered persons;

(6) The Health carrier's method of informing covered persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(7) The Health carrier's method for assessing consumer satisfaction;

(8) The Health carrier's method for using assessments of enrollee complaints and satisfaction to improve carrier performance;

(9) The Health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(10) The Health carrier's process for enabling covered persons to change primary care professionals;

(11) The Health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

(12) Any other information required by the Commissioner to determine compliance with the provisions of this Rule.

J. Provider Directories. A health carrier shall make a provider directory available for online publication by the Commissioner and shall also make its provider directory accessible by a link to the health carrier's website and to potential enrollees in hardcopy upon request. The provider directory shall identify providers who are currently accepting new patients.

(1) Health carriers shall update any changes to the provider directory within fourteen (14) days of that change becoming effective.

(2) If the provider directory must be taken off line for any reason for a period to exceed 48 hours, that carrier shall notify the Department at least two (2) weeks in advance of the provider directory going off line, or as soon as practically known. In the Department notification, health carriers shall state the reason for online unavailability, what steps are being taken to get the information back online, and expected online re-launch date.

(3) Online provider directories must be available in Spanish.

(4) The directory search must include the ability to filter by each category of ECP.

(5) The directory search must include an indication of hours of operation including part-time or full-time as well as after-hours availability as reported by providers.

(6) Providers who participate in the Patient-Centered Medical Home program must be indicated in the provider directory.

K. If a Health carrier has accreditation that includes an audit of the Health carrier's network adequacy, the Commissioner will accept that accreditation in lieu of the Health carrier demonstrating it has complied with the requirements under Section 5 (A) through (H) of this Rule, if the following conditions are met:

(1) A certificate of accreditation must be submitted by the certified accrediting entity that is recognized pursuant to 45 CFR 275, or any other certified entity as recognized by the Arkansas Insurance Department;

(2) The certified accrediting entity has submitted information showing that its audit includes a review of all reasonable and/or necessary requirements of state and federal law; and

(3) The Health carrier agrees to provide to the Arkansas Insurance Department any and all material and information submitted to the certified accrediting entity upon the Commissioner's request.

(4) The accredited Health carrier has submitted annual geographical access maps and performance metrics as required in Section 5 of this Rule for reporting purposes only.

(5) The Commissioner reserves the right to reverify compliance of network adequacy as a part of any quarterly audit or request for certification of a Qualified Health Plan.

Section 6. Stand-alone Dental Plans

(A) For stand-alone dental plans offered through the ACA approved Marketplace or where a stand-alone dental plan is offered outside of the ACA approved marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits, all such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions. Dental networks for oral services must be sufficient for the enrollee population in the service area based on potential utilization. Networks shall strive to meet the following guidelines through geographical access maps or other information:

(1) In the case of a non-specialist oral care provider, a covered person will have access to at least one dentist within a thirty (30) mile radius between the location of the dentist and the residence of the covered person;

(2) In the case of a specialist oral care provider, a covered person will have access to at least one specialist dentist within a sixty (60) mile radius between the location of the Specialty care professional and the residence of the covered person; and

(3) A covered person will have access to at least one Essential community provider within a thirty (30) mile radius between the location of the Essential community provider and the residence of the covered person.

For purposes of satisfying the requirements of Section 6(A)(1)-(3) of this Rule, a Stand-alone dental carrier may submit an accreditation that such requirements are met by a certified accredited entity abiding by the same conditions as described in Section 5(K)(1)-(5) of this Rule.

(B) Stand-alone dental carriers participating in the Marketplace will be required to submit metrics demonstrating performance for each of the standards above for each county in the service area and overall service area. These figures should be provided overall (entire state) for each category as well as stratified by county for each category. For example, the percent of enrolled members that are within 30 minutes or 30 miles of a general dentist will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be submitted overall and for each county. These include:

(1) The number of members and percentage of total members meeting the geographical requirements under Section 6 (A) of this Rule.

(2) The average distance to first, second, and third closest provider for each provider type.

(3) Stand alone dental carriers who do not yet have enrollees in the State of Arkansas will be exempt from this requirement and must attest to not currently having enrollees in Arkansas.

(C) In the event that a Stand-alone dental carrier has an insufficient number or type of participating providers to provide a covered benefit, the Health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from Participating providers, or shall make other arrangements acceptable to the Commissioner that shall include reasonable criteria utilized by the carrier including but not limited to:

(1) provider to covered person ratios by dental specialty;
(2) general dentist to covered person ratios;
(3) typical referral patterns;
(4) geographic accessibility;
(5) waiting times for appointments with participating providers;
(6) general hours of operation, including part or full time status and weekend and after hour availability; and

(D) In determining whether a health carrier has complied with the requirements in this Section, the Commissioner shall give due consideration to the relative availability of dental providers in the service area under consideration.

(E) A Stand-alone dental carrier shall monitor, on an ongoing basis, the ability of its Participating providers to furnish all contracted benefits to covered persons.

(F) Access plans. A Stand alone dental carrier shall file with the Commissioner an access plan meeting the requirements of Section 6(F)(1)- (12) of this Rule for Stand-alone dental plans issued or renewed in this State on or after January 1, 2015. A Health carrier may request the Commissioner to deem sections of the access plan to be proprietary or competitive information that shall not be made public. For the purposes of this subsection, information is proprietary or competitive if revealing the information would cause the Stand-alone dental carrier's competitors to obtain valuable business information that could place the competing carrier at a competitive advantage. The Stand-alone dental carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to any interested party upon request. The Stand-alone dental carrier shall prepare an access plan prior to offering a new stand-alone dental plan, and shall update an existing access plan whenever it makes any material change to an existing stand-alone dental plan such as the loss of a material provider. The access plan shall describe or contain at least the following:

(1) The Stand-alone dental carrier's network;

(2) The Stand-alone dental carrier's procedures for making referrals within and outside its network and for notifying enrollees and potential enrollees regarding availability of network and out-of-network providers;

(3) The Stand-alone dental carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans;

(4) The Stand-alone dental carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(5) The Stand-alone dental carrier's methods for assessing the health care needs of covered persons;

(6) The Stand-alone dental carrier's method of informing covered persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(7) The Stand-alone dental carrier's method for assessing consumer satisfaction;

(8) The Stand-alone dental carrier's method for using assessments of enrollee complaints and satisfaction to improve carrier performance;

(9) The Stand-alone dental carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(10) The Stand-alone dental carrier's process for enabling covered persons to change non-specialist dental providers;

(11) The Stand-alone dental carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's

insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

(12) Any other information required by the Commissioner to determine compliance with the provisions of this Rule.

(G) Provider Directories. A Stand-alone dental carrier shall make a provider directory available for online publication by the Commissioner and shall also make its provider directory accessible by a link to the Stand-alone dental carrier's website and to potential enrollees in hardcopy upon request. The provider directory shall identify providers who are currently accepting new patients.

(1) Stand-alone dental carriers shall update any changes to the provider directory within fourteen (14) days of that change becoming effective.

(2) If the provider directory must be taken off line for any reason for a period to exceed 48 hours, that carrier shall notify the Department at least two (2) weeks in advance of the provider directory going off line, or as soon as practically known. In the Department notification, Stand-alone dental carriers shall state the reason for online unavailability, what steps are being taken to get the information back online, and expected online re-launch date.

(3) Online provider directories must be available in Spanish.

(4) The directory search must include the ability to filter by ECP.

(5) The directory search must include an indication of hours of operation including part-time or full-time as well as after-hours availability as reported by providers.

(6) Providers who participate in the Patient-Centered Medical Home program must be indicated in the provider directory.

Section 7. Enforcement

The penalties, license actions or orders as authorized under Ark. Code Ann. § 23-66-210 shall apply to violations of this Rule.

Section 8. Effective Date

The effective date of this Rule is January 1, 2015.

JAY BRADFORD
INSURANCE COMMISSIONER

DATE

LoRraine Rowland

From: Legal Ads <legalads@arkansasonline.com>
Sent: Thursday, September 11, 2014 1:43 PM
To: LoRraine Rowland
Subject: Re: Legal ad 106

Received and processed to begin on the 14th of Sept. for 3 days
Thanks
Pam

From: LoRraine Rowland
Sent: Thursday, September 11, 2014 1:38 PM
To: Legal Ads (legalads@arkansasonline.com)
Cc: LoRraine Rowland ; Booth Rand
Subject: Legal ad 106

Please find attached a Legal Notice for Proposed Rule 106. Please provide me with the dates this ad will run.

Thank you,

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

EXHIBIT
4a

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 11, 2014

Arkansas Democrat-Gazette
P O Box 2221
Little Rock, AR 72203
Attn: Ms. Pam Dicus, Legal Ad Department
Facsimile: 501-378-3591

RE: Legal Notices: Public Hearing on Proposed Rule # 106

Dear Ms. Dicus:

The Insurance Commissioner is proposing to adopt Rule 106, "Network Adequacy Requirements For Health Benefit Plans." In order to publish it per the Arkansas Administrative Procedure Act, as amended, and per the Arkansas Insurance Code, we need to publish a **FULL RUN** legal ad or notice on the Commissioner's Public Hearing for the Rule set on October 29, 2014 at 10:00 a.m.

In compliance with Ark. Code Ann. § 25-15-204 and § 16-3-102, please find enclosed a legal ad for Notice of Public Hearing which should be published for three (3) consecutive days beginning on April 14, 2014.

Please send the billing invoices to Mrs. Pam Looney, Assistant Commissioner, Accounting Division, Arkansas Insurance Department, 1200 West Third, Little Rock, Arkansas 72201-1904, accompanied by a printed copy of the Legal Ad and proof of publication. Thank you in advance for your cooperation.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

LRR

Attachment – Legal Ad for Proposed Rule 106 Adoption

cc: LoRraine Rowland, Administrative Analyst

EXHIBIT
4b

NOTICE OF PUBLIC HEARING

The Arkansas Insurance Department will host a Public Hearing on October 29, 2014 beginning at 10:00 a.m. in the First Floor Hearing Room, Arkansas Insurance Department, 1200 West Third Street (Third and Cross Streets), Little Rock, Arkansas, to consider adoption of proposed Rule 106, "Network Adequacy Requirements For Health Benefit Plans." Copies of proposed Rule 106 may be obtained by writing or calling the Arkansas Insurance Department, or by visiting our Internet site at http://www.state.ar.us/insurance/legal/legal_p1.html. Or www.accessarkansas.org/insurance for links there. For more information, please contact Ms. LoRraine Rowland, Legal Division, Arkansas Insurance Department at 501-371-2820.

Arkansas Democrat Gazette

STATEMENT OF LEGAL ADVERTISING

ARK INSURANCE DEPARTMENT
1200 W THIRD
LITTLE ROCK AR 72201

ATTN: Pam Looney
DATE : 09/16/14 INVOICE #: 2938105
ACCT #: L801001 P.O. #:

REMIT TO:
ARKANSAS DEMOCRAT-GAZETTE, INC.
P.O. BOX 2221
LITTLE ROCK, AR 72203

BILLING QUESTIONS CALL 378-3812

STATE OF ARKANSAS,)
COUNTY OF PULASKI,) ss.

I, Annette Holcombe do solemnly swear that I am the Legal Billing Clerk of the Arkansas Democrat - Gazette, a daily newspaper printed and published in said County, State of Arkansas; that I was so related to this publication at and during the publication of the annexed legal advertisement in the matter of:

HEARING

pending in the Court, in said County, and at the dates of the several publications of said advertisement stated below, and that during said periods and at said dates, said newspaper was printed and had a bona fide circulation in said County; that said newspaper had been regularly printed and published in said County, and had a bona fide circulation therein for the period of one month before the date of the first publication of said advertisement; and that said advertisement was published in the regular daily issues of said newspaper as stated below.

DATE	DAY	LINAGE	RATE	DATE	DAY	LINAGE	RATE
09/14	Sun	33	1.45				
09/15	Mon	33	1.25				
09/16	Tue	33	1.25				

TOTAL COST ---------- 130.35
Billing Ad #: 72803371

OFFICIAL SEAL - No. 12347408
DEANNA GRIFFIN
NOTARY PUBLIC - ARKANSAS
PULASKI COUNTY
MY COMMISSION EXPIRES 01-30-2016

Kenneth M Holcombe

Subscribed and sworn to me this 16
day of Sept ,20 14

Deanna Griffin
Notary Public

NOTICE OF PUBLIC HEARING
The Arkansas Insurance Department will host a Public Hearing on October 29, 2014 beginning at 10:00 a.m. in the First Floor Hearing Room, Arkansas Insurance Department, 1200 West Third Street (Third and Cross Streets), Little Rock, Arkansas, to consider adoption of proposed Rule 106, "Network Adequacy Requirements For Health Benefit Plans." Copies of proposed Rule 106 may be obtained by writing or calling the Arkansas Insurance Department, or by visiting our Internet site at http://www.state.ar.us/insurance/legal/legal_p1.html. Or www.accessarkansas.org/insurance for links there. For more information, please contact Ms. LoRraine Rowland, Legal Division, Arkansas Insurance Department at 501-371-2820.
72803371f

RECEIVED
SEP 18 2014
ACCOUNTING
ARKANSAS INSURANCE DEPARTMENT

EXHIBIT
4d

Arkansas Democrat Gazette

STATEMENT OF LEGAL ADVERTISING

ARK INSURANCE DEPARTMENT
1200 W THIRD
LITTLE ROCK AR 72201

ATTN: Pam Looney
DATE : 09/16/14 INVOICE #: 2938105
ACCT #: L801001 P.O. #:

REMIT TO:
ARKANSAS DEMOCRAT-GAZETTE, INC.
P.O. BOX 2221
LITTLE ROCK, AR 72203

BILLING QUESTIONS CALL 378-3812

STATE OF ARKANSAS, }
COUNTY OF PULASKI, } ss.

I, Annette Holcombe do solemnly swear that I am the Legal Billing Clerk of the Arkansas Democrat - Gazette, a daily newspaper printed and published in said County, State of Arkansas; that I was so related to this publication at and during the publication of the annexed legal advertisement in the matter of:

HEARING

pending in the Court, in said County, and at the dates of the several publications of said advertisement stated below, and that during said periods and at said dates, said newspaper was printed and had a bona fide circulation in said County; that said newspaper had been regularly printed and published in said County, and had a bona fide circulation therein for the period of one month before the date of the first publication of said advertisement; and that said advertisement was published in the regular daily issues of said newspaper as stated below.

DATE	DAY	LINAGE	RATE	DATE	DAY	LINAGE	RATE
09/14	Sun	33	1.45				
09/15	Mon	33	1.25				
09/16	Tue	33	1.25				

TOTAL COST ---------- 130.35
Billing Ad #: 72803371

AD COPY

PLEASE REMIT THIS COPY WITH PAYMENT

IN ACCORDANCE WITH FEDERAL RESERVE GUIDELINES, CHECKS YOU SEND US FOR PAYMENT MAY BE PROCESSED ELECTRONICALLY. THIS MEANS CHECKS CLEAR FASTER AND BANK STATEMENTS ARE VALID PROOF OF PAYMENT.

Subscribed and sworn to me this _____ day of _____, 20 _____

Notary Public

EXHIBIT
4e

LoRraine Rowland

From: LoRraine Rowland
Sent: Tuesday, September 16, 2014 11:27 AM
To: LoRraine Rowland
Subject: E-Mail Scheduled

The following e-mail was successfully scheduled.

Subject: Proposed Rule 106

Message: Please click on the link below to view the Department's Proposed Rule 106 "Network Adequacy Requirements For Health Benefits Plans" and the Notice of Hearing:.
http://insurance.arkansas.gov/prop-rules.htm
Should you have questions please contact the Legal Division at 501-371-2820. Thank you,

Attachment: None

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 11, 2014

HAND DELIVERY

Ms. Donna Davis
Arkansas Legislative Council
Arkansas Bureau of Legislative Research
State Capitol, Suite 315
Little Rock, Arkansas 72201

RE: Proposed Rule 106: "Network Adequacy Requirements For Health Benefit Plans"

Dear Ms. Davis:

Enclosed for your review and for filing with the Subcommittee of the Arkansas Legislative Council, is proposed Rule 106, "Network Adequacy Requirements For Health Benefit Plans."

The Arkansas Insurance Department ("Department") is proposing a Rule to establish medical provider network adequacy requirements for health benefit plans in the individual and group market in this State. The proposed Rule is intended to require that health benefit plans have an adequate number of medical providers and services for consumers as contracted in the health benefit plan or policy, largely based on geographical distances.

The Department has scheduled a public hearing for October 29, 2014, at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

I have enclosed a triplicate set of the proposed Rule, our Notice of Public Hearing, the standard Questionnaire, Financial Impact Statement as well as a summary of the proposed Rule.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

cc: LoRraine Rowland, Administrative Analyst

BR/lrr

EXHIBIT
6

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Arkansas Insurance Department
DIVISION Legal Division
DIVISION DIRECTOR William Lacy
CONTACT PERSON Booth Rand
ADDRESS 1200 West Third Street, Little Rock, Arkansas 72201
PHONE NO. 501-371-2820 **FAX NO.** 501-371-2639 **E-MAIL** booth.rand@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Booth Rand
PRESENTER E-MAIL booth.rand@arkansas.gov

INSTRUCTIONS

A. **Please make copies of this form for future use.**
B. **Please answer each question completely using layman terms. You may use additional sheets, if necessary.**
C. **If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.**
D. **Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:**

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

RECEIVED
SEP 11 2014
BUREAU OF LEGISLATIVE RESEARCH

****

1. What is the short title of this rule?

Rule 106, "Network Adequacy Requirements For Health Benefit Plans"

EXHIBIT 6a

2. What is the subject of the proposed rule?

The proposed Rule establishes medical network requirements for health benefit plans in the individual and group market in this State. The proposed Rule establishes criteria for health benefit plans to have an adequate medical providers and services for consumers as contracted in the health benefit plan or policy, primarily based on geographical distances to the consumer.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes X No ____ It is needed to help comply with Section 2702 of the Public Health Service Act under the Affordable Care Act and 45 CFR 156.203, which necessitate "network adequacy" for "qualified health plans" This proposed Rule is also independently needed at the State level, regardless of the federal law or rule, to provide network adequacy standards for health maintenance organizations under Ark. Code Ann. § 23-76-108(a) as well as to health plans with managed care networks in individual and group policies outside a federally facilitated exchange, or health insurance marketplace, because we currently have no expressed state statutory or promulgated rule based standards related to network adequacy.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?

Yes_____ No__X__

If yes, what is the effective date of the emergency rule? _____N/A_____

When does the emergency rule expire? _____N/A_____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes_____ No_____ N/A

5. Is this a new rule? Yes___X___ No_____ If yes, please provide a brief summary explaining the regulation.

Please find an attached Summary explaining the background, purpose and need for this proposed Rule.

Does this repeal an existing rule? Yes_____ No__X__ If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

Is this an amendment to an existing rule? Yes___ No__X__If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

Ark. Code Ann. §§ 23-61-108(a)(1), 23-61-108(b)(1), and 23-76-108(a)

7. What is the purpose of this proposed rule? Why is it necessary?

See summary and answers to #2 and #3 of this Questionnaire. The short answer is that this proposed Rule is urgently needed because the State does not have any statutory or rule-based network adequacy requirements for health insurance plans using medical provider networks, outside the plans or contracts issued by health maintenance organizations.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

http://insurance.arkansas.gov/Legal%20Dataservices/divpage.htm

9. Will a public hearing be held on this proposed rule? Yes__X__ No_____
If yes, please complete the following:
Date: October 29, 2014
Time: 10:00 a.m.
Place: Arkansas Insurance Department, First Floor Hearing Room

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

Upon the conclusion of the October 29, 2014 hearing, unless the Commissioner desires to keep the record open for more comments following the hearing. If we have significant medical provider or insurer disputes or concerns, we will keep the record open for as long as possible to consider everyone's comments or concerns.

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

January 1, 2015.

12. Do you expect this rule to be controversial? Yes__X___ No ___ If yes, please explain.

Although we do not know for sure, we anticipate medical providers and insurers may differ in view as to the amount of access, number and sufficiency of medical providers needed for certain medical provider types.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

We do not know right now which specific groups or organizations will comment for or against the Rule. We will be glad to update this information including providing Legislative Research with a transcript and copy of all comments made to the proposed Rule when we receive those comments.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Arkansas Insurance Department
DIVISION Legal Division
PERSON COMPLETING THIS STATEMENT Booth Rand
TELEPHONE NO. 371-2820 **FAX NO.** 371-2820 **EMAIL:** booth.rand@arkansas.gov

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Rule 106, "Network Adequacy Requirements For Health Benefit Plans"

1. Does this proposed, amended, or repealed rule have a financial impact?
Yes _____ No _____ Unknown.

We have not calculated financial impact to health benefit plans subject to the proposed Rule in terms of premium rate or cost impact, for example. Currently, as it relates to qualified health plans in the federally facilitated exchange, those plans are already abiding by an Arkansas Insurance Department Bulletin which issued network adequacy guidelines, much of which is similar to this proposed Rule.

2. Does this proposed, amended, or repealed rule affect small businesses?
Yes _____ No _____ Unknown.

If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

The Economic Impact Statement is included in our filings.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

We have not calculated premium or plan rate impact this proposed Rule would or would not have, at this time.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

We do not anticipate any costs to the Department or State in our implementation of this Rule.

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

N/A

Current Fiscal Year	**Next Fiscal Year**
$_____N/A_____	$_____N?A_____

6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain.

N/A

Current Fiscal Year	**Next Fiscal Year**
$_____	$_____

_____

_____

_____

SUMMARY
PROPOSED RULE 106

"NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS"

The proposed Rule establishes network adequacy requirements for individual and group health policies both in and outside the current federally facilitated health care exchange, to policies which use medical provider networks (this includes most health insurance policies today). Therefore, this Rule will govern most of the fully insured individual and group health insurance market in this State. This will however only apply to health insurance policies or contracts the Arkansas Insurance Department has jurisdiction to regulate. We have therefore excepted from this Rule, health policies or contracts which are self funded under ERISA, auto liability med pay, workers compensation, and disability income, and a host of other policies which, although they may have a medical provider network, are not actually traditional health insurance policies or subject to the Department's jurisdiction.

In essence, the Rule addresses the sufficiency in which an insurer has set out its medical services and providers to service its issued health care policies. The proposed Rule largely establishes this sufficiency through geographical distance ratios between the residence of the consumer insured and the medical providers available to the consumer by the insurer in the network. A brief look at Section 5 of the Proposed Rule will give one the general geographical distance requirements the Rule imposes on plans, for proximity of emergency care, primary care physicians, specialists, essential community providers and others. Under the proposed Rule, insurers will be required to file with us these GeoAccess Maps and requirements set out in the Rule, so we can review how adequate a network is served by the insurer. The proposed Rule requires updating the network adequacy after modifications to the plan, addresses the circumstance of requiring in-network coverage to consumers when a provider is not available, and also requires a variety of disclosures to the public of medical provider network information by the health care plans.

Insurers subject to the Rule can file with us a network adequacy "accreditation" from an organization certified to audit and review network adequacy of health carriers, such as the National Committee of Quality Assurance ("NCQA") to meet compliance with this Rule. Quite a few of our insurers are already accredited by NCQA.

The Department needs to promulgate this Rule because we simply have no statutory or rule based network adequacy standards outside of brief references to this subject in the health maintenance organization code.

This Rule will only apply to health care plans as defined in the proposed Rule which are issued or renewed on or after January 1, 2015.

ECONOMIC IMPACT STATEMENT
OF PROPOSED RULES OR REGULATIONS
EO 05-04: Regulatory Flexibility

Department: Arkansas Insurance Department
Division: Legal
Contact Person: Booth Rand
Date: September 11, 2014
Contact Phone: 501-371-2820
Contact Email: booth.rand@arkansas.gov

Title or Subject:

Proposed Rule 106 "Network Adequacy Requirements For Health Benefit Plans"

Benefits of the Proposed Rule or Regulation

1. Explain the need for the proposed change(s). Did any complaints motivate you to pursue regulatory action? If so, please explain the nature of such complaints.
   No complaints however the proposed Rule is needed to provide explicit network adequacy standard for health benefit plans using medical provider networks both in and out of the Exchange in individual and group health policies because we have no statutory or rule based standards at this time and have recently been issuing Bulletins to describe these standards.

2. What are the top three benefits of the proposed rule or regulation?
   1. Provides consumer protection by helping ensure sufficient or adequate medical providers and services in health care plans using provider networks based on geographical access or travel time to medical providers
   2. Modernizes Arkansas insurance regulatory requirements by providing for the first time explicit rule-based standards for network adequacy for individual and group health plans in and outside the exchange market.
   3. Provides insurers with more concrete requirements to meet network adequacy and permits them to use accreditation organizations to meet compliance requirements for this proposed Rule.

3. What, in your estimation, would be the consequence of taking no action, thereby maintaining the status quo?
   Confusion or uncertainty as to the sufficiency or adequacy of medical providers and services as contracted and represented to us in health plans.

4. Describe market-based alternatives or voluntary standards that were considered in place of the proposed regulation and state the reason(s) for not selecting those alternatives.
   We are aware of no market-based, voluntary standards for network adequacy. The Department believes the proposed Rule provides enough broad standards or health carriers to achieve network adequacy based on their own unique, individual markets.

Impact of Proposed Rule or Regulation

5. Estimate the cost to state government of collecting information, completing paperwork, filing, recordkeeping, auditing and inspecting associated with this new rule or regulation.
   None.

6. What types of small businesses will be required to comply with the proposed rule or regulation? Please estimate the number of small businesses affected.
   None.

7. Does the proposed regulation create barriers to entry? If so, please describe those barriers and why those barriers are necessary.
   None.

8. Explain the additional requirements with which small business owners will have to comply and estimate the costs associated with compliance.
   None.

9. State whether the proposed regulation contains different requirements for different sized entities, and explain why this is, or is not, necessary.
   None.

10. Describe your understanding of the ability of small business owners to implement changes required by the proposed regulation.
    The propose Rule does not require "small business owners" to implement provisions in the proposed Rule.

11. How does this rule or regulation compare to similar rules and regulations in other states or the federal government?
    The proposed Rule copies a substantial number of provisions or sections in the NAIC Model Act related to "Network Adequacy in Health Benefit Plans."

12. Provide a summary of the input your agency has received from small business or small business advocates about the proposed rule or regulation.

    None so far as of the date of filing. We will be glad to submit this summary and comments as soon as, or if we receive them.

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 11, 2014

VIA STATE MESSENGER

Mr. James Miller
Regulatory Liaison
Office of the Governor
State Capitol Building
Little Rock, AR 72201

RE: Arkansas Insurance Department Rule 106: "Network Adequacy Requirements For Health Benefit Plans"

Dear Mr. Miller:

Enclosed for your review is the Arkansas Insurance Department's proposed Rule 106, "Network Adequacy Requirements For Health Benefit Plans."

The Arkansas Insurance Department ("Department") is proposing a Rule to establish medical provider network adequacy requirements for health benefit plans in the individual and group market in this State. The proposed Rule is intended to require that health benefit plans have an adequate number of medical providers and services for consumers as contracted in the health benefit plan or policy, largely based on geographical distances to the insurance consumers.

The Department has scheduled a public hearing for October 29, 2014, at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

Please do not hesitate to contact me at 371-2820 if you have any questions.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

cc: LoRraine Rowland, Administrative Analyst

EXHIBIT
7

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 11, 2014

Mr. Brandon Robinson, ESQ.
Office of the Attorney General
323 Center Street, Suite 200
Little Rock, AR 72201

RE: Arkansas Insurance Department Rule 106: "Network Adequacy Requirements For Health Benefit Plans"

Dear Mr. Robinson:

Enclosed for your review is the Arkansas Insurance Department's proposed Rule 106, "Network Adequacy Requirements For Health Benefit Plans."

The Arkansas Insurance Department ("Department") is proposing a Rule to establish medical provider network adequacy requirements for health benefit plans in the individual and group market in this State. The proposed Rule is intended to require that health benefit plans have a sufficient number of medical providers and services for consumers as contracted in the health benefit plan or policy, largely based on geographical distances to the insurance consumers.

The Department has scheduled a public hearing for October 29, 2014, at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

Please do not hesitate to contact me at 371-2820 if you have any questions.

Sincerely,

Booth Rand
Managing Attorney/Legal Division
booth.rand@arkansas.gov

cc: LoRraine Rowland, Administrative Analyst

EXHIBIT
8

LoRraine Rowland

From: LoRraine Rowland
Sent: Thursday, September 11, 2014 4:05 PM
To: 'register@sos.arkansas.gov'
Cc: Booth Rand
Subject: RE: Rule 106

Please find attached Proposed Rule 106. Should you need additional information please contact me.

Sincerely,

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

EXHIBIT 9

LoRraine Rowland

From: LoRraine Rowland
Sent: Monday, September 15, 2014 9:33 AM
To: 'Josh Bridges'
Cc: LoRraine Rowland
Subject: RE: Rule 106
Attachments: FINAL RULE 106.doc

Mr. Bridges,

Here you go, I apologize for that.

LoRraine Rowland
Administrative Analyst/Legal Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201
501-371-2831 (office)
501-371-2639 (fax)
lorraine.rowland@arkansas.gov

"I have seeds in the ground and I am in a great place"

From: Josh Bridges [mailto:josh.bridges@sos.arkansas.gov]
Sent: Friday, September 12, 2014 11:12 AM
To: LoRraine Rowland
Subject: RE: Rule 106

Ms. Rowland,

There was no attachment in your previous email that was sent yesterday.

Thanks,

Josh Bridges

From: LoRraine Rowland [mailto:LoRraine.Rowland@arkansas.gov]
Sent: Thursday, September 11, 2014 4:05 PM
To: Arkansas Register
Cc: Booth Rand
Subject: RE: Rule 106

Please find attached Proposed Rule 106. Should you need additional information please contact me.

