November 6, 2015

SENT VIA EMAIL

The Honorable Dave Jones
Insurance Commissioner
California Department of Insurance
300 Capital Mall, Suite 1700
Sacramento, CA 95814

Re: Notice of Proposed Rulemaking: Provider Network Adequacy Regulation (Permanent), File No. Reg-2015-00001

Dear Commissioner Jones:

I write on behalf of Consumer Watchdog regarding amendments to the Provider Network Adequacy Regulations (Permanent) proposed by the Department in its Notice of Proposed Rulemaking, dated September 25, 2015. Consumer Watchdog supports the Department's efforts to strengthen provider network regulations in the proposed amendments to California Code of Regulations, title 10 ("10 CCR"), sections 2240 through 2240.7.

Consumer Watchdog attorneys are currently litigating four class action lawsuits against major California health insurance companies—Blue Shield, Anthem Blue Cross, Health Net, and Cigna—regarding significant misrepresentations concerning those companies' provider networks. We believe that Department's provider rules are needed to help ensure that California consumers receive the coverage to which they are entitled under their policies and the law in the future. However, some of the proposed regulations need additional clarity and increased safeguards to ensure consumers are not subject to unexpected out-of-network costs and delays in needed medical care. Consumer Watchdog's analysis of portions of the proposed regulations[1] follows.

I. 10 CCR § 2240.1: Adequacy and Accessibility of Provider Services

Consumer Watchdog supports the proposed amendments to 10 CCR § 2240.1 specifying standards for insurers to meet in order to ensure that their provider networks are adequate and accessible to enrollees. However, we believe that more specificity and clarity in portions of the proposed regulation is necessary in order to ensure consumers are not hit with unexpected medical bills.

[1] Consumer Watchdog may provide additional commentary at the November 9, 2015 hearing regarding the proposed regulations not addressed in these written comments (10 CCR §§ 2240 (Definitions), 2240.16 (Access Standards for Pediatric Vision and Oral Essential Health Benefits), and 2240.2 (Insurance Contract Provisions).

Subdivision (b)(1):

Consumer Watchdog proposes the following amendments to the Department's proposed addition to subdivision (b)(6) (hereafter, the Department's proposed new language is in underline; Consumer Watchdog's additions to the Department's proposed text are in double underline; deletions to the Department's proposed text are in ~~strikethrough~~):

> If a network provider does not provide a service otherwise within the provider's scope of practice covered under the insurance contract, the insurer shall ensure that there are sufficient providers in the network to provide that service. Subdivision (e) of this section shall apply if there are no providers in the network to provide that service.

As proposed, this provision does not appear to address the reality that some consumers may be forced to visit out-of-network providers and specialists if their health plan's network is inadequate. Additional language clarifying that proposed 10 CCR § 2240.1(e)—which, as discussed in more detail below, will guarantee consumers who are forced to seek services out-of-network do not suffer a financial penalty—applies in the event there are no available in-network providers to perform the service.

Subdivision (b)(6):

The Department states that subdivision (b)(6) helps "to avoid surprise out-of-network bills from non-network providers providing care in a network facility[.]" (Initial Statement of Reasons, Sep. 25, 2015, p. 12.) However, without the proposed clarification it is far from certain that the Department's proposed language achieves the stated goal.

Consumer Watchdog proposes the following amendments to subdivision (b)(6):

> An adequate network is one in which the care provided to an insured person in a network facility is provided by network providers. Only i~~I~~f an insured person ~~chooses~~provides written consent to receive care while in a network facility from a provider who is not in the insurer's network, then the use of that out-of-network provider does not render the network inadequate. If an insured does not provide written consent, then the insured is responsible for paying only cost-sharing in an amount equal to the cost-sharing they would have paid for provision of that service in-network. In addition to in-network copayments and coinsurance, in-network cost sharing includes applicability of the in-network deductible and accrual of cost sharing to the in-network out-of-pocket maximum.

