STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

James A. Dodrill
Insurance Commissioner

August 11, 2020

The Honorable Mac Warner
West Virginia Secretary of State
Building 1, Suite 157-K
1900 Kanawha Blvd., East
Charleston, WV 25305

Re: Comments Received Regarding 114 CSR 100

Dear Secretary Warner,

During the public comment period for the above-referenced Legislative Rule relating to standards and guidance regarding network access plan filings and provider directories for insurance carriers offering health benefit plans, the Offices of the Insurance Commissioner (OIC) of the Department of Revenue received comment letters from six entities. The comment letters are attached and individually addressed below.

Two of the comments letters, received from Mountain Health Network and the American Speech-Language-Hearing Association (ASHA), expressed general support for the rule's promulgation. ASHA specifically notes the beneficial aspects of instituting the network adequacy standards established under Section 3.2 of the rule, which requires the adherence to time and distance standards regarding the geographic accessibility of covered specialists. It is posited by ASHA that "[a]lternative approaches to geographic accessibility, such as a ratio of providers to patients, are insufficient because they do not consider individual patient needs."

The West Virginia Hospital Association (WVHA) indicated that it "strongly supports" the proposed rule and suggested that the OIC explore adding other quantitative standards in addition to the time and distance requirements set forth in Section 3.2 of the rule. WVHA proposed that the OIC look to including standards with respect to minimum provider-to-enrollee ratios; maximum travel time to a provider; a minimum percentage of contracted providers that are accepting new patients; minimum hours of operation requirement; or a combination of quantitative measures. The OIC responds that the rule already contains minimum standards regarding provider-to-enrollee ratios, as stated in Section 3.1. The rule further provides travel time and distance standards in Section 3.2. The OIC agrees that a minimum percentage of contracted providers should be available to accept new patients and will amend the rule accordingly. Moreover, the OIC believes that in response to this comment, it will reiterate the underlying statute by adding a subdivision within Section 3.2 which states: "If a carrier cannot meet the standards set forth in this subsection, the carrier must have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits from a nonparticipating provider or make other

arrangements acceptable to the Commissioner, which may include contracting with the nearest like provider." Should the OIC find that other measures are necessary to assure the accessibility of providers within network plans, or that additional standards should be added, it will accordingly propose revisions to the rule at a later time.

A comment proffered by Highmark West Virginia recommends a modification of the time and distance standards in Section 3.2 of the rule by allowing compliance to be based upon a percentage of members that meet the requirements. The OIC acknowledges Highmark's concern that many West Virginia counties and areas are sparsely populated and have historically experienced challenges attracting and retaining medical providers. Thus, the OIC responds to this comment by noting that it will revise the rule to state that if an insurer meets the time and distance standards provided by Section 3.2 for ninety percent of its members, then the standard will be satisfied.

Highmark further suggests a revision to Section 7.4 of the rule, which states: "No less frequently than quarterly, a health carrier shall audit at least twenty percent (20%) of the providers contained in its provider directories for accuracy and update that directory based upon its findings." Highmark agrees that consumers must be provided access to accurate and comprehensive provider directories, but believes that can be accomplished by requiring the audit to occur no less than three times per year, as opposed to quarterly, so long as the carrier audits no less than 50% of its network providers at each audit. Essentially, Highmark contends that auditing a greater percentage of a carrier's provider directory three times per year, as opposed to a lesser percentage quarterly, provides flexibility to carriers while accomplishing the statutory requirement that health carriers shall periodically audit at least a reasonable sample size of its provider directories for accuracy to ensure members have access to up to date comprehensive information. The OIC believes that this request is reasonable and shall revise Section 7.4 as follows:

> No less frequently than three times during each plan year, a health carrier shall audit at least fifty percent (50%) of the providers contained in its provider directories for accuracy and update that directory based upon its findings. Every provider in the directory must be audited at least once during each plan year.