Sincerely,

LoRraine Rowland

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

September 11, 2014

Ms. Pat Brown
Economic Development Commission
One Capitol Mall
Little Rock, AR 72202

RE: Rule 106, "Network Adequacy Requirements For Health Benefit Plans"

Dear Ms. Brown:

Enclosed for your review is the Arkansas Insurance Department's proposed Rule 106, "Network Adequacy Requirements For Health Benefit Plans."

The Arkansas Insurance Department ("Department") is proposing a Rule to establish medical network requirements for health benefit plans in the individual and group market in this State. The proposed Rule is intended to require that health benefit plans have an adequate number of medical providers and services for consumers as contracted in the health benefit plan or policy, largely based on geographical and travel time distances.

The Department has scheduled a public hearing for October 29, 2014 at 10:00 A.M., at the Arkansas Insurance Department, to consider adopting this proposed Rule.

Please do not hesitate to contact me at 371-2820 if you have any questions.

Sincerely yours,

LoRraine Rowland

LoRraine Rowland
Administrative Analyst/Legal Division
Lorraine.rowland@arkansas.gov
501-371-2831

Enclosures

LRR/

EXHIBIT
10

Booth Rand

From: Bricker, Dianne <dbricker@ahip.org>
Sent: Wednesday, October 01, 2014 11:24 AM
To: Booth Rand
Cc: Derrick Smith; Bryant, Rebecca
Subject: Quick question regarding applicability of proposed Network Adequacy requirements

Good morning, Booth,

Based on your September 11 notice of public hearing regarding proposed network adequacy requirements for Arkansas, I distributed the proposed rules to AHIP members for their input. One of the responses was a question which I hope that you will. The question is this: Would Proposed Rule 106 be applicable to all stand alone dental plans or is it intended only for plans containing pediatric dental Essential Health Benefits?

Any insights you could offer would be most appreciated. Thank you!

Dianne Bricker

Dianne Bricker
Regional Director - State Advocacy
America's Health Insurance Plans
601 Pennsylvania Avenue, NW, Suite 500 South
Washington, DC 20004
Phone: 202-861-6378; Fax 202-778-8492

LoRraine Rowland

From: Erin Estey Hertzog <ehertzog@bio.org>
Sent: Monday, October 06, 2014 3:41 PM
To: LoRraine Rowland
Cc: Kristin Viswanathan
Subject: BIO Comments - Rule 106: "Network Adequacy Requirements for Health Benefit Plans"
Attachments: FINAL BIO Comments - Arkansas Network Adequacy Regulations 10_6_14.pdf

To Whom It May Concern:

Please find attached the Biotechnology Industry Organization's (BIO's) comments regarding the Arkansas Insurance Department's proposed rule entitled "Rule 106: Network Adequacy Requirements for Health Benefit Plans." We appreciate the opportunity to offer input. Please do not hesitate to contact us if we can provide any further information or additional clarification.

Best regards,

Erin

Erin Estey Hertzog, JD, MPH
Director, Reimbursement & Health Policy
Biotechnology Industry Organization
Direct: (202) 449-6384
Cell: (202) 368-6859
ehertzog@bio.org

Biotechnology Industry Organization

October 6, 2014

BY ELECTRONIC SUBMISSION

Jay Bradford
Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Rule 106: Network Adequacy Requirements for Health Benefit Plans

Dear Mr. Bradford:

The Biotechnology Industry Organization (BIO) appreciates this opportunity to submit the following comments on Proposed Rule 106 on Network Adequacy Requirements for Health Benefit Plans (the "Proposed Rule") issued by the Arkansas Insurance Department ("Department") on September 11, 2014.[1] BIO represents more than 1,000 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. BIO members include manufacturers and developers of vaccines, therapeutics, and diagnostics, and we have worked closely with stakeholders across the spectrum, including the public health and advocacy communities, to support policies that help expand access to preventive, wellness, and therapeutic services for all individuals.

BIO believes that patient access to the most appropriate healthcare providers is crucial to be able to translate insurance coverage to real healthcare access. Patients must be able to access providers with the expertise to provide highly-specialized care if needed, who are located in sufficient proximity to them, and who can provide essential care in a timely manner in settings where they may already seek care. BIO applauds the Department for addressing the important issue of network adequacy through the Proposed Rule.

We believe this Proposed Rule makes important strides in ensuring that insured patients in the state of Arkansas are able to obtain timely access to the most appropriate providers for their healthcare needs. Nonetheless, in the subsequent sections of this letter, we propose several recommendations to strengthen the Proposed Rule. Our comments are organized by subject, but generally follow the order in which these issues were addressed in the Proposed Rule.

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[1] Arkansas Insurance Department, Rule 106: "Network Adequacy Requirements for Health Benefit Plans," (Sept. 11, 2014), http://insurance.arkansas.gov/index_htm_files/Rule106.pdf.

1201 Maryland Avenue SW
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bio.org

I. BIO Supports the Department's Efforts to Ensure Access to Specialty Care Providers Through the use of Geographic Accessibility Guidelines.

BIO supports the Department's efforts to ensure access to specialty care providers in the Proposed Rule, including through the use of geographic accessibility guidelines. First, BIO supports Section 5(F)(2) of the Proposed Rule, which requires health carriers to provide geographical access maps for a number of different specialty types in order to determine whether the carrier meets the geographic accessibility standards outlined in Section 5(B)(3). BIO strongly supports this requirement, as access to medical specialists is of critical importance to many patients, including those suffering from rare or chronic conditions. To ensure that all patients who rely on care from medical specialists are able to benefit from this requirement, however, we urge the Department to consider the inclusion of additional specialty groups to Section 5(F)(2), including pain specialists, neurologists, hematologists, and dermatologists.

We also urge the Department to consider breaking down certain specialty categories by sub-specialty. For example, while we agree that plans' inclusion of oncologists should be specifically assessed—given the importance of timely and convenient access to this type of specialist for those with cancer—not all cancers are the same, and access to subspecialists, where they are available in a given geographic area, can be crucial to ensuring that patients obtain expert and individualized care. Thus, we ask the Department to consider including the subspecialties of the five most prevalent cancers by incidence—breast, prostate, lung, colorectal, and melanoma—in the list of specialties requiring specific scrutiny.[2] Similarly, we urge the Department to require the inclusion of sub-specialists that that treat patients suffering from rare diseases. We note that rare diseases, particularly those affecting pediatric populations, require highly skilled sub-specialists that may not be reflected in typical specialist networks. Prospective enrollees and existing patients must have a clear path to access to these sub-specialists.

Second, BIO also supports that the geographical access maps must indicate which providers are accepting patients,[3] and that carriers must monitor, on an ongoing basis, the ability of participating providers to furnish all contracted benefits to covered persons.[4] We are concerned, however, that the geographic accessibility standard for specialists articulated in Section 5(B)(3) is inadvertently underinclusive. Specifically, while Section 5(F)(2) outlines a number of specialty types for inclusion on geographical access maps, Section 5(B)(3) merely states that, "[i]n the case of a Specialty care professional, a covered person will have access to at least one Specialty care professional within a sixty (60) mile radius between the location of the Specialty care professional and the residence of the covered person." We do not believe the Department meant to require merely that the plan include only one specialist, regardless of specialty type, within this 60-mile radius. For example, it would not be helpful for a patient suffering from cancer if the only specialist within a 60-mile radius was a rheumatologist. Instead, we presume that the intent is that plans include at least one specialist of each type outlined in Section 5(F)(2) within the requisite radius.

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[2] National Cancer Institute, National Institutes of Health. 2014. Common Cancer Types. Available at: http://www.cancer.gov/cancertopics/types/commoncancers (last viewed 9/4/2014).
[3] Id. at § 5(F).
[4] Id. at § 5(E).

Accordingly, we urge the Department to revise section 5(B)(3) to read (underlined text proposed for inclusion): "[i]n the case of a Specialty care professional, a covered person will have access to at least one Specialty care professional from within each Specialty Care Provider Category outlined in Section 5(F)(2) . . . ."

We believe that there was a similar drafting error with respect to the Essential Community Providers (ECP) provision. Specifically, Section 5(F)(4) outlines each of the categories of ECPs, however Section 5(B)(4) states that "a covered person will have access to at least one Essential Community Provider within a thirty (30) mile radius . . . ." We similarly urge the Department to revise this provision such that (underlined text proposed for inclusion) "a covered person will have access to at least one Essential Community Provider from within each ECP category outlined in Section 5(F)(4) . . .."

Third, BIO supports the inclusion of a robust number of mental and behavioral health providers to ensure compliance with the Essential Health Benefits requirements, as well as the federal mental health parity statute and regulations. However, we urge the Department to specify that a carrier cannot double-count mental and behavioral health providers for purposes of meeting their network adequacy requirements, even though some of these provider types may be included in geographic access maps outlined in both Section 5(F)(2)(l)-(m), as well as Section 5(F)(3). We similarly urge the Department to consider adding a geographic access standard specific to mental health providers under Section 5(B).

II. The Proposed Rule Should Ensure Compliance with Provider Non-Discrimination Requirements.

The Affordable Care Act (ACA) specifically prohibits health plans from discriminating against "any health care provider who is acting within the scope of that provider's license or certification under applicable state law."[5] We believe that this requirement is inextricably tied to network adequacy requirements. Indeed, a July 2013 report from the Senate Committee on Appropriations, expressly states that the basis for the ACA's provider nondiscrimination requirement was the tenet that "patients have the right to access covered health services from the full range of providers licensed and certified in their State."[6] Accordingly, we urge the Department to incorporate a provider non-discrimination provision into the Proposed Rule.

Among other things, we believe that such a provider non-discrimination provision should include both: (1) a re-articulation of the ACA's prohibition on discriminating against "any health care provider who is acting within the scope of that provider's license or certification under applicable state law"; and (2) reporting requirements for issuers, along with an active review of the information reported by the Department, in order to assess plan compliance with provider non-discrimination requirements.

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[5] ACA § 1201 (codified as Public Health Service Act § 2706(a)).
[6] S. Rep. No. 113-71, at 126 (2013).

III. Provider Networks Should Include Complementary Immunizers.

While we strongly support the proposed inclusion of school-based providers as ECPs under Section 5(H)(2)-(3), BIO requests that the Department consider adding language to the Proposed Rule requiring carriers to include all types of complementary immunizers in their provider networks as a means to ensure broad access to this critical preventive service. One of the most important provisions of the ACA was the establishment of the "immunization coverage standard," which requires plans to cover immunizations recommended by the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) without cost-sharing when administered by an in-network provider.[7] Ensuring that health plans include immunization providers in their networks has been identified as a critical issue by a diverse group of stakeholders who have worked together through the National Adult and Influenza Immunization Summit (NAIIS) to advance the goals of expanding access to immunizations for the entire population and achieving the *Healthy People 2020* goals for immunization.[8]

Immunization services have a unique set of providers. In addition to traditional immunizers, such as pediatricians and other primary care providers, complementary immunizers—pharmacists, public health department clinicians, school-based providers, and other community providers operating within their scope of practice under state law—provide many vaccines.

Complementary immunizers are particularly important for the hard-to-reach adolescent and adult populations. Indeed, adults have demonstrated a preference to be vaccinated outside of their medical home, where and when it is convenient for them, and the system has evolved to support that access. For instance, more than 230,000 pharmacists have been trained to administer vaccines in the United States,[9] and nearly all Americans (94 percent) live within five miles of a community pharmacy.[10] During the 2011-2012 influenza season, nearly 20 percent of adult influenza vaccines were administered in retail pharmacies.[11] All 50 states allow pharmacists to administer pneumococcal and zoster vaccines, and many adults seek these vaccines in the pharmacy setting.[12]

Complementary immunizers also serve low-income medically underserved populations, mitigating the barriers these vulnerable patients have long faced with respect to access to care. For instance, community pharmacies provide patient access to important immunizations against vaccine-preventable diseases, including for individuals residing in medically underserved areas (MUAs). One nationwide community pharmacy corporation,

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[7] See ACA § 1001 (codified as Public Health Service Act § 2713(a)(2)).

[8] NAIIS is a public-private partnership compromised of more than 140 organizational stakeholders, including vaccine manufacturers, professional medical societies, public health organizations, federal agencies, pharmacists, health insurers, and hospitals, among others. NAIIS has identified the issue of network adequacy for immunization providers as critical to vaccine access

[9] M. Rothholz, *Opportunities for Collaboration to Advance Progress towards "The Immunization Neighborhood:" Recognition and Compensation of Pharmacists*, American Pharmacists Association (Aug. 30, 2012).

[10] NCPDP Pharmacy File, *ArcGIS Census Tract File*, National Association of Chain Drug Stores Economics Department.

[11] CDC, *March Flu Vaccination Coverage United States, 2011-12 Influenza Season* (March 2012), http://www.cdc.gov/flu/pdf/fluvaxview/national-flu-survey-mar2012.pdf.

[12] See American Pharmacists Association, *Pharmacist Authority to Immunize* (Oct. 11, 2013), http://www.pharmacist.com/sites/default/files/PharmacistIZAuthority.pdf.

Walgreens, indicated that over one-third of their influenza vaccines administered last year were in pharmacies located in MUAs; in states with the largest MUAs, they provided up to 77.1 percent of their influenza vaccines in these areas. Moreover, of all influenza vaccinations Walgreens delivered last flu season, 31 percent were during off-peak times (59 percent on weekends and 31 percent in the evenings), and approximately 31 percent of patients during off-peak times were age 65 or older, and 36 percent had underlying medical conditions. Notably, efforts to provide immunizations other than influenza were complicated by lack of insurance coverage or recognition of community pharmacies as in-network providers.

Many public health stakeholders have supported efforts under way at the CDC to include additional complementary immunization sites, such as public health and school-based clinics, in provider networks. The most significant such CDC initiative, known as the "Third Party Billing Project," works with state health departments, public health clinics, and health insurers to include public health clinics in provider networks.[13] Thirty-five states and large cities are currently planning or implementing the Billing Project, which will allow them to bill insurers for immunization services provided to insured persons of all ages. Data from the Billing Project underscore the sheer volume of immunizations furnished by these complementary immunizers: in 2010, local health units billed private insurance for $1,964,267 in immunization-related costs in North Dakota alone.[14] Other states such as Arizona, California, Arkansas, Georgia, and Montana experienced success with the Billing Project.[15]

In spite of these efforts, when a health insurance plan does not include complementary immunization sites in its provider network, the ACA's intent of expanding access to immunizations is compromised. For instance, a plan enrollee who seeks to be immunized at a public health clinic or pharmacy that has been excluded from a plan's provider network would be denied first dollar coverage (or coverage at all) for that service. In turn, the patient may decide not to receive the vaccine due to cost and an immunization opportunity would be lost. Alternatively, a more affluent patient could elect to pay the bill, but none of these costs would count toward the patient's deductible, and the patient would understandably be upset and confused as to why they did not receive the benefits they were promised.[16]

In our experience, complementary immunizers are currently being excluded from provider networks across the country. For instance, school-based clinics in Carson City, Nevada have been excluded from the network of a major health insurer. Similarly, two insurers will not contract with the School-Located Vaccine Clinic program operated by the health department in Pomperaug, Connecticut. And the Los Angeles Unified School District cannot bill insurers due to the perception that a vaccine given in a school will interfere with the medical home.

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[13] CDC, Billing Project Success Stories, http://www.cdc.gov/vaccines/programs/billables-project/success-stories.html (last accessed Feb. 6, 2014).
[14] M. Sander, *Lessons Learned: Billing Insurance at Local Health Units in North Dakota*, North Dakota Dep't of Health (March 30, 2011), https://cdc.confex.com/cdc/nic2011/webprogram/Paper25418.html.
[15] D. Kilgus D, *Billing Program Final Plans*, Centers for Disease Control and Prevention (Feb. 2012), http://www.cdc.gov/vaccines/programs/billables-project/downloads/billing-final-plans-from-stkhldr-mtg-slides.pdf.
[16] M. Andrews, *Consumers Expecting Free "Preventive Care" Sometimes Surprised by Charges*, Kaiser Health News, Jan. 21, 2014, http://www.kaiserhealthnews.org/Stories/2014/January/21/Michelle-Andrews-Consumers-Expecting-Free-Preventive-Care.aspx.

As acknowledged by the National Vaccine Advisory Committee (NVAC) in the updated Standards for Adult Immunization Practice, "there is an increased recognition of community vaccinators and pharmacists as integral to achieving higher adult vaccination rates."[17] BIO urges the Department to consider requiring carriers to include all types of complementary immunizers within their provider networks, as expanded access to immunization services will improve vaccination rates and thereby reduce morbidity, mortality, and overall medical costs for enrollees.

IV. The Proposed Rule Should Adopt Processes and Timelines for Reviewing Network Adequacy.

The Proposed Rule requires carriers to provide information to the Commissioner so the adequacy of each plan's network can be judged against the specific standards identified. However, we ask that the Department consider including provisions for the timely and diligent review of this information to prevent plans with inadequate networks from being offered in the state. Specifically, we urge the Department to consult Washington State's new regulation on network adequacy, as it could strengthen the Proposed Rule's provisions for plan review.[18] Under this regulation, the State Insurance Commissioner is required to consider eight specific factors in assessing network adequacy and establish a process for adjudication if a carrier's plan is deemed noncompliant with the state's network adequacy standards. In particular, BIO believes that the eight identified criteria to assess network adequacy are important to ensure patient access to the providers they need. As with the Proposed Rule, the Washington State rule also requires that due consideration be given to the relative availability of healthcare providers or facilities in a given geographic area. We have included the Washington State rule as an appendix to this letter for your reference.

V. BIO Supports the Department's Efforts to Ensure Continued Access to Covered Benefits through the Proposed Rule.

BIO supports the Department's efforts to ensure continued access to covered benefits through various provisions of the Proposed Rule. First, BIO supports proposed Section 5(C), which provides that "[i]n the event that a Health carrier has an insufficient number or type of participating providers to provide a covered benefit, the Health Carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from Participating providers, or shall make other arrangements acceptable to the Commissioner that shall include reasonable criteria utilized by the carrier." BIO believes that this requirement is important in order to ensure that covered persons are not penalized for the fact that a given provider is not included in-network, as only in-network services are subject to the ACA's out-of-pocket limits and, as described above, exemptions from cost-sharing for preventive services. This provision is particularly crucial for patients with rare diseases, since there may be only a few providers across the country who specialize in a particular rare disease. We also note that this

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[17] National Vaccine Advisory Committee, *Standards for Adult Immunization Practice* (Sept. 2013), http://www.hhs.gov/nvpo/nvac/meetings/pastmeetings/2013/adult_immunization_update-sept2013.pdf.

[18] See Wash. Admin. Code § 284-43-130, et seq. (2014), available at: http://apps.leg.wa.gov/documents/laws/wsr/2014/10/14-10-017.htm.

language largely aligns with language in the NAIC Model Act, and has been adopted in a number of other states.[19]

Nonetheless, we recommend that this provision be strengthened to ensure patients have timely access to the out-of-network providers they may need. Specifically, the Department should add a requirement that carriers develop and disclose policies and timelines for requesting out-of-network services, which should be transparent to patients. We also ask that the Department specify that this provision does not obviate plans' responsibility to include a sufficient number and diversity of providers in-network to guarantee in-network access to covered benefits, including the Essential Health Benefits, to the extent possible.

Second, BIO supports the proposed requirement that health carriers file an access plan with the Commissioner beginning in 2015, which must be prepared before offering a new health benefit plan, and updated whenever the carrier makes a material change to its existing health benefit plan.[20] In particular, we support the aspects of the access plan that relate to ensuring continuity of care, such as:

- The requirement that health carriers describe their "system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning"[21]; and
- The requirement that carriers describe their "proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations,"[22] including that this description "explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner."[23]

We also strongly support the proposed components of the access plan that relate to ensuring that a plan's network continues to serve the needs of its covered persons, including that carriers must describe their processes for "monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans,"[24] as well as "for assessing the health care needs of covered persons,"[25] and "for using assessments of enrollee complaints and satisfaction to improve carrier performance."[26]

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[19] See, e.g., Mich. Comp. Laws § 500.3530; Tit. 19 Ch. 16 Miss. Code R. § 16.05.
[20] Supra note 1 at § 5(I).
[21] Id. at § 5(I)(9).
[22] Id. at § 5(I)(11).
[23] Id. at § 5(I)(11).
[24] Id. at § 5(I)(3).
[25] Id. at § 5(I)(5).
[26] Id. at § 5(I)(8).

VI. BIO Supports the Department's Efforts to Increase Transparency to Consumers through the Proposed Rule.

BIO supports the Department's efforts to increase transparency to consumers through various provisions of the Proposed Rule. First, we strongly support the proposed requirement that health carriers make a provider directory available for online publication by the Commissioner, as well as on the carrier's website, and that this directory be updated within 14 days of any change.[27] Making this information available to consumers, both as they are deciding between plans, as well as once they are enrolled, will greatly facilitate informed plan selection and the ability of enrollees to act as educated consumers. We further urge the Department to consider working with the U.S. Department of Health and Human Services (HHS)—and eventually, the state's own state-based exchange, if and when it is established—to include a link to the directory on the state's Exchange website to facilitate access to this important information to prospective beneficiaries throughout the state. We also urge the Department to ensure that the directory includes the ability to search by each category of Specialty Care Provider, in addition to ECPs, in Section 5(J)(4).

Second, we support aspects of the proposed access plan that relate to transparency with beneficiaries. For example, we strongly support the proposed requirement that this access plan describe the health carrier's procedures for "making referrals within and outside its network and for notifying enrollees and potential enrollees regarding the availability of network and out-of-network providers."[28] We also support the requirement that carriers describe their method for "informing covered persons of the plan's services and features, including cost-sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care."[29]

VII. BIO Supports Applicability of the Department's Enforcement Provision and Associated Penalties to the Network Adequacy Standards.

Section 7 of the Proposed Rule provides that "[t]he penalties, license actions or orders authorized under Ark. Code Ann. § 23-66-210 shall apply to violations of this Rule." BIO supports this provision, under which the Insurance Commissioner would be authorized to impose penalties, up to and including the suspension of an insurer's license, for engaging in an "unfair method of competition or an unfair or deceptive act or practice." We believe that failure to comply with the applicable standards regarding network adequacy, as outlined in the Proposed Rule, fall squarely within the definition of "unfair methods of competition and unfair or deceptive acts and practices," as defined under Ark. Code Ann. § 23-66-206, and accordingly urge the Department to finalize proposed Section 7.

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[27] Id. at § 5(J).
[28] Id. at § 5(I)(2).
[29] Id. at § 5(I)(6).

VIII. Conclusion

BIO is pleased to be able to comment on the Proposed Rule and looks forward to additional opportunities to provide feedback on the evolution of these provisions. We encourage the Department to continue to inclusively engage stakeholders in the development and implementation of the provisions, and appreciate your attention to this important issue. Please do not hesitate to contact me at 202-449-6384 with any questions or if I can provide any further information.

Sincerely,

/s/

Erin Estey Hertzog, J.D., M.P.H.
Director
Reimbursement & Health Policy

Appendix: Wash. Admin. Code § 284-43-205 (2014)

Effective Date of Rule: Thirty-one days after filing.

Purpose: Based on the significant changes in health care delivery and access to care that will occur after January 1, 2014, due to health care reform, the commissioner determined that updating regulations is reasonable and necessary. Both qualified health plans and health plans offered outside of the exchange must have networks that at a minimum ensure access to covered services without unreasonable delay and address the specific needs of the populations served. Clarification of the provider network criteria in these areas is needed to support issuer filings. Issuers will benefit from written guidance regarding the commissioner's review standards for provider networks in general and the inclusion of essential community providers in networks for qualified health plans. The proposed rule also includes requirements for provider directories and creates a more transparent process for the building and maintenance of provider networks.

Citation of Existing Rules Affected by this Order: Repealing WAC 284-43-340; and amending WAC 284-43-130, 284-43-200, 284-43-205, 284-43-220, 284-43-250, and 284-43-331.

Statutory Authority for Adoption: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200.

Other Authority: RCW 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 45 C.F.R. 156.235, 45 C.F.R. 156.245.

Adopted under notice filed as WSR 13-19-092 [14-07-102] on March 19, 2014.

Changes Other than Editing from Proposed to Adopted Version: WAC 284-43-130(15), stand alone definition of "issuer" was stricken as it created an internal discrepancy in the definition section. Maintained as part of the definition of "health carrier," WAC 284-43-130(14). Renumbered section.

WAC 284-43-130(30), struck "within the state" from definition. Stricken to more accurately reflect the marketplace as issuers offer plans in border counties which utilize providers and facilities in neighboring states to provide sufficient number and choice of providers to enrollees in a manner that limits the amount of travel.

WAC 284-43-130(30), changed "health plan" to "product" for consistency.

WAC 284-43-200 (11)(a), changed "medical" to "mental" to accurately reflect the name of the publication.

WAC 284-43-200(12), changed "preventative" to "preventive" for consistency with WAC 284-43-878(9).

WAC 284-43-200 (13)(b)(i), ratio of "enrollee to primary care provider" was changed to "primary care provider to enrollee" to accurately reflect the ratio.

WAC 284-43-200 (13)(b)(iii), changed "their" to "a" in reference to a primary care provider for consistency.

WAC 284-43-200 (15)(d), struck reference to subsection (d) of (3) and subsection (4) as these are no longer valid cross references.

WAC 284-43-220 (3)(e)(i)(E), struck "each area" and made "specialty" plural. Also struck "each" and included "the." Both changes made to accurately reflect the intent of the section.

WAC 284-43-220 (3)(e)(iii), struck "this" for readability.

WAC 284-43-220 (3)(f), changed "health plan" to "product" for consistency.

WAC 284-43-220 (3)(f)(i)(K), changed "processes" to "issuer's process" to differentiate from the department of health's corrective actions.

WAC 284-43-220 (4)(b), corrected "An area with" to "An area within" to accurately reflect the definition.

WAC 284-43-220 (3)(d)(i)(A), added "and facilities" for consistency.

WAC 284-43-220 (3)(e)(i)(C), include "substance use disorder" in title of map and also included "substance use disorder" where specialty mental health providers are referenced. Amended language for consistency with other areas of the rule that reference mental health and substance use disorder providers.

WAC 284-43-222 (5)(a), name of addendum was corrected.

WAC 284-43-229(4), amended language to make consistent with the section, changed "lowest cost tier of the network" to read "lowest cost-sharing tier of the network."

Throughout rule reference to "file" or "filing" was changed to "submit" or "submitted" to make the rule consistent.

A final cost-benefit analysis is available by contacting Kate Reynolds, P.O. Box 40258, Olympia, WA 98504-0258, phone (360) 725-7170, fax (360) 586-3109, e-mail rulescoordinator@oic.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 4, Amended 2, Repealed 1; Federal Rules or Standards: New 4, Amended 2, Repealed 1; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 5, Amended 6, Repealed 1.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.
Date Adopted: April 25, 2014.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 12-23-005, filed 11/7/12, effective 11/20/12)

WAC 284-43-130 Definitions.

Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Authorization" or "certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.

(4) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(5) "Covered person" or "enrollee" means an individual covered by a health plan including ((~~an enrollee,~~)) a subscriber, policyholder, or beneficiary of a group plan.

(6) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(7) "Emergency services" has the meaning set forth in RCW 48.43.005.

(8) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(9) "Facility" means an institution providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

(10) "Formulary" means a listing of drugs used within a health plan.

(11) "Grievance" has the meaning set forth in RCW 48.43.005.

(12) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(13) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(14) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health

maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

(15) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(16) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. §1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. §450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. §47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. §1603(29).

(17) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

((~~(17)~~)) (18) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

((~~(18)~~)) (19) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

((~~(19)~~)) (20) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

((~~(20)~~)) (21) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for ((~~carriers~~)) issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

((~~(21)~~)) (22) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology,* published by the American Medical Association.

((~~(22)~~)) (23) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care

services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

((~~(23)~~)) (24) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

((~~(24)~~)) (25) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

((~~(25)~~)) (26) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

((~~(26)~~)) (27) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(27)~~)) (28) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(28)~~)) (29) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

(30) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005(33) comprising from one to fifty eligible employees.

((~~(29)~~)) (31) "Substitute drug" means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

((~~(30)~~)) (32) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

AMENDATORY SECTION (Amending WSR 01-03-033, filed 1/9/01, effective 7/1/01)

WAC 284-43-200 Network ((~~adequacy~~)) access—General standards.

(1) ((~~A health carrier shall~~)) An issuer must maintain each ((~~plan~~)) provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to ((~~covered persons~~)) enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.

(2) Each ((~~covered person shall~~)) enrollee must have adequate choice among ((~~each type of~~)) health care providers, including those ((~~types of providers who~~)) providers which must be included in the network under WAC 284-43-205, and for qualified health plans and qualified stand-alone dental plans, under WAC 284-43-222. ((~~In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. The carrier's~~))

(3) An issuer's service area ((~~shall~~)) must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, gender identity, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status((~~. Each carrier shall ensure that its networks will meet these requirements by the end of the first year of initial operation of the network and at all times thereafter~~)).

((~~(2)~~)) (4) An issuer must establish sufficiency and adequacy of choice ((~~may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) and by private managed care accreditation organizations may be used to demonstrate~~

~~sufficiency. At a minimum, a carrier will be held accountable for meeting those standards described under WAC 284-43-220.~~

~~(3) In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.~~

~~(4) The health carrier shall~~)) of providers based on the number and type of providers and facilities necessary within the service area for the plan to meet the access requirements set forth in this subchapter. Where an issuer establishes medical necessity or other prior authorization procedures, the issuer must ensure sufficient qualified staff is available to provide timely prior authorization decisions on an appropriate basis, without delays detrimental to the health of enrollees.

