Exhibit 1

POSITION STATEMENT OF DELTA DENTAL OF RHODE ISLAND CONCERNING PROPOSED "NETWORK PLANS" REGULATIONS (230-RICR-20-30-9)

Delta Dental of Rhode Island respectfully provides the following comments with respect to certain of the Department's proposed regulations concerning "Network Plans":

30 DAY MAXIMUM TURN-AROUND FOR THE RESOLUTION OF COMPLAINTS (Sec. 9.6.A(2))

- This proposed new requirement does not provide adequate time to feasibly and accurately process complaints to final resolution.

- Complaints are received both verbally and in writing, and have no set format. Most complaints, particularly those involving quality of care or other matters concerning participating providers and their services, require additional information and documents in order to professionally investigate and manage to final resolution. Quite often the complaint arrives without a phone number or e-mail contact information for the Complainant, and the necessary information can initially only be procured by letter. Provider offices and other third parties over whom DDRI has limited control also have to be depended on to respond and provide information and documents on a timely basis. And then, once all the information has been collected, the complaint is required to be vetted by the Dental Director, Quality Assurance Committee, and staff, and sometimes external compliance and legal resources.

- The Department of Health ("DOH") Regulations that have governed this issue for many years prior to the jurisdictional transition to OHIC last year recognized the limitations that carriers have in terms of quickly investigating and reaching full resolution of complaints. (They are the same limitations the DOH and OHIC face themselves in resolving Complaints regarding matters in which they have had little or no direct involvement). Those DOH Regulations (Sec. 21.8. I(4)(c)) duly provided for complaints to be resolved "within 60 business days of receipt of the necessary information" (except as to complaints concerning nursing home facility inspections). For the reasons set forth above, it is already difficult to fully resolve complaints within that 60 business day requirement.

- The proposed new required "30 calendar day" maximum final resolution time drastically cuts – by more than half - the current "60 business day" required turn-around time, and will simply not work. It would defeat the goal of ensuring professional, well considered complaint resolution by not providing sufficient time for that to be accomplished, leading only to the further disappointment of the members and providers the Regulation was intended to protect.

REQUIRED ANNUAL COMMUNICATION TO MEMBERS AND DENTISTS EXPLAINING GRIEVANCE PROCESS (Sec. 9.6.A(3))

• In view of the near-universal utilization of the internet for information, and in order to avert the substantial costs involved in "paper" mailings to each member and provider every year (as DDRI does not have email addresses for each member and provider), this information should be allowed to be displayed prominently – and permanently – on the carrier's website or, as it is now for DDRI (in its annual communication to subscribers advising them how to obtain an up-to-date provider list), in a newspaper of general circulation.

• Apart from being a dated form of mass commercial communication, repetitive, duplicative paper mailings unnecessarily add to the administrative cost of providing and receiving health care benefits.

ADDING PROVIDER DIRECTORY INFORMATION TO ID CARDS (Sec. 9.7.D.5)

• The requirement in proposed Section 9.7.D.5 that, "contact information to obtain an updated directory must be clearly evidenced on the health care entity website" is certainly appropriate. However, the additional requirement of that Section that this information be included "on the beneficiary's insurance/health plan card is problematic. The industry is moving away from reliance on ID cards. DDRI does not re-issue them to members after their initial enrollment as a matter of course, and they have fallen out of use (in favor of government picture ID's) by members and providers even for identification purposes. Moreover, these small cards are already so cluttered back and front with basic ID information and HIPAA disclosure language that there is no room for further content.

• Again, the near universal medium for information concerning health benefits carriers and their participating providers is their website as opposed to dated paper and card media. Also, as already required by the Regulation, printed and paper copies of provider directories must still be made available upon request. The "print" I.D. cards already include DDRI's Customer Service Center telephone number and website domain address for all inquiries.

Thank you for the opportunity to provide these comments. We will be available at your convenience to discuss further. Please contact Melissa Gennari, Director of Compliance (401)-752-6239; mgennari@deltadentalri.com.

Exhibit 2

September 24, 2018

Alyssa R. Metivier
Department of Business Regulation
Office of the Health Insurance Commissioner
1511 Pontiac Ave
Cranston, RI 02920

Re: Network Plans
230RICR20309
Proposed Adoption

Dear Ms. Metivier:

As the chair for the council on dental benefits for the Rhode Island Dental Association I would like to express opposition to definition 10 of the proposal. As written the proposal states: ***"Covered service" or "Covered benefit" means those health care services to which a beneficiary is entitled under the terms of the health benefit plan.*** This is too broad a definition for the term covered service.