Delta Dental of West Virginia submitted a comment letter that requested a number of revisions to the rule. First, the insurer recommended the addition of a definition for "limited scope dental and vision plans" in order to differentiate between such plans and general health insurance plans. The OIC agrees with Delta Dental that limited scope dental and vision plans should be distinguished from more comprehensive health plans and thus will include definitions within the rule for "limited scope dental plan" and "limited scope vision plan" and amend the rule to exclude such plans from Sections 3.1 and 3.2 of the current rule. However, the OIC would like to note that it does not believe that limited scope dental plans and limited scope vision plans are exempt from all requirements of the rule's enabling legislation, the *Health Benefit Plan Network Access and Adequacy Act*, including the provision in W.Va. Code §33-53-3(a)(1) that requires a health carrier providing a network plan to maintain a network that is sufficient in numbers to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay. Additionally, the OIC anticipates revising the rule in the future to

include specific network adequacy requirements for adult dental plans, including limited scope dental plans, and limited scope vision plans.

Delta Dental also notes that the rule proposes a thirty minute/twenty-five mile standard for dentists serving pediatric patients, and a sixty minute/forty-five mile standard for oral surgeons and orthodontists. While noting the time and distance standards set by the federal Health and Human Services for dentists, Delta Dental recommends that the OIC consider tracking these standards and provide additional geographic flexibility in order to meet adequacy standards, as opposed to one standard statewide. The OIC has not revised the rule to add the federal Health and Human Services for dentists. However, the OIC has agreed to provide additional flexibility, as noted above, by providing that if an insurer meets the time and distance standards provided by Section 3.2 for ninety percent of its members, then the standard will be satisfied. The OIC has also added a subdivision within Section 3.2 which states: "If a carrier cannot meet the standards set forth in this subsection, the carrier must have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits from a nonparticipating provider or make other arrangements acceptable to the Commissioner, which may include contracting with the nearest like provider."

Finally, Delta Dental also requested that the rule define "pediatric" as meaning up to age nineteen, considering the term appears in the rule several times. The OIC believes that such a definition would provide clarity to the use of the term "pediatric" and accordingly agrees to define the term as recommended. Delta Dental concludes its recommendations by suggesting that the OIC only require insurers to conduct provider audits, as set forth in Section 7.4 of the rule, "periodically" so long as each plan remains obligated to audit all providers in the directory at least once every eighteen months. The OIC believes that specific audit standards should be set forth in the rule but has agreed to modify Section 7.4 of the rule as indicated in its response to Highmark West Virginia above.

The final comment letter was received from UnitedHealthcare (UHC). It was first noted by UHC that "the value of uniform requirements and regulations in complex areas such as network access and adequacy cannot be overestimated" considering the fact that insurance companies conduct business nationwide. UHC recommends that the OIC replace the geographic accessibility standards set forth in Section 3.2 of the rule with industry standards provided by the National Committee for Quality Assurance (NCQA), which are based on the federal Centers for Medicare & Medicaid Services (CMS) geographic designations by county and specialty type time and distance measurements. UHC asserts that "the section's requirements, as currently written, would not be practical and will potentially result in significant deficiencies and constant requests for review of justifications by the carriers." The OIC agrees that uniform requirements are beneficial, but generally disagrees with the remainder of this comment from UHC. In the interests of network adequacy uniformity within West Virginia, the OIC drafted its standards set forth in 3.1 and 3.2 of the rule based upon the current West Virginia Medicaid standards for network adequacy as promulgated by the Bureau for Medical Services (BMS) within the West Virginia Department of Health and Human Resources (DHHR). As such, managed care organizations, which are a part of Mountain Health Trust, including Unicare, The Health Plan and Aetna Better Health of WV, already meet these same network adequacy standards in West Virginia or, alternatively, obtain a waiver from BMS in certain geographic areas where standards cannot be met. Moreover, the OIC has agreed in response to a comment by Highmark West Virginia that it will amend the rule to

require ninety percent compliance with the standards set forth in Section 3.2, thus promoting some level of flexibility for carriers and ameliorating the concern that not all areas of the state will have certain providers to be included within a network. Additionally, as noted above, the OIC has added a section within 3.2,which states that if a carrier cannot meet the standards, it must have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits from a nonparticipating provider or make other arrangements acceptable to the Commissioner, which may include contracting with the nearest like provider. Since these geographic challenges would apply to all carriers in certain areas of the state, if a carrier submits documentation of the counties in which it cannot fulfill the standard, the OIC will be able to compare it to other carriers' data to determine whether there are providers the carrier is possibly missing or if the carrier should be exempted or granted a "waiver" from that particular standard and, therefore, must make other acceptable arrangements for their insureds. The OIC is willing to work with UHC to make sure that adequate standards are in place for their policyholders and consumers while also recognizing the challenges that UHC may face in certain rural areas of the state.