(5) In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. An issuer must satisfy this obligation even if an alternate access delivery request has been submitted and is pending commissioner approval.

An issuer may use facilities in neighboring service areas to satisfy a network access standard if one of the following types of facilities is not in the service area, or if the issuer can provide substantial evidence of good faith efforts on its part to contract with the facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the facility. This applies to the following types of facilities:

(a) Tertiary hospitals;

(b) Pediatric community hospitals;

(c) Specialty or limited hospitals, such as burn units, rehabilitative hospitals, orthopedic hospitals, and cancer care hospitals;

(d) Neonatal intensive care units; and

(e) Facilities providing transplant services, including those that provide solid organ, bone marrow, and stem cell transplants.

(6) An issuer must establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of ((~~covered persons. Health carriers shall~~)) enrollees, and located so as to not result in unreasonable barriers to accessibility. Issuers must make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. ((~~For example, a carrier should not require travel of thirty miles or more when a provider who meets carrier standards is available for inclusion in the network and practices within five miles of enrollees.~~

~~In determining whether a health carrier has complied with this provision, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the carrier under reasonable terms and conditions.~~

~~(5) A health carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to covered persons.~~

~~(6) Beginning July 1, 2000, the health carrier shall disclose to covered persons~~))

(7) A single case provider reimbursement agreement must be used only to address unique situations that typically occur out-of-network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in the network and do not support a determination of network access.

(8) An issuer must disclose to enrollees that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of ((~~participating providers and facilities. The carrier shall provide instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes. For example, a covered person relying on such instructions or processes could discover if the choice of a particular primary care provider would result in the covered person's inability to obtain a referral to certain other participating providers.~~

~~(7)~~)) the issuer. A description of the health plan's referral and authorization practices, including information about how to contact customer service for guidance, must be set forth as an introduction or preamble

to the provider directory for a health plan. In the alternative, the description of referral and authorization practices may be included in the summary of benefits and explanation of coverage for the health plan.

(9) To provide adequate choice to ((~~covered persons~~)) enrollees who are American Indians/Alaska Natives, each health ((~~carrier shall~~)) issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are ((~~covered persons~~)) enrollees have access to covered medical and behavioral health services provided by Indian health care ((~~services and facilities that are part of the Indian health system~~)) providers.

((~~Carriers shall~~)) Issuers must ensure that such ((~~covered persons~~)) enrollees may obtain covered medical and behavioral health services from the Indian health ((~~system~~)) care provider at no greater cost to the ((~~covered person~~)) enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider. ((~~Carriers~~)) Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits ((~~a carrier~~)) an issuerfrom limiting coverage to those health services that meet ((~~carrier~~)) issuer standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

(10) An issuer must have a demonstrable method and contracting strategy to ensure that contracting hospitals in a plan's service area have the capacity to serve the entire enrollee population based on normal utilization.

(11) At a minimum, an issuer's provider network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy.

(a) Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from mental health providers. There must be mental health providers of sufficient number and type to provide diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* or other recognized diagnostic manual or standard.

(b) An issuer must establish a reasonable standard for the number and geographic distribution of mental health providers who can treat serious mental illness of an adult and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure.

The issuer must measure the adequacy of the mental health network against this standard at least twice a year, and submit an action plan with the commissioner if the standard is not met.

(c) Emergency mental health services, including crisis intervention and crisis stabilization services, must be included in an issuer's provider network.

(d) An issuer must include a sufficient number and type of mental health and substance use disorder treatment providers and facilities within a service area based on normal utilization patterns.

(e) An issuer must ensure that an enrollee can identify information about mental health services and substance use disorder treatment including benefits, providers, coverage, and other relevant information by calling a customer service representative during normal business hours.

(12) The provider network must include preventive and wellness services, including chronic disease management and smoking cessation services as defined in RCW 48.43.005(37) and WAC 284-43-878(9). If these services are provided through a quit-line or help-line, the issuer must ensure that when follow-up services are medically necessary, the enrollee will have access to sufficient information to access those services within the service area. Contracts with quit-line or help-line services are subject to the same conditions and terms as other provider contracts under this section.

(13) For the essential health benefits category of ambulatory patient services, as defined in WAC 284-43-878(1), an issuer's network is adequate if:

(a) The issuer establishes a network that affords enrollee access to urgent appointments without prior authorization within forty-eight hours, or with prior authorization, within ninety-six hours of the referring provider's referral.

(b) For primary care providers the following must be demonstrated:

(i) The ratio of primary care providers to enrollees within the issuer's service area as a whole meets or exceeds the average ratio for Washington state for the prior plan year;

(ii) The network includes such numbers and distribution that eighty percent of enrollees within the service area are within thirty miles of a sufficient number of primary care providers in an urban area and within sixty miles of a sufficient number of primary care providers in a rural area from either their residence or work; and

(iii) Enrollees have access to an appointment, for other than preventive services, with a primary care provider within ten business days of requesting one.

(c) For specialists:

(i) The issuer documents the distribution of specialists in the network for the service area in relation to the population distribution within the service area; and

(ii) The issuer establishes that when an enrollee is referred to a specialist, the enrollee has access to an appointment with such a specialist within fifteen business days for nonurgent services.

(d) For preventive care services, and periodic follow-up care including, but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, the issuer permits scheduling such services in advance, consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

(14) The network access requirements in this subchapter apply to stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered outside of the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. All such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions.

(a) An issuer of such stand-alone dental plans must demonstrate that, for the dental plan's defined service area, all services required under WAC 284-43-879(3) are available to all enrollees without unreasonable delay.

(b) Dental networks for pediatric oral services must be sufficient for the enrollee population in the service area based on expected utilization.

(15) Issuers must meet all requirements of this subsection for all provider networks. An alternate access delivery request under WAC 284-43-201 may be proposed only if:

(a) There are sufficient numbers and types of providers or facilities in the service area to meet the standards under this subchapter but the issuer is unable to contract with sufficient providers or facilities to meet the network standards in this subchapter; or

(b) An issuer's provider network has been previously approved under this section, and a provider or facility type subsequently becomes unavailable within a health plan's service area; or

(c) A county has a population that is fifty thousand or fewer, and the county is the sole service area for the plan, and the issuer chooses to propose an alternative access delivery system for that county; or

(d) A qualified health plan issuer is unable to meet the standards for inclusion of essential community providers, as provided under WAC 284-43-222(3).

(16) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-201 Alternate access delivery request.

(1) Where an issuer's network meets one or more of the criteria in WAC 284-43-200 (15)(a) through (d), the issuer may submit an alternate access delivery request for the commissioner's review and approval. The alternate access delivery request must be made using the Alternate Access Delivery Request Form C, as provided in WAC 284-43-220 (3)(d).

(a) An alternate access delivery system must provide enrollees with access to medically necessary care on a reasonable basis without detriment to their health.

(b) The issuer must ensure that the enrollee obtains all covered services in the alternate access delivery system at no greater cost to the enrollee than if the service was obtained from network providers or facilities or must make other arrangements acceptable to the commissioner.

(i) Copayments and deductible requirements must apply to alternate access delivery systems at the same level they are applied to in-network services.

(ii) The alternate access delivery system may result in issuer payment of billed charges to ensure network access.

(c) An issuer must demonstrate in its alternate access delivery request a reasonable basis for not meeting a standard as part of its filing for approval of an alternate access delivery system, and include an explanation of why the alternate access delivery system provides a sufficient number or type of the provider or facility to which the standard applies to enrollees.

(d) An issuer must demonstrate a plan and practice to assist enrollees to locate providers and facilities in neighboring service areas in a manner that assures both availability and accessibility. Enrollees must be able to obtain health care services from a provider or facility within the closest reasonable proximity of the enrollee in a timely manner appropriate for the enrollee's health needs.

Alternate access delivery systems include, but are not limited to, such provider network strategies as use of out-of-state and out of county or service area providers, and exceptions to network standards based on rural locations in the service area.

(2) The commissioner will not approve an alternate access delivery system unless the issuer provides substantial evidence of good faith efforts on its part to contract with providers or facilities, and can demonstrate

that there is not an available provider or facility with which the issuer can contract to meet provider network standards under WAC 284-43-200.

(a) Such evidence of good faith efforts to contract, where required, will be submitted as part of the issuer's Alternate Access Delivery Request Form C submission, as described in WAC 284-43-220 (3)(d).

(b) Evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The practice of entering into a single case provider reimbursement agreement with a provider or facility in relation to a specific enrollee's condition or treatment requirements is not an alternate access delivery system for purposes of establishing an adequate provider network. A single case provider reimbursement agreement must be used only to address unique situations that typically occur out of network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in a network for the whole population of enrollees under a plan, and do not support a determination of network access.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-203 Use of subcontracted networks.

(1) The primary contractor with each provider and facility in an issuer's network must be specifically identified in network report filings with the commissioner. An issuer may use subcontracted networks as part of a provider network for a service area, subject to the following requirements:

(a) An issuer must not elect to use less than one hundred percent of the subcontracted network or networks in its service area.

(b) An issuer may use a combination of directly contracting with providers and use of a subcontracted network in the same service area.

(2) Upon request by the commissioner, an issuer must produce an executed copy of its agreement with a subcontracted network, and certify to the commissioner that there is reasonable assurance the providers listed as part of the subcontracted network are under enforceable contracts with the subcontractor. The contract with the subcontracted network's administrator must provide the issuer with the ability to require providers to conform to the requirements in chapter 284-43 WAC, subchapter B.

(3) If an issuer permits a facility or provider to delegate functions, the issuer must require the facility or provider to:

(a) Include the requirements of this subchapter in its contracting documents with the subcontractor, including providing the commissioner with access to any pertinent information related to the contract during the contract term, for up to ten years from the final date of the contract period, and in certain instances, where required by federal or state law, periods in excess of ten years;

(b) Provide the issuer with the right to approve, suspend or terminate any such arrangement.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-204 Provider directories.

(1) Provider directories must be updated at least monthly, and must be offered to accommodate individuals with limited-English proficiency or disabilities. An issuer must post the current provider directory for each health plan online, and must make a printed copy of the current directory available to an enrollee upon request as required under RCW 48.43.510 (1)(g).

(2) For each health plan, the associated provider directory must include the following information for each provider:

(a) The specialty area or areas for which the provider is licensed to practice and included in the network;

(b) Any in-network institutional affiliation of the provider, such as hospitals where the provider has admitting privileges or provider groups with which a provider is a member;

(c) Whether the provider may be accessed without referral;

(d) Any languages, other than English, spoken by the provider.

(3) An issuer must include in its electronic posting of a health plan's provider directory a notation of any primary care, chiropractor, women's health care provider, or pediatrician whose practice is closed to new patients.

(4) If an issuer maintains more than one provider network, its posted provider directory or directories must make it reasonably clear to an enrollee which network applies to which health plan.

(5) Information about any available telemedicine services must be included and specifically described.

(6) Information about any available interpreter services, communication and language assistance services, and accessibility of the physical facility must be identified in the directory, and the mechanism by which an enrollee may access such services.

(7) An issuer must include information about the network status of emergency providers as required by WAC 284-43-252.

(8) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

AMENDATORY SECTION (Amending WSR 99-16-036, filed 7/28/99, effective 8/28/99)

WAC 284-43-205 Every category of health care providers.

(1) ((~~To effectuate the requirement of RCW 48.43.045 that health plans provide coverage for treatments and services by every category of provider, health carriers shall~~)) Issuers must not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for ((~~conditions covered by basic health plan (BHP) services as defined by RCW 48.43.005(4). If the BHP covers the condition, the carrier may~~)) services covered as essential health benefits, as defined in WAC 284-43-878 and RCW 48.43.715, for individual and small group plans; and as covered by the basic health plan, as defined in RCW 48.43.005(4), for plans other than individual and small group.

For individual and small group plans, the issuer must not exclude a category of provider who is licensed to provide services for ((~~that~~)) a covered condition, and is acting within the scope of practice, unless such services would not meet the ((~~carrier's~~)) issuer's standards pursuant to RCW 48.43.045 (1)(((~~(b)~~))) (a). For example, ((~~if the BHP provides coverage for~~)) if the issuer covers outpatient treatment of lower back pain as part of the essential health benefits, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope of practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(((~~(b) may~~))) (a) must not be excluded from the network.

(2) RCW 48.43.045 (1)(((~~(b)~~))) (a) permits ((~~health carriers~~)) issuers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, ((~~health carriers may~~)) issuers must not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude that category of provider completely from health plans on that basis. ((~~However, health carriers may determine that particular services for particular conditions by particular categories of providers are not cost-effective or clinically efficacious, and may exclude such services from coverage or reimbursement under a health plan. Any such determinations must be supported by relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy.~~))

(3) Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers based on relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy. However, health plans ((~~may~~)) must not contain unreasonable limits, and ((~~may~~)) must not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)(((~~(b)~~))) (a).

(4) This section does not prohibit health plans from using restricted networks. ((~~Health carriers~~)) Issuers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. ((~~A health carrier~~)) An issuer is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan.

(a) Health plan((~~s~~)) networks that use "gatekeepers" or "medical homes" for access to specialist providers may use them for access to specified categories of providers.

(b) For purposes of this section:

(i) "Gatekeeper" means requiring a referral from a primary care or direct access provider or practitioner to access specialty or in-patient services.

(ii) "Medical home" means a team based health care delivery model for patient centered primary care that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes as modified and updated by the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services (HRSA), and other state and federal agencies.

(5) ((~~Health carriers may~~)) Issuers must not offer coverage for health services for certain categories of providers solely as a separately priced optional benefit.

(6) The insurance commissioner may grant reasonable temporary extensions of time for implementation of RCW 48.43.045 or this section, or any part thereof, for good cause shown.

((~~(7) All health carriers and their plans, provider contracts, networks and operations shall conform to the provisions of this section WAC 284-43-205, by January 1, 2000.~~))

AMENDATORY SECTION (Amending WSR 11-07-015, filed 3/8/11, effective 4/8/11)

WAC 284-43-220 Network reports—Format.

((~~Each health carrier must file with the commissioner a Provider Network Form A and a Network Enrollment Form B.~~)) (1) An issuer must submit its provider network materials to the commissioner for approval prior to or at the time it files a newly offered health plan.

(a) For individual and small groups, the submission must occur when the issuer submits its plan under WAC 284-170-870. For groups other than individual and small, the submission must occur when the issuer submits a new health plan and as required in this section.

(b) The commissioner may extend the time for filing for good cause shown.

(c) For plan year 2015 only, the commissioner will permit a safe harbor standard. An issuer who can not meet the submission requirements in (e) and (f) of this subsection will be determined to meet the requirements of those subsections even if the submissions are incomplete, provided that the issuer:

(i) Identifies specifically each map required under subsection (3)(e)(i) of this section, or Access Plan component required under subsection (3)(f) of this section, which has not been included in whole or part;

(ii) Explains the specific reason each map or component has not been included; and

(iii) Sets forth the issuer's plan to complete the submission, including the date(s) by which each incomplete map and component will be completed and submitted.

(2) Unless indicated otherwise, the issuer's reports must be submitted electronically and completed consistent with the posted submission instructions on the commissioner's web site, using the required formats.

(3) For plan years beginning January 1, 2015, an issuer must submit the following specific documents and data to the commissioner to document network access:

(a) **Provider Network Form A.** ((~~A carrier~~)) An issuer must ((~~file an electronic~~)) submit a report of all participating providers by network.

((~~This report must contain all data items shown in Provider Network Form A prescribed by and available from the commissioner. Updated reports must be filed each month.~~))

(i) The Provider Network Form A must be submitted for each network being reviewed for network access. A network may be used by more than one plan.

(ii) An issuer must indicate whether a provider is an essential community provider as instructed in the commissioner's Provider Network Form A instructions.

(iii) An issuer must submit an updated, accurate Provider Network Form A on a monthly basis by the 5th of each month for each network and when a material change in the network occurs as described in subchapter B.

(iv) Filing of this data satisfies the reporting requirements of RCW 48.44.080 and the requirements of RCW 48.46.030 relating to filing of notices that describe((~~s~~)) changes in the provider network.

(((~~2~~))) (b) **Provider directory certification.** An issuer must submit at the time of each Provider Network Form A submission a certification that the provider directory posted on the issuer's web site is specific to each plan, accurate as of the last date of the prior month. A certification signed by an officer of the issuer must confirm that the provider directory contains only providers and facilities with which the issuer has a signed contract that is in effect on the date of the certification.

(c) **Network Enrollment Form B.** ((~~By March 31, 2004, and every year thereafter, a carrier must prepare an electronic report showing the total number of covered persons who were entitled to health care services during each month of the year, excluding nonresidents. A separate~~)) The Network Enrollment Form B report provides the commissioner with an issuer's count of total covered lives for the prior year, during each month of the year, for each health plan by county.

(i) The report must be ((~~filed~~)) submitted for each network ((~~by line of business~~)) as a separate report. The report must contain all data items shown in and conform to the format of Network Enrollment Form B prescribed by and available from the commissioner.

(((~~3~~))) (ii) An issuer must submit this report by March 31st of each year.

(d) **Alternate Access Delivery Request Form C.** For plan years that begin on or after January 1, 2015, alternate access delivery requests must be submitted when an issuer's network meets one or more of the criteria in WAC 284-43-200 (15)(a) through (d). Alternate access delivery requests must be submitted to the commissioner using the Alternate Access Delivery Request Form C.

(i) The Alternate Access Delivery Request Form C submission must address the following areas, and may include other additional information as requested by the commissioner:

(A) A description of the specific issues the alternate access delivery system is intended to address, accompanied by supporting data describing how the alternate access delivery system ensures that enrollees have reasonable access to sufficient providers and facilities, by number and type, for covered services;

(B) A description and schedule of cost-sharing requirements for providers that fall under the alternate access delivery system;

(C) The issuer's proposed method of noting on its provider directory how an enrollee can access provider types under the alternate access delivery system;

(D) The issuer's marketing plan to accommodate the time period that the alternate access delivery system is in effect, and specifically describe how it impacts current and future enrollment and for what period of time;

(ii) Provider Network Form A and Network Enrollment Form B submissions are required in relation to an alternate access delivery system on the basis described in subsections (1) and (2) of this section.

(iii) If a network becomes unable to meet the network access standards after approval but prior to the health product's effective date, an alternate access delivery request must include a timeline to bring the network into full compliance with this subchapter.

(e) **Geographic Network Reports.**

(i) The geographic mapping criteria outlined below are minimum requirements and will be considered in conjunction with the standards set forth in WAC 284-43-200 and 284-43-222. One map for each of the following provider types must be submitted:

(A) Hospital and emergency services. Map must identify provider locations, and demonstrate that each enrollee in the service area has access within thirty minutes in an urban area and sixty minutes in a rural area from either their residence or workplace to general hospital facilities including emergency services.

(B) Primary care providers. Map must demonstrate that eighty percent of the enrollees in the service area have access within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace to a primary care provider with an open practice. The provider type selected must have a license under Title 18 RCW that includes primary care services in the scope of license.

(C) Mental health and substance use disorder providers. For general mental health providers, such as licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners, the map must demonstrate that eighty percent of the enrollees in the service area have access to a mental health provider within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace. For specialty mental health providers and substance use disorder providers, the map must demonstrate that eighty percent of the enrollees have access to the following types of service provider or facility: Evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment, and behavioral therapy. If one of the types of specialty providers is not available as required above, the issuer must propose an alternate access delivery system to meet this requirement.

(D) Pediatric services. For general pediatric services, the map must demonstrate that eighty percent of the covered children in the service area have access to a pediatrician or other provider whose license under Title 18 RCW includes pediatric services in the scope of license. This access must be within thirty miles in an urban area and sixty miles in a rural area of their family or placement residence. For specialty pediatric services, the map must demonstrate that eighty percent of covered children in the service area have access to pediatric specialty care within sixty miles in an urban area and ninety miles in a rural area of their family or placement residence. The pediatric specialty types include, but are not limited to, nephrology, pulmonology, rheumatology, hematology-oncology, perinatal medicine, neurodevelopmental disabilities, cardiology, endocrinology, and gastroenterology.

(E) Specialty services. An issuer must provide one map for the service area for specialties found on the American Board of Medical Specialties list of approved medical specialty boards. The map must demonstrate that eighty percent of the enrollees in the service area have access to an adequate number of providers and facilities in each specialty. Subspecialties are subsumed on the map.

(F) Therapy services. An issuer must provide one map that demonstrates that eighty percent of the enrollees have access to the following types of providers within thirty miles in an urban area and sixty miles in a rural area of their residence or workplace: Chiropractor, rehabilitative service providers and habilitative service providers.

(G) Home health, hospice, vision, and dental providers. An issuer must provide one map that identifies each provider or facility to which an enrollee has access in the service area for home health care, hospice, vision, and pediatric oral coverage, including allied dental professionals, dental therapists, dentists, and orthodontists.

(H) Covered pharmacy dispensing services. An issuer must provide one map that demonstrates the geographic distribution of the pharmacy dispensing services within the service area. If a pharmacy benefit manager is used by the issuer, the issuer must establish that the specifically contracted pharmacy locations within the service area are available to enrollees through the pharmacy benefit manager.

(I) Essential community providers. An issuer must provide one map that demonstrates the geographic distribution of essential community providers, by type of provider or facility, within the service area. This requirement applies only to qualified health plans as certified in RCW43.71.065.

(ii) Each report must include the provider data points on each map, title the map as to the provider type or facility type it represents, include the network identification number the map applies to, and the name of each county included on the report.

(iii) For plan years beginning January 1, 2015, and every year thereafter, an issuer must submit reports as required in subsection (1) of this section to the commissioner for review and approval, or when an alternate access delivery request is submitted.

(f) **Access Plan.** An issuer must establish an access plan specific to each product that describes the issuer's strategy, policies, and procedures necessary to establishing, maintaining, and administering an adequate network.

(i) At a minimum, the issuer's policies and procedures referenced in the access plan must address:

(A) Referral of enrollees out-of-network, including criteria for determining when an out-of-network referral is required or appropriate;

(B) Copayment and coinsurance determination standards for enrollees accessing care out-of-network;

(C) Standards of accessibility expressed in terms of objectives and minimum levels below which corrective action will be taken, including the proximity of specialists and hospitals to primary care sources, and a method and process for documentation confirming that access will not result in delay detrimental to health of enrollees;

(D) Monitoring policies and procedures for compliance, including tracking and documenting network capacity and availability;

(E) Standard hours of operation, and after-hours, for prior authorization, consumer and provider assistance, and claims adjudication;

(F) Triage and screening arrangements for prior authorization requests;

(G) Prior authorization processes that enrollees must follow, including the responsibilities and scope of use of nonlicensed staff to handle enrollee calls about prior authorization;

(H) Specific procedures and materials used to address the needs of enrollees with limited-English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(I) Assessment of the health status of the population of enrollees or prospective enrollees, including incorporation of the findings of local public health community assessments, and standardized outcome measures, and use of the assessment data and findings to develop network or networks in the service area;

(J) Notification to enrollees regarding personal health information privacy rights and restrictions, termination of a provider from the network, and maintaining continuity of care for enrollees when there is a material change in the provider network, insolvency of the issuer, or other cessation of operations;

(K) Issuer's process for corrective action for providers related to the provider's licensure, prior authorization, referral and access compliance. The process must include remedies to address insufficient access to appointments or services.

(ii) An access plan applicable to each product must be submitted with every Geographic Network Report when the issuer seeks initial certification of the network, submits its annual rate filing to the commissioner for review and approval, or when an alternative access delivery request is required due to a material change in the network.

(iii) The current access plan, with all associated data sets, policies and procedures, must be made available to the commissioner upon request, and a summary of the access plan's associated procedures must be made available to the public upon request.

(4) For purposes of this section((~~: (a) "Line of business" means either individual, small group or large group coverage;~~

~~(b) "Network" means the group of participating providers and facilities providing health care services to a particular line of business.~~)), "urban area" means:

(a) A county with a density of ninety persons per square mile; or

(b) An area within a twenty-five mile radius around an incorporated city with a population of more than thirty thousand.

NEW SECTION

WAC 284-43-221 Essential community providers for exchange plans—Definition.

"Essential community provider" means providers listed on the Centers for Medicare and Medicaid Services Non-Exhaustive List of Essential Community Providers. This list includes providers and facilities that have demonstrated service to medicaid, low-income, and medically underserved populations in addition to those that meet the federal minimum standard, which includes:

(1) Hospitals and providers who participate in the federal 340B Drug Pricing Program;

(2) Disproportionate share hospitals, as designated annually;

(3) Those eligible for Section 1927 Nominal Drug Pricing;

(4) Those whose patient mix is at least thirty percent medicaid or medicaid expansion patients who have approved applications for the Electronic Medical Record Incentive Program;

(5) State licensed community clinics or health centers or community clinics exempt from licensure;

(6) Indian health care providers as defined in WAC 284-43-130(17);

(7) Long-term care facilities in which the average residency rate is fifty percent or more eligible for medicaid during the preceding calendar year;

(8) School-based health centers as referenced for funding in Sec. 4101 of Title IV of ACA;

(9) Providers identified as essential community providers by the U.S. Department of Health and Human Services through subregulatory guidance or bulletins;

(10) Facilities or providers who waive charges or charge for services on a sliding scale based on income and that do not restrict access or services because of a client's financial limitations;

(11) Title X Family Planning Clinics and Title X look-alike Family Planning Clinics;

(12) Rural based or free health centers as identified on the Rural Health Clinic and the Washington Free Clinic Association web sites; and

(13) Federal qualified health centers (FQHC) or FQHC look-alikes.

NEW SECTION

WAC 284-43-222 Essential community providers for exchange plans—Network access.

(1) An issuer must include essential community providers in its provider network for qualified health plans and qualified stand-alone dental plans in compliance with this section and as defined in WAC 284-43-221.

(2) An issuer must include a sufficient number and type of essential community providers in its provider network to provide reasonable access to the medically underserved or low-income in the service area, unless the issuer can provide substantial evidence of good faith efforts on its part to contract with the providers or facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The following minimum standards apply to establish adequate qualified health plan inclusion of essential community providers:

(a) Each issuer must demonstrate that at least thirty percent of available primary care providers, pediatricians, and hospitals that meet the definition of an essential community provider in each plan's service area participate in the provider network;

(b) The issuer's provider network must include access to one hundred percent of Indian health care providers in a service area, as defined in WAC 284-43-130(17), such that qualified enrollees obtain all covered services at no greater cost than if the service was obtained from network providers or facilities;

(c) Within a service area, fifty percent of rural health clinics located outside an area defined as urban by the 2010 Census must be included in the issuer's provider network;

(d) For essential community provider categories of which only one or two exist in the state, an issuer must demonstrate a good faith effort to contract with that provider or providers for inclusion in its network, which will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider;

(e) For qualified health plans that include pediatric oral services or qualified dental plans, thirty percent of essential community providers in the service area for pediatric oral services must be included in each issuer's provider network;

(f) Ninety percent of all federally qualified health centers and FQHC look-alike facilities in the service area must be included in each issuer's provider network;

(g) At least one essential community provider hospital per county in the service area must be included in each issuer's provider network;

(h) At least fifteen percent of all providers participating in the 340B program in the service area, balanced between hospital and nonhospital entities, must be included in the issuer's provider network;

(i) By 2016, at least seventy-five percent of all school-based health centers in the service area must be included in the issuer's network.

(4) An issuer must, at the request of a school-based health center or group of school-based health centers, offer to contract with such a center or centers to reimburse covered health care services delivered to enrollees under an issuer's health plan.

(a) If a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with a school-based health center or group of school-based health centers. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(b) "School-based health center" means a school-based location for the delivery of health services, often operated as a partnership of schools and community health organizations, which can include issuers, which provide on-site medical and mental health services through a team of medical and mental health professionals to school-aged children and adolescents.

(5) An issuer must, at the request of an Indian health care provider, offer to contract with such a provider to reimburse covered health care services delivered to qualified enrollees under an issuer's health plan.

(a) Issuers are encouraged to use the current version of the Washington State Indian Health Care Provider Addendum, as posted onhttp://www.aihc-wa.com, to supplement the existing provider contracts when contracting with an Indian health care provider.

(b) If an Indian health care provider requests a contract and a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with the Indian health care provider. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(6) These requirements do not apply to integrated delivery systems pursuant to RCW 43.71.065.

NEW SECTION

WAC 284-43-229 Tiered provider networks.

(1) "Tiered provider network" means a network that identifies and groups providers and facilities into specific groups to which different provider reimbursement, enrollee cost-sharing, or provider access requirements, or any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.

(a) An issuer may use a term other than tiered network as long as the term is not misleading or susceptible to confusion with a specific licensee designation, such as accountable care organization.

(b) An issuer must not use tiered networks to limit access to certain categories of providers or facilities.

(2) When an issuer's contracts include the placement of providers or facilities in tiers, and the network design results in cost differentials for enrollees, the issuer must disclose to enrollees at the time of enrollment the cost difference and the basis for the issuer's placement of providers or facilities in one tier or another.

(3) The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among health care providers and facilities for essential health benefits as set forth in WAC 284-43-878, 284-43-879, and 284-43-880.

(4) Cost-sharing differentials between tiers must not be imposed on an enrollee if the sole provider or facility type or category required to deliver a covered service is not available to the enrollee in the lowest cost-sharing tier of the network.

(a) All enrollees must have reasonable access to providers and facilities at the lowest cost tier of cost-sharing.

(b) Variations in cost-sharing between tiers must be reasonable in relation to the premium rate charged.

(5) An issuer must include with the Provider Compensation Agreement the metrics and methodology used to assign participating providers and facilities to tiers. An issuer must be able to demonstrate to the commissioner's satisfaction that its assignment of providers and facilities to tiers, when based on a rating system, is consistent with the issuer's placement methodology.