In most cases an insured would not willingly "choose" to be treated by an out-of-

network provider at an in-network facility. This is especially true for consumers with Exclusive Provider Organization ("EPO") policies, which provide no out-of-network benefits thus requiring a consumer to pay the full cost of the services. Without more guidance and specificity, this new rule would allow insurers to claim without support that an insured "chose" to use an out-of-network provider. Replacing the word "chooses" with "provides written consent" will prevent insurers from making such unsupported claims.

Moreover, this regulation must require insurers to cover out-of-network provider services at in-network benefit levels if an insured does not provide written consent to receive care while in a network facility from an out-of-network provider. With this added language, consumers will be protected against surprise out-of-network bills after receiving treatment or care at an in-network facility.

Subdivision (e):

The Department proposes to add the following new subdivision (e):

> Networks must provide access to medically appropriate care from a qualified provider. If medically appropriate care cannot be provided within the network, the insurer shall arrange for the required care with available and accessible providers outside the network, with the patient responsible for paying only cost-sharing in an amount equal to the cost-sharing they would have paid for provision of that or a similar service in-network. In addition to in-network copayments and coinsurance, in-network cost sharing includes applicability of the in-network deductible and accrual of cost sharing to the in-network out-of-pocket maximum.

The Department must also add provisions to this section or elsewhere in Article 6 requiring disclosure of an insured's right to receive medically appropriate care outside the network at in-network benefit levels pursuant to subdivision (e) in the policy, on the insurer's website, and through adequately trained customer service representatives. Without consumer education, the benefit of this important regulation will be diluted.

II. 10 CCR § 2240.15: Network Access Appointment Waiting Time Standards; Quality Assurance; Disclosure and Education

Proposed New Subdivision:

Insurers should not be allowed to evade network adequacy requirements by stuffing the deck with lower "tier" providers and facilities for which insurers provide far less coverage.

As the Department notes, "If the network for the lowest cost-sharing tier is hollow and inadequate, the promise of a particular actuarial value is also hollow, and the legal

requirement goes unmet." (Initial Statement of Reasons, Sep. 25, 2015, p. 20.) Like 10 CCR § 2240.1(k), Consumer Watchdog's proposed subdivision, below, will prevent "hollow and inadequate" networks by prohibiting insurers from evading the standards in 10 CCR § 2240.15 by characterizing providers in a high cost-sharing tier, for which there is little coverage, as "network providers" for the purpose of meeting the standards.

We propose adding the following subdivision to 10 CCR § 2240.15:

> An insurer that uses a tiered network must demonstrate compliance with the standards established by this section [10 CCR § 2240.15] based on providers available at the lowest cost-sharing tier.

This language is modeled after proposed 10 CCR § 2240.1(k), which states: "An insurer that uses a tiered network must demonstrate adequacy using the providers available at the lowest cost-sharing tier."

III. 10 CCR § 2240.3: Provisions of Policies and Certificates

Proposed New Subdivisions:

As documented in Consumer Watchdog's lawsuits, during the Open Enrollment Periods, many consumers were not told about significant limitations related to network coverage in their Affordable Care Act-compliant Preferred Provider Organization ("PPO") policies. Specifically, insurance companies failed to make clear that these new PPOs contain out-of-network deductibles and out-of-network out-of-pocket maximums that are drastically higher than the in-network equivalents, and/or utilize a tiered network of providers. Consumers need to know if their policy contains such limitations. Thus, the following two subdivisions should be added to the list of required "brief and prominent warning[s] [in the policy] reflecting the limitations in the contract pertaining to network provider services" set forth in 10 CCR § 2240.3(d) through (f):

> If applicable, a prominent disclosure stating that insureds must meet higher deductibles and higher out-of-pocket maximums for out-of-network provider services than for in-network provider services.

> If applicable, a prominent disclosure stating that coverage varies depending on the tier in which a provider is classified.