UHC also indicates that the compliance date regarding the requirement for carriers to file access plans with the OIC, as provided in Section 4.1, appears to deviate from the date set forth in the rule's enabling legislation, House Bill 4061 (2020), which provides: "Beginning January 1, 2021, a health carrier shall file with the commissioner for review prior to or at the time it files a newly offered network, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this article." Considering the OIC could not promulgate a rule that would become effective prior to January 1, 2021, without emergency rulemaking authority, Section 4.1 had to be crafted as follows:

> For health benefit plan years beginning January 1, 2022, a health carrier shall file with the Commissioner an access plan meeting the requirements of this rule and W. Va. Code §33-53-3. An access plan for a newly offered network must be filed for review and approval on or before April 1 of the year preceding the plan year. For the purposes of this rule, a "newly offered network" includes an existing network at the time this rule becomes effective irrespective of whether the Commissioner has approved the network.

Thus, this language ensures that access plan filings occur at the earliest possible time.

UHC's next comment concerns Section 4.2, which requires the posting of a carrier's access plan on the carrier's website. UHC maintains that access plan information may be located in separate areas on the carrier's website and requests guidance from the OIC as to whether this would be acceptable to satisfy the Section 4.2 requirement. The OIC believes the authorizing statute contemplates that the access plan will be a single document, as filed with the OIC, and should be represented as such on the carrier's website.

It is further recommended by UHC that Section 4.5, which requires a carrier to clearly disclose the existence and availability of the access plan in its health plans and marketing materials, be removed from the rule. UHC asserts that marketing materials already contain much of the required information, therefore the requirement seems unnecessary and burdensome. The OIC believes that the requirement is reasonable and supports House Bill 4061 by encouraging carriers

to bring awareness of the access plan to its members. Accordingly, the OIC declines to remove the provision from the rule.

Finally, UHC requests that the OIC create a checklist regarding the rule's network adequacy requirements to ensure uniformity of compliance among all carriers. The OIC intends to create such an internal checklist so that the applicable statutory and rule requirements are consistently applied to all insurers.

The OIC would like to thank all of the entities that submitted comments. Their attention and time spent on this matter is greatly appreciated.

Sincerely,

Erin K. Hunter
Deputy Commissioner and General Counsel
West Virginia Offices of the Insurance Commissioner

Attachments

ASHA
American Speech-Language-Hearing Association

Submitted via email: victor.a.mullins@wv.gov

July 24, 2020

Victor Mullins, Associate Counsel
Insurance Commission
900 Pennsylvania Avenue
Charleston, WV 25302

RE: Health Benefit Plan Network Access and Adequacy (114-100)

Dear Mr. Mullins:

On behalf of the American Speech-Language-Hearing Association, I write to comment in support of the Insurance Commission's proposed rules for health benefit plan network access and adequacy. This proposal would ensure greater transparency about the availability of covered providers within state-regulated health plans and enhance access to audiology and speech-language pathology services for consumers, particularly in rural areas.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 211,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Over 1,000 ASHA members reside in West Virginia.[1]

ASHA lauds the Commission for including audiologists and speech-language pathologists (SLPs) under the list of specialty providers covered under Section 3.2. ASHA also supports the Commission's decision to determine carrier compliance with the network adequacy standards established under Section 3.2 using a time and distance standard to evaluate the geographic accessibility of covered specialists. Alternative approaches to geographic accessibility, such as a ratio of providers to patients, are insufficient because they do not consider individual patient needs.

Even within specific disciplines, ensuring appropriate access to providers to meet a range of patient needs is a complex task. For example, an SLP with expertise in treating aphasia among adult patients recovering from a stroke or traumatic brain injury, may not be able to effectively care for a child requiring pediatric dysphagia treatment. A ratio or formula standard may lead to long wait times and/or long drives to appointments, especially for those in need of specialty services.