(a) When an issuer revises or amends a quality, cost-efficiency or tiering program related to its provider network, it must provide notice to affected providers and facilities of the proposed change sixty days before notifying the public of the program. The notice must explain the methodology and data, if any, used for particular providers and facilities and include information on provider appeal rights as stated in the provider agreement.

(b) An issuer must make its physician cost profile available to providers and facilities under a tiered network, including the written criteria by which the provider's performance is measured.

(6) An issuer's provider and facility ranking program, and the criteria used to assign providers and facilities to different tiers, must not be described in advertising or plan documents so as to deceive consumers as to issuer rating practices and their affect on available benefits. When a tiered network is used, an issuer must provide detailed information on its web site and if requested, make available in paper form information about the tiered network including, but not limited to:

(a) The providers and facilities participating in the tiered network;

(b) The selection criteria, if any, used to place the providers and facilities, but not including the results of applying those selection criteria to a particular provider or facility;

(c) The potential for providers and facilities to move from one tier to another at any time; and

(d) The tier in which each participating provider or facility is assigned.

(7) For any health plan in effect on a tiered network's reassignment date, an issuer must make a good faith effort to provide information to affected enrollees at least sixty days before the reassignment takes effect. This information includes, but is not limited to, the procedure the enrollee must follow to choose an alternate provider or facility to obtain treatment at the same cost-sharing level. The specific classes of enrollees to whom notice must be sent are:

(a) Patients of a reassigned primary care provider if their primary care provider is reassigned to a higher cost-sharing level;

(b) A patient in the second or third trimester of pregnancy if a care provider or facility in connection with her pregnancy is reassigned to a higher cost-sharing level;

(c) A terminally ill patient if a provider or facility in connection with the illness is reassigned to a higher cost-sharing level; and

(d) Patients under active treatment for cancer or hematologic disorders, if the provider or facility that is delivering the care is reassigned to a higher cost-sharing level.

NEW SECTION

WAC 284-43-230 Assessment of access.

(1) The commissioner will assess whether an issuer's provider network access meets the requirements of WAC 284-43-200, 284-43-201, and 284-43-205 such that all health plan services to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. Factors considered by the commissioner will include the following:

(a) The location of the participating providers and facilities;

(b) The location of employers or enrollees in the health plan;

(c) The range of services offered by providers and facilities for the health plan;

(d) Health plan provisions that recognize and provide for extraordinary medical needs of enrollees that cannot be adequately treated by the network's participating providers and facilities;

(e) The number of enrollees within each service area living in certain types of institutions or who have chronic, severe, or disabling medical conditions, as determined by the population the issuer is covering and the benefits provided;

(f) The availability of specific types of providers who deliver medically necessary services to enrollees under the supervision of a provider licensed under Title 18 RCW;

(g) The availability within the service area of facilities under Titles 70 and 71 RCW;

(h) Accreditation as to network access by a national accreditation organization including, but not limited to, the National Committee for Quality Assurance (NCQA), the Joint Commission, Accreditation Association of Ambulatory Health Care (AAAHC), or URAC.

(2) In determining whether an issuer has complied with the provisions of WAC 284-43-200, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the issuer under reasonable terms and conditions.

(3) If the commissioner determines that an issuer's proposed or current network for a health plan is not adequate, the commissioner may, for good cause shown, permit the issuer to propose changes sufficient to make the network adequate within a sixty-day period of time. The proposal must include a mechanism to ensure that new enrollees have access to an open primary care provider within ten business days of enrolling in the plan while the proposed changes are being implemented. This requirement is in addition to such enforcement action as is otherwise permitted under Title 48 RCW.

AMENDATORY SECTION (Amending WSR 00-04-034, filed 1/24/00, effective 2/24/00)

WAC 284-43-250 ((~~Health carrier~~)) Issuer standards for women's right to directly access certain health care practitioners for women's health care services.

(1)(a) "Women's health care services" ((~~is defined to~~)) means organized services to provide health care to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The servicesinclude, but ((~~need~~)) are not ((~~be~~)) limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. ((~~General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations.~~)) Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include((~~,~~)): Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

(b) ((~~A carrier may~~)) An issuer must not exclude or limit access to covered women's health care services offered by a particular type of women's health care provider, practitioner, or facility in a manner that would unreasonably restrict access to that type of provider, practitioner, or facility or covered service. For example, ((~~a carrier may~~)) an issuer must not impose a limitation on maternity services that would require all child birth to occur in a hospital attended by a physician, thus((~~,~~)) preventing a woman from choosing between and using the birthing services of an advanced registered nurse practitioner ((~~specialist in midwifery~~)), a certified midwife, or a licensed midwife.

(c) ((~~A carrier may~~)) An issuer must not impose notification or prior authorization requirements upon women's health care practitioners, providers, and facilities who render women's health care services or upon women who directly access such services unless such requirements are imposed upon other providers offering similar types of service. For example, ((~~a carrier may~~)) an issuer must not require a directly accessed women's health care practitioner to notify the plan within seven days of providing direct women's health care services if a primary care provider would not also be required to provide seven-day notice to the ((~~carrier~~)) issuer for the same or similar service.

(2) ((~~A health carrier shall~~)) An issuer must not deny coverage for medically appropriate laboratory services, imaging services, diagnostic services, or prescriptions for pharmaceutical or medical supplies, which are ordered by a directly accessed women's health care practitioner, and which are within the practitioner's scope of practice, if such services would be covered when provided by another type of health care practitioner. ((~~A health~~

~~carrier shall~~)) An issuer must not require authorization by another type of health care practitioner for these services. For example, if the ((~~carrier~~)) issuer would cover a prescription if the prescription had been written by the primary care provider, the ((~~carrier shall~~)) issuer must cover the prescription written by the directly accessed women's health care practitioner.

(3)(a) All ((~~health carriers shall~~)) issuers must permit each female ((~~policyholder, subscriber, enrolled participant, or beneficiary of carrier policies, plans, and programs written, amended, or renewed after July 23, 1995,~~)) enrollee of a health plan to directly access ((~~the types of women's health care practitioners identified in RCW 48.42.100(2),~~)) providers or practitioners for appropriate covered women's health care services without prior referral from another health care practitioner.

(b) ((~~Beginning July 1, 2000,~~)) An issuer may limit direct access ((~~may be limited~~)) to those women's health care practitioners who have signed participating provider agreements with the ((~~carrier~~)) issuer for a specific ((~~benefit~~)) health plan network. Irrespective of the financial arrangements ((~~a carrier~~)) an issuer may have with participating providers, ((~~a carrier~~)) an issuer may not limit and ((~~shall~~)) must not permit a network provider to limit access to a subset of participating women's health care practitioners within the network. Such an impermissible limitation might arise when a primary care provider's group practice receives a capitation payment for comprehensive care to ((~~a covered person~~))an enrollee and then represents to the ((~~covered person~~)) enrollee that only those gynecologists in the primary care provider's clinic are available for direct access. Nothing in this subsection ((~~shall~~)) must be interpreted to prohibit ((~~a carrier~~)) an issuer from contracting with a provider to render limited health care services.

(c) Every ((~~carrier shall~~)) issuer must include in each provider network((~~,~~)) a sufficient number of each type of practitioner included in the definition of women's health care practitioners in RCW 48.42.100(2). A "sufficient number" means enough to reasonably ensure that enrollees can exercise their right of direct access within their service area, based on the number of providers with women's health care service in the scope of their license, and the number of enrollees. An issuer must demonstrate the basis on which it determined the sufficiency of the number and type of providers under this section.

(d) ((~~Beginning July 1, 2000,~~)) A woman's right to directly access practitioners for health care services, as provided under RCW 48.42.100, includes the right to obtain appropriate women's health care services ordered by the practitioner from a participating facility used by the practitioner.

(4) To inform enrollees of their rights under RCW 48.42.100, all ((~~health carriers shall~~)) issuers must include in enrollee handbooks a written explanation of a woman's right to directly access ((~~women's health care practitioners for~~)) covered women's health care services. Enrollee handbooks ((~~shall~~)) must include information regarding any limitations to direct access, including, but not limited to:

(a) Limited direct access based on a benefit plan's closed network of practitioners, if appropriate; and

(b) The ((~~carrier's~~)) issuer's right to limit coverage to medically necessary and appropriate women's health care services.

(5) No ((~~carrier~~)) issuer shall impose cost-sharing, such as copayments or deductibles, for directly accessed women's health care services, that are not required for access to health care practitioners acting as primary care providers.

NEW SECTION

WAC 284-43-252 Hospital emergency service departments and practice groups.

Enrollees must have access to emergency services twenty-four hours per day, seven days per week. An issuer must make good faith attempts to contract with provider groups offering services within hospital emergency departments, if the hospital is included in its network. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider groups. If the issuer is unsuccessful in contracting with provider groups offering services within contracted hospital emergency departments, the issuer's provider directory must prominently note that while the hospital's emergency department is contracted, the providers within the department are not.

AMENDATORY SECTION (Amending WSR 99-21-016, filed 10/11/99, effective 11/11/99)

WAC 284-43-331 Effective date.

(1) All participating provider and facility contracts entered into after the effective date of these rules ((~~shall~~)) must comply with these rules no later than ((~~July 1, 2000~~)) January 1, 2015.

(2) Participating provider and facility contracts entered into prior to the effective date of these rules ((~~shall~~)) must be amended upon renewal to comply with these rules, and all such contracts ((~~shall~~)) must conform to these provisions no later than January 1, ((~~2001~~)) 2015. The commissioner may extend the January 1, ((~~2001~~)) 2015, deadline for ((~~a health carrier~~)) an issuer for an additional ((~~six months~~)) one year, if the ((~~health carrier~~)) issuer makes a written request. That request must explain how a good faith effort at compliance has been made, provide the specific reasons the deadline cannot be met, and state the date the ((~~health carrier~~)) issuer expects to be in compliance (no more than ((~~six months~~)) one year beyond January 1, ((~~2001~~)) 2015).

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 284-43-340	Effective date.

Biotechnology Industry Organization

October 6, 2014

BY ELECTRONIC SUBMISSION

Jay Bradford
Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Rule 106: Network Adequacy Requirements for Health Benefit Plans

Dear Mr. Bradford:

The Biotechnology Industry Organization (BIO) appreciates this opportunity to submit the following comments on Proposed Rule 106 on Network Adequacy Requirements for Health Benefit Plans (the "Proposed Rule") issued by the Arkansas Insurance Department ("Department") on September 11, 2014.[1] BIO represents more than 1,000 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. BIO members include manufacturers and developers of vaccines, therapeutics, and diagnostics, and we have worked closely with stakeholders across the spectrum, including the public health and advocacy communities, to support policies that help expand access to preventive, wellness, and therapeutic services for all individuals.

BIO believes that patient access to the most appropriate healthcare providers is crucial to be able to translate insurance coverage to real healthcare access. Patients must be able to access providers with the expertise to provide highly-specialized care if needed, who are located in sufficient proximity to them, and who can provide essential care in a timely manner in settings where they may already seek care. BIO applauds the Department for addressing the important issue of network adequacy through the Proposed Rule.

We believe this Proposed Rule makes important strides in ensuring that insured patients in the state of Arkansas are able to obtain timely access to the most appropriate providers for their healthcare needs. Nonetheless, in the subsequent sections of this letter, we propose several recommendations to strengthen the Proposed Rule. Our comments are organized by subject, but generally follow the order in which these issues were addressed in the Proposed Rule.

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[1] Arkansas Insurance Department, Rule 106: "Network Adequacy Requirements for Health Benefit Plans," (Sept. 11, 2014), http://insurance.arkansas.gov/index_htm_files/Rule106.pdf.

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I. BIO Supports the Department's Efforts to Ensure Access to Specialty Care Providers Through the use of Geographic Accessibility Guidelines.

BIO supports the Department's efforts to ensure access to specialty care providers in the Proposed Rule, including through the use of geographic accessibility guidelines. First, BIO supports Section 5(F)(2) of the Proposed Rule, which requires health carriers to provide geographical access maps for a number of different specialty types in order to determine whether the carrier meets the geographic accessibility standards outlined in Section 5(B)(3). BIO strongly supports this requirement, as access to medical specialists is of critical importance to many patients, including those suffering from rare or chronic conditions. To ensure that all patients who rely on care from medical specialists are able to benefit from this requirement, however, we urge the Department to consider the inclusion of additional specialty groups to Section 5(F)(2), including pain specialists, neurologists, hematologists, and dermatologists.

We also urge the Department to consider breaking down certain specialty categories by sub-specialty. For example, while we agree that plans' inclusion of oncologists should be specifically assessed—given the importance of timely and convenient access to this type of specialist for those with cancer—not all cancers are the same, and access to subspecialists, where they are available in a given geographic area, can be crucial to ensuring that patients obtain expert and individualized care. Thus, we ask the Department to consider including the subspecialties of the five most prevalent cancers by incidence—breast, prostate, lung, colorectal, and melanoma—in the list of specialties requiring specific scrutiny.[2] Similarly, we urge the Department to require the inclusion of sub-specialists that that treat patients suffering from rare diseases. We note that rare diseases, particularly those affecting pediatric populations, require highly skilled sub-specialists that may not be reflected in typical specialist networks. Prospective enrollees and existing patients must have a clear path to access to these sub-specialists.

Second, BIO also supports that the geographical access maps must indicate which providers are accepting patients,[3] and that carriers must monitor, on an ongoing basis, the ability of participating providers to furnish all contracted benefits to covered persons.[4] We are concerned, however, that the geographic accessibility standard for specialists articulated in Section 5(B)(3) is inadvertently underinclusive. Specifically, while Section 5(F)(2) outlines a number of specialty types for inclusion on geographical access maps, Section 5(B)(3) merely states that, "[i]n the case of a Specialty care professional, a covered person will have access to at least one Specialty care professional within a sixty (60) mile radius between the location of the Specialty care professional and the residence of the covered person." We do not believe the Department meant to require merely that the plan include only one specialist, regardless of specialty type, within this 60-mile radius. For example, it would not be helpful for a patient suffering from cancer if the only specialist within a 60-mile radius was a rheumatologist. Instead, we presume that the intent is that plans include at least one specialist of each type outlined in Section 5(F)(2) within the requisite radius.

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[2] National Cancer Institute, National Institutes of Health. 2014. Common Cancer Types. Available at: http://www.cancer.gov/cancertopics/types/commoncancers (last viewed 9/4/2014).
[3] Id. at § 5(F).
[4] Id. at § 5(E).

Accordingly, we urge the Department to revise section 5(B)(3) to read (underlined text proposed for inclusion): "[i]n the case of a Specialty care professional, a covered person will have access to at least one Specialty care professional from within each Specialty Care Provider Category outlined in Section 5(F)(2) . . . ."

We believe that there was a similar drafting error with respect to the Essential Community Providers (ECP) provision. Specifically, Section 5(F)(4) outlines each of the categories of ECPs, however Section 5(B)(4) states that "a covered person will have access to at least one Essential Community Provider within a thirty (30) mile radius . . . ." We similarly urge the Department to revise this provision such that (underlined text proposed for inclusion) "a covered person will have access to at least one Essential Community Provider from within each ECP category outlined in Section 5(F)(4) . . .."

Third, BIO supports the inclusion of a robust number of mental and behavioral health providers to ensure compliance with the Essential Health Benefits requirements, as well as the federal mental health parity statute and regulations. However, we urge the Department to specify that a carrier cannot double-count mental and behavioral health providers for purposes of meeting their network adequacy requirements, even though some of these provider types may be included in geographic access maps outlined in both Section 5(F)(2)(l)-(m), as well as Section 5(F)(3). We similarly urge the Department to consider adding a geographic access standard specific to mental health providers under Section 5(B).

II. The Proposed Rule Should Ensure Compliance with Provider Non-Discrimination Requirements.

The Affordable Care Act (ACA) specifically prohibits health plans from discriminating against "any health care provider who is acting within the scope of that provider's license or certification under applicable state law."[5] We believe that this requirement is inextricably tied to network adequacy requirements. Indeed, a July 2013 report from the Senate Committee on Appropriations, expressly states that the basis for the ACA's provider nondiscrimination requirement was the tenet that "patients have the right to access covered health services from the full range of providers licensed and certified in their State."[6] Accordingly, we urge the Department to incorporate a provider non-discrimination provision into the Proposed Rule.

Among other things, we believe that such a provider non-discrimination provision should include both: (1) a re-articulation of the ACA's prohibition on discriminating against "any health care provider who is acting within the scope of that provider's license or certification under applicable state law"; and (2) reporting requirements for issuers, along with an active review of the information reported by the Department, in order to assess plan compliance with provider non-discrimination requirements.

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[5] ACA § 1201 (codified as Public Health Service Act § 2706(a)).
[6] S. Rep. No. 113-71, at 126 (2013).

III. Provider Networks Should Include Complementary Immunizers.

While we strongly support the proposed inclusion of school-based providers as ECPs under Section 5(H)(2)-(3), BIO requests that the Department consider adding language to the Proposed Rule requiring carriers to include all types of complementary immunizers in their provider networks as a means to ensure broad access to this critical preventive service. One of the most important provisions of the ACA was the establishment of the "immunization coverage standard," which requires plans to cover immunizations recommended by the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) without cost-sharing when administered by an in-network provider.[7] Ensuring that health plans include immunization providers in their networks has been identified as a critical issue by a diverse group of stakeholders who have worked together through the National Adult and Influenza Immunization Summit (NAIIS) to advance the goals of expanding access to immunizations for the entire population and achieving the *Healthy People 2020* goals for immunization.[8]

Immunization services have a unique set of providers. In addition to traditional immunizers, such as pediatricians and other primary care providers, complementary immunizers—pharmacists, public health department clinicians, school-based providers, and other community providers operating within their scope of practice under state law—provide many vaccines.

Complementary immunizers are particularly important for the hard-to-reach adolescent and adult populations. Indeed, adults have demonstrated a preference to be vaccinated outside of their medical home, where and when it is convenient for them, and the system has evolved to support that access. For instance, more than 230,000 pharmacists have been trained to administer vaccines in the United States,[9] and nearly all Americans (94 percent) live within five miles of a community pharmacy.[10] During the 2011-2012 influenza season, nearly 20 percent of adult influenza vaccines were administered in retail pharmacies.[11] All 50 states allow pharmacists to administer pneumococcal and zoster vaccines, and many adults seek these vaccines in the pharmacy setting.[12]

Complementary immunizers also serve low-income medically underserved populations, mitigating the barriers these vulnerable patients have long faced with respect to access to care. For instance, community pharmacies provide patient access to important immunizations against vaccine-preventable diseases, including for individuals residing in medically underserved areas (MUAs). One nationwide community pharmacy corporation,

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[7] See ACA § 1001 (codified as Public Health Service Act § 2713(a)(2)).

[8] NAIIS is a public-private partnership compromised of more than 140 organizational stakeholders, including vaccine manufacturers, professional medical societies, public health organizations, federal agencies, pharmacists, health insurers, and hospitals, among others. NAIIS has identified the issue of network adequacy for immunization providers as critical to vaccine access

[9] M. Rothholz, *Opportunities for Collaboration to Advance Progress towards "The Immunization Neighborhood:" Recognition and Compensation of Pharmacists*, American Pharmacists Association (Aug. 30, 2012).

[10] NCPDP Pharmacy File, *ArcGIS Census Tract File*, National Association of Chain Drug Stores Economics Department.

[11] CDC, *March Flu Vaccination Coverage United States, 2011-12 Influenza Season* (March 2012), http://www.cdc.gov/flu/pdf/fluvaxview/national-flu-survey-mar2012.pdf.

[12] See American Pharmacists Association, *Pharmacist Authority to Immunize* (Oct. 11, 2013), http://www.pharmacist.com/sites/default/files/PharmacistIZAuthority.pdf.

Walgreens, indicated that over one-third of their influenza vaccines administered last year were in pharmacies located in MUAs; in states with the largest MUAs, they provided up to 77.1 percent of their influenza vaccines in these areas. Moreover, of all influenza vaccinations Walgreens delivered last flu season, 31 percent were during off-peak times (59 percent on weekends and 31 percent in the evenings), and approximately 31 percent of patients during off-peak times were age 65 or older, and 36 percent had underlying medical conditions. Notably, efforts to provide immunizations other than influenza were complicated by lack of insurance coverage or recognition of community pharmacies as in-network providers.

Many public health stakeholders have supported efforts under way at the CDC to include additional complementary immunization sites, such as public health and school-based clinics, in provider networks. The most significant such CDC initiative, known as the "Third Party Billing Project," works with state health departments, public health clinics, and health insurers to include public health clinics in provider networks.[13] Thirty-five states and large cities are currently planning or implementing the Billing Project, which will allow them to bill insurers for immunization services provided to insured persons of all ages. Data from the Billing Project underscore the sheer volume of immunizations furnished by these complementary immunizers: in 2010, local health units billed private insurance for $1,964,267 in immunization-related costs in North Dakota alone.[14] Other states such as Arizona, California, Arkansas, Georgia, and Montana experienced success with the Billing Project.[15]

In spite of these efforts, when a health insurance plan does not include complementary immunization sites in its provider network, the ACA's intent of expanding access to immunizations is compromised. For instance, a plan enrollee who seeks to be immunized at a public health clinic or pharmacy that has been excluded from a plan's provider network would be denied first dollar coverage (or coverage at all) for that service. In turn, the patient may decide not to receive the vaccine due to cost and an immunization opportunity would be lost. Alternatively, a more affluent patient could elect to pay the bill, but none of these costs would count toward the patient's deductible, and the patient would understandably be upset and confused as to why they did not receive the benefits they were promised.[16]

In our experience, complementary immunizers are currently being excluded from provider networks across the country. For instance, school-based clinics in Carson City, Nevada have been excluded from the network of a major health insurer. Similarly, two insurers will not contract with the School-Located Vaccine Clinic program operated by the health department in Pomperaug, Connecticut. And the Los Angeles Unified School District cannot bill insurers due to the perception that a vaccine given in a school will interfere with the medical home.

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[13] CDC, Billing Project Success Stories, http://www.cdc.gov/vaccines/programs/billables-project/success-stories.html (last accessed Feb. 6, 2014).
[14] M. Sander, *Lessons Learned: Billing Insurance at Local Health Units in North Dakota*, North Dakota Dep't of Health (March 30, 2011), https://cdc.confex.com/cdc/nic2011/webprogram/Paper25418.html.
[15] D. Kilgus D, *Billing Program Final Plans*, Centers for Disease Control and Prevention (Feb. 2012), http://www.cdc.gov/vaccines/programs/billables-project/downloads/billing-final-plans-from-stkhldr-mtg-slides.pdf.
[16] M. Andrews, *Consumers Expecting Free "Preventive Care" Sometimes Surprised by Charges*, Kaiser Health News, Jan. 21, 2014, http://www.kaiserhealthnews.org/Stories/2014/January/21/Michelle-Andrews-Consumers-Expecting-Free-Preventive-Care.aspx.

As acknowledged by the National Vaccine Advisory Committee (NVAC) in the updated Standards for Adult Immunization Practice, "there is an increased recognition of community vaccinators and pharmacists as integral to achieving higher adult vaccination rates."[17] BIO urges the Department to consider requiring carriers to include all types of complementary immunizers within their provider networks, as expanded access to immunization services will improve vaccination rates and thereby reduce morbidity, mortality, and overall medical costs for enrollees.

IV. The Proposed Rule Should Adopt Processes and Timelines for Reviewing Network Adequacy.

The Proposed Rule requires carriers to provide information to the Commissioner so the adequacy of each plan's network can be judged against the specific standards identified. However, we ask that the Department consider including provisions for the timely and diligent review of this information to prevent plans with inadequate networks from being offered in the state. Specifically, we urge the Department to consult Washington State's new regulation on network adequacy, as it could strengthen the Proposed Rule's provisions for plan review.[18] Under this regulation, the State Insurance Commissioner is required to consider eight specific factors in assessing network adequacy and establish a process for adjudication if a carrier's plan is deemed noncompliant with the state's network adequacy standards. In particular, BIO believes that the eight identified criteria to assess network adequacy are important to ensure patient access to the providers they need. As with the Proposed Rule, the Washington State rule also requires that due consideration be given to the relative availability of healthcare providers or facilities in a given geographic area. We have included the Washington State rule as an appendix to this letter for your reference.

V. BIO Supports the Department's Efforts to Ensure Continued Access to Covered Benefits through the Proposed Rule.

BIO supports the Department's efforts to ensure continued access to covered benefits through various provisions of the Proposed Rule. First, BIO supports proposed Section 5(C), which provides that "[i]n the event that a Health carrier has an insufficient number or type of participating providers to provide a covered benefit, the Health Carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from Participating providers, or shall make other arrangements acceptable to the Commissioner that shall include reasonable criteria utilized by the carrier." BIO believes that this requirement is important in order to ensure that covered persons are not penalized for the fact that a given provider is not included in-network, as only in-network services are subject to the ACA's out-of-pocket limits and, as described above, exemptions from cost-sharing for preventive services. This provision is particularly crucial for patients with rare diseases, since there may be only a few providers across the country who specialize in a particular rare disease. We also note that this

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[17] National Vaccine Advisory Committee, *Standards for Adult Immunization Practice* (Sept. 2013), http://www.hhs.gov/nvpo/nvac/meetings/pastmeetings/2013/adult_immunization_update-sept2013.pdf.

[18] See Wash. Admin. Code § 284-43-130, et seq. (2014), available at: http://apps.leg.wa.gov/documents/laws/wsr/2014/10/14-10-017.htm.

language largely aligns with language in the NAIC Model Act, and has been adopted in a number of other states.[19]

Nonetheless, we recommend that this provision be strengthened to ensure patients have timely access to the out-of-network providers they may need. Specifically, the Department should add a requirement that carriers develop and disclose policies and timelines for requesting out-of-network services, which should be transparent to patients. We also ask that the Department specify that this provision does not obviate plans' responsibility to include a sufficient number and diversity of providers in-network to guarantee in-network access to covered benefits, including the Essential Health Benefits, to the extent possible.

Second, BIO supports the proposed requirement that health carriers file an access plan with the Commissioner beginning in 2015, which must be prepared before offering a new health benefit plan, and updated whenever the carrier makes a material change to its existing health benefit plan.[20] In particular, we support the aspects of the access plan that relate to ensuring continuity of care, such as:

- The requirement that health carriers describe their "system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning"[21]; and
- The requirement that carriers describe their "proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations,"[22] including that this description "explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner."[23]

We also strongly support the proposed components of the access plan that relate to ensuring that a plan's network continues to serve the needs of its covered persons, including that carriers must describe their processes for "monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans,"[24] as well as "for assessing the health care needs of covered persons,"[25] and "for using assessments of enrollee complaints and satisfaction to improve carrier performance."[26]

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[19] See, e.g., Mich. Comp. Laws § 500.3530; Tit. 19 Ch. 16 Miss. Code R. § 16.05.
[20] Supra note 1 at § 5(I).
[21] Id. at § 5(I)(9).
[22] Id. at § 5(I)(11).
[23] Id. at § 5(I)(11).
[24] Id. at § 5(I)(3).
[25] Id. at § 5(I)(5).
[26] Id. at § 5(I)(8).

VI. BIO Supports the Department's Efforts to Increase Transparency to Consumers through the Proposed Rule.

BIO supports the Department's efforts to increase transparency to consumers through various provisions of the Proposed Rule. First, we strongly support the proposed requirement that health carriers make a provider directory available for online publication by the Commissioner, as well as on the carrier's website, and that this directory be updated within 14 days of any change.[27] Making this information available to consumers, both as they are deciding between plans, as well as once they are enrolled, will greatly facilitate informed plan selection and the ability of enrollees to act as educated consumers. We further urge the Department to consider working with the U.S. Department of Health and Human Services (HHS)—and eventually, the state's own state-based exchange, if and when it is established—to include a link to the directory on the state's Exchange website to facilitate access to this important information to prospective beneficiaries throughout the state. We also urge the Department to ensure that the directory includes the ability to search by each category of Specialty Care Provider, in addition to ECPs, in Section 5(J)(4).

Second, we support aspects of the proposed access plan that relate to transparency with beneficiaries. For example, we strongly support the proposed requirement that this access plan describe the health carrier's procedures for "making referrals within and outside its network and for notifying enrollees and potential enrollees regarding the availability of network and out-of-network providers."[28] We also support the requirement that carriers describe their method for "informing covered persons of the plan's services and features, including cost-sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care."[29]

VII. BIO Supports Applicability of the Department's Enforcement Provision and Associated Penalties to the Network Adequacy Standards.

Section 7 of the Proposed Rule provides that "[t]he penalties, license actions or orders authorized under Ark. Code Ann. § 23-66-210 shall apply to violations of this Rule." BIO supports this provision, under which the Insurance Commissioner would be authorized to impose penalties, up to and including the suspension of an insurer's license, for engaging in an "unfair method of competition or an unfair or deceptive act or practice." We believe that failure to comply with the applicable standards regarding network adequacy, as outlined in the Proposed Rule, fall squarely within the definition of "unfair methods of competition and unfair or deceptive acts and practices," as defined under Ark. Code Ann. § 23-66-206, and accordingly urge the Department to finalize proposed Section 7.

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[27] Id. at § 5(J).
[28] Id. at § 5(I)(2).
[29] Id. at § 5(I)(6).

VIII. Conclusion

BIO is pleased to be able to comment on the Proposed Rule and looks forward to additional opportunities to provide feedback on the evolution of these provisions. We encourage the Department to continue to inclusively engage stakeholders in the development and implementation of the provisions, and appreciate your attention to this important issue. Please do not hesitate to contact me at 202-449-6384 with any questions or if I can provide any further information.

Sincerely,

/s/

Erin Estey Hertzog, J.D., M.P.H.
Director
Reimbursement & Health Policy

Appendix: Wash. Admin. Code § 284-43-205 (2014)

Effective Date of Rule: Thirty-one days after filing.