In 2009 the RI State Legislature passed the nation's first Non-Covered Services legislation. At odds during the hearings was the definition of the term "covered service". The law 27-18.8-4 defines covered services as those services which are ***"reimbursable under the applicable beneficiary agreement"*** and based on that definition it was originally understood that a benefit payment had to be made for the service to be considered "covered".

Since 2009, some benefit plans have re-interpreted "reimbursable" to mean a service must only be "capable" of being reimbursed. Any and all services listed within a subscriber's contract are "capable" of being reimbursed and therefore they would all be considered covered services. As a result, if a benefit plan denies or disallows the benefit for those services, the providers are still required to reduce the fee charged to a contractual allowance. This is exactly what the law was designed to prevent. The proposal of the word "entitled" to define whether a service or benefit is covered leaves too much to interpretation and therefore I would ask you to amend this section of the proposal.

In early 2018 the RIDA proposed an amendment to RIGL 27-18.8-4. We proposed that covered services be re-defined as those services ***"reimbursed in whole or in part to the dentist (provider)"***. Using those terms strengthens the understanding that a benefit payment for the service rendered must be made to satisfy the law. In addition, we asked that all exclusions to this provision such as waiting periods, frequency limitations, and alternate benefit provisions be removed from the language of the law since none of those conditions result in benefit payments for the services performed.

Therefore representing the dentists of the Rhode Island Dental Association, I request that your definition of covered services be amended to terms which better reflect that a payment must be made by the benefit provider for the services rendered in order for a service or benefit to be considered "covered".

Respectfully,

Andrew Gazerro III, D.M.D.
Chair – Council on Dental Benefits
Rhode Island Dental Association

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September 28, 2018

Alyssa R. Metivier
Department of Business Regulation
Office of the Health Insurance Commissioner
1511 Pontiac Avenue
Cranston, RI 02920

Re: Further Position Statement of Delta Dental of Rhode Island Concerning Proposed "Network Plans" Regulations (230-RICR-20-30-9); Non-Covered Services Issue

Dear Ms. Metivier:

I am writing in behalf of Delta Dental of Rhode Island ("DDRI") to supplement the comments provided by DDRI at the September 24, 2018 hearing on OHIC's Network Plans Regulations ("the Regulations"), another copy of which is herewith enclosed.

In particular, DDRI wishes to address the letter and comments provided on the Regulations by Andrew Gazerro III, D.M.D., the Chair of the Council on Dental Benefits of the Rhode Island Dental Association, a copy of which is also enclosed.

Dr. Gazerro's letter and comments focus entirely on the definition of "covered service"/"covered benefit" in the proposed Regulations. It also seeks to have the Regulations re-define the term "covered services", as used in R.I. Gen. Laws § 27-18.8-4, a distinct provision of the Health Care Accessibility And Quality Assurance Act dealing with non-covered services.

Axiomatically, agency regulations are neither intended nor authorized to modify, add to, or subtract from, in any material way, the statutory provisions they implement. Dr. Gazerro's proposed revision would purport to replace fully half of all the language in the non-covered services law with something radically different. State agencies have no power or authority to decimate a statute enacted by the general Assembly in that fashion.

DDRI also respectfully – but emphatically – disagrees that the language of the non-covered services law, enacted in 2009, was the product of some type of "mistake". Quite the opposite, the statute – particularly its definition of "covered services" – was carefully considered, unambiguous, and painstakingly and collectively crafted by consensus and compromise

involving a wide variety of stakeholders in the health benefits sector. It has become a model that several dozen other States have emulated, and that is not at all deserving of the destruction Dr. Gazerro advocates.

Thank you for your assistance in communicating these supplemental comments.