IV. 10 CCR § 2240.4: Contracts with Network Providers

Subdivision (e):

Prior to and during the Open Enrollment Periods, providers were not notified by, and could not get accurate information from, insurers regarding their network status. This

led to consumers being turned away by providers who were not sure of their network status and getting hit with unexpected out-of-network charges for visiting providers who believed they were in-network. To prevent another incidence of mass confusion, providers must be properly informed.

Consumer Watchdog proposes the following amendments to subdivision (e):

> If a provider has contracted with an insurer to participate in a particular network, the insurer must obtain the provider's written or electronic assent before that provider may be included as a participant in other networks of that insurer.

Requiring provider "assent" for participation in a particular network, as proposed by the Department, is a step in the right direction, but more specificity is needed as to what constitutes "assent" to prevent further gaming by insurers. The regulation must specify that an insurer obtain the provider's *written or electronic* consent to ensure that providers are completely informed about which network they are participating in.

V. 10 CCR § 2240.5: Filing and Reporting Requirements

Recent reports demonstrating how narrow networks restrict access to care highlight the need for audits, review, and public disclosure of network adequacy reports and related documentation. For example, a recent study of ACA-compliant plans sold through the federal exchange in 2015 revealed that plans with narrow networks are lacking in number and types of specialists, resulting in huge bills for consumers who are forced to go out-of-network to get care from a specialist.[2] Also, recent reports expose that the lack of specialists and primary care physicians in narrow network plans are driving patients into emergency rooms to seek nonemergency care.[3]

The Department's proposed amendments to 10 CCR § 2240.5(a)(1) through (3) require insurers to file network adequacy reports to the Department annually, upon request by the Commissioner, and/or with a policy form for which an insurer seeks approval from the Department. Under the proposed rules in 10 CCR § 2240.5(b) through

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[2] JAMA, *Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act*, Oct. 27, 2015, http://jama.jamanetwork.com/article.aspx?articleid=2466113; see Noam N. Levey, *Obamacare Plans Could Be Forcing People to Pay Extra for Specialist Care*, LA Times, Oct. 27, 2015, http://www.latimes.com/nation/la-na-obamacare-specialists-20151027-story.html.

[3] Robert Lowes, *Emergency Physicians Say Narrow Networks Push Patients to ED,* Medscape Medical News, Oct. 26, 2015, http://www.medscape.com/viewarticle/853205; Julie Bird, *High Out-of-Pocket Expenses, Narrow Insurance Networks Send More Patients to ERs*, FierceHealthcare.com, Oct. 26, 2015, http://www.fiercehealthcare.com/story/high-out-pocket-expenses-narrow-insurance-networks-send-more-patients-ers/2015-10-26.

(d), network adequacy reports include, among other things: data on the number and location of primary care physicians and specialists within a network, a narrative report regarding compliance with mental health network requirements, policies for designing provider networks and developing tiering standards, copies of provider contracts, data regarding compliance with timely access standards, self-reported incidences of noncompliance with the provider network standards, reports of complaints, and data on out-of-network and emergency room claims.

As set forth below, proposed rule 10 CCR § 2240.5 should be amended so that all components of network adequacy reports (not just compliance reports) be subject to audit by the Commissioner, and so that all components of network adequacy reports (not just consumer complaint reports) are reviewed and made public by the Department.

Subdivision (h):

The Department states, "This new subdivision is necessary so that the Commissioner can evaluate and monitor the accuracy of insurer compliance reports." (Initial Statement of Reasons, Sep. 25, 2015, p. 40.) The proposed regulations require the Commissioner to review and approve an insurer's internal "[c]ompliance monitoring policies and procedures" (see proposed 10 CCR § 2240.15(c)(2)), but the Commissioner does not actually review independently collected information or data to determine whether an insurer is complying with the rules. Under the proposed regulations (10 CCR § 2240.5(7) and (8)), as well as the Department of Managed Health Care's analogous regulations (see, e.g., 28 CCR § 1300.67.2.2(g)(2)), insurers are required to self-monitor and self-report their compliance and noncompliance with the network adequacy standards and rules. The rules create an honor system where we are trusting insurance companies to disclose when they are not meeting the requirements of the law – this is not a trustworthy system. Thus, it is not only necessary to have the Department's language enabling the Commissioner to evaluate and monitor the accuracy of those compliance reports, but it is also necessary to add language so that the Commissioner can evaluate and monitor the accuracy of all network adequacy reports and supporting documents submitted pursuant to proposed 10 CCR § 2240.5(a) through (g).