Purpose: Based on the significant changes in health care delivery and access to care that will occur after January 1, 2014, due to health care reform, the commissioner determined that updating regulations is reasonable and necessary. Both qualified health plans and health plans offered outside of the exchange must have networks that at a minimum ensure access to covered services without unreasonable delay and address the specific needs of the populations served. Clarification of the provider network criteria in these areas is needed to support issuer filings. Issuers will benefit from written guidance regarding the commissioner's review standards for provider networks in general and the inclusion of essential community providers in networks for qualified health plans. The proposed rule also includes requirements for provider directories and creates a more transparent process for the building and maintenance of provider networks.

Citation of Existing Rules Affected by this Order: Repealing WAC 284-43-340; and amending WAC 284-43-130, 284-43-200, 284-43-205, 284-43-220, 284-43-250, and 284-43-331.

Statutory Authority for Adoption: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200.

Other Authority: RCW 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 45 C.F.R. 156.235, 45 C.F.R. 156.245.

Adopted under notice filed as WSR 13-19-092 [14-07-102] on March 19, 2014.

Changes Other than Editing from Proposed to Adopted Version: WAC 284-43-130(15), stand alone definition of "issuer" was stricken as it created an internal discrepancy in the definition section. Maintained as part of the definition of "health carrier," WAC 284-43-130(14). Renumbered section.

WAC 284-43-130(30), struck "within the state" from definition. Stricken to more accurately reflect the marketplace as issuers offer plans in border counties which utilize providers and facilities in neighboring states to provide sufficient number and choice of providers to enrollees in a manner that limits the amount of travel.

WAC 284-43-130(30), changed "health plan" to "product" for consistency.

WAC 284-43-200 (11)(a), changed "medical" to "mental" to accurately reflect the name of the publication.

WAC 284-43-200(12), changed "preventative" to "preventive" for consistency with WAC 284-43-878(9).

WAC 284-43-200 (13)(b)(i), ratio of "enrollee to primary care provider" was changed to "primary care provider to enrollee" to accurately reflect the ratio.

WAC 284-43-200 (13)(b)(iii), changed "their" to "a" in reference to a primary care provider for consistency.

WAC 284-43-200 (15)(d), struck reference to subsection (d) of (3) and subsection (4) as these are no longer valid cross references.

WAC 284-43-220 (3)(e)(i)(E), struck "each area" and made "specialty" plural. Also struck "each" and included "the." Both changes made to accurately reflect the intent of the section.

WAC 284-43-220 (3)(e)(iii), struck "this" for readability.

WAC 284-43-220 (3)(f), changed "health plan" to "product" for consistency.

WAC 284-43-220 (3)(f)(i)(K), changed "processes" to "issuer's process" to differentiate from the department of health's corrective actions.

WAC 284-43-220 (4)(b), corrected "An area with" to "An area within" to accurately reflect the definition.

WAC 284-43-220 (3)(d)(i)(A), added "and facilities" for consistency.

WAC 284-43-220 (3)(e)(i)(C), include "substance use disorder" in title of map and also included "substance use disorder" where specialty mental health providers are referenced. Amended language for consistency with other areas of the rule that reference mental health and substance use disorder providers.

WAC 284-43-222 (5)(a), name of addendum was corrected.

WAC 284-43-229(4), amended language to make consistent with the section, changed "lowest cost tier of the network" to read "lowest cost-sharing tier of the network."

Throughout rule reference to "file" or "filing" was changed to "submit" or "submitted" to make the rule consistent.

A final cost-benefit analysis is available by contacting Kate Reynolds, P.O. Box 40258, Olympia, WA 98504-0258, phone (360) 725-7170, fax (360) 586-3109, e-mail rulescoordinator@oic.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 4, Amended 2, Repealed 1; Federal Rules or Standards: New 4, Amended 2, Repealed 1; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 5, Amended 6, Repealed 1.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.
Date Adopted: April 25, 2014.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 12-23-005, filed 11/7/12, effective 11/20/12)

WAC 284-43-130 Definitions.

Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Authorization" or "certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.

(4) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(5) "Covered person" or "enrollee" means an individual covered by a health plan including ((~~an enrollee,~~)) a subscriber, policyholder, or beneficiary of a group plan.

(6) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(7) "Emergency services" has the meaning set forth in RCW 48.43.005.

(8) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(9) "Facility" means an institution providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

(10) "Formulary" means a listing of drugs used within a health plan.

(11) "Grievance" has the meaning set forth in RCW 48.43.005.

(12) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(13) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(14) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health

maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

(15) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(16) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. §1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. §450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. §47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. §1603(29).

(17) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

((~~(17)~~)) (18) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

((~~(18)~~)) (19) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

((~~(19)~~)) (20) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

((~~(20)~~)) (21) "Network" means the group of participating providers and facilities providing health care services to a particular health planor line of business (individual, small, or large group). A health plan network for ((~~carriers~~)) issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

((~~(21)~~)) (22) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology,* published by the American Medical Association.

((~~(22)~~)) (23) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care

services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

((~~(23)~~)) (24) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

((~~(24)~~)) (25) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

((~~(25)~~)) (26) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

((~~(26)~~)) (27) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(27)~~)) (28) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(28)~~)) (29) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

(30) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005(33) comprising from one to fifty eligible employees.

((~~(29)~~)) (31) "Substitute drug" means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

((~~(30)~~)) (32) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

AMENDATORY SECTION (Amending WSR 01-03-033, filed 1/9/01, effective 7/1/01)

WAC 284-43-200 Network ((~~adequacy~~)) access—General standards.

(1) ((~~A health carrier shall~~)) An issuer must maintain each ((~~plan~~)) provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to ((~~covered persons~~)) enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.

(2) Each ((~~covered person shall~~)) enrollee must have adequate choice among ((~~each type of~~)) health care providers, including those ((~~types of providers who~~)) providers which must be included in the network under WAC 284-43-205, and for qualified health plans and qualified stand-alone dental plans, under WAC 284-43-222. ((~~In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. The carrier's~~))

(3) An issuer's service area ((~~shall~~)) must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, gender identity, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status((~~. Each carrier shall ensure that its networks will meet these requirements by the end of the first year of initial operation of the network and at all times thereafter~~)).

((~~(2)~~)) (4) An issuer must establish sufficiency and adequacy of choice ((~~may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) and by private managed care accreditation organizations may be used to demonstrate~~

~~sufficiency. At a minimum, a carrier will be held accountable for meeting those standards described under WAC 284-43-220.~~

~~(3) In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.~~

~~(4) The health carrier shall~~)) of providers based on the number and type of providers and facilities necessary within the service area for the plan to meet the access requirements set forth in this subchapter. Where an issuer establishes medical necessity or other prior authorization procedures, the issuer must ensure sufficient qualified staff is available to provide timely prior authorization decisions on an appropriate basis, without delays detrimental to the health of enrollees.

(5) In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. An issuer must satisfy this obligation even if an alternate access delivery request has been submitted and is pending commissioner approval.

An issuer may use facilities in neighboring service areas to satisfy a network access standard if one of the following types of facilities is not in the service area, or if the issuer can provide substantial evidence of good faith efforts on its part to contract with the facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the facility. This applies to the following types of facilities:

(a) Tertiary hospitals;

(b) Pediatric community hospitals;

(c) Specialty or limited hospitals, such as burn units, rehabilitative hospitals, orthopedic hospitals, and cancer care hospitals;

(d) Neonatal intensive care units; and

(e) Facilities providing transplant services, including those that provide solid organ, bone marrow, and stem cell transplants.

(6) An issuer must establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of ((~~covered persons. Health carriers shall~~)) enrollees, and located so as to not result in unreasonable barriers to accessibility. Issuers must make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. ((~~For example, a carrier should not require travel of thirty miles or more when a provider who meets carrier standards is available for inclusion in the network and practices within five miles of enrollees.~~

~~In determining whether a health carrier has complied with this provision, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the carrier under reasonable terms and conditions.~~

~~(5) A health carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to covered persons.~~

~~(6) Beginning July 1, 2000, the health carrier shall disclose to covered persons~~))

(7) A single case provider reimbursement agreement must be used only to address unique situations that typically occur out-of-network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in the network and do not support a determination of network access.

(8) An issuer must disclose to enrollees that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of ((~~participating providers and facilities. The carrier shall provide instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes. For example, a covered person relying on such instructions or processes could discover if the choice of a particular primary care provider would result in the covered person's inability to obtain a referral to certain other participating providers.~~

~~(7)~~)) the issuer. A description of the health plan's referral and authorization practices, including information about how to contact customer service for guidance, must be set forth as an introduction or preamble

to the provider directory for a health plan. In the alternative, the description of referral and authorization practices may be included in the summary of benefits and explanation of coverage for the health plan.

(9) To provide adequate choice to ((~~covered persons~~)) enrollees who are American Indians/Alaska Natives, each health ((~~carrier shall~~)) issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are ((~~covered persons~~)) enrollees have access to covered medical and behavioral health services provided by Indian health care ((~~services and facilities that are part of the Indian health system~~)) providers.

((~~Carriers shall~~)) Issuers must ensure that such ((~~covered persons~~)) enrollees may obtain covered medical and behavioral health services from the Indian health ((~~system~~)) care provider at no greater cost to the ((~~covered person~~)) enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider. ((~~Carriers~~)) Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits ((~~a carrier~~)) an issuerfrom limiting coverage to those health services that meet ((~~carrier~~)) issuer standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

(10) An issuer must have a demonstrable method and contracting strategy to ensure that contracting hospitals in a plan's service area have the capacity to serve the entire enrollee population based on normal utilization.

(11) At a minimum, an issuer's provider network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy.

(a) Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from mental health providers. There must be mental health providers of sufficient number and type to provide diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* or other recognized diagnostic manual or standard.

(b) An issuer must establish a reasonable standard for the number and geographic distribution of mental health providers who can treat serious mental illness of an adult and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure.

The issuer must measure the adequacy of the mental health network against this standard at least twice a year, and submit an action plan with the commissioner if the standard is not met.

(c) Emergency mental health services, including crisis intervention and crisis stabilization services, must be included in an issuer's provider network.

(d) An issuer must include a sufficient number and type of mental health and substance use disorder treatment providers and facilities within a service area based on normal utilization patterns.

(e) An issuer must ensure that an enrollee can identify information about mental health services and substance use disorder treatment including benefits, providers, coverage, and other relevant information by calling a customer service representative during normal business hours.

(12) The provider network must include preventive and wellness services, including chronic disease management and smoking cessation services as defined in RCW 48.43.005(37) and WAC 284-43-878(9). If these services are provided through a quit-line or help-line, the issuer must ensure that when follow-up services are medically necessary, the enrollee will have access to sufficient information to access those services within the service area. Contracts with quit-line or help-line services are subject to the same conditions and terms as other provider contracts under this section.

(13) For the essential health benefits category of ambulatory patient services, as defined in WAC 284-43-878(1), an issuer's network is adequate if:

(a) The issuer establishes a network that affords enrollee access to urgent appointments without prior authorization within forty-eight hours, or with prior authorization, within ninety-six hours of the referring provider's referral.

(b) For primary care providers the following must be demonstrated:

(i) The ratio of primary care providers to enrollees within the issuer's service area as a whole meets or exceeds the average ratio for Washington state for the prior plan year;

(ii) The network includes such numbers and distribution that eighty percent of enrollees within the service area are within thirty miles of a sufficient number of primary care providers in an urban area and within sixty miles of a sufficient number of primary care providers in a rural area from either their residence or work; and

(iii) Enrollees have access to an appointment, for other than preventive services, with a primary care provider within ten business days of requesting one.

(c) For specialists:

(i) The issuer documents the distribution of specialists in the network for the service area in relation to the population distribution within the service area; and

(ii) The issuer establishes that when an enrollee is referred to a specialist, the enrollee has access to an appointment with such a specialist within fifteen business days for nonurgent services.

(d) For preventive care services, and periodic follow-up care including, but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, the issuer permits scheduling such services in advance, consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

(14) The network access requirements in this subchapter apply to stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered outside of the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. All such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions.

(a) An issuer of such stand-alone dental plans must demonstrate that, for the dental plan's defined service area, all services required under WAC 284-43-879(3) are available to all enrollees without unreasonable delay.

(b) Dental networks for pediatric oral services must be sufficient for the enrollee population in the service area based on expected utilization.

(15) Issuers must meet all requirements of this subsection for all provider networks. An alternate access delivery request under WAC 284-43-201 may be proposed only if:

(a) There are sufficient numbers and types of providers or facilities in the service area to meet the standards under this subchapter but the issuer is unable to contract with sufficient providers or facilities to meet the network standards in this subchapter; or

(b) An issuer's provider network has been previously approved under this section, and a provider or facility type subsequently becomes unavailable within a health plan's service area; or

(c) A county has a population that is fifty thousand or fewer, and the county is the sole service area for the plan, and the issuer chooses to propose an alternative access delivery system for that county; or

(d) A qualified health plan issuer is unable to meet the standards for inclusion of essential community providers, as provided under WAC 284-43-222(3).

(16) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-201 Alternate access delivery request.

(1) Where an issuer's network meets one or more of the criteria in WAC 284-43-200 (15)(a) through (d), the issuer may submit an alternate access delivery request for the commissioner's review and approval. The alternate access delivery request must be made using the Alternate Access Delivery Request Form C, as provided in WAC 284-43-220 (3)(d).

(a) An alternate access delivery system must provide enrollees with access to medically necessary care on a reasonable basis without detriment to their health.

(b) The issuer must ensure that the enrollee obtains all covered services in the alternate access delivery system at no greater cost to the enrollee than if the service was obtained from network providers or facilities or must make other arrangements acceptable to the commissioner.

(i) Copayments and deductible requirements must apply to alternate access delivery systems at the same level they are applied to in-network services.

(ii) The alternate access delivery system may result in issuer payment of billed charges to ensure network access.

(c) An issuer must demonstrate in its alternate access delivery request a reasonable basis for not meeting a standard as part of its filing for approval of an alternate access delivery system, and include an explanation of why the alternate access delivery system provides a sufficient number or type of the provider or facility to which the standard applies to enrollees.

(d) An issuer must demonstrate a plan and practice to assist enrollees to locate providers and facilities in neighboring service areas in a manner that assures both availability and accessibility. Enrollees must be able to obtain health care services from a provider or facility within the closest reasonable proximity of the enrollee in a timely manner appropriate for the enrollee's health needs.

Alternate access delivery systems include, but are not limited to, such provider network strategies as use of out-of-state and out of county or service area providers, and exceptions to network standards based on rural locations in the service area.

(2) The commissioner will not approve an alternate access delivery system unless the issuer provides substantial evidence of good faith efforts on its part to contract with providers or facilities, and can demonstrate

that there is not an available provider or facility with which the issuer can contract to meet provider network standards under WAC 284-43-200.

(a) Such evidence of good faith efforts to contract, where required, will be submitted as part of the issuer's Alternate Access Delivery Request Form C submission, as described in WAC 284-43-220 (3)(d).

(b) Evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The practice of entering into a single case provider reimbursement agreement with a provider or facility in relation to a specific enrollee's condition or treatment requirements is not an alternate access delivery system for purposes of establishing an adequate provider network. A single case provider reimbursement agreement must be used only to address unique situations that typically occur out of network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in a network for the whole population of enrollees under a plan, and do not support a determination of network access.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-203 Use of subcontracted networks.

(1) The primary contractor with each provider and facility in an issuer's network must be specifically identified in network report filings with the commissioner. An issuer may use subcontracted networks as part of a provider network for a service area, subject to the following requirements:

(a) An issuer must not elect to use less than one hundred percent of the subcontracted network or networks in its service area.

(b) An issuer may use a combination of directly contracting with providers and use of a subcontracted network in the same service area.

(2) Upon request by the commissioner, an issuer must produce an executed copy of its agreement with a subcontracted network, and certify to the commissioner that there is reasonable assurance the providers listed as part of the subcontracted network are under enforceable contracts with the subcontractor. The contract with the subcontracted network's administrator must provide the issuer with the ability to require providers to conform to the requirements in chapter 284-43 WAC, subchapter B.

(3) If an issuer permits a facility or provider to delegate functions, the issuer must require the facility or provider to:

(a) Include the requirements of this subchapter in its contracting documents with the subcontractor, including providing the commissioner with access to any pertinent information related to the contract during the contract term, for up to ten years from the final date of the contract period, and in certain instances, where required by federal or state law, periods in excess of ten years;

(b) Provide the issuer with the right to approve, suspend or terminate any such arrangement.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-204 Provider directories.

(1) Provider directories must be updated at least monthly, and must be offered to accommodate individuals with limited-English proficiency or disabilities. An issuer must post the current provider directory for each health plan online, and must make a printed copy of the current directory available to an enrollee upon request as required under RCW 48.43.510 (1)(g).

(2) For each health plan, the associated provider directory must include the following information for each provider:

(a) The specialty area or areas for which the provider is licensed to practice and included in the network;

(b) Any in-network institutional affiliation of the provider, such as hospitals where the provider has admitting privileges or provider groups with which a provider is a member;

(c) Whether the provider may be accessed without referral;

(d) Any languages, other than English, spoken by the provider.

(3) An issuer must include in its electronic posting of a health plan's provider directory a notation of any primary care, chiropractor, women's health care provider, or pediatrician whose practice is closed to new patients.

(4) If an issuer maintains more than one provider network, its posted provider directory or directories must make it reasonably clear to an enrollee which network applies to which health plan.

(5) Information about any available telemedicine services must be included and specifically described.

(6) Information about any available interpreter services, communication and language assistance services, and accessibility of the physical facility must be identified in the directory, and the mechanism by which an enrollee may access such services.

(7) An issuer must include information about the network status of emergency providers as required by WAC 284-43-252.

(8) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

AMENDATORY SECTION (Amending WSR 99-16-036, filed 7/28/99, effective 8/28/99)

WAC 284-43-205 Every category of health care providers.

(1) ((~~To effectuate the requirement of RCW 48.43.045 that health plans provide coverage for treatments and services by every category of provider, health carriers shall~~)) Issuers must not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for ((~~conditions covered by basic health plan (BHP) services as defined by RCW 48.43.005(4). If the BHP covers the condition, the carrier may~~)) services covered as essential health benefits, as defined in WAC 284-43-878 and RCW 48.43.715, for individual and small group plans; and as covered by the basic health plan, as defined in RCW 48.43.005(4), for plans other than individual and small group.

For individual and small group plans, the issuer must not exclude a category of provider who is licensed to provide services for ((~~that~~)) a covered condition, and is acting within the scope of practice, unless such services would not meet the ((~~carrier's~~)) issuer's standards pursuant to RCW 48.43.045 (1)(((~~(b)~~))) (a). For example, ((~~if the BHP provides coverage for~~)) if the issuer covers outpatient treatment of lower back pain as part of the essential health benefits, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope of practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(((~~(b) may~~))) (a) must not be excluded from the network.

(2) RCW 48.43.045 (1)(((~~(b)~~))) (a) permits ((~~health carriers~~)) issuers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, ((~~health carriers may~~)) issuers must not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude that category of provider completely from health plans on that basis. ((~~However, health carriers may determine that particular services for particular conditions by particular categories of providers are not cost-effective or clinically efficacious, and may exclude such services from coverage or reimbursement under a health plan. Any such determinations must be supported by relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy.~~))

(3) Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers based on relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy. However, health plans ((~~may~~)) must not contain unreasonable limits, and ((~~may~~)) must not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)(((~~(b)~~))) (a).

(4) This section does not prohibit health plans from using restricted networks. ((~~Health carriers~~)) Issuers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. ((~~A health carrier~~)) An issuer is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan.

(a) Health plan((~~s~~)) networks that use "gatekeepers" or "medical homes" for access to specialist providers may use them for access to specified categories of providers.

(b) For purposes of this section:

(i) "Gatekeeper" means requiring a referral from a primary care or direct access provider or practitioner to access specialty or in-patient services.

(ii) "Medical home" means a team based health care delivery model for patient centered primary care that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes as modified and updated by the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services (HRSA), and other state and federal agencies.

(5) ((~~Health carriers may~~)) Issuers must not offer coverage for health services for certain categories of providers solely as a separately priced optional benefit.

(6) The insurance commissioner may grant reasonable temporary extensions of time for implementation of RCW 48.43.045 or this section, or any part thereof, for good cause shown.

((~~(7) All health carriers and their plans, provider contracts, networks and operations shall conform to the provisions of this section WAC 284-43-205, by January 1, 2000.~~))

AMENDATORY SECTION (Amending WSR 11-07-015, filed 3/8/11, effective 4/8/11)

WAC 284-43-220 Network reports—Format.

((~~Each health carrier must file with the commissioner a Provider Network Form A and a Network Enrollment Form B.~~)) (1) An issuer must submit its provider network materials to the commissioner for approval prior to or at the time it files a newly offered health plan.

(a) For individual and small groups, the submission must occur when the issuer submits its plan under WAC 284-170-870. For groups other than individual and small, the submission must occur when the issuer submits a new health plan and as required in this section.

(b) The commissioner may extend the time for filing for good cause shown.

(c) For plan year 2015 only, the commissioner will permit a safe harbor standard. An issuer who can not meet the submission requirements in (e) and (f) of this subsection will be determined to meet the requirements of those subsections even if the submissions are incomplete, provided that the issuer:

(i) Identifies specifically each map required under subsection (3)(e)(i) of this section, or Access Plan component required under subsection (3)(f) of this section, which has not been included in whole or part;

(ii) Explains the specific reason each map or component has not been included; and

(iii) Sets forth the issuer's plan to complete the submission, including the date(s) by which each incomplete map and component will be completed and submitted.

(2) Unless indicated otherwise, the issuer's reports must be submitted electronically and completed consistent with the posted submission instructions on the commissioner's web site, using the required formats.

(3) For plan years beginning January 1, 2015, an issuer must submit the following specific documents and data to the commissioner to document network access:

(a) **Provider Network Form A.** ((~~A carrier~~)) An issuer must ((~~file an electronic~~)) submit a report of all participating providers by network.

((~~This report must contain all data items shown in Provider Network Form A prescribed by and available from the commissioner. Updated reports must be filed each month.~~))

(i) The Provider Network Form A must be submitted for each network being reviewed for network access. A network may be used by more than one plan.

(ii) An issuer must indicate whether a provider is an essential community provider as instructed in the commissioner's Provider Network Form A instructions.

(iii) An issuer must submit an updated, accurate Provider Network Form A on a monthly basis by the 5th of each month for each network and when a material change in the network occurs as described in subchapter B.

(iv) Filing of this data satisfies the reporting requirements of RCW 48.44.080 and the requirements of RCW 48.46.030 relating to filing of notices that describe((~~s~~)) changes in the provider network.

((~~(2)~~)) (b) **Provider directory certification.** An issuer must submit at the time of each Provider Network Form A submission a certification that the provider directory posted on the issuer's web site is specific to each plan, accurate as of the last date of the prior month. A certification signed by an officer of the issuer must confirm that the provider directory contains only providers and facilities with which the issuer has a signed contract that is in effect on the date of the certification.

(c) **Network Enrollment Form B.** ((~~By March 31, 2004, and every year thereafter, a carrier must prepare an electronic report showing the total number of covered persons who were entitled to health care services during each month of the year, excluding nonresidents. A separate~~)) The Network Enrollment Form B report provides the commissioner with an issuer's count of total covered lives for the prior year, during each month of the year, for each health plan by county.

(i) The report must be ((~~filed~~)) submitted for each network ((~~by line of business~~)) as a separate report. The report must contain all data items shown in and conform to the format of Network Enrollment Form B prescribed by and available from the commissioner.

((~~(3)~~)) (ii) An issuer must submit this report by March 31st of each year.

(d) **Alternate Access Delivery Request Form C.** For plan years that begin on or after January 1, 2015, alternate access delivery requests must be submitted when an issuer's network meets one or more of the criteria in WAC 284-43-200 (15)(a) through (d). Alternate access delivery requests must be submitted to the commissioner using the Alternate Access Delivery Request Form C.

(i) The Alternate Access Delivery Request Form C submission must address the following areas, and may include other additional information as requested by the commissioner:

(A) A description of the specific issues the alternate access delivery system is intended to address, accompanied by supporting data describing how the alternate access delivery system ensures that enrollees have reasonable access to sufficient providers and facilities, by number and type, for covered services;

(B) A description and schedule of cost-sharing requirements for providers that fall under the alternate access delivery system;

(C) The issuer's proposed method of noting on its provider directory how an enrollee can access provider types under the alternate access delivery system;

(D) The issuer's marketing plan to accommodate the time period that the alternate access delivery system is in effect, and specifically describe how it impacts current and future enrollment and for what period of time;

(ii) Provider Network Form A and Network Enrollment Form B submissions are required in relation to an alternate access delivery system on the basis described in subsections (1) and (2) of this section.

(iii) If a network becomes unable to meet the network access standards after approval but prior to the health product's effective date, an alternate access delivery request must include a timeline to bring the network into full compliance with this subchapter.

(e) **Geographic Network Reports.**

(i) The geographic mapping criteria outlined below are minimum requirements and will be considered in conjunction with the standards set forth in WAC 284-43-200 and 284-43-222. One map for each of the following provider types must be submitted:

(A) Hospital and emergency services. Map must identify provider locations, and demonstrate that each enrollee in the service area has access within thirty minutes in an urban area and sixty minutes in a rural area from either their residence or workplace to general hospital facilities including emergency services.

(B) Primary care providers. Map must demonstrate that eighty percent of the enrollees in the service area have access within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace to a primary care provider with an open practice. The provider type selected must have a license under Title 18 RCW that includes primary care services in the scope of license.

(C) Mental health and substance use disorder providers. For general mental health providers, such as licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners, the map must demonstrate that eighty percent of the enrollees in the service area have access to a mental health provider within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace. For specialty mental health providers and substance use disorder providers, the map must demonstrate that eighty percent of the enrollees have access to the following types of service provider or facility: Evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment, and behavioral therapy. If one of the types of specialty providers is not available as required above, the issuer must propose an alternate access delivery system to meet this requirement.

(D) Pediatric services. For general pediatric services, the map must demonstrate that eighty percent of the covered children in the service area have access to a pediatrician or other provider whose license under Title 18 RCW includes pediatric services in the scope of license. This access must be within thirty miles in an urban area and sixty miles in a rural area of their family or placement residence. For specialty pediatric services, the map must demonstrate that eighty percent of covered children in the service area have access to pediatric specialty care within sixty miles in an urban area and ninety miles in a rural area of their family or placement residence. The pediatric specialty types include, but are not limited to, nephrology, pulmonology, rheumatology, hematology-oncology, perinatal medicine, neurodevelopmental disabilities, cardiology, endocrinology, and gastroenterology.

(E) Specialty services. An issuer must provide one map for the service area for specialties found on the American Board of Medical Specialties list of approved medical specialty boards. The map must demonstrate that eighty percent of the enrollees in the service area have access to an adequate number of providers and facilities in each specialty. Subspecialties are subsumed on the map.

(F) Therapy services. An issuer must provide one map that demonstrates that eighty percent of the enrollees have access to the following types of providers within thirty miles in an urban area and sixty miles in a rural area of their residence or workplace: Chiropractor, rehabilitative service providers and habilitative service providers.

(G) Home health, hospice, vision, and dental providers. An issuer must provide one map that identifies each provider or facility to which an enrollee has access in the service area for home health care, hospice, vision, and pediatric oral coverage, including allied dental professionals, dental therapists, dentists, and orthodontists.

(H) Covered pharmacy dispensing services. An issuer must provide one map that demonstrates the geographic distribution of the pharmacy dispensing services within the service area. If a pharmacy benefit manager is used by the issuer, the issuer must establish that the specifically contracted pharmacy locations within the service area are available to enrollees through the pharmacy benefit manager.

(I) Essential community providers. An issuer must provide one map that demonstrates the geographic distribution of essential community providers, by type of provider or facility, within the service area. This requirement applies only to qualified health plans as certified in RCW43.71.065.

(ii) Each report must include the provider data points on each map, title the map as to the provider type or facility type it represents, include the network identification number the map applies to, and the name of each county included on the report.

(iii) For plan years beginning January 1, 2015, and every year thereafter, an issuer must submit reports as required in subsection (1) of this section to the commissioner for review and approval, or when an alternate access delivery request is submitted.

(f) **Access Plan.** An issuer must establish an access plan specific to each product that describes the issuer's strategy, policies, and procedures necessary to establishing, maintaining, and administering an adequate network.

(i) At a minimum, the issuer's policies and procedures referenced in the access plan must address:

(A) Referral of enrollees out-of-network, including criteria for determining when an out-of-network referral is required or appropriate;

(B) Copayment and coinsurance determination standards for enrollees accessing care out-of-network;

(C) Standards of accessibility expressed in terms of objectives and minimum levels below which corrective action will be taken, including the proximity of specialists and hospitals to primary care sources, and a method and process for documentation confirming that access will not result in delay detrimental to health of enrollees;

(D) Monitoring policies and procedures for compliance, including tracking and documenting network capacity and availability;

(E) Standard hours of operation, and after-hours, for prior authorization, consumer and provider assistance, and claims adjudication;

(F) Triage and screening arrangements for prior authorization requests;

(G) Prior authorization processes that enrollees must follow, including the responsibilities and scope of use of nonlicensed staff to handle enrollee calls about prior authorization;

(H) Specific procedures and materials used to address the needs of enrollees with limited-English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(I) Assessment of the health status of the population of enrollees or prospective enrollees, including incorporation of the findings of local public health community assessments, and standardized outcome measures, and use of the assessment data and findings to develop network or networks in the service area;

(J) Notification to enrollees regarding personal health information privacy rights and restrictions, termination of a provider from the network, and maintaining continuity of care for enrollees when there is a material change in the provider network, insolvency of the issuer, or other cessation of operations;

(K) Issuer's process for corrective action for providers related to the provider's licensure, prior authorization, referral and access compliance. The process must include remedies to address insufficient access to appointments or services.