Sincerely,

William R. Landry

Enclosures

AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION®

Executive Office
444 East Algonquin Road • Arlington Heights, IL 60005-4664
847-228-9900 • Fax: 847-228-9131 • www.plasticsurgery.org

September 28, 2018

Alyssa R. Metivier
Department of Business Regulation
Office of the Health Insurance Commissioner
1511 Pontiac Avenue
Cranston, RI 02920

RE: Proposed rule 230-RICR-20-30-9

Dear Ms. Metivier:

I am writing on behalf of the American Society of Plastic Surgeons (ASPS) regarding the proposed adoption of 230-RICR-20-30-9. ASPS is the largest association of plastic surgeons in the world, representing more than 94 percent of all board-certified plastic surgeons in the United States. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

Following passage of the Affordable Care Act, insurers have created health plans with narrow, inadequate, and non-transparent physician networks. Following the growing prevalence of these "narrow networks," patients have shown a limited understanding of the nuances of their plan, unknowingly receive "out-of-network" care, and are charged high out of pocket fees for their health care.

We encourage Rhode Island to adopt more explicit regulations on the provider directories outlined in proposed rule 230-RICR-20-30-9.7. Patients rely on insurer-maintained provider directories to guide their healthcare choices. Therefore, insurance carriers must be held accountable for the information that they provide to patients and prospective patients. Patients and physicians should not be penalized when insurance carriers do not update their directories, causing responsible patients to unintentionally seek care from out-of-network providers. Accordingly, 230-RICR-20-30-9.7(D) must include the following clause:

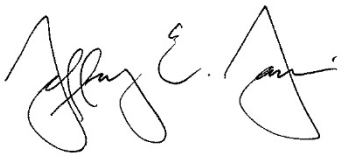
> *If a patient receives care from a provider listed in the directory as participating, but unintentionally receives out-of-network care due to an inaccurate carrier directory, the carrier is required to compensate the provider at the provider's billed rate at no expense to the patient beyond their regular cost-sharing obligation for in-network services.*

Furthermore, we recommend that 230-RICR-20-30-9.7(D)(4) be amended to read:

4. Electronic and paper directories must be updated at least ~~monthly~~ every fifteen days with daily updates available telephonically.

For the reasons outlined above, we respectfully request that you amend the proposal to hold insurance carriers accountable. Thank you for your consideration of our position on this important issue. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Government Relations, at phermes@plasticsurgery.org or (847) 228-3331 with any questions or concerns.

Sincerely,



Jeffrey E. Janis, MD, FACS
President, American Society of Plastic Surgeons

BROWN NEUROLOGY
BROWN PHYSICIANS, INC.
A Clinical, Research and Teaching Affiliate
of the Warren Alpert Medical School of Brown University

October 3, 2018

Alyssa R. Metivier
Department of Business Regulation
Office of the Health Insurance Commissioner
1511 Pontiac Ave
Cranston, RI 02920

Re: Comments on proposed adoption of rule 230RICR20309 (Network Plans)

Dear Ms. Metivier,

I am a practicing neurologist in Providence and a member of the Board of Trustees for the Greater New England Chapter of the National Multiple Sclerosis Society. I would like to provide comments on the proposed adoption of new regulations for health plan network adequacy, quality, continuity and reasonable access to covered benefits.

In my practice, I see many patients with multiple sclerosis (MS), a chronic disease of the central nervous system which can cause permanent disability, especially if not treated promptly and adequately with effective medication. People with multiple sclerosis are fortunate that over the past twenty years, multiple medications have been developed and approved which slow or halt this progressive disability. At the same time, the cost of these medications has increased several-fold; all while health insurance plans and pharmacy benefit managers have implemented cost saving measures including formulary changes, network limitations, and increasingly challenging prior authorization processes.

Maintaining an adequate network plan for people with MS is essential, and the proposed rules (section 9.7) are a good step toward ensuring Rhode Islanders with MS can access the specialized care they require. However, the regulations could go further to make sure that people with MS are provided access to the medications they need as well.

Section 9.6(C)1 requires that network plan providers shall have input to formulary changes. In my practice, this is a good regulation and I would welcome the opportunity to provide input myself, but more detail as to how this regulation is to be implemented by health insurance plans would be helpful.

Section 9.6(C)3 requires thirty-day notice to prescribers and beneficiaries for any formulary changes. Many people with MS are on the same medications for multiple years. Others, because of MS disease progression or side effect, require changing from

one medication to another. These decisions are best left to the prescribers and the people living with MS. We know that patients whose disease remains stable on one medication should continue that medication. A thirty-day notice is not adequate to transition from one MS medication to another, and the switch to a covered formulary drug may be harmful to the individual and costly to the insurance plans long term. Disease modifying therapies are not interchangeable. I suggest that patients on covered medications be allowed to continue at least through the remainder of the policy term whenever a formulary change is implemented. Furthermore, formulary changes at the beginning of a new policy term must be communicated to prescribers and beneficiaries as soon as possible.