Consumer Watchdog proposes the following amendments to subdivision (h):

> The Commissioner may audit compliance with the requirements of this article and the accuracy of all network adequacy reports and supporting documents submitted pursuant to this article. Audits can be conducted through requests for additional background information regarding surveys undertaken by an insurer, and through direct surveys of providers and covered persons.

The additional language specifying that the Commissioner may audit network adequacy reports, which include information on number and types of in-network

specialists and data on emergency room claims, is necessary to ensure that California consumers have access to providers under their plans.

Subdivision (i):

This proposed subdivision should not limit review and public disclosure to just the complaint reports submitted under 10 CCR § 2240.5. All of the information provided to the Department pursuant to the proposed rules should be reviewed and public.

As documented in Consumer Watchdog's lawsuits, Californians received wildly inaccurate information regarding provider networks during the 2014 and 2015 Open Enrollment Periods. Full review and disclosure of network adequacy reports is necessary to ensure that consumers can access accurate information and insurers are meeting the requirements of the law.

For example, as discussed above, federal exchange plans with narrow networks have been found to exclude certain specialties from their network entirely. Given that 75% of networks available under Covered California exchange plans are considered narrow networks and cover less than 25% of doctors in a region,[4] the lack of specialists is a major problem in California. Without complete transparency, there is no way for Californians to know if the plan they are choosing will provide access to care when they need it.

Consumer Watchdog proposes the following amendments to subdivision (i):

> The department shall review all network adequacy reports and supporting documents submitted pursuant to this article, including these complaint reports and any complaints received by the department regarding timely access to care, and shall make this information public, consistent with applicable law regarding the confidentiality of personally-identifiable information."

The additional language requiring Department review and public disclosure of network adequacy reports would ensure access to care and provide an additional avenue for consumers to obtain information about provider networks.

VI. 10 CCR § 2240.6: Notice and Information to Covered Persons

Consumer Watchdog supports the proposed new regulation 10 CCR § 2240.6, establishing rules regarding provider network directories. However, we believe that the

[4] Leonard Davis Institute of Health Economics, *State Variation in Narrow Networks on the ACA Marketplaces*, Aug. 2015, http://www.rwjf.org/en/library/research/2015/08/state-variation-in-narrow-networks-on-the-aca-marketplaces.html.

changes set forth below are necessary to ensure consumers get the most accurate information about their coverage in a timely manner.

Subdivision (d):

Printing the paper directories annually and adding inserts or addenda on a quarterly basis, as proposed by the Department, will not result in insureds getting accurate, current information. Under proposed 10 CCR § 2240.6(b) (and Insurance Code section 10133.15, which is effective July 1, 2016), online provider directories are to be updated on a weekly basis. Clearly insurers have the capability to ensure that paper provider lists are accurate more frequently than on a quarterly basis. The regulation should thus require paper copies of the network provider directories to be as up to date as the online directories at the time the insured requests the paper copy.

Consumer Watchdog proposes the following amendments to subdivision (d):

In addition to providing the network provider directory on its internet web site, the insurer shall also inform its covered persons of the availability of a paper copy of the network provider directory at no cost in its coverage material and on its internet web site.

(1) The paper copy of the network provider directory shall be printed upon request of the insured. At the time the paper copy is printed, it shall be as up-to-date as the network provider directory on the insurer's internet web site ~~annually and updated quarterly during the calendar year~~.