(ii) An access plan applicable to each product must be submitted with every Geographic Network Report when the issuer seeks initial certification of the network, submits its annual rate filing to the commissioner for review and approval, or when an alternative access delivery request is required due to a material change in the network.

(iii) The current access plan, with all associated data sets, policies and procedures, must be made available to the commissioner upon request, and a summary of the access plan's associated procedures must be made available to the public upon request.

(4) For purposes of this section((~~: (a) "Line of business" means either individual, small group or large group coverage;~~

~~(b) "Network" means the group of participating providers and facilities providing health care services to a particular line of business.~~)), "urban area" means:

(a) A county with a density of ninety persons per square mile; or

(b) An area within a twenty-five mile radius around an incorporated city with a population of more than thirty thousand.

NEW SECTION

WAC 284-43-221 Essential community providers for exchange plans—Definition.

"Essential community provider" means providers listed on the Centers for Medicare and Medicaid Services Non-Exhaustive List of Essential Community Providers. This list includes providers and facilities that have demonstrated service to medicaid, low-income, and medically underserved populations in addition to those that meet the federal minimum standard, which includes:

(1) Hospitals and providers who participate in the federal 340B Drug Pricing Program;

(2) Disproportionate share hospitals, as designated annually;

(3) Those eligible for Section 1927 Nominal Drug Pricing;

(4) Those whose patient mix is at least thirty percent medicaid or medicaid expansion patients who have approved applications for the Electronic Medical Record Incentive Program;

(5) State licensed community clinics or health centers or community clinics exempt from licensure;

(6) Indian health care providers as defined in WAC 284-43-130(17);

(7) Long-term care facilities in which the average residency rate is fifty percent or more eligible for medicaid during the preceding calendar year;

(8) School-based health centers as referenced for funding in Sec. 4101 of Title IV of ACA;

(9) Providers identified as essential community providers by the U.S. Department of Health and Human Services through subregulatory guidance or bulletins;

(10) Facilities or providers who waive charges or charge for services on a sliding scale based on income and that do not restrict access or services because of a client's financial limitations;

(11) Title X Family Planning Clinics and Title X look-alike Family Planning Clinics;

(12) Rural based or free health centers as identified on the Rural Health Clinic and the Washington Free Clinic Association web sites; and

(13) Federal qualified health centers (FQHC) or FQHC look-alikes.

NEW SECTION

WAC 284-43-222 Essential community providers for exchange plans—Network access.

(1) An issuer must include essential community providers in its provider network for qualified health plans and qualified stand-alone dental plans in compliance with this section and as defined in WAC 284-43-221.

(2) An issuer must include a sufficient number and type of essential community providers in its provider network to provide reasonable access to the medically underserved or low-income in the service area, unless the issuer can provide substantial evidence of good faith efforts on its part to contract with the providers or facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The following minimum standards apply to establish adequate qualified health plan inclusion of essential community providers:

(a) Each issuer must demonstrate that at least thirty percent of available primary care providers, pediatricians, and hospitals that meet the definition of an essential community provider in each plan's service area participate in the provider network;

(b) The issuer's provider network must include access to one hundred percent of Indian health care providers in a service area, as defined in WAC 284-43-130(17), such that qualified enrollees obtain all covered services at no greater cost than if the service was obtained from network providers or facilities;

(c) Within a service area, fifty percent of rural health clinics located outside an area defined as urban by the 2010 Census must be included in the issuer's provider network;

(d) For essential community provider categories of which only one or two exist in the state, an issuer must demonstrate a good faith effort to contract with that provider or providers for inclusion in its network, which will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider;

(e) For qualified health plans that include pediatric oral services or qualified dental plans, thirty percent of essential community providers in the service area for pediatric oral services must be included in each issuer's provider network;

(f) Ninety percent of all federally qualified health centers and FQHC look-alike facilities in the service area must be included in each issuer's provider network;

(g) At least one essential community provider hospital per county in the service area must be included in each issuer's provider network;

(h) At least fifteen percent of all providers participating in the 340B program in the service area, balanced between hospital and nonhospital entities, must be included in the issuer's provider network;

(i) By 2016, at least seventy-five percent of all school-based health centers in the service area must be included in the issuer's network.

(4) An issuer must, at the request of a school-based health center or group of school-based health centers, offer to contract with such a center or centers to reimburse covered health care services delivered to enrollees under an issuer's health plan.

(a) If a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with a school-based health center or group of school-based health centers. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(b) "School-based health center" means a school-based location for the delivery of health services, often operated as a partnership of schools and community health organizations, which can include issuers, which provide on-site medical and mental health services through a team of medical and mental health professionals to school-aged children and adolescents.

(5) An issuer must, at the request of an Indian health care provider, offer to contract with such a provider to reimburse covered health care services delivered to qualified enrollees under an issuer's health plan.

(a) Issuers are encouraged to use the current version of the Washington State Indian Health Care Provider Addendum, as posted onhttp://www.aihc-wa.com, to supplement the existing provider contracts when contracting with an Indian health care provider.

(b) If an Indian health care provider requests a contract and a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with the Indian health care provider. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(6) These requirements do not apply to integrated delivery systems pursuant to RCW 43.71.065.

NEW SECTION

WAC 284-43-229 Tiered provider networks.

(1) "Tiered provider network" means a network that identifies and groups providers and facilities into specific groups to which different provider reimbursement, enrollee cost-sharing, or provider access requirements, or any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.

(a) An issuer may use a term other than tiered network as long as the term is not misleading or susceptible to confusion with a specific licensee designation, such as accountable care organization.

(b) An issuer must not use tiered networks to limit access to certain categories of providers or facilities.

(2) When an issuer's contracts include the placement of providers or facilities in tiers, and the network design results in cost differentials for enrollees, the issuer must disclose to enrollees at the time of enrollment the cost difference and the basis for the issuer's placement of providers or facilities in one tier or another.

(3) The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among health care providers and facilities for essential health benefits as set forth in WAC 284-43-878, 284-43-879, and 284-43-880.

(4) Cost-sharing differentials between tiers must not be imposed on an enrollee if the sole provider or facility type or category required to deliver a covered service is not available to the enrollee in the lowest cost-sharing tier of the network.

(a) All enrollees must have reasonable access to providers and facilities at the lowest cost tier of cost-sharing.

(b) Variations in cost-sharing between tiers must be reasonable in relation to the premium rate charged.

(5) An issuer must include with the Provider Compensation Agreement the metrics and methodology used to assign participating providers and facilities to tiers. An issuer must be able to demonstrate to the commissioner's satisfaction that its assignment of providers and facilities to tiers, when based on a rating system, is consistent with the issuer's placement methodology.

(a) When an issuer revises or amends a quality, cost-efficiency or tiering program related to its provider network, it must provide notice to affected providers and facilities of the proposed change sixty days before notifying the public of the program. The notice must explain the methodology and data, if any, used for particular providers and facilities and include information on provider appeal rights as stated in the provider agreement.

(b) An issuer must make its physician cost profile available to providers and facilities under a tiered network, including the written criteria by which the provider's performance is measured.

(6) An issuer's provider and facility ranking program, and the criteria used to assign providers and facilities to different tiers, must not be described in advertising or plan documents so as to deceive consumers as to issuer rating practices and their affect on available benefits. When a tiered network is used, an issuer must provide detailed information on its web site and if requested, make available in paper form information about the tiered network including, but not limited to:

(a) The providers and facilities participating in the tiered network;

(b) The selection criteria, if any, used to place the providers and facilities, but not including the results of applying those selection criteria to a particular provider or facility;

(c) The potential for providers and facilities to move from one tier to another at any time; and

(d) The tier in which each participating provider or facility is assigned.

(7) For any health plan in effect on a tiered network's reassignment date, an issuer must make a good faith effort to provide information to affected enrollees at least sixty days before the reassignment takes effect. This information includes, but is not limited to, the procedure the enrollee must follow to choose an alternate provider or facility to obtain treatment at the same cost-sharing level. The specific classes of enrollees to whom notice must be sent are:

(a) Patients of a reassigned primary care provider if their primary care provider is reassigned to a higher cost-sharing level;

(b) A patient in the second or third trimester of pregnancy if a care provider or facility in connection with her pregnancy is reassigned to a higher cost-sharing level;

(c) A terminally ill patient if a provider or facility in connection with the illness is reassigned to a higher cost-sharing level; and

(d) Patients under active treatment for cancer or hematologic disorders, if the provider or facility that is delivering the care is reassigned to a higher cost-sharing level.

NEW SECTION

WAC 284-43-230 Assessment of access.

(1) The commissioner will assess whether an issuer's provider network access meets the requirements of WAC 284-43-200, 284-43-201, and 284-43-205 such that all health plan services to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. Factors considered by the commissioner will include the following:

(a) The location of the participating providers and facilities;

(b) The location of employers or enrollees in the health plan;

(c) The range of services offered by providers and facilities for the health plan;

(d) Health plan provisions that recognize and provide for extraordinary medical needs of enrollees that cannot be adequately treated by the network's participating providers and facilities;

(e) The number of enrollees within each service area living in certain types of institutions or who have chronic, severe, or disabling medical conditions, as determined by the population the issuer is covering and the benefits provided;

(f) The availability of specific types of providers who deliver medically necessary services to enrollees under the supervision of a provider licensed under Title 18 RCW;

(g) The availability within the service area of facilities under Titles 70 and 71 RCW;

(h) Accreditation as to network access by a national accreditation organization including, but not limited to, the National Committee for Quality Assurance (NCQA), the Joint Commission, Accreditation Association of Ambulatory Health Care (AAAHC), or URAC.

(2) In determining whether an issuer has complied with the provisions of WAC 284-43-200, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the issuer under reasonable terms and conditions.

(3) If the commissioner determines that an issuer's proposed or current network for a health plan is not adequate, the commissioner may, for good cause shown, permit the issuer to propose changes sufficient to make the network adequate within a sixty-day period of time. The proposal must include a mechanism to ensure that new enrollees have access to an open primary care provider within ten business days of enrolling in the plan while the proposed changes are being implemented. This requirement is in addition to such enforcement action as is otherwise permitted under Title 48 RCW.

AMENDATORY SECTION (Amending WSR 00-04-034, filed 1/24/00, effective 2/24/00)

WAC 284-43-250 ((~~Health carrier~~)) Issuer standards for women's right to directly access certain health care practitioners for women's health care services.

(1)(a) "Women's health care services" ((~~is defined to~~)) means organized services to provide health care to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The servicesinclude, but ((~~need~~)) are not ((~~be~~)) limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. ((~~General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations.~~)) Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include((~~,~~)): Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

(b) ((~~A carrier may~~)) An issuer must not exclude or limit access to covered women's health care services offered by a particular type of women's health care provider, practitioner, or facility in a manner that would unreasonably restrict access to that type of provider, practitioner, or facility or covered service. For example, ((~~a carrier may~~)) an issuer must not impose a limitation on maternity services that would require all child birth to occur in a hospital attended by a physician, thus((~~,~~)) preventing a woman from choosing between and using the birthing services of an advanced registered nurse practitioner ((~~specialist in midwifery~~)), a certified midwife, or a licensed midwife.

(c) ((~~A carrier may~~)) An issuer must not impose notification or prior authorization requirements upon women's health care practitioners, providers, and facilities who render women's health care services or upon women who directly access such services unless such requirements are imposed upon other providers offering similar types of service. For example, ((~~a carrier may~~)) an issuer must not require a directly accessed women's health care practitioner to notify the plan within seven days of providing direct women's health care services if a primary care provider would not also be required to provide seven-day notice to the ((~~carrier~~)) issuer for the same or similar service.

(2) ((~~A health carrier shall~~)) An issuer must not deny coverage for medically appropriate laboratory services, imaging services, diagnostic services, or prescriptions for pharmaceutical or medical supplies, which are ordered by a directly accessed women's health care practitioner, and which are within the practitioner's scope of practice, if such services would be covered when provided by another type of health care practitioner. ((~~A health~~

~~carrier shall~~)) An issuer must not require authorization by another type of health care practitioner for these services. For example, if the ((~~carrier~~)) issuer would cover a prescription if the prescription had been written by the primary care provider, the ((~~carrier shall~~)) issuer must cover the prescription written by the directly accessed women's health care practitioner.

(3)(a) All ((~~health carriers shall~~)) issuers must permit each female ((~~policyholder, subscriber, enrolled participant, or beneficiary of carrier policies, plans, and programs written, amended, or renewed after July 23, 1995,~~)) enrollee of a health plan to directly access ((~~the types of women's health care practitioners identified in RCW 48.42.100(2),~~)) providers or practitioners for appropriate covered women's health care services without prior referral from another health care practitioner.

(b) ((~~Beginning July 1, 2000,~~)) An issuer may limit direct access ((~~may be limited~~)) to those women's health care practitioners who have signed participating provider agreements with the ((~~carrier~~)) issuer for a specific ((~~benefit~~)) health plan network. Irrespective of the financial arrangements ((~~a carrier~~)) an issuer may have with participating providers, ((~~a carrier~~)) an issuer may not limit and ((~~shall~~)) must not permit a network provider to limit access to a subset of participating women's health care practitioners within the network. Such an impermissible limitation might arise when a primary care provider's group practice receives a capitation payment for comprehensive care to ((~~a covered person~~))an enrollee and then represents to the ((~~covered person~~)) enrollee that only those gynecologists in the primary care provider's clinic are available for direct access. Nothing in this subsection ((~~shall~~)) must be interpreted to prohibit ((~~a carrier~~)) an issuer from contracting with a provider to render limited health care services.

(c) Every ((~~carrier shall~~)) issuer must include in each provider network((~~,~~)) a sufficient number of each type of practitioner included in the definition of women's health care practitioners in RCW 48.42.100(2). A "sufficient number" means enough to reasonably ensure that enrollees can exercise their right of direct access within their service area, based on the number of providers with women's health care service in the scope of their license, and the number of enrollees. An issuer must demonstrate the basis on which it determined the sufficiency of the number and type of providers under this section.

(d) ((~~Beginning July 1, 2000,~~)) A woman's right to directly access practitioners for health care services, as provided under RCW 48.42.100, includes the right to obtain appropriate women's health care services ordered by the practitioner from a participating facility used by the practitioner.

(4) To inform enrollees of their rights under RCW 48.42.100, all ((~~health carriers shall~~)) issuers must include in enrollee handbooks a written explanation of a woman's right to directly access ((~~women's health care practitioners for~~)) covered women's health care services. Enrollee handbooks ((~~shall~~)) must include information regarding any limitations to direct access, including, but not limited to:

(a) Limited direct access based on a benefit plan's closed network of practitioners, if appropriate; and

(b) The ((~~carrier's~~)) issuer's right to limit coverage to medically necessary and appropriate women's health care services.

(5) No ((~~carrier~~)) issuer shall impose cost-sharing, such as copayments or deductibles, for directly accessed women's health care services, that are not required for access to health care practitioners acting as primary care providers.

NEW SECTION

WAC 284-43-252 Hospital emergency service departments and practice groups.

Enrollees must have access to emergency services twenty-four hours per day, seven days per week. An issuer must make good faith attempts to contract with provider groups offering services within hospital emergency departments, if the hospital is included in its network. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider groups. If the issuer is unsuccessful in contracting with provider groups offering services within contracted hospital emergency departments, the issuer's provider directory must prominently note that while the hospital's emergency department is contracted, the providers within the department are not.

AMENDATORY SECTION (Amending WSR 99-21-016, filed 10/11/99, effective 11/11/99)

WAC 284-43-331 Effective date.

(1) All participating provider and facility contracts entered into after the effective date of these rules ((~~shall~~)) must comply with these rules no later than ((~~July 1, 2000~~)) January 1, 2015.

(2) Participating provider and facility contracts entered into prior to the effective date of these rules ((~~shall~~)) must be amended upon renewal to comply with these rules, and all such contracts ((~~shall~~)) must conform to these provisions no later than January 1, ((~~2001~~)) 2015. The commissioner may extend the January 1, ((~~2001~~)) 2015, deadline for ((~~a health carrier~~)) an issuer for an additional ((~~six months~~)) one year, if the ((~~health carrier~~)) issuer makes a written request. That request must explain how a good faith effort at compliance has been made, provide the specific reasons the deadline cannot be met, and state the date the ((~~health carrier~~)) issuer expects to be in compliance (no more than ((~~six months~~)) one year beyond January 1, ((~~2001~~)) 2015).

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 284-43-340	Effective date.

UnitedHealthcare
EMPLOYER & INDIVIDUAL
10 Cadillac Drive Suite 200
Brentwood, TN 37027
615 372 3614 fax 615 372 3640

October 14, 2014

Booth Rand, Senior Counsel
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

RE: Proposed Rule 106

Dear Mr. Rand,

Please consider this letter a record of written comments to Proposed Rule 106, Network Adequacy Requirements for Health Benefit Plans, on behalf of UnitedHealthcare ("UHC"). Thank you for the opportunity provided to carriers to submit comments prior to the hearing. If you have any questions about the comments below, please feel free to contact me directly.

Section 5. Network Adequacy

Section 5.B.(2) contains the requirement that a member shall have access to a primary care physician within a thirty (30) mile radius of his residence. UHC has no objection to the distance specified in the requirement, but would ask the Department ("DOI") to consider circumstances outside of our control that could render us in violation of the distance limit, including a lack of available primary care physicians in some locations. Additionally, a PCP might be physically located within the parameter established who is unwilling or unable to meet the terms and conditions of our provider agreements, or unwilling or unable to accept new patients (and therefore has no reason to join the network), or simply does not want to join our network. Taking those examples into consideration, UHC would like to ask the DOI to insert the words "where available and in accordance with ACA § 23-99-204(3)" after the word "person" and before the semi-colon in subparagraph 2.

Section 5.C. states that where a carrier falls short of the standards established in the rule as to number or type of providers, the member must be allowed to obtain the service from a non-participating provider at the same benefit level as if the services had been provided by a participating provider. UHC worries that this requirement could have the unintended consequence of incentivizing providers in rural areas to choose not to join our network. The member benefit is based on a percentage of billed charges. Where there is no contract between the provider and the carrier, the provider is not obligated to hold those charges to a limit and could charge any amount for his services. If the provider can rely on the carrier to pay a high percentage of whatever is billed and does not have to worry about seeking any part of the payment from his patient, there may be no reason for him to join our network. Providing this incentive to remain non-participating could have a strong impact on medical costs generally, but could also have the effect of leaving the member with a higher out of pocket cost than if the out of network benefit had been utilized. UHC asks that the DOI consider removing paragraph C. from the rules or that a reasonable limit be placed on what carriers are required to pay of the billed charges of non-participating providers. Should this paragraph stand as

is, UHC requests that the DOI defines "insufficient" for purposes of this paragraph. A defined threshold for insufficiency in number or type of providers would be necessary in order to be able to properly implement this requirement as proposed.

Section 5.E. gives the carrier responsibility for monitoring the ability of its participating providers to furnish all contracted benefits to covered persons. UHC suggests that the DOI consider a carrier's credentialing process, including verifying adequate malpractice insurance, sufficient to meet this standard. Please indicate whether the DOI would find those actions acceptable.

Section 5.F. requires the submission of geographical access maps for certain categories of providers. How frequently would the maps need to be submitted and is the list contained in subparagraph (2) intended to be exclusive? Please establish the required frequency of submission in the text of the rule.

Section 5.G. requires both non-accredited and accredited carriers to submit performance metrics for certain standards established in the rule. How frequently would a carrier be required to submit the report? Provisions in this paragraph require a carrier to break out the metrics by counties within a service area and the overall service area. In this context, a county line seems like an artificial boundary as a resident could theoretically live closer to a certain type of physician in another county than one within his own county. Please consider instead requiring performance metrics to be reported at the level of service area only.

Section 5.G.(2) allows an exemption from the requirement to submit performance metrics to carriers who do not yet have membership in the state. First, UHC assumes this determination would be made at the legal entity level. If the DOI intends something else, please clarify. Also, in order to assure fairness and compliance across the market, UHC recommends that the DOI set some trigger that would compel new entrants to begin reporting; such as after a carrier meets a certain number of members.

Section 5.I. states that a carrier must file an access plan for all health benefit plans issued or renewed after January 1, 2015 and sets the standards for what is to be included in the access plans. This paragraph requires a carrier to submit an access plan prior to offering a new health benefit plan and to update existing access plans after any material change. Should this provision be interpreted to require development and submission of an access plan with each new product design? UHC would like the DOI to consider requiring access plan submissions at the legal entity level, as long as each product sold under that license shares the same network. Also, please clarify whether this requirement is intended to be a pre-requisite to selling a product. In other words, is this a form requiring prior approval by the DOI before the carrier can begin marketing a new product? UHC recommends that carriers be required to submit an access plan within one hundred and eighty (180) days of the promulgation of this rule and only be required to update the plan for a material change or at the request of the commissioner. UHC further recommends that material change be defined in a way that makes it clear that a refiling will not be required at each future provider termination, and would only be required where a termination would violate one of the standards established in Section 5.

Section 5.I.(11) requires the access plan to establish the carrier's plan for providing continuity of care in the event of a provider termination. Because carriers are already

subject to continuity of care standards established in statute, UHC recommends that this subparagraph be removed.

Section 5.J.(1) mandates carriers to make a provider directory available to members online and in hardcopy form where requested, and requires that carriers update the directory within fourteen (14) days of any change becoming effective. Given that we rely on the providers to notify us of changes to their practice, UHC recommends instead that the requirement be for carriers to make any changes to the directory within fourteen (14) days of receiving notice of the change from a provider.

Section 5.J.(3) providing a directory in Spanish would be very costly. Could this provision be removed in favor of indicating in the directory any and all languages spoken by each provider?

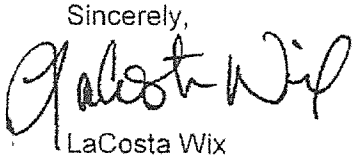
Section 5.K. allows an accredited carrier to demonstrate compliance with paragraphs A. through H. of Section 5 by providing to the commissioner proof of the accreditation where the accreditation also includes an audit of the carrier's network adequacy. UHC requests that the DOI consider accepting such accreditation in lieu of promulgating these rules. Accreditation, in conjunction with Arkansas' already existing Any Willing Provider law ensure that carriers must maintain a robust network within the state without the burden created by and potential unintended consequences associated with compliance with these rules. Any provider who wants to join our network can do so, thanks to AWP and we worry these rules (particularly Section 5.C.) will incentivize providers to stay out of our networks or to use their existence as leverage to drive up reimbursement rates, thereby driving up overall medical costs.

Section 8. Effective Date

The rule as drafted establishes an effective date of January 1, 2015. Likewise, Section 4, Applicability and Scope, states that the rule shall apply to all carriers issuing or renewing health benefit plans on or after January 1, 2015. Neither Section addresses when and how frequently geographic access maps and performance metrics reports should be submitted. Aside from establishing a timeline for those requirements, UHC recommends the DOI give carriers adequate time to comply with the standards established in the Rule after it becomes effective. We suggest that the language of Section 8 reflect that carriers have one hundred and eighty (180) days after the Rule's effective date to comply with its standards.

Again, thank you for your efforts to be collaborative in this process. We look forward to working with you to achieve reasonable network adequacy standards in Arkansas, and are happy to provide any further information you might find helpful.

Sincerely,



LaCosta Wix
Director of Regulatory Affairs, MidSouth

Booth Rand

From: Cynthia Crone
Sent: Monday, October 20, 2014 11:38 AM
To: Booth Rand
Subject: RE: Comments on Rule 106--Network Adequacy Requirements

thanks

Cynthia C. Crone, APRN
Deputy Commissioner
Arkansas Insurance Department
Arkansas Health Connector Division
1200 West Third Street
Little Rock, AR 72201

Phone: 501-683-3634
Fax: 501-371-2629
Email: Cynthia.Crone@Arkansas.Gov

From: Booth Rand
Sent: Monday, October 20, 2014 9:45 AM
To: Zane Chrisman; Cynthia Crone
Subject: FW: Comments on Rule 106--Network Adequacy Requirements

We've only had 2 written comments to Network Adequacy Rule.

Here's AMS

From: Robert Wright [mailto:rwright@mitchellblackstock.com]
Sent: Monday, October 20, 2014 9:40 AM
To: Booth Rand
Subject: Comments on Rule 106--Network Adequacy Requirements

Booth—I am submitting the following comments regarding Proposed Rule 106. I do not intend to speak at the Public Hearing, but I would appreciate these comments being included in the record.

1. In Section 5B(4), the standard for essential community providers is not meaningful. Given the broad spectrum of providers who are considered ECPs, meeting this standard does not really provide improved access to care for many people. The fact that a school-based clinic is located within 30 miles of my residence does not benefit me at all.
2. It is likely that carriers will rely on the alternative in Section 5C more than occasionally. However, the carriers are essentially off the hook due to the use of the term "reasonable criteria."
3. In Section 5F(4), for the last item, the language says "included, but not limited to, school based providers." Is the carrier free to make their own designation of other essential provider types, thereby improving the likelihood of meeting the access standard for ECPs?
4. In Section 5J, it appears that ECPs are the only provider types for which the provider directories must have the capacity to filter. Shouldn't there be a filtering requirement for other types of providers?
5. Again, in Section 5J, how are providers with multiple locations to be listed in the directory? The insurance representatives on the Plan Design Committee were very clear that carriers license ***individuals***, not locations. Does the requirement to indicate full-time or part-time hours include listing the various locations at which a provider practices?

Thank you for the opportunity to comment on this proposed rule.

Robert Wright

Robert W. Wright
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please don't print this e-mail unless you really need to.

October 23, 2014

Mr. Jay Bradford
Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Proposed Rule 106, Network Adequacy Requirements for Health Benefit Plans

Dear Commissioner Bradford:

On behalf of the more than 13,000 U.S. members of the American Academy of Dermatology Association ("Academy"), I appreciate the opportunity to comment on the proposed rule that would establish network adequacy requirements. We support the Arkansas Insurance Department ("Department") decision to ensure plans offered in Arkansas provide adequate access to physicians; however, in review of the proposed rule, the Academy provides the following recommendations:

Recommendation #1: The Academy acknowledges that as a state with "Any Willing Provider" mandates, any provider willing and able to provide care under the terms and conditions of an insurance company is permitted to deliver care. However, the Academy is concerned that a carrier can set terms and conditions for providing care within a plan that a majority of providers are unable to accept. In so doing, we believe the health carrier could circumvent the network adequacy requirements set forth in Section 5 by failing to make a good faith effort to include physicians in its network.

The Academy requests the Department to include criteria that would ensure good faith efforts were made when negotiating contracts with providers and setting their terms and conditions.

Recommendation #2: Section 5.A of the proposed rule indicates that "*services to covered persons will be accessible without unreasonable delay*"; however, the Academy is unable to determine how the Department defines "unreasonable delay". The Academy believes provider networks exist to serve patient needs, specifically by ensuring that patients have adequate and timely access to providers with appropriate training and specialty or subspecialty expertise.

American Academy of Dermatology Association
Excellence in Dermatology™

1445 New York Ave., NW,
Suite 800
Washington, DC 20005-2134

Main: 202.842.3555
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Website: www.aad.org

Skin cancer is the most commonly diagnosed cancer in the United States; however, with adequate access to dermatologic care most cases are manageable. Further, according to the recent Surgeon Generals Call to Action to Prevent Skin Cancer:

> "Each year in the United States, nearly 5 million people are treated for all skin cancers combined, with an annual cost estimated at $8.1 billion.[1] Melanoma is responsible for the most deaths of all skin cancers, with nearly 9,000 people dying from it each year.[2] It is also one of the most common types of cancer among U.S. adolescents and young adults.[3] Annually, about $3.3 billion of skin cancer treatment costs are attributable to melanoma.[2]"

To this end, requiring carriers to provide for a maximum 30-day wait-time for non-urgent care would save lives and reduce health care costs.

Recommendation #3: Section 5.E would require health carriers to monitor their network of providers on an ongoing basis, but it does not specifically detail how often the carrier must update its network directory if a physician is no longer contracting with the plan.

The Academy seeks clarification that the health carrier would be required to update the provider directory within 14 days as required in Section 5.J.1 if the carrier discovered during ongoing monitoring the removal of a physician or inability to accept new patients.

Recommendation #4: Section 5.F.2 would omit Dermatology as one of the specialty care providers in order for a network to be deemed adequate. Access to dermatology is essential to a patients well-being because a key aspect of dermatology is oncologic – treatment of non-melanoma skin cancer (NMSC) and melanoma. Dermatologists manage treatment for 82% of NMSC Medicare episodes in the United States. The training dermatologists receive also allows them to also use a wider range of treatment options than other specialists. As a result dermatologists performed 90% of the biopsies, 56% of the excisions, 95% of the destructions, and 100% of the Mohs micrographic surgeries for these NMSC episodes.

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[1] Medical Expenditure Panel Survey. Rockville, MD: Agency for Healthcare Research and Quality. http://meps.ahrq.gov/mepsweb/data_stats/ download_data_files.jsp. Accessed January 2014

[2] U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999–2010 Incidence and Mortality Web-based report. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services and National Cancer Institute, National Institutes of Health; 2013. http://www.cdc.gov/uscs. Accessed January 20, 2014.

[3] Weir HK, Marrett LD, Cokkinides V, et al. Melanoma in adolescents and young adults (ages 15-39 years): United States, 1999-2006. J Am AcadDermatol. 2011;65(5 suppl 1):S38-S49.