I would be pleased to answer any questions about my comments, and I look forward to seeing the new regulations implemented. Thank you for your time in reviewing my comments.

Sincerely,

Jonathan F. Cahill, MD
Rhode Island Hospital Multiple Sclerosis Center
401-444-3799
jonathan_cahill@brown.edu

Alyssa R. Metivier
Office of the Health Insurance Commissioner (OHIC)
By Email To: Alyssa.Metivier@ohic.ri.gov

October 4, 2018

Re: **Proposed Regulation 230-RICR-20-30-9 (Network Plans)**

To Whom It May Concern:

Thank you for the opportunity to provide these comments in **support** of the many pro-consumer provisions contained in proposed regulation 230-RICR-20-30-9. RIPIN is a statewide nonprofit founded in 1991 by a group of parents of children with special healthcare needs. While RIPIN's roots are in serving children and families with special needs, RIPIN now serves all Rhode Islanders who might benefit from education, advocacy, and peer-to-peer support in navigating healthcare and education systems. RIPIN also operate the State's designated health insurance consumer assistance program (RIREACH), created under the ACA, which helps several thousand Rhode Islanders access healthcare and health insurance every year.

RIPIN is particularly supportive of the provisions which:

- ✓ Require carriers to notify prescribers and patients in advance of formulary changes (Section 9.6(C)(3)).
- ✓ Hold beneficiaries harmless for denied claims resulting from providers' failure to adhere to referral processes (Section 9.9(A)(1)(a)).
- ✓ Ensure that network providers are prohibited from charging separate facility fees or other charges beyond standard cost sharing (Section 9.9(A)(1)(b)).
- ✓ Guarantee continuity of care for up to one year for patients in active treatment when their providers leaves their network (Section 9.9(A)(2)).

RIPIN is also supportive of the provision which attempts to address "surprise" out-of-network billing by providers that the patient had no role in choosing, such as radiologists, pathologists, emergency service providers, and anesthesiologists (Section 9.9(3)). This is likely as far as OHIC can go under current statutory authority, and it is a positive step forward. It should also be noted, however, that statutory changes would be required to prevent out-of-network providers from balance billing patients when the providers and carriers are unable to agree on price. RIPIN also has a few technical comments on this provision that may also be helpful:

- There appears to be a typo in subsection (a): The phrase "receipt of a covered service from a non-network facility in these instances" should probably read "receipt of a covered service from a non-network provider in these instances"
- The introductory language listing the types of facilities covered by the provision could be written more broadly, e.g.: "… delivers service in a network facility to include (without limitation), a network hospital, emergency room, urgent care, primary care or specialist provider office, ambulatory surgery center, laboratory, radiology or diagnostic site of service or other similar facility that may utilize non-network providers, the health care entity…."
- The notification requirements in subsection (b) should be made more stringent, to prevent network providers from providing blanket pro-forma "notifications" to all patients as part of general intake paperwork. Such notifications do not genuinely give notice to consumers. The patient should also be informed before they have presented themselves (often already taking time out of work, etc.) at the facility in question. In this light, subsection (b) should require that the written notification state the specific service and specific provider in question, and should also require that any such notification be given in advance of the date of service. For example, the language could read: "… it will be the responsibility of the network facility to inform the beneficiary in writing of the out-of-network status of the specific provider in question, the specific service to be provided, and any financial implications to the beneficiary ~~within a reasonable period of time and~~ at least 24 hours in advance of any related out-of-network provider services."
- Another provision should be added (likely a subsection 4) to address instances of mistakes in carriers' provider directories. If a member can document that she confirmed a provider's network status through the carrier's online provider directory or member services call center, and that confirmation ended up being in error, then the member should be held harmless beyond ordinary cost sharing. RIPIN has assisted several clients who received large bills from out-of-network providers after relying on a carrier's inaccurate provider directory.

Thank you again for the opportunity to provide these comments. Should you have any questions, please do not hesitate to contact me.