Thank you for the opportunity to share ASHA's position regarding the proposed rules. If you or your staff have any questions, please contact Tim Boyd, ASHA's director of state health care and education affairs, at tboyd@asha.org.

Sincerely,

Theresa H. Rodgers

Theresa H. Rodgers, MA, CCC-SLP
2020 ASHA President

[1] American Speech-Language-Hearing Association. (2020). *West Virginia* [Quick Facts]. https://www.asha.org/uploadedFiles/West-Virginia-State-Flyer.pdf.

HIGHMARK
WEST VIRGINIA

July 24, 2020

Erin K. Hunter, Deputy Commissioner/General Counsel
West Virginia Offices of the Insurance Commissioner
900 Pennsylvania Avenue
Charleston, WV 25302

Re: Draft Network Access and Adequacy Rule

Dear Ms. Hunter:

I write today on behalf of Highmark West Virginia Inc. to provide comments regarding the Office of the Commissioner of Insurance's draft network access and adequacy rule, 114-100-1 *et seq*. Highmark West Virginia Inc. ("Highmark") appreciates the opportunity to comment on certain provisions. We have historically been and remain committed to providing our members with affordable products that offer comprehensive networks of quality, cost-efficient providers wherever our members live and work. Your consideration of the comments below is much appreciated.

1. **Title 114-100-7 Provider Directories**

   Proposed 114-100-7.4 requires that a health carrier, no less frequently than quarterly, audit at least twenty percent (20%) of the providers contained in it provider directories for accuracy and update that directory based upon its findings.

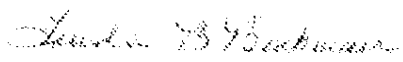
   Highmark appreciates and agrees that members must be afforded the opportunity to access accurate and comprehensive provider directories and endeavors to ensure that its directories meet those needs. We believe that accuracy and completeness can be accomplished by requiring that the audit period be no less frequent than three (3) times per year as long the carrier audits no less 50% of its network providers at each audit. This request for consideration is based upon our belief that the flexibility afforded by allowing a carrier to audit a higher percentage of providers no less than three (3) times per year accomplishes the statutory requirement that health carriers shall periodically audit at least a reasonable sample size of its provider directories for accuracy to ensure members have access to up to date comprehensive information, while not unduly adding to the administrative burden and costs of providers and health carriers.

2. **Title 114-100-3 Network Adequacy Standards**
   Highmark has historically maintained comprehensive and robust provider networks within West Virginia and devotes considerable resources and focus to contracting and working with providers throughout West Virginia. We share the concern that members have access to a comprehensive suite of providers spanning many specialties without having to travel unreasonable distances. However, we all recognize that many West Virginia counties and areas within geographically large counties are relatively sparsely populated and have historically

experienced challenges attracting and retaining providers. In recognition of these challenges, Highmark respectfully requests consideration of the suggestion to modify Section 3.2 by allowing compliance to be based upon a percentage (e.g., 90%) of members meeting the time and distance requirements set forth in the rule.

Highmark West Virginia Inc. appreciates your consideration of the above concerns and suggestions. Please do not hesitate to contact me at linda.beckman@highmark.com (304-424-9858) should you have any questions.

Sincerely,



Linda Beckman
Senior Counsel
Highmark West Virginia Inc.

WEST VIRGINIA HOSPITAL ASSOCIATION

100 Association Drive
Charleston, WV 25311-1571
Phone (304)344-9748
www.wvha.org

July 22, 2020

Victor Mullins
West Virginia Office of the Insurance Commissioner
West Virginia Lottery Building
900 Pennsylvania Avenue
Charleston, WV 25302

Dear Mr. Mullins-

Re: **HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY PROPOSED LEGISLATIVE RULE**

On behalf of the West Virginia Hospital Association and its 61 member hospitals and health systems, we respectfully submit this letter to provide public comments in support of the above referenced **Health Benefit Plan Network Access and Adequacy Proposed Legislative Rule.**

The WVHA strongly supports this proposed legislative rule. Network adequacy is a significant issue for patients and providers, and the WVHA appreciates the attention the WVOIC is giving this important topic.