~~(2) An insurer may satisfy this quarterly update requirement by providing a paper copy insert or addendum to any existing paper copy network provider directory.~~

Subdivision (g):

In order to ensure consumers are properly informed about a provider's network status and other essential information, Consumer Watchdog proposes the following amendments to subdivision (g):

The network provider directory shall list the following for each provider:

(1) The name of the provider,

(2) The provider type [physician, nurse practitioner, physician assistant, etc.] and specialty area or areas of the provider,

(3) Whether the provider is currently accepting new patients,

(4) Whether the provider may be accessed without referral,

(5) The location(s), including address, and contact information for the provider,

(6) The gender of the provider,

(7) Languages spoken by the provider,
(8) Languages spoken by office staff,
(9) List of network facilities where the provider has admitting privileges,
(10) Whether the provider is a primary care provider (PCP),
(11) The name of each insurance policy that the provider is in-network under;
(12) The name of each specific network that the provider is participating in;
(13~~1~~) Network tier to which the provider is assigned, if applicable, and
(14~~2~~) Whether the office is ADA accessible.

VII. 10 CCR § 2240.7: Discretionary Waiver of Network Access Standards

The proposed new regulation 10 CCR § 2240.7 allows insurers to apply for a waiver of network adequacy standards set forth in Article 6 if an insurer is unable to meet the standards "due to circumstances beyond the insurer's control[.]" (Initial Statement of Reasons, Sep. 25, 2015, p. 44.)

However, the rule, as proposed, would allow insurers to obtain a waiver due to circumstances that are within an insurer's control. Proposed subdivision (b) states:

(b) An application for waiver shall only be reviewed and may be granted for the following reasons:
(1) Absence of practicing providers located within sufficient geographic proximity based upon the time or distance standards of this article.
(2) There are sufficient numbers or types of providers or facilities in the service area to meet the standards required by this article, but the insurer, after good faith efforts, is unable to contract with sufficient providers or facilities to meet the network access standards set forth in this article.
(3) An insurer's provider network has been previously approved under this article, and a provider or facility subsequently becomes unavailable within the service area.
(4) The application includes a proposal regarding innovative network design, such as primary care medical homes, "Centers of Excellence," or accountable care organizations.

These bases for allowing a waiver of network access standards are far too broad. While it is comprehensible that the situation in subdivision (b)(1) could arise in rural areas, we do not understand how subdivisions (b)(2) through (4) "assure that waivers are only granted for reasons outside the control of insurers[.]" (Initial Statement of Reasons, Sep. 25, 2015, p. 45.)

Under proposed subdivision (b)(2), it is unclear what constitutes an insurer being "unable to contract with sufficient providers or facilities" or what constitutes "good faith efforts." The breadth of this language allows an insurer to transform virtually any situation where the insurer claims to have attempted to contract with a provider into a basis for seeking a waiver. Similarly, under proposed subdivision (b)(3), it is unclear what circumstances constitute "a provider or facility subsequently becom[ing] unavailable within the service area."

We understand that proposed subdivision (e)(1) would require an insurer to "provide[] substantial evidence of good faith efforts on its part to contract with providers or facilities and [] demonstrate that there is not an available provider or facility with which the insurer can contract to meet the standards set forth in this article" (proposed 10 CCR § 2240.7(e)(1)) in order to get the Commissioner's approval of a waiver. However, requiring an insurer to provide unverified support does not solve the problem of the breadth of the language in subdivisions (b)(2) and (3).

Finally, under proposed subdivision (b)(4), the term "innovative network design" is vague and undefined. Without a definition, an insurer could easily characterize an inadequate network as utilizing an "innovative network design" by using creative jargon to name programs and projects designed to limit access to care. The examples in the proposed regulation (primary care medical homes, "Centers of Excellence," or accountable care organizations) do not make this provision any clearer.[5]

As drafted, the breadth of 10 CCR § 2240.7 will create a loophole for insurers to avoid having to comply with the standards and requirements of Article 6.