Sincerely,

/s/

Samuel Salganik
Attorney / Health Policy Analyst
401-270-0101, ext. 131
Salganik@ripin.org

From: Chrusciel-Desrosiers, Kathleen A
To: Metivier, Alyssa (OHIC)
Cc: Richards, Tinisha
Subject: [EXTERNAL] : UHC comments on RI Proposed Network Plan Rule
Date: Thursday, October 4, 2018 5:44:55 PM
Attachments: RevisedNetworkPlanReg.UHCcomments 10.3.18.pdf
CAQH_Provider_Applicationv5_2006-10-311 with code lists.pdf

Good afternoon Alyssa,

The attached document contains UnitedHealthcare's comments on the Proposed Network Plan Rule. We appreciate the opportunity to provide input. While our comments are in the document, I want to bring two sections to your attention.

The credentialing section of the draft is of concern because UHC and, I believe, most carriers, use the Council for Affordable Quality Healthcare (CAQH) process for credentialing. The language of the proposed regulation sets out a less fluid process and one that is more burdensome for providers. You can view our more detailed comments in the document, but one example would be section 9.8.A.3.c which seems to require plans to post their own credentialing applications. Health care entities use the national application and database established by CAQH (the CAQH application is attached). Practitioners submit their credentialing information to CAQH, for access by health plans and hospitals. CAQH determines whether an application is complete or incomplete. Another example is in section 9.8.A.4, dealing with re-credentialing. The language does not reflect the fact that today the CAQH recredentialing process is invisible to the provider and happens automatically. There is only a need to communicate with the provider if any required information is missing or out of date. Also, section 9.8.D (elements that comprise a completed credentialing application) doesn't include critical elements. Carriers use CAQH because it is designed to the comply with the National Committee for Quality Assurance (NCQA) requirements for health plan accreditation. The list in this section omits essential credentialing information required by NCQA. We respectfully request that OHIC consider revising the credentialing section to give plans the flexibility to use the CAQH process.

We are also requesting that OHIC add more detail around the process for assuring a "sufficient network in terms of scope or volume." Can standards be added to define what constitutes sufficient scope and volume? Without those the carrier cannot assess whether it is compliant.

Thank you for considering our input. We would be happy to discuss any of our comments, at your convenience.

Kathleen Chrusciel-Desrosiers
Associate General Counsel

UnitedHealthcare Employer & Individual
4 Research Drive
Shelton, CT 06484
Tel. (203) 447-4476
Fax (203) 447-4908
Email: kathleen_chrusciel@uhc.com

RHODE ISLAND GOVERNMENT REGISTER
AMENDED PUBLIC NOTICE OF PROPOSED RULEMAKING

DEPARTMENT OF BUSINESS REGULATION (INCLUDES THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER)

Title of Rule: Network Plans

Rule Identifier: 230-RICR-20-30-9

Rulemaking Action: Proposed Adoption

Important Dates:
Date of Public Notice: 09/05/2018
Hearing Date: 09/19/2018
End of Public Comment: 10/05/2018

Authority for this Rulemaking:
R.I. Gen. Laws § Chapter 27-18.8

Summary of Rulemaking Action:
The purpose of this regulation is to enforce the Office of Health Insurance Commissioner's (OHIC) jurisdiction pursuant to R.I. Gen. Laws Chapter 27-18.8, the Health Care Accessibility and Quality Assurance Act (the Act) effective on January 1, 2018. Prior to OHIC's jurisdiction, similar protections of the Act and subsequent regulations were under the jurisdiction of the Rhode Island Department of Health (DOH). The current Act reflects not only the change to OHIC's jurisdiction but reflects changes to bring the Act to current national protective standards to assure that health care entities maintain network adequacy, quality, continuity and reasonable access to covered benefits. The statute was updated accordingly and the proposed regulations designed and developed to clarify, for the health care entities, the expectations in order to comply with mandated requirements of the Act.

OHIC is proposing to establish standards and procedures for the certification/recertification process of Network Plans, and to generally assist OHIC in carrying out the administration and enforcement of the terms and provisions of the Health Care Accessibility and Quality Assurance Act, R.I. Gen. Laws § 27-18.8 et seq. The proposed regulation supplements the statutory requirements by:

- Specifying the application requirements for Network Plan certification in Rhode Island;
- Establishing requirements for delegates of a health care entity as well as general network plan requirements for a health care entity to follow;
- Establishing requirements for network adequacy, access and continuity of care for a health care entity;
- Setting requirements for professional provider credentialing and re-credentialing

- Establishing provider contracting requirements for a health care entity
- Setting reporting requirements for the health care entities, annually on or before March 1st of each calendar year
- Establishing procedures for the renewal of certifications;
- Setting fees for initial and renewal certifications.