One area of concern for the WVHA is the appropriateness of uniformly applying the time and distance standards. In some instances, it has been shown that time and distance analysis can produce results that do not accurately reflect provider availability. Nationally, we have been encouraged to see other measures being utilized in addition to time and distance. The WVHA request that the WVOIC explore adding additional quantitative standards, including: minimum provider-to-enrollee ratios; maximum travel time to a provider; a minimum percentage of contracted providers that are accepting new patients; minimum hours of operation requirement; or a combination of quantitative measures.

We appreciate the opportunity to submit comments in support of this proposed rule, and we look forward to working with the Office of the Insurance Commissioner on this and other issues facing our hospitals.

If you have any questions or concerns, please contact me at (304) 353-9720.

Sincerely,

Brandon Hatfield
General Counsel

MOUNTAIN HEALTH NETWORK 519 Ninth Street, 9th Floor • Huntington, WV 25701 • www.mountainhealthnetwork.org

July 24, 2020

Mr. Victor Mullins
900 Pennsylvania Avenue
Charleston, WV 25302

RE: Proposed Rule: 114-100, Health Benefit Plan Network Access and Adequacy

On behalf of Mountain Health Network, which includes Cabell Huntington Hospital, St. Mary's Medical Center, and, as of September 1, 2020, is expected to include Huntington Internal Medicine Group, a Huntington-based multi-specialty group practice with 75 physicians and other providers, I write in support of the network adequacy rule.

An adequate provider network is an essential attribute of health insurance coverage. Patients are more likely to seek medical care from physicians and other health care providers who are part of the network. Inadequate networks could prevent patients from being able to access the physicians that they know, trust and depend upon for care throughout their lives. Patients who lose their usual physicians, including specialists, due to inadequate networks or network changes implemented after the enrollment period may experience interruptions in care, delayed care and undue harm. They can also prevent patients who are newly insured from being able to access the physicians who suit their needs in a timely manner.

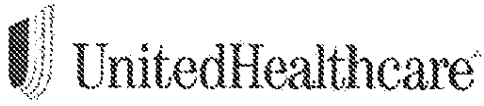
As a health system that provides specialty services which include neurology, neurosurgery, orthopedics, high-risk obstetrics, primary and specialty physician practices, as well as the State's only Burn Unit, the Regional Heart Institute, Edward's Comprehensive Cancer Center, and Hoop's Family Children's Hospital (which includes both a neonatal intensive care unit and a pediatric intensive care unit) an adequate network is key to meeting our community's health care needs by providing the best specialty service close to home.

We appreciate your consideration.

Sincerely,

Michael L. Mullins

Michael L. Mullins, FACHE
President & CEO



VIA ELECTRONIC MAIL

Mr. Victor Mullins
900 Pennsylvania Ave
Charleston, WV 25302
victor.a.mullins@wv.gov

RE: Comments to Proposed Rule 114-100 on Health Benefit Plan Network Access and Adequacy

Dear Mr. Mullins –

Please accept these comments on behalf of UnitedHealthcare. In general, we would like to state that as companies which do business across the country, the value of uniform requirements and regulations in complex areas such as network access and adequacy cannot be overestimated. To the extent that the Department can stay consistent with uniform standards such as those published by NCQA and CMS, it benefits UHC in streamlining its operations and ensures compliance. It is recommended that the Department consider this in enacting its rules on network access and adequacy to provide a balance between providing important protections to the public while recognizing the costs and complexities associated with complying with such requirements across the country.

§114-100-3. Network Adequacy Standards

Comment – In order to ensure consistency from all carriers, it is recommended that the Department create a template and a checklist for completion of the data requirements listed in the rule.

3.2

Comment – It is recommended that the Department consider replacing the requirements in this section as currently written and replacing them with adoption of the NCQA industry standards of network accessibility and adequacy based on CMS geographic designations by county (Large Metro/Metro/ Micro/Rural/CEAC) and specialty type time and distance measurements. For instance, CMS county designations take county population into consideration for rural areas that have limited provider availability. Further, the section's requirements, as currently written, would not be practical and will potentially result in significant deficiencies and constant requests for review of justifications by the carriers.