Proposed New Subdivision:

Regardless of the reason for an exemption from having to comply with the network adequacy standards, an insurer cannot be exempt from providing coverage required by law. Specifically, consumers must be able to avail themselves of the coverage required by proposed 10 CCR § 2240.1(e), which would guarantee that consumers are not subject to increased out-of-pocket costs. Thus, 10 CCR § 2240.7 should include the following subdivision:

> A waiver does not exempt an insurer from the requirements of 10 CCR § 2240.1(e).

[5] Because Consumer Watchdog is generally unclear as to what circumstances would qualify as a "reason" in subdivisions (b)(2) through (4) sufficient to warrant a waiver, we are not proposing specific line edits to subdivisions (b)(2) through (4). However, for clarity, we propose the following amendment to the first line of subdivision (b): An application for waiver ~~shall only be reviewed and~~ may only be granted for the following reasons[.]

Proposed New Subdivision:

Additionally, to inform consumers when insurance policies utilize alternative standards, Consumer Watchdog proposes the following subdivision, modeled after Health and Safety Code section 1367.03(j)[6]:

> The Department will post on its Internet Web site any waivers or alternative standards that the Department approves under this section on or after [DATE].

VIII. Additional Proposal: Regulation Regarding Approval of Network Adequacy Reports and Waiver Applications

Consumer Watchdog proposes the following additional regulation based on text from the Department's rate approval letters to property-casualty insurance companies under Proposition 103:

> If any portion of a network adequacy report or related documentation submitted to the Department pursuant to Section 2240.5, subdivision (a), or of an application for a waiver of network access standards submitted to the Department pursuant to Section 2240.7, conflicts with California law, that portion is specifically not approved.

This regulation is necessary to prevent insurance companies from seeking to transform the Department's "approval" of a provider network based on information in a network adequacy report, or in an application of waiver of network adequacy standards, from a mechanism designed to ensure consumers have access to affordable health care into a shield to immunize themselves from civil or administrative liability for unlawful practices.

The following example illustrates the need for this regulation: the proposed rule in 10 CCR § 2240.5(c)(4) requires insurers to include in a network adequacy report their policies and procedures for designing provider networks and developing tiering standards. The proposed rule in 10 CCR § 2240.1(h) states: "***[a] service area or network must not be created in a manner*** designed to discriminate or ***that results in discrimination against persons***" for several enumerated reasons.[7] (Emphasis added.) If a

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[6] Health and Safety Code section 1367.03(j) states: "The [DMHC] shall post on its Internet Web site any waivers or alternative standards that the [DMHC] approves under this section [regarding timely access standards] on or after January 1, 2015."

[7] 10 CCR § 2240.1(h), as proposed, prohibits discrimination "because of age, gender, actual or perceived gender … or on the basis that the insured is a transgender person …, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, color, national origin, ancestry,

network is created in a manner ***that results in discrimination***, it would not become apparent until after the Commissioner had already "approved" the network. If an insurer is able to argue that anything that the Department can be said to have "approved" in connection with a network adequacy report (like the insurer's policies and procedures for designing provider networks and developing tiering standards) cannot be subsequently challenged by a consumer or by the Commissioner, then an insurer could get away with illegal discrimination without consequence.

Thank you for the opportunity to provide our comments on the proposed regulations. Should you have any questions concerning these comments, please do not hesitate to contact me at laura@consumerwatchdog.org or (310) 392-0522 ext. 318.

Sincerely,

Laura Antonini
Staff Attorney

cc: Bruce Hinze, Senior Health Policy Attorney (via email)
Stesha Hodges, Attorney III (via email)

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religion, utilization of medical or mental health or substance use disorder services or supplies, marital status, health insurance coverage, present or predicted disability, expected length of life, degree of medical dependency, quality of life, health status or medical condition, including physical and mental illnesses, claims experience, medical history, genetic information, or evidence of insurability, including conditions arising out of domestic violence."