Additional Information and Comments:
All interested parties are invited to request additional information or submit written or oral comments concerning the proposed adoption until October 5, 2018 by contacting the appropriate party at the address listed below:

Alyssa R. Metivier
Department of Business Regulation (includes the Office of the Health Insurance Commissioner)
Office of the Health Insurance Commissioner
1511 Pontiac Ave
Cranston, RI 02920
alyssa.metivier@ohic.ri.gov

Public Hearing:
A public hearing, in accordance with R.I. Gen. Laws § 42-35-2.8, to consider the proposed adoption shall be held on September 19, 2018 at 1:00 pm at Department of Labor & Training, Conference Room 73-1, 1511 Pontiac Ave, Bldg 73, Cranston, RI 0RI at which time and place all persons interested therein will be heard. The seating capacity of the room will be enforced and therefore the number of persons participating in the hearing may be limited at any given time by the hearing officer, in order to comply with safety and fire codes.

The place of the public hearing is accessible to individuals who are handicapped. If communication assistance (readers/interpreters/captioners) is needed, or any other accommodation to ensure equal participation, please call 401-462-9551 or RI Relay 711 at least three (3) business days prior to the meeting so arrangements can be made to provide such assistance at no cost to the person requesting.

Regulatory Analysis Summary and Supporting Documentation:
Based on the provisions of the proposed regulation, OHIC has determined that there are minimal overall costs to the health care entities/network plans and providers, and great benefits to the consumers. In developing the rules for Network Plans, it was the OHIC's goal to streamline content and provide added clarity consistent with the applicable statutes and OHIC's existing procedural rules and practices.

Monetizing the benefits and costs accruing to stakeholders from the proposed regulation is not a straightforward task. In this case, the cost side of the social accounting ledger is slightly more tractable than the benefit side. The costs of the proposed regulation include the direct costs of compliance to health care entities. R.I. Gen. Laws 27-18.8-3(4) allows the Commissioner to charge health care entities

for the costs of the program. Prior to the transition of the Health Care Accessibility and Quality Assurance Act to OHIC, DOH administered a similar program funded by an assessment on health care entities. Therefore, the core cost of the program is built into the status quo. The proposed regulations may cause some marginal cost to health care entities' administration and operations. For example, notice requirements for formulary changes, notice to OHIC for potential substantial systemic changes to network plans, network adequacy reporting to OHIC (if it differs materially from prior reporting to DOH), and provider contracting changes may increase administrative burden on the health care entities and result in additional administrative costs. The marginal cost of compliance is unlikely to be significant.

The benefits of the proposed regulation described above, such as the consumer benefit of network adequacy and timely access to health care are harder to quantify. Theoretically, access to care increases the probability that patients will receive the care they need and avoid more costly health care interventions later on. Screening for cancer, as an example, offers the potential for avoiding costly episodes of care and potentially improving mortality rates for certain conditions, thus increasing patient life years. Based on a recent analysis of episode of care cost and variation using the Rhode Island All Payer Claims Database (APCD), the average commercial cost for an episode of breast cancer was $49,281. The average cost of colon cancer was $53, 823 and the average cost of prostate cancer was $50,390. Therefore, if a single case of colon cancer is avoided, then savings of approximately $53,823 accrue to society. When added to the benefit of avoided health care costs, the addition of quality life years that accrue to patients also add significant benefits to society. Given the weight of the potential health benefits to consumers, and the less significant costs to health care entities and providers, OHIC feels strongly that the benefit to cost ratio associated with this proposed regulation is greater than one.

For full regulatory analysis or supporting documentation see agency contact person above.

230-RICR-20-30-9

TITLE 230 - DEPARTMENT OF BUSINESS REGULATION

CHAPTER 20 - INSURANCE

SUBCHAPTER 30 - HEALTH INSURANCE

Part 9 – Network Plans

9.1 Authority

These rules and regulations are promulgated pursuant to R.I. Gen. Laws § 27-18.8-1 *et seq*., entitled the Health Care Accessibility and Quality Assurance Act (the Act).

9.2 Purpose and Scope

A. It is in the best interest of the public that those individuals and health care entities involved with the delivery of network plan coverage in our state meet the standards set forth in R.I. Gen. Laws § 27-18.8-1 *et seq*. and any regulations promulgated thereunder to ensure accessibility and quality for the state's patients; and

B. Nothing in this Act and these regulations is intended to prohibit a health care entity from forming limited networks of providers.