The Academy requests that the Department add Dermatology as a specialty care provider category or include Dermatology within the Oncologic evaluation. Further, the Academy requests the Department specifies that Dermatologists are physicians who are board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

Recommendation #5: Section 5.F.2 would limit the Department's evaluation of provider access to only the general specialty for each of the categories detailed; however, adequate access to sub-specialties should also be ensured. Dermatology has several sub-specialties, including Mohs Micrographic Surgery and Pediatric Dermatology that without adequate access, care could be delayed or deferred, resulting in higher costs.

The Academy requests the Department evaluate access to sub-specialties when certifying the adequacy of a network.

Recommendation #6: Section I details processes and procedures by which the health carrier would substantiate the adequacy of the network. Absent from the requirements is the carriers' process for monitoring the average wait time for care in the network.

The Academy requests the Department add the following language:

> "The Health Carriers' process for monitoring and assuring on an ongoing basis the mean and median wait time for a covered person to request an appointment with a provider."

Recommendation #7: Section 5.I.11 detail the process carriers would follow should a termination of a provider occur. The Academy requests that the Department include language that would provide physicians with a meaningful appeal whenever a physician is terminated from a network, regardless of how the plan characterizes the termination, including "without cause" terminations. The appeal review should consider whether the removal of the physician from the network would result in network inadequacy, and this should be a basis for reinstatement. Additionally, beneficiaries should always be provided reasonable and adequate notice of physician termination, and should be allowed to stay with a physician until the next open enrollment period if the provider is eliminated from a network during the plan year "without cause".

Recommendation #8: Section J.5 would require the provider directory indicate the "*hours of operation including part-time or full-time as well as after-hours availability as reported by providers*". The Academy has found that in many instances physicians will practice in multiple locations in order to meet the needs of the patient population.

Despite the physician not being present and seeing patients, the office may be open to answer questions from patients.

The Academy recommends that health carriers be required to request from the physician and provide to covered persons the hours a physician is present and accepting appointments rather than the hours of operation.

Conclusion

I commend the Arkansas Insurance Department for its effort to ensure the citizens of Arkansas have access to needed health care services in a timely fashion and urge the Department to include the proposed amendments described above. Should you have any questions, please contact David Brewster, Assistant Director for Practice Advocacy, at 202-842-3555 or dbrewster@aad.org.

Sincerely,

Brett Coldiron MD

Brett Coldiron, MD, FAAD
President
American Academy of Dermatology Association

LoRraine Rowland

From: Lisle Thielbar <lthielbar@asds.net>
Sent: Friday, October 24, 2014 8:11 AM
To: LoRraine Rowland
Subject: Proposed Rule 106 Network Adequacy Requirements for Health Benefit Plans
Attachments: ASDSA-AR106.docx

Dear Ms. Rowland:

Please find attached the letter from the American Society for Dermatologic Surgery Association in response to proposed Rule 106 Network Adequacy Requirements for Health Benefit Plans.

Should you have any questions or need further information, please do not hesitate to contact me.

Sincerely,

Lisle Thielbar
Director of State and Grassroots Advocacy
American Society for Dermatologic Surgery Association
5550 Meadowbrook Drive, Suite 120, Rolling Meadows, IL 60008
Direct: 847- 956-9126
Fax: 847-956-0900
lthielbar@asds.net
sdsa.asds.net

ASDSA
American Society for Dermatologic Surgery ASSOCIATION

October 24, 2014

Ms. LoRraine Rowland, Legal Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

RE: Proposed Rule 106 Network Adequacy Requirements for Health Benefit Plans

Dear Ms. Rowland:

As President-Elect of the American Society for Dermatologic Surgery Association (ASDSA), a surgical specialty organization representing nearly 6,000 physician members, I appreciate the opportunity to provide input on proposed rule 106. As the largest dermatologic surgery association in the country, the ASDSA is very concerned about the impact on patient access to care associated with the narrowing of provider networks, particularly as it relates to skin cancer surgery. Our dermatologic surgeons often treat some of the sickest and most complex cases related to skin cancer and the subsequent removal of tissue in complicated Mohs surgery procedures.

Definition of specialty care should not be subjective (Section 3T)
ASDSA has some concerns over the definition of "specialty care professionals" proposed in Section 3T. It is not enough for a medical professional to deem himself qualified to be a specialist by virtue of experience; he should be able to demonstrate training and competency by virtue of being board certified or board eligible in the specialty by the American Board of Medical Specialties or the American Osteopathic Association.

Patient access to comprehensive, timely specialty and subspecialty care (Section 5A-5F)
We appreciate the intent of Section 5 with regard to patient access to comprehensive, timely care. We respectfully request that in addition to allowances made for availability of specialty care in Section 5A, that specific language ensuring subspecialty care also be included. Not every specialist provides every type of procedure. For example, there are some specialized skin cancer procedures, such as Mohs surgery, which are not performed by every dermatologist.

We have some concerns with the incorporation of hospital privileges as criteria for inclusion in section 5C. Virtually all of the minimally invasive procedures performed by dermatologic surgeons are done in outpatient settings. Privileges are generally granted to physicians who practice or treat patients in the hospital setting. However, too often hospital privileges are granted to physicians based on the revenue they are expected to generate for the hospital, not their qualifications. This practice, known as economic credentialing, is opposed by the American Medical Association, national medical specialty organizations, and state medical boards. Case

law has also established the link between restraint of trade issues and the requirement for hospital privileges (for office-based surgery). In addition, the United States Federal Trade Commission (FTC) has offered an opinion that this type of requirement is, in fact, restraint of trade. We recommend that Section 5C be amended to allow written emergency transfer protocols that do not mandate hospital transfer agreements or admitting privileges as an alternative pathway for inclusion.

Finally, we would like to request the dermatologists be added to the list of "Specialty Care Providers" in section 5F(2). According to a 2012 study analyzing skin cancer rates, skin cancer rates have reached epidemic proportions, with an annual increase of at least four percent per year. The same study found that "dermatologists are first responders to the skin cancer epidemic, from diagnosis through treatment. Dermatologists perform more skin surgery procedures than any other specialty."[1]

Insurers have a responsibility to patients to provide comprehensive and timely access to primary, specialty and subspecialty care. Provider networks that do not have an adequate number of contracted physicians and other health care providers in each specialty, subspecialty and geographic region deprive patients' access to contractually entitled benefits. Of particular concern to ASDSA is access to dermatologists qualified and willing to perform skin cancer surgery.

Transparency, appeals process, continuity of care (Section 5I)

We appreciate the call for transparency for network inclusion decisions in section 5I. We would like to request that a distinction be made between information considered to be "competitive" and that which is considered to be simply "proprietary." Insurance companies should not be able to claim information is proprietary as an excuse for not being transparent with consumers with regard to competitive difference for choosing different plans.

Currently there is no language included in this section or any other section of the proposed rule with regard to an appeals process for physicians that have been excluded from networks. For physicians who have been excluded from participation in a provider network, there should be an explicit, fixed, and reasonable timeline for the appeals process.

Likewise, while continuity of care is referenced in Section 5I(11), there is no provision for mid-term terminations. Too often, physicians are being terminated from networks in the middle of a plan year, making it very difficult for patients to keep their doctors as they would be subject to often very high out of network out of pocket costs that most cannot afford and they are not able to change plans in the middle of the plan year to one that has their doctors in it. Provider terminations should be carried out with an effective date that occurs during the plan open enrollment period. This way, patients will have the option of changing their doctor to one

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within the network or to switch their plan to one that has their current doctors within it. Enough notice should be given by the insurance plan to patients before provider terminations are final to allow the patient to make decisions about the best way to proceed to get their continuing health care.

Accurate, up-to-date provider directories (Section J)

Thank you for including the provisions ensuring that provider directories are kept up-to-date so that patients have the most timely, accurate information possible to make informed decisions about where to receive their medical care in Section J. Patients continue to need access to an up-to-date provider directory to enable them to determine which physicians, other health care professionals, and health facilities remain in the network as their medical needs change.

Comparative effectiveness, patient population considerations in network inclusion decision-making

Currently, there is no language in the proposed rule to ensure that network inclusion decisions are not based on cost alone. Patients who live in high-risk areas or who require treatments that are costly on a short-term basis should not be penalized with reduced access to care resulting in network inclusion decisions made on the basis of cost alone. While some physicians may be incurring higher total reimbursement than others, there may be good reason for these differences. Some relate to the socioeconomic or ethnic make-up of their patient populations. Seniors and other at-risk populations may be more costly to treat. The cost data is usually not risk-adjusted, so that the providers taking care of the oldest and sickest patients get penalized as being "high cost." Dropping physicians that treat these populations from networks can seriously threaten patient access to care.

Any decision with regard to physician evaluation or network inclusion should take into account comparative effectiveness of treatment. While some treatments or procedures may be more costly in the short term, their high cure rates save healthcare system costs in the long run. For example, a Mohs surgeon may stand out as being more expensive per patient encounter. Mohs surgery is indicated for certain types of recurrent or aggressive cancers or cancers that are located in areas where there is a high risk of subsequent cancer recurrence and where it is important to preserve healthy tissue for functional reasons. While Mohs surgery can be more expensive than some other types of skin cancer treatments, clinical studies conducted at various national and international medical institutions - including the Mayo Clinic, the University of Miami School of Medicine and the Royal Perth Hospital in Australia - demonstrate that with a cure rate of 99 percent for basal cell carcinoma and 95 percent for squamous cell carcinoma, Mohs surgery has the highest cure rate in comparison to other skin cancer removal procedures that may result in recurrence and additional procedures.

The data insurance companies rely on is primarily based on claims. Such data, by its nature, is not granular enough to pick up different practice patterns and patient mix of various subspecialties of dermatology. For example, a dermatologist limiting their practice to treating

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patients with difficult skin cancers with Mohs surgery, will stand out as being "high cost" when compared with a dermatologist taking care of patients with psoriasis and eczema. His cost per patient encounter will stand out as being higher than the average. He is not high cost, he is just taking care of sicker patients that require a more intensive treatment to take care of their skin cancer.

Without the protections outlined above, patients will experience the loss of their established doctor-patient relationships, longer wait times and further distances to see a dermatologist at a time when skin cancer has reached epidemic status.

Thank you for your consideration. Should you have any questions or need further information, please feel free to contact Director of State and Grassroots Advocacy Lisle Thielbar at (847) 956-9126 or *lthielbar@asds.net*.

Sincerely,

George J. Hruza, MD, President-Elect
American Society for Dermatologic Surgery Association

cc: Mitchel P. Goldman, President
Timothy C. Flynn, MD, Immediate Past President
Naomi Lawrence, MD, Vice President
Abel Torres, MD, Treasurer
Murad Alam, MD, Secretary
Katherine J. Duerdoth, CAE, Executive Director
Lisle Thielbar, Director of State and Grassroots Advocacy
Scott M. Dinehart, MD, Arkansas State Advocacy Network for Dermatologic Surgery Representative

ASDSA
American Society for Dermatologic Surgery ASSOCIATION

October 24, 2014

Ms. LoRraine Rowland, Legal Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

RE: Proposed Rule 106 Network Adequacy Requirements for Health Benefit Plans

Dear Ms. Rowland:

As President-Elect of the American Society for Dermatologic Surgery Association (ASDSA), a surgical specialty organization representing nearly 6,000 physician members, I appreciate the opportunity to provide input on proposed rule 106. As the largest dermatologic surgery association in the country, the ASDSA is very concerned about the impact on patient access to care associated with the narrowing of provider networks, particularly as it relates to skin cancer surgery. Our dermatologic surgeons often treat some of the sickest and most complex cases related to skin cancer and the subsequent removal of tissue in complicated Mohs surgery procedures.

Definition of specialty care should not be subjective (Section 3T)
ASDSA has some concerns over the definition of "specialty care professionals" proposed in Section 3T. It is not enough for a medical professional to deem himself qualified to be a specialist by virtue of experience; he should be able to demonstrate training and competency by virtue of being board certified or board eligible in the specialty by the American Board of Medical Specialties or the American Osteopathic Association.

Patient access to comprehensive, timely specialty and subspecialty care (Section 5A-5F)
We appreciate the intent of Section 5 with regard to patient access to comprehensive, timely care. We respectfully request that in addition to allowances made for availability of specialty care in Section 5A, that specific language ensuring subspecialty care also be included. Not every specialist provides every type of procedure. For example, there are some specialized skin cancer procedures, such as Mohs surgery, which are not performed by every dermatologist.

We have some concerns with the incorporation of hospital privileges as criteria for inclusion in section 5C. Virtually all of the minimally invasive procedures performed by dermatologic surgeons are done in outpatient settings. Privileges are generally granted to physicians who practice or treat patients in the hospital setting. However, too often hospital privileges are granted to physicians based on the revenue they are expected to generate for the hospital, not their qualifications. This practice, known as economic credentialing, is opposed by the American Medical Association, national medical specialty organizations, and state medical boards. Case

law has also established the link between restraint of trade issues and the requirement for hospital privileges (for office-based surgery). In addition, the United States Federal Trade Commission (FTC) has offered an opinion that this type of requirement is, in fact, restraint of trade. We recommend that Section 5C be amended to allow written emergency transfer protocols that do not mandate hospital transfer agreements or admitting privileges as an alternative pathway for inclusion.

Finally, we would like to request the dermatologists be added to the list of "Specialty Care Providers" in section 5F(2). According to a 2012 study analyzing skin cancer rates, skin cancer rates have reached epidemic proportions, with an annual increase of at least four percent per year. The same study found that "dermatologists are first responders to the skin cancer epidemic, from diagnosis through treatment. Dermatologists perform more skin surgery procedures than any other specialty."[1]

Insurers have a responsibility to patients to provide comprehensive and timely access to primary, specialty and subspecialty care. Provider networks that do not have an adequate number of contracted physicians and other health care providers in each specialty, subspecialty and geographic region deprive patients' access to contractually entitled benefits. Of particular concern to ASDSA is access to dermatologists qualified and willing to perform skin cancer surgery.

Transparency, appeals process, continuity of care (Section 5I)

We appreciate the call for transparency for network inclusion decisions in section 5I. We would like to request that a distinction be made between information considered to be "competitive" and that which is considered to be simply "proprietary." Insurance companies should not be able to claim information is proprietary as an excuse for not being transparent with consumers with regard to competitive difference for choosing different plans.

Currently there is no language included in this section or any other section of the proposed rule with regard to an appeals process for physicians that have been excluded from networks. For physicians who have been excluded from participation in a provider network, there should be an explicit, fixed, and reasonable timeline for the appeals process.

Likewise, while continuity of care is referenced in Section 5I(11), there is no provision for mid-term terminations. Too often, physicians are being terminated from networks in the middle of a plan year, making it very difficult for patients to keep their doctors as they would be subject to often very high out of network out of pocket costs that most cannot afford and they are not able to change plans in the middle of the plan year to one that has their doctors in it. Provider terminations should be carried out with an effective date that occurs during the plan open enrollment period. This way, patients will have the option of changing their doctor to one

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Thank you for including the provisions ensuring that provider directories are kept up-to-date so that patients have the most timely, accurate information possible to make informed decisions about where to receive their medical care in Section J. Patients continue to need access to an up-to-date provider directory to enable them to determine which physicians, other health care professionals, and health facilities remain in the network as their medical needs change.

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Without the protections outlined above, patients will experience the loss of their established doctor-patient relationships, longer wait times and further distances to see a dermatologist at a time when skin cancer has reached epidemic status.

Thank you for your consideration. Should you have any questions or need further information, please feel free to contact Director of State and Grassroots Advocacy Lisle Thielbar at (847) 956-9126 or *lthielbar@asds.net*.

Sincerely,

George J. Hruza, MD, President-Elect
American Society for Dermatologic Surgery Association

cc: Mitchel P. Goldman, President
Timothy C. Flynn, MD, Immediate Past President
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Lisle Thielbar, Director of State and Grassroots Advocacy
Scott M. Dinehart, MD, Arkansas State Advocacy Network for Dermatologic Surgery Representative

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

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fbsewall@arkbluecross.com

October 27, 2014

The Honorable Booth Rand
Managing Attorney
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Proposed Rule 106 Network Adequacy Requirements for Health Benefit Plans

Dear Mr. Rand:

In response to the notice of public hearing issued by the Arkansas Insurance Department on September 11, 2014 in connection with the proposed Rule 106, "Network Adequacy Requirements for Health Benefit Plans," I am writing to provide comments on behalf of Arkansas Blue Cross and Blue Shield.

Arkansas Blue Cross and Blue Shield believes that carriers which issue health insurance plans providing insureds richer benefits if the insured utilizes health care providers in a preferred provider network, have an obligation to include a breadth of in-network providers that give insureds the ability to receive necessary health care.

Arkansas Blue Cross appreciates the Department's development of a network adequacy rule to ensure Arkansans have a choice of affordable products that provide access to timely, appropriate, quality health care services. We would urge that such a rule adhere to the following tenets:

- Be flexible to reflect the geography, demographics, patterns of care and market conditions in Arkansas;

- Ensure that provider directories and access tools include sufficient information so that consumers can make informed decisions when purchasing a health plan or seeking care, but at the same time not require carriers to produce special documentation for the Department when carriers already provide this information as a result of attaining accreditation through a national accreditation entity such as NCQA or URAC.

With respect to the provisions of the proposed rule, I have the following comments:

Section 5.B.	Arkansas Blue Cross appreciates the standard set out in this section requiring carriers *to strive to meet* the guidelines related to geographic accessibility set out in the proposed rule. This allows a degree of flexibility reflecting the geography, demographics and patterns of care in Arkansas.
Sections 5.B.(1), (2), (3) and (4).	These sections indicate that 100% of a carrier's covered persons must be within the mileage radiuses. However, later in the proposed rule, Section 5.F., there is a reference to "compliance percentages." Arkansas Blue Cross recommends the rule provide a reasonable compliance percentage, e.g. 80% or 90%, of a carrier's covered persons be within the mileage radiuses.
Section 5.C.	We find this section both vague and confusing for the following reasons: The first clause "In the event that a Health carrier has an insufficient number or type of participating provider, . . ." does not give an objective standard as to what number is "insufficient." Indeed, the standards set out in the proposed rule do not mention a minimum number of participating providers. The second clause requires a health carrier to "ensure that the covered person obtains the covered benefits at no *greater cost* to the covered person than if the benefit were obtained from participating providers." A carrier can not provide this assurance in as much as a carrier will have no contractual relationship with an out-of-network provider. There is no reason that an out-of-network provider can not bill the covered person the difference between the health plan benefits and the providers billed charge. What carriers can and commonly do ensure today is provide the covered benefit at the plan's in-network cost sharing—copayment or coinsurance—when a covered person must

Section 5.C. (cont.)

go out-of-network in order to receive the benefit.

The language in the rest of this section is confusing. It states that as an alternative to paying a covered person's covered benefits, the carrier can make other arrangements using reasonable criteria listed in sections (a) through (i). These criteria do not appear to be alternatives to paying a benefit, rather they appear to be alternatives to the mileage radiuses listed in the proposed rule Section 5.B.

Section 5.F.(3)(a).

Currently there is no state license category "clinical psychologist," only "psychologist." Arkansas Blue Cross recommends the removal of "clinical" or the rule will exclude all those licensed psychologists in the state who may hold a doctorate in a related field, e.g. EdD or PsyD.

Section 5.I.

Section 5.I. appears to be copied from Section 5.B of the *NAIC Managed Care Plan Network Adequacy Model Act.* Both the proposed rule and the NAIC model act requires a health carrier to develop and file an access plan with the insurance commissioner, make a copy of the access plan available at its business premises and provide it to any interested party upon request.

It is important to note that the NAIC model act was adopted in February 1996, long before the development of the internet and other forms of electronic communication available to modern consumers. National accreditation of health plans was just beginning. A provider network access plan may have been necessary twenty years ago, but for today's accredited health carriers this provision of the proposed rule is little more than "make work."

Carriers accredited by URAC, and I assume by NCQA, are required to meet rigorous standards applicable to the first eleven elements of an access plan outlined in Section 5.I. Among other things, the URAC standards require its accredited health plans to provide covered persons information about the network, locations of participating providers, procedures for changing primary care providers

Section 5.I. (cont.)	and for obtaining out-of-network referrals, procedures to appeal or file a grievance, and continuity of care in the event the covered person's treating provider is not in the network. URAC requires the carrier to continually monitor its standards and to periodically update information the carrier has submitted for accreditation.[1] Arkansas Blue Cross respectfully recommends that the proposed rule include Section 5.I. among those sections listed in Section 5.K. which the Commissioner will accept accreditation in lieu of a carrier's demonstration.
Section 6.A.	Arkansas Blue Cross appreciates the standard set out in this section requiring carriers *to strive to meet* the guidelines related to geographic accessibility set out in the proposed rule. This allows a degree of flexibility reflecting the geography, demographics and patterns of care in Arkansas.
Section 6.C.	See comments concerning Section 5.C. above.
Section 6.F.	See comments concerning Section 5.I. above.

Mr. Rand, I plan to be present at the hearing on October 29, 2014. Accompanying me will be Karen Black, Quality and Accreditation Manager for Arkansas Blue Cross.

Cordially yours,

Frank B. Sewall

FBS:rt
cc: Karen Black, R.N.

[1] Because URAC standards are protected by copyright and trademark laws, Arkansas Blue Cross has not enclosed the specific URAC network adequacy standards in this letter; however, we will be happy to discuss these standards generally at the hearing and to provide them to the Department after the hearing so long as they are treated as confidential information not subject to disclosure to persons outside the Department.

Immune Deficiency Foundation

The National Patient Organization Dedicated to Advocacy, Education and Research for Primary Immunodeficiency Diseases

October 27, 2014

The Honorable Jay Bradford
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

RE: Support for Proposed Rule 106

Dear Commissioner Bradford:

The Immune Deficiency Foundation (IDF) is the national patient organization dedicated to improving the diagnosis and quality of life of individuals with primary immunodeficiency diseases (PI) through advocacy, education and research. We write today in support of proposed rule 106, "Network Adequacy Requirements for Health Benefit Plans." The proposed rule would increase network adequacy requirements for health plans in the individual and small group markets, requiring that carriers maintain a sufficient number of providers according to geographic accessibility guidelines.

Primary immunodeficiency represents a group of more than 200 related, rare genetic diseases. The defining characteristic throughout each different PI condition is that the immune system is malfunctioning, resulting in a decreased ability to fight off infection. Throughout their lives, people with PI are more susceptible to infections, endure chronic diverse health problems and often develop serious and debilitating illnesses.

We support the creation of regulation that requires health plans to have an adequate number of providers to serve members in each geographic service, but because of the diversity of clinical manifestations, patients with PI may be cared for by immunologists, allergists, rheumatologists, otolaryngologists, pulmonologists, gastroenterologists, infectious disease specialists and hematology-oncologists. While we recognize that it would be nearly impossible to specifically outline every medical specialty as a necessary category of health care in the regulation, it is unclear how patients with PI who rely on expert treatment by a variety of specialists would be protected by the categories outlined in the regulation. The categories outlined are not all-inclusive and patients with rare diseases may need access to specialists not included. There should be a mechanism for patients, especially those who have rare and chronic conditions requiring the expertise of specialists to manage, to have access to their needed specialists whether in-network or out of network without incurring large out-of-pocket expenses.

The requirement for transparency in the provider networks, requiring health insurance carriers to make a provider directory available for online publication with identification of which providers are currently accepting new patients, will allow our patients to be conscientious consumers. All too often, patients are not fully aware of the provider networks until after they purchase a health plan and then find themselves locked into that choice for an entire plan year. It is important that these vulnerable patients are adequately protected and covered by these health plan options.

Thank you for the opportunity to comment on the proposed regulation. Should you have any questions please contact Emily Hovermale at 443-632-2544 or at ehovermale@primaryimmune.org.

Sincerely,

Lawrence A. LaMotte
Vice President, Public Policy

LoRraine Rowland

From: Lisa Albany <LAlbany@aad.org>
Sent: Friday, October 24, 2014 12:24 PM
To: LoRraine Rowland
Cc: Victoria Pasko; David Brewster; Scott Smith
Subject: AADA Comments regarding Arkansas Network Adequacy Proposed Rule 106
Attachments: AADA Comments re Arkansas Proposed Network Adequacy Reg.pdf

Importance: High

Ms. Rowland,

Attached you will find comments submitted by the American Academy of Dermatology Association concerning Proposed Rule 106 that would establish network adequacy standards. Should you have any questions, please do not hesitate to contact me or David Brewster, Assistant Director for Practice Advocacy at dbrewster@aad.org.

Lisa

Lisa Percy Albany, J.D.
Assistant Director, State Policy
American Academy of Dermatology Association
1445 New York, Ave., NW, Suite 800
Washington, D.C. 20005-2134
Tel. 202-712-2615
Fax 202-842-4355
Mobile 202-286-1041
LAlbany@aad.org

October 23, 2014

Mr. Jay Bradford
Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Proposed Rule 106, Network Adequacy Requirements for Health Benefit Plans

Dear Commissioner Bradford:

On behalf of the more than 13,000 U.S. members of the American Academy of Dermatology Association ("Academy"), I appreciate the opportunity to comment on the proposed rule that would establish network adequacy requirements. We support the Arkansas Insurance Department ("Department") decision to ensure plans offered in Arkansas provide adequate access to physicians; however, in review of the proposed rule, the Academy provides the following recommendations:

Recommendation #1: The Academy acknowledges that as a state with "Any Willing Provider" mandates, any provider willing and able to provide care under the terms and conditions of an insurance company is permitted to deliver care. However, the Academy is concerned that a carrier can set terms and conditions for providing care within a plan that a majority of providers are unable to accept. In so doing, we believe the health carrier could circumvent the network adequacy requirements set forth in Section 5 by failing to make a good faith effort to include physicians in its network.

The Academy requests the Department to include criteria that would ensure good faith efforts were made when negotiating contracts with providers and setting their terms and conditions.

Recommendation #2: Section 5.A of the proposed rule indicates that "*services to covered persons will be accessible without unreasonable delay*"; however, the Academy is unable to determine how the Department defines "unreasonable delay". The Academy believes provider networks exist to serve patient needs, specifically by ensuring that patients have adequate and timely access to providers with appropriate training and specialty or subspecialty expertise.

American Academy of Dermatology Association
Excellence in Dermatology℠

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Website: www.aad.org

Skin cancer is the most commonly diagnosed cancer in the United States; however, with adequate access to dermatologic care most cases are manageable. Further, according to the recent Surgeon Generals Call to Action to Prevent Skin Cancer:

> "Each year in the United States, nearly 5 million people are treated for all skin cancers combined, with an annual cost estimated at $8.1 billion.[1] Melanoma is responsible for the most deaths of all skin cancers, with nearly 9,000 people dying from it each year.[2] It is also one of the most common types of cancer among U.S. adolescents and young adults.[3] Annually, about $3.3 billion of skin cancer treatment costs are attributable to melanoma.[2]"

To this end, requiring carriers to provide for a maximum 30-day wait-time for non-urgent care would save lives and reduce health care costs.

Recommendation #3: Section 5.E would require health carriers to monitor their network of providers on an ongoing basis, but it does not specifically detail how often the carrier must update its network directory if a physician is no longer contracting with the plan.

The Academy seeks clarification that the health carrier would be required to update the provider directory within 14 days as required in Section 5.J.1 if the carrier discovered during ongoing monitoring the removal of a physician or inability to accept new patients.

Recommendation #4: Section 5.F.2 would omit Dermatology as one of the specialty care providers in order for a network to be deemed adequate. Access to dermatology is essential to a patients well-being because a key aspect of dermatology is oncologic – treatment of non-melanoma skin cancer (NMSC) and melanoma. Dermatologists manage treatment for 82% of NMSC Medicare episodes in the United States. The training dermatologists receive also allows them to also use a wider range of treatment options than other specialists. As a result dermatologists performed 90% of the biopsies, 56% of the excisions, 95% of the destructions, and 100% of the Mohs micrographic surgeries for these NMSC episodes.

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[1] Medical Expenditure Panel Survey. Rockville, MD: Agency for Healthcare Research and Quality. http://meps.ahrq.gov/mepsweb/data_stats/ download_data_files.jsp. Accessed January 2014

[2] U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999–2010 Incidence and Mortality Web-based report. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services and National Cancer Institute, National Institutes of Health; 2013. http://www.cdc.gov/uscs. Accessed January 20, 2014.

[3] Weir HK, Marrett LD, Cokkinides V, et al. Melanoma in adolescents and young adults (ages 15-39 years): United States, 1999-2006. J Am AcadDermatol. 2011;65(5 suppl 1):S38-S49.

The Academy requests that the Department add Dermatology as a specialty care provider category or include Dermatology within the Oncologic evaluation. Further, the Academy requests the Department specifies that Dermatologists are physicians who are board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

Recommendation #5: Section 5.F.2 would limit the Department's evaluation of provider access to only the general specialty for each of the categories detailed; however, adequate access to sub-specialties should also be ensured. Dermatology has several sub-specialties, including Mohs Micrographic Surgery and Pediatric Dermatology that without adequate access, care could be delayed or deferred, resulting in higher costs.

The Academy requests the Department evaluate access to sub-specialties when certifying the adequacy of a network.

Recommendation #6: Section I details processes and procedures by which the health carrier would substantiate the adequacy of the network. Absent from the requirements is the carriers' process for monitoring the average wait time for care in the network.

The Academy requests the Department add the following language:

> "The Health Carriers' process for monitoring and assuring on an ongoing basis the mean and median wait time for a covered person to request an appointment with a provider."

Recommendation #7: Section 5.I.11 detail the process carriers would follow should a termination of a provider occur. The Academy requests that the Department include language that would provide physicians with a meaningful appeal whenever a physician is terminated from a network, regardless of how the plan characterizes the termination, including "without cause" terminations. The appeal review should consider whether the removal of the physician from the network would result in network inadequacy, and this should be a basis for reinstatement. Additionally, beneficiaries should always be provided reasonable and adequate notice of physician termination, and should be allowed to stay with a physician until the next open enrollment period if the provider is eliminated from a network during the plan year "without cause".