§114-100-4. Network Access Plan Standards

4.1

Comment – It appears that the date in this section varies from the statute. It is recommended that the Department keep the effective date at January 1, 2022, as it will allow for a more realistic compliance date.

4.2

Comment – This section would require the posting of a carrier's access plan on the carrier's website. It is requested that guidance be provided as to whether the access plan would have to be posted in one place, as much of the information that would be in the access plan is already publicly available on the website. It is the recommendation that the access plan not have to be placed in place to allow for less disruption with a carrier's operations. It should be sufficient that the information be published on the website and the information can be placed at the carrier's discretion.

4.5

Comment – It is recommended that this section be removed. Sales and marketing materials already contain a lot of required information and it does not seem useful to notify an average consumer of the existence and availability of a carrier's access plan on all of its collateral. Such would make more sense in a certificate of coverage or other related document.

Again, UnitedHealthcare appreciates the opportunity to provide these comments. We would welcome any questions by the Department or opportunity to discuss on these important issues.

Sincerely,

John F. Morris
Sr. Associate General Counsel
UnitedHealthcare Employer & Individual
10 Cadillac Drive – Suite 200
Brentwood, TN 37027-5078
john_f_morris@uhc.com

July 24, 2020

SUBMITTED VIA EMAIL
Mr. Victor Mullins
West Virginia Office of the Insurance Commissioner
900 Pennsylvania Avenue
Charleston, WV 25302
Victor.a.mullins@wv.gov

RE: WEST VIRGINIA HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY

Dear Mr. Mullins:

Delta Dental of West Virginia (Delta Dental)) is providing comments and recommendations to the Office of the Insurance Commissioner (OIC) proposed rulemaking regarding Health Benefit Plan Network Access and Adequacy (114-100-1, et seq.). We appreciate that this first set of rules provides some separate consideration for limited scope dental plans and offer the following comments on other areas where similar consideration may be warranted.

Recommendations:

We recommend adding a definition to 114-100-2 for "limited scope dental and vision plans" as does HB 4061, the authorizing legislation, and as included in the NAIC Model Act MDL-74 (2015) that addresses network access and adequacy. This will allow the Department to clearly indicate as necessary where standards are being applied to dental and vision, and where they are not. For instance, in the current draft, ratio standards are applied to "health carriers" which technically includes dental and vision, yet the standards are not inclusive of dental or vision (see 114-100-3.1).

We also recommend adding a definition for "pediatric" as meaning up to age 19. The draft version of the rules have standards which apply only for pediatric so adding this definition will ensure that all impacted dental plans approach this age limit consistently.

The rule proposes a 30 minute/25 mile standard for dentists serving pediatric patients, and a 60 minute/45 mile standard for oral surgeons and orthodontists. Of note, for the West Virginia marketplace, HHS has set the following time and distance standards:

Large Metro areas... 1 dentist in 15 miles or 30 minutes
Metro areas... 1 dentist in 30 miles or 45 minutes
Micro areas... 1 dentist in 60 miles or 80 minutes
Rural areas... 1 dentist in 75 miles or 90 minutes
CEAC areas... 1 dentist in 110 miles or 125 minutes

We note that West Virginia is mostly very rural and ranks 38th for population density, so we recommend that the OIC consider tracking with standards that have been established and provide added geographic flexibility in order to meet adequacy standards, as opposed to one standard statewide.

On the provider directory standards, we note that the OIC is currently looking to require quarterly audits of at least 20% of the plan's network. We note that the NAIC model only suggests that such audits be conducted "periodically" and recommend the OIC adopt this more flexible approach, so long as each plan remains obligated to audit all providers in the directory at least once every 18 months.

We appreciate the OIC's providing this opportunity to provide comments where the treatment of dental is concerned in these proposed rules and look forward to further discussions with the Department.

If you have any questions, please do not hesitate to contact me at 415-972-8418 or jalbum@delta.org.

Sincerely,

Jeff Album

Jeff Album
Delta Dental of the District of Columbia
Vice-President, Public and Government Affairs