9.3 Definitions

A. As used in this regulation:

1. "Active treatment" means;

   a. An ongoing course of treatment for a life-threatening condition;

   b. An ongoing course of treatment for an acute medical, behavioral health, dental, vision or other clinical condition;

   c. The second or third trimester of what has been documented as a non-high-risk pregnancy; and/or

   d. An ongoing course of treatment for a health condition which a treating provider attests that discontinuing care by that provider would worsen the condition or clinical outcome of that beneficiary.

2. "Adverse benefit determination" means a decision not to authorize a health care service, including a denial, reduction, or termination of, or a

failure to provide or make a payment, in whole or in part, for a benefit. A decision by a utilization review agent to authorize a health care service in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute an adverse determination if the review agent and provider are in agreement regarding the decision. Adverse benefit determinations include:

a. "Administrative adverse benefit determinations," meaning any adverse benefit determination that does not require the use of medical judgment or clinical criteria such as a determination of an individual's eligibility to participate in coverage, a determination that a benefit is not a covered benefit, a determination that an administrative requirement was not followed or any rescission of coverage; and;

b. "Non -administrative adverse benefit determinations," meaning any adverse benefit determination that requires or involves the use of medical judgement or clinical criteria to determine whether the service reviewed is medically necessary and/or appropriate. This includes the denial of treatments determined to be experimental or investigational, and any denial of coverage of a prescription drug because that drug is not on the health care entity's formulary.

3. "Appeal" or "Internal appeal" means a subsequent review of an adverse benefit determination upon request by a claimant to include the beneficiary or provider to reconsider all or part of the original adverse benefit determination.

4. "Authorized representative" means an individual acting on behalf of the beneficiary and shall include: the ordering provider; any individual to whom the beneficiary has given express written consent to act on his or her behalf; a person authorized by law to provide substituted consent for the beneficiary; and, when the beneficiary is unable to provide consent, a family member of the beneficiary.

5. "Beneficiary" means a policy holder subscriber, enrollee, or other individual participating in a health benefit plan.

6. "Benefit determination" means a decision to approve or deny a request to provide or make payment for a health care service or treatment.

7. "Certificate" means a certificate granted by the Commissioner to a health care entity meeting the requirements of this chapter.

8. “Commissioner" means the Commissioner of the Office of the Health Insurance Commissioner.

9. "Complaint" or "Grievance" means an oral or written expression of dissatisfaction by a beneficiary, authorized representative, or provider. The appeal of an adverse benefit determination is not considered a complaint or grievance.

10. "Covered service" or "Covered benefit" means those health care services to which a beneficiary is entitled under the terms of the health benefit plan.

11. "Delegate" means a person or other party authorized pursuant to a delegation of authority or directly or re-delegation of authority, by a health care entity or network plan to perform one or more of the functions and responsibilities of a health care entity and/or network plan set forth in the Act or regulations or guidance promulgated thereunder.

12. "Emergency services" or "Emergent services" means those resources provided in the event of the sudden onset of a medical, behavioral health, or other health condition that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part.

13. "Health benefit plan" or "Health plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health care entity to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

14. "Health care entity" means an insurance company licensed, or required to be licensed, by the state of Rhode Island or other entity subject to the jurisdiction of the Commissioner or the jurisdiction of the department of business regulation 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, without limitation: a for-profit or nonprofit hospital, medical or dental service corporation or plan, a health maintenance organization, a health insurance company, or any other entity providing health insurance, accident and sickness insurance, health benefits, or health care services. Entity shall have the same meaning as health care entity for purposes of these regulations.

15. "Health care services" means and includes, but is not limited to: an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary or non-formulary medications, and any other medical, behavioral, dental, vision care services, activities, or supplies that are covered by the beneficiary's health benefit plan.

16. "Material change" means a substantial systemic change determined by the Office, that could reasonably be expected to adversely affect the

access, availability, quality or continuity of services for a significant number of beneficiaries of a health care entity to include, but not limited to the following:

a. Termination of a hospital or facility contract;

b. Termination of professional provider contract(s);

c. Professional provider contract changes affecting any one professional provider specialty within any of the health care entity's network plans;

d. A change to the tiered products, multi-tiered, layered or multi-level network plan structures during a network plan contract year; and/or

e. Termination or transition of any Benefit Determination delegate; and

f. Surrender or withdrawal of any network plan holding a certificate under the Act or these regulations; and/or

g. Other operational and network plan changes that meet the definition of material change.