Recommendation #8: Section J.5 would require the provider directory indicate the "*hours of operation including part-time or full-time as well as after-hours availability as reported by providers*". The Academy has found that in many instances physicians will practice in multiple locations in order to meet the needs of the patient population.

Despite the physician not being present and seeing patients, the office may be open to answer questions from patients.

The Academy recommends that health carriers be required to request from the physician and provide to covered persons the hours a physician is present and accepting appointments rather than the hours of operation.

Conclusion

I commend the Arkansas Insurance Department for its effort to ensure the citizens of Arkansas have access to needed health care services in a timely fashion and urge the Department to include the proposed amendments described above. Should you have any questions, please contact David Brewster, Assistant Director for Practice Advocacy, at 202-842-3555 or dbrewster@aad.org.

Sincerely,

Brett Coldiron MD

Brett Coldiron, MD, FAAD
President
American Academy of Dermatology Association

DELTA DENTAL

VIA EMAIL (Original to Follow by Regular Mail)

October 28, 2014

Mr. Booth Rand, Esq.
Managing Attorney
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Delta Dental Plan of Arkansas, Inc. Comments on Proposed Rule 106

Dear Mr. Rand:

Please accept this letter as Delta Dental Plan of Arkansas, Inc.'s comments on Proposed Rule 106 ("Network Adequacy Requirements for Health Benefit Plans"). We intend to present some of these comments during the public hearing on October 29, 2014.

Our comments can be placed into two (2) categories:

1. Substantive Comments; and
2. Definitional Comments

Substantive Comments

1. Section 3(U) – Definition of "Stand-alone Dental Carrier" – It is our understanding that the requirements for Rule 106 only apply to a dental carrier to the extent the carrier is either (i) offering an ACA certified product *on* the Marketplace or (ii) offering an ACA certified product *outside* of the Marketplace. As currently written, this definition would seem to trigger Rule 106 applying even if a dental carrier was not offering an ACA certified product. For that reason, we would propose the definition make it clear that Rule 106 only applies when an ACA certified plan is being offered by modifying this definition to read:

   > *"Stand-alone Dental Carrier" means an entity . . . that (i) offers plans through the ACA approved Marketplace and/or (ii) offers plans outside the ACA approved Marketplace for the purpose of providing the essential health benefits category of pediatric level oral benefits and that contracts or offers . . ."*

2. Section 6(A) --- Section 5(A) contains important language that addresses how "sufficiency" of a medical plan's network will be evaluated. Similar language does *not* appear in Section 6(A) with respect to dental plans. It would seem that these standards would be the same for both medical and dental plans in this

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DELTA DENTAL

regard. Therefore, we recommend the following be added to Section 6(A) to largely parallel the language applicable to medical plans in Section 5(A):

> *". . . sufficient for the enrollee population in the service area based on potential utilization. Determination of whether a Stand-alone dental carrier's network is sufficient will be based on reasonable criteria used by the Stand-alone dental carrier, including, but not limited to: provider to covered person ratios by dental specialist; provider to covered person ratios by general dentist; typical referral patterns; geographic accessibility; waiting times for appointments with Participating providers; hours of operation; and the volume of technologically advanced or specialty care. Stand-alone dental carriers shall . . ."*

3. Section 6(A)(3) – ECP Access – The requirement in Section 5(A) that medical plans provide members access to at least one essential community provider (ECP) within a 30 mile radius of their residence has been duplicated in Section 6(A) for dental plans. Delta Dental has the largest provider network in the State and will not be able to meet this criteria as currently written.

   Currently there are only eleven (11) locations of ECPs in the State that have dental care providers and Delta Dental is contracted with all of them. Given that Delta Dental offers its ACA-certified products in every county in the State, there are clearly portions of the State that do not have ECPs providing dental services within the required 30 mile radius.

   In short, absent a dramatic increase in the number of ECPs across the state that provide dental services and who are willing to contract with ACA certified dental plans, neither Delta Dental nor any other dental plan will be able to meet this standard. For these reasons, this requirement should be reconsidered.

4. Section 6(B) – Submission of Metrics – This section states that "Stand-alone dental carriers participating in the Marketplace will be required to submit metrics demonstrating performance . . ." As written, these standards would not appear to apply to a SADP that is offering ACA-certified plans only <u>outside</u> the Marketplace (" . . . participating <u>in the Marketplace</u> . . ."). We believe the requirements of Section 6(B) are intended to apply not only to dental plans applying for participation, but also to plans wanting to offer ACA-certified products off the Marketplace. This statement can be clarified by restating this sentence as:

   > *"Stand-alone dental carriers applying to the Commissioner to participate in the ACA approved Marketplace or offer a stand-alone dental plan outside of the ACA approved Marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits will be . . ."*

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, AR 72231

Telephone: 501-835-3400
Toll free: 800-462-5410

DELTA DENTAL

5. Section 6(F) – Referrals – This provision appears to have been duplicated from the requirements for medical health plans. It requires describing in an access plan the SADP's procedures for making referrals between healthcare providers. Unlike medical plans, referrals are not a common requirement for SADPs in this market. For that reason, there may very well be no such requirements. This provision could be more accurately stated as:

   "The Stand-alone dental carrier's procedures for making referrals to the extent applicable within and outside its network . . ."

6. Section 6(G)(6) – PCMH Participating Providers – The PCMH program does not apply to SADP's, therefore, this requirement should be struck.

Definitional Comments

1. Use of "Health carrier" in Sections 5(A), (B) and (C): The definition of "Health carrier" in Section 3(I) includes *both* medical *and* dental plans. The term "Health carrier" is used in Sections 5(A), (B), and (C) which is intended to set out requirements only for *medical* plans. This could lead to confusion since the requirements for dental plans are set out in Section 6. This potential confusion could be avoided by adding parentheticals after the term "Health carrier" throughout Section 5 that state:

   "(other than a Stand-alone Dental Plan which must meet the standards set out in Section 6)"

2. Use of "Health carrier" in Sections 6(C), (D), and (F)(11): For the same reason mentioned above with respect to using "Health carrier" in Section 5, using "Health carrier" in Section 6 which addresses requirements for dental plans could cause confusion. This could be addressed by using "Stand-alone dental carrier" in Section 6 where "Health carrier" is currently being used.

Thank you for allowing Delta Dental of Arkansas the opportunity to comment on Proposed Rule 106. If you have any question or wish to discuss our comments further, please feel free to contact me.

Sincerely yours,

/S/ James W. Couch

James W. Couch
Vice President, General Counsel

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, AR 72231

Telephone: 501-835-3400
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Arkansas Children's Hospital

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www.archildrens.org

October 28, 2014

Mr. Jay Bradford
Arkansas Insurance Commissioner
1200 W. Third Street
Little Rock, AR 72201

Dear Commissioner Bradford:

Arkansas Children's Hospital (ACH) appreciates the opportunity to submit comments on the proposed Network Adequacy Requirements, Rule 106 and Patient Centered Medical Home (PCMH), Rule 108. ACH supports Rule 108 as written for PCMH with the addition of language in section 5D that would provide some type of appeal process or remedy timeframe prior to a health carrier terminating practice payment support.

Although there are many issues that could be addressed in the rules, ACH respectfully requests that the Commissioner focus on the following areas in the Network Adequacy Requirements, Rule 106:

- **Section 3 (M)** *Health carrier* definition. In the definition of Health carrier, self-insured employer health benefits plans are specifically exempted. Although we recognize the Department of Insurance does not have jurisdiction over self-insured plans, those plans should still be held to the same standards. It is estimated that over 700,000 Arkansans receive coverage through self-insured policies, including ACH employees. All Arkansans should have the same level of adequacy requirements no matter how they are insured.
- **Section 5 (A & B)** This section appears to allow Health carriers to set "reasonable criteria" and then states health carriers shall "strive" to meet the guidelines. It seems specific requirements should be set for the Health carriers which includes accountability and penalties.
- **Section 5 (C)** Health carriers should not be allowed to rely on single case contracts to demonstrate network adequacy. ACH is concerned that Section 5.C. allows health carriers to implement a strategy of avoiding network adequacy requirements by making other arrangements that are acceptable. Health carriers should contract "in-network" with a full range of providers including pediatric sub-specialists and their facilities. It is unacceptable to allow health carriers to contract for the majority of services required on an out-of-network or single case agreement basis. Health carriers that develop limited or restricted networks to support their benefit plans should be required to have in-state pediatric hospitals in their limited or restricted network. Additionally, health carriers should include all

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10/7/2014

Essential Community Providers (ECP) in limited or restricted networks if identified as ECPs for Exchange products. Existing ACH contracts with health carriers were negotiated with the understanding that ACH would provide its full scope of services to the carriers' members. Restricting access to this full range of pediatric care via any restricted network or by not providing full coverage for pediatric services does not meet the needs of patients who rely on ACH's specialty, tertiary, or quaternary care.

- **Section 5 (F2) and (B3)** Network adequacy should be evaluated in consideration of providing access to an appropriate dedicated pediatric provider in the state of Arkansas. Qualified health plans should be designed to provide services for all levels of complexity, including rare conditions, without administrative or cost barriers for covered persons. Health carriers' insurance products should provide access to the full range of pediatric subspecialty services provided by dedicated pediatric providers. Health carriers that exclude in-state pediatric providers should not be deemed adequate. Access should include, but not be limited to pediatric cardiology, neurology, nephrology, developmental medicine, psychiatry, gastroenterology, orthopedics, pulmonology, oncology, radiology and urology. Health carriers should demonstrate that the specialists in question have been trained and credentialed to treat children in need of these services. In plans with tiered provider networks, pediatric specialty care providers should be included in all tiers at the highest benefit level and lowest out of pocket cost.
- **Section 5 (I)** Access plans should be available not only in the business premises but also on the internet, and children (0-18 ages) should be included in the access plans.

For additional information, contact Rosi Smith, VP Government Affairs at Smithro@archildrens.og or 364-1481. Thank you for your consideration,

Sincerely,

Marcy Doderer, FACHE

President & CEO

Arkansas Children's Hospital

Booth Rand

From: David Laffoon <dclaffoon@sbcglobal.net>
Sent: Monday, October 27, 2014 2:46 PM
To: Booth Rand
Cc: Meg
Subject: Rule 106, Network Adequacy

The following are recommendations for improvement in Rule 106:

Sec. 5 A. "Any reasonable criteria used by Health carrier" should be "any reasonable criteria accepted as a national standard".
Sec. 5. B. 3 Insert after "covered person;" except those undergoing daily routine treatment or therapy it shall be a thirty (30) mile radius".
Sec. 5. C. Eliminate language starting line 5 after commissioner. Everything else allows the network methods to provide the service which may meet a criteria but not needs of the patient.
Sec 5. D. Needs to be more specific as currently written, it gives Network a way out with the argument that no providers are available.
Sec. 5. F. 3 (c). Needs to add BCBA (board certified behavior analyst) Therapist after behavioral health. Only BCBA's can provide treatment mandated by AR law and CMS.
Sec 5. K. An exception for BCBA's is needed unless accreditation specifically audits for this qualification.

Thanks for the opportunity to provide these recommendations. Hopefully they can assist in improving network adequacy in AR.

David C. Laffoon, LFACHE
60 Country Club Circle
Searcy, AR 72143

Sent from my iPad

DATE: October 28, 2014

TO: Arkansas Insurance Department, Legal Division

FROM: Arkansas Health & Wellness Solutions

SUBJECT: Proposed Rule 106: "Network Adequacy Requirements for Health Benefit Plans"

We respectfully submit the following comments for consideration by the Commissioner when determining whether or not to adopt Proposed Rule 106:

- The proposed rule describes the "ideal state." It does not define an acceptable threshold or take into consideration "acceptable gaps" when there is no provider available.
    - For instance: If the Goal is to achieve 100%, then what would be considered an acceptable threshold when evaluating whether or not a Carrier has met the standard (80%)?
    - Section 5(b) - Consider establishing a threshold establishing that the standard is met if 80% of members within a region meet these criteria.
- The proposed rule is unclear on how the standard/threshold would be evaluated.
    - For instance, Carriers are certified by Region, so will network adequacy also be evaluated by Region or will it be evaluated by County or Zip Code?
    - We believe it would be appropriate to evaluate network adequacy based on Region in order to maintain consistency in application.
- Consider adding language to the proposed rule to account for Carriers with limited membership (new to the market) - i.e. a Model Membership Standard whereby a minimum number of members in each area meet the standard.
- The rule does not define a standard for hospitals (we recommend 60 miles).
- Section 5(b)(1) - Emergency Services are not clearly defined (i.e. emergency room vs. urgent care). We believe this standard should be consistent with the above recommendation for hospitals (60 miles).
- Mental Health - Psychologists and Psychiatrists - We believe 30 miles is not appropriate. These should be consistent with specialists (60 miles).
- The Rule should define an acceptable threshold of primary care and specialists to membership (i.e. PCP per 1,000 members; Specialists per 1,000 members). Consider adopting NCQA or other established thresholds.
- Geo Maps - The rule is unclear on how the assessment by county will be evaluated. As noted above, we believe that it would be appropriate to evaluate by region (rather than county or zip code).

THRIVE AUTISM SOLUTIONS℠

Because kids have no limits

October 28, 2014

Jay Bradford
Insurance Commissioner
Arkansas Insurance Department
1200 West Third St.
Little Rock, AR 72201

Re: Proposed Rule 106—Network Adequacy

VIA EMAIL

Dear Commissioner Bradford:

We have reviewed the proposed rules and we are concerned that they do not consider network adequacy for Applied Behavior Analysis (ABA) for the treatment of children with autism. Applied Behavior Analysis is the only treatment for autism endorsed by the Surgeon General. Insurance coverage for this treatment is as mandated by Ark. Code Ann. §23-99-418 and Arkansas has categorized it as an Essential Health Benefit under the Affordable Care Act.

The Centers for Disease Control has determined that Arkansas has a higher than average prevalence of autism. The CDC estimates that autism effects 1 in 64 children in our state.[1] The rate has been growing at nearly 14% annually over the past decade. Bases on the 2010 Census data, we can estimate that approximately 12,000 Arkansas children are on the autism spectrum.

As is well documented, autistic children deprived of the benefits of ABA often face the prospect of remaining dependent on their families and society for the entirety of their adult lives. The cost of supporting a person with autism throughout his or her lifetime averages $2.4 million with a co-occurring

[1] "Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years—Autism and Developmental Disabilities Monitoring Network," *Morbidity and Mortality Weekly Report*, Mar. 28, 2014.

intellectual disability and $1.4 million without.[2] ABA therapy has been scientifically shown to lower these costs.[3]

Without ABA treatment, the cost in human dignity is profound and the anticipated economic harm to Arkansas will range between $16.8 and $28.8 billion over the children's lifetimes. This number threatens to be larger, given that the number of children with autism has been increasing at nearly 14% annually.

Shockingly, most of the children of Arkansas covered under private individual and group health insurance do not have access to this Essential Health Benefit. Currently, the state's largest insurer has only 4 providers in network and has none in Northwest Arkansas, the state's fastest growing region. Arkansas' second largest insurer has only 7 in network.

In contrast, neighboring Missouri which passed an autism mandate the same time as Arkansas has nearly 120 providers in its Blue Cross networks.[4] The children of Arkansas deserve the same access to healthcare as the children of Missouri.

Without this legally mandated access, the burden of autism will be pushed back onto Arkansas families, the Arkansas Department of Education and the Arkansas Department of Human Services. The State of Arkansas will be forced to shoulder the economic burden of autism alone and this lack of treatment will multiply the cost to the Arkansas economy into the billions over the children's lifetimes.

For the children of Arkansas and for the future of Arkansas, we urge you to put strict mechanisms in place to monitor access to this Essential Health Benefit.

In particular, Section 5B of the Proposed Rule 106 needs to be revised to include a clause setting the standard for access to Applied Behavior Analysis services. ABA is an intense therapy. Research has indicated that children with autism need 25-40 hours per week of intensive Applied Behavior Analysis interventions for a period of one to three years for maximum effectiveness and this is the recommendation of the Behavior Analyst Certification Board.[5] This translates into families driving from their homes to drop off the child at a clinic, then driving back to pick him up. The 60 mile standard used for medical specialists occasionally seen does not seem reasonable. The 30 miles from a patient's home used for primary care specialists is less burdensome, but is not reasonable for a family to travel to drop off and pick their child up each day. A more reasonable standard for ABA treatment would be 15 miles from the home.

Section 5C is designed to provide remedies for families who do not have access to providers of covered benefits and it seems reasonable that the "carrier shall ensure that the covered person obtains the covered benefit at no great cost to the covered person... or make other arrangements

---

[2] Buescher, A., et al., "Cost of Autism Spectrum Disorders in the United States," *Journal of the American Medical Association Pediatrics*. June 2014.

[3] Chasson, G., et al, "Cost Comparison of Early Intensive Behavioral Intervention and Special Education for Children with Autism," *Journal of Child and Family Studies* (2007), 16:401-143.

[4] Anthem Blue Cross Blue Shield *Provider Directory*, updated 7/18/2014, and *Provider Directory, Blue-Care HMP, Other Healthcare Professionals Listing*. Blue Cross Blue Shield, Kansas City, 2014.

[5] *Behavior Analyst Certification Board. "Guidelines. Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder." Tallahassee (2012).*

acceptable to the Commissioner." However, the addition of "that shall include reasonable criteria utilized by the carrier...." and the list of eight statistical data sets would in no way provide a remedy to provide access to covered benefits to a covered person. This addition undermines the remedy the paragraph purports to establish and appears to allow data to be substituted for a remedy, something that will be little consolation to a family without access to an ABA provider or even a kidney patient without access to dialysis.

Section 5F(3) Should be amended to add "Board Certified Behavior Analysts" since Ark. Code Ann. §23-99-418 mandates insurers to cover Applied Behavior Analysis treatment provided by Board Certified Behavior Analysts and also because only Board Certified Behavior Analysts can provide the Essential Health Benefit. The earlier cited statistics of the severe shortage of Board Certified Behavior Analysts in Arkansas insurance networks underscores the need of the Department to closely monitor access to this profession as to protect the public's access.

Finally, Section K should be amended with an exception requiring accredited health carriers to report data on network availability of Board Certified Behavior Analysts unless accreditation audits specifically audit network adequacy for this qualification. None do at this time.

We sincerely hope that the Arkansas Insurance Department puts the regulatory framework into place to ensure access of the children of Arkansas to this Essential Health Benefit and to reduce the long-term economic impact of autism upon our state.

Sincerely,

Raelynn Hillhouse, Ph.D.
CEO
Thrive Autism Solutions

Arkansas Children's Hospital

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October 28, 2014

Mr. Jay Bradford
Arkansas Insurance Commissioner
1200 W. Third Street
Little Rock, AR 72201

Dear Commissioner Bradford:

Arkansas Children's Hospital (ACH) appreciates the opportunity to submit comments on the proposed Network Adequacy Requirements, Rule 106 and Patient Centered Medical Home (PCMH), Rule 108. ACH supports Rule 108 as written for PCMH with the addition of language in section 5D that would provide some type of appeal process or remedy timeframe prior to a health carrier terminating practice payment support.

Although there are many issues that could be addressed in the rules, ACH respectfully requests that the Commissioner focus on the following areas in the Network Adequacy Requirements, Rule 106:

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For additional information, contact Rosi Smith, VP Government Affairs at Smithro@archildrens.og or 364-1481. Thank you for your consideration,

Sincerely,

Marcy Doderer, FACHE

President & CEO

Arkansas Children's Hospital

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October 28, 2014

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Arkansas Insurance Commissioner
1200 W. Third Street
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For additional information, contact Rosi Smith, VP Government Affairs at Smithro@archildrens.og or 364-1481. Thank you for your consideration,

Sincerely,

Marcy Doderer, FACHE

President & CEO

Arkansas Children's Hospital

Booth Rand

From: Wilson, Craig <JCWilson@uams.edu>
Sent: Wednesday, October 29, 2014 1:33 PM
To: Booth Rand
Cc: Zane Chrisman; Thompson, Joseph W
Subject: Comments Regarding Rule 106 for Network Adequacy

Booth,

Please accept these comments from the Arkansas Center for Health Improvement (ACHI) regarding the Arkansas Insurance Department's (AID) Proposed Rule 106 with respect to plan network adequacy. Led by Joe Thompson, M.D., M.P.H, the Arkansas Center for Health Improvement is a nonpartisan, independent health policy organization committed to improving the health of Arkansans through policy research, building collaborative relationships, and issue advocacy.

We are appreciative of the thought and collaborative approach that AID has taken to develop Rule 106. We are in support of efforts to enforce network adequacy so that enrollees are assured that they can access care when they need it and without unreasonable burden. We believe Rule 106 is an important step to gain better access for Arkansans, and are especially pleased that plans will be required to note which practices are participating in the state's patient-centered medical home initiative. Additionally, the rule is an important mechanism to help ensure that the Arkansas Department of Human Services' Health Care Independence Program, which represents 80 percent of the Arkansas Health Insurance Marketplace, can meet federal requirements for equal access.

In 2013, ACHI published some analyses related to the state's health care workforce, including drive-time analyses for primary and specialty care. (An issue brief explaining these analyses may be found here: http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=132.) These analyses are pertinent to the rule because they may provide a guiding framework for assessing specialty access. The maps in the document illustrate areas in which Arkansans might not have reasonable access to specialty care. In the maps, cities were determined to have a "full complement" of specialists if they had hospitals that met either Level I or Level II trauma system designation by the Arkansas Department of Health or could, based on an assessment of ACHI's master provider file, meet requirements for those designations if they applied. Cities were determined to have a "partial complement" of specialists if they had at least a general surgeon and internist.

This framework for assessment of adequacy might be useful to AID as it seeks to meet the federal requirements while providing flexibility to carriers to enable market entry and foster competition. Again, we are appreciative of the opportunity to comment. Please let us know if you have any questions.

J. Craig Wilson, J.D., M.P.A.
Director of Access to Quality Care
Arkansas Center for Health Improvement
1401 Capitol Avenue
Suite 300, Victory Building
Little Rock, AR 72201

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AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

October 29, 2014

Ms. LoRraine Rowland
Legal Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Proposed Rule 106 Network Adequacy Requirements for Health Benefit Plans

Dear Ms. Rowland:

On behalf of the physician and student members of the American Medical Association (AMA), I thank you for the opportunity to submit comments regarding Proposed Rule 106 for Network adequacy requirements for Health Benefit Plans. We commend the Arkansas Insurance Department (Department) for addressing the important issue associated with network adequacy and ask that you consider the following comments as you draft your final regulation.

Strong patient protections

The AMA supports strong consumer protections when a provider network is inadequate. Specifically, the insurer should ensure that the patient is not responsible for additional costs associated going out-of-network when in-network care is not available. However, we are concerned about reliance on an appeals process as a remedy for an inadequate network. We ask that the final regulation make clear that out-of-network arrangements are not an acceptable alternative to plans having an adequate network. The most effective policy to ensure access to care is for the plans to meet the state network adequacy requirements.

Patient access to specialty care providers

We are concerned that the list of specialty care providers contained in Section 5(F)(2) is incomplete, and we encourage the Department to work with the medical societies in Arkansas to establish an effective means of identifying all the specialists, and potentially subspecialists, to whom patients will need access.

Public transparency in insurers' access plans

We have concerns that the access plan described in Section 5(I) allows for insurer information contained in the plan to be deemed "proprietary" and therefore, not publicly accessible. We strongly encourage the Department to remove this provision and allow for full transparency of the information contained in the access plans.

Access to accurate provider directories

We greatly appreciate the Department's attention to ensuring accurate and up-to-date provider directories. Consumers need access to robust, up-to-date provider directories to enable them to determine which providers are in-network as they purchase their plans, and which providers continue to be in-network as their medical needs change. Additionally, providers need accurate information from health plans to allow for in-network referrals when further treatment is needed. We hope the final regulation will continue to recognize the connection between accurate provider directories and meaningful access to provider networks for consumers.

Active state regulation of networks

Finally, Section 5(K) allows for third-party accreditation to be accepted in lieu of a health plan demonstrating that the health plan meets the state's network adequacy requirements. The AMA urges you to reconsider this provision in the final regulation. While accreditation is an important part of assessing health plan quality, it should not replace the active regulation and monitoring of provider networks by the Department.

Again, we very much appreciate the opportunity to participate in this process and look forward to working with you toward the final regulation. If you have any questions, please contact Emily Carroll, Senior Legislative Attorney, Advocacy Resource Center, at emily.carroll@ama-assn.org or 312-464-4967.

Sincerely,

James L. Madara, MD

cc: Arkansas Medical Society

AMERICAN OSTEOPATHIC ASSOCIATION
TREATING OUR FAMILY AND YOURS

AOMA
arkansas osteopathic medical association

ARKANSAS SOCIETY OF THE ACOFP
OSTEOPATHIC

October 31, 2014

The Honorable Jay Bradford
Insurance Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Dear Commissioner Bradford:

The American Osteopathic Association (AOA), the Arkansas Osteopathic Medical Association (AOMA) and the Arkansas Society of the American College of Osteopathic Family Physicians (ARSACOFP) are writing to request amendments to proposed Rule 106. The proposed rule will provide standards for health carrier network adequacy. We strongly support the idea of ensuring that patients are provided with access to safe health care treatment. However, the rule, as currently proposed, is too vague to guarantee that patients will have adequate access to the health care professionals with the highest level of training -- physicians. Additionally, the definition of a patient centered medical home (PCMH) provided in the regulation is not in line with current Arkansas law and regulatory proposals.

The AOA proudly represents its professional family of more than 104,000 osteopathic physicians and osteopathic medical students, promotes public health, encourages scientific research, serves as the primary certifying body for DOs, is the accrediting agency for osteopathic medical schools and has federal authority to accredit hospitals and other health care facilities. AOMA is a professional organization that represents the more than 325 DOs who reside in Arkansas. ARSACFOP is a professional organization that represents osteopathic family physicians in Arkansas.

The AOA, AOMA and the ARSACOFP support the idea of providing regulations regarding minimum standards for network adequacy as a means of protecting patient access to health care. However, Proposed Rule 106 Section 3(R) defining "primary care professional" and Section 3(T) defining "specialty care professional" create a situation where patients could be left without access to the highest levels of health care. Arkansas Statutes Title 17 Chapter 87 on nurses currently protects patient safety by requiring nurse practitioners to be in a collaborative relationship with physicians. Other non-physician clinician professions regulated under Title 17 are also subject to physician supervision. Patients selecting a health insurance plan should be afforded these same protections, and be guaranteed access to high quality health care provided by a physician as part of their insurance plan. The best way to provide the highest quality of health care and protect patient

safety is to evaluate network adequacy based upon the amount of physicians available, not on the entire health profession that is ultimately overseen by physicians.

Sections 3(R) and 3(T) are too vague in defining "primary care professional" and "specialty care professional". Additionally, the definition for specialist in 3(T) is not clear enough in defining the requirements for a specialist. These definitions should be more clearly stated as referring to physicians, by amending the text:

> "R. "Primary care ~~professional~~ physician" means a ~~participating health care professional practicing within their licensed scope of practice and~~ licensed physician designated by the health carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered by the covered person."
>
> "T. "Specialty care ~~professional~~ physician" means a participating ~~health care professional~~ licensed physician that is ~~specialty qualified to practice by having attended an advanced program of study, passed an examination given by an organization of the members of the specialty, or gained experience through extensive~~ board certified by member board of the American Board of Medical Specialties or the American Osteopathic Association to practice in the specialty."

Subsequently, Section 5(B) (2) and (3) should also be amended to replace "professional" with "physician". These changes will guarantee that Arkansas patients have in network access to a primary care physician within a 30 mile radius, and a specialty care physician within a 60 mile radius.

Additionally, while the AOA, AOMA, and ARSACOFP support the intent of this proposal to define PCMH, the current definition of "Patient Centered Medical Home" in Proposed Rule 106 section (3)(P) is general and fails to state that a physician should be the leader of a PCMH. This oversight could lead to non-physician clinicians inappropriately leading comprehensive patient care, which is beyond their education and training. This could also create incongruity in state regulation of medical practice whereby the scope of practice for nurse practitioners and other healthcare professionals may greatly expand without appropriate oversight and supervision.

PCMH standards already established in Arkansas as defined in the Arkansas Medicaid Provider Manual states that PCMH is: "A team-based care delivery model led by Primary Care Physicians (PCPs) who comprehensively manage beneficiaries' health needs with an emphasis on health care value." In fact, in section 171.630 stipulates that "licensed nurse practitioners or licensed physician assistants employed by a Medicaid-enrolled RHC provider may not function as PCP substitutes." Additionally, Proposed Rule 108, which is also currently under consideration by the Arkansas Insurance Department, was recently amended to change a definition from "primary care provider" to "primary care physician." We believe that Proposed Rule 106 should receive a similar amendment:

> "P. "Patient Centered Medical Home" ("PCMH") means a local point of access to care that proactively looks after patients' health on a "24-7" basis. A PCMH supports patients to connect with other providers to form a physician-led health services team, customized for

> their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care."

Potentially allowing non-physician clinicians to serve as PCMH leader would run counter to existing state policy and another proposal before this department. Additionally, not ensuring that physicians are included within network adequacy requirements jeopardizes patient safety and access to health care. **As such, we recommend that proposed Rule 106 be amended to protect patient safety and provide high quality health care.** Should you need any additional information, please feel free to contact Nicholas A. Schilligo, MS, Associate Vice President, State Government Affairs, at nschilligo@osteopathic.org or (800) 621-1773, ext. 8185.

Sincerely,

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