17. "Most-favored-rate clause" means a provision in a provider contract whereby the rates or fees to be paid by a health care entity are fixed, established, or adjusted to be equal to or lower than the rates or fees paid to the provider by any other health care entity.

18. "Network" means the group or groups of participating providers providing health care services under a network plan.

19. "Network plan" means a health benefit plan or health plan that either requires a beneficiary to use, or creates incentives, including financial incentives, for a beneficiary to use the providers managed, owned, under contract with, or employed by the health care entity.

20. "Office" means the Office of the Health Insurance Commissioner.

21. "Participating provider" or "Network provider" means a provider under contract with a health care entity, or one of its delegates, who has agreed under this contract to provide health care services to the health care entity's beneficiaries with an expectation of receiving payment, other than coinsurance, copayments, or deductibles from the beneficiary, only from the health care entity under the terms of the contract.

22. "Professional provider" means an individual provider or health care professional licensed, accredited, or certified to perform specified health

care services consistent with state law and who provides these health care services and is not part of a separate facility or institutional contract.

23. "Provider" means a physician, hospital, professional provider, pharmacy, laboratory, dental, medical, or behavioral health provider, or other state-licensed or other state-recognized provider of health care or behavioral health services or supplies.

24. "Substantial systemic change" means any modification of a health care entity's network plan's contracting, credentialing, operational policies and/or procedures adversely affecting beneficiaries, a group of providers, an entire specialty provider type, a hospital, a facility provider, or a delegate having responsibilities relevant to these regulations, or any other entity's modification that may impact a significant portion of its beneficiaries' access to a network provider, the availability of network providers, or the quality and continuity of care.

25. "Tiered network" means a network that identifies and groups some or all types of providers into specific groups to which different provider reimbursement, beneficiary cost-sharing, or provider access requirements, or any combination thereof, apply for the same services.

Comment [W1]: Could you clarify that the type of policy or procedural change contemplated here is one which affects network access?

9.4 General Requirements - Certification, Recertification, and Material Change

A. A health care entity operating a network plan shall:

1. Not enroll consumers into its plan unless the Commissioner has certified the network plan pursuant to the Act and these regulations;

2. Be required to submit a recertification application every two (2) years in form and content consistent with instructions by the Office for that purpose;

3. Notify the Office at least thirty (30) calendar days prior to any substantial systemic change to any of its certified network plans; and

Comment [W2]: Can this language be modified to be consistent with current practice (i.e. 90 days' notice)?

4. Upon a determination by the Office that a substantial systemic change constitutes a material change, file an application consistent with instructions and requests for information issued by the Office for that purpose.

B. A health care entity applying for certification, recertification or material change approval shall provide information to the Office sufficient to enable the Office to determine/evaluate compliance with the requirements of the Act and these regulations according to instructions issued as a guidance document by the Office for that purpose.

C. The cost of the application processes (certification, recertification, and material change), application reviews, complaint processing, investigations, and other activities related to obtaining and maintaining network plan certifications shall be borne by the health care entities, as determined by the Commissioner, including:

1. An application fee established by the Commissioner for each application processed, not to exceed five hundred dollars ($500), which fee must accompany each application.

2. The total cost of obtaining and maintaining a certificate under this Act and in compliance with the requirements of the applicable rules and regulations shall be borne by the applicant and shall include one hundred and fifty percent (150%) of the total salaries paid to the personnel engaged in certifications and ensuring compliance with the requirements herein and the applicable rules and regulations.

3. These monies shall be paid to the Commissioner to and for the use of the office and shall be in addition to any taxes and fees otherwise payable to the state.

4. The Commissioner may not issue a certification, recertification, approval of a material change, or may suspend a currently certified network plan, if a health care entity fails to pay any of the fees, assessments and costs noted above in a timely manner.

9.5 Delegate Requirements

A. A health care entity must provide evidence to the Office of current state certification under the Act for each of its delegates, if any, to which the health care entity has delegated activity as defined in R.I. Gen. Laws Chapters 27-18.9 and/or 27-18.8.

B. A health care entity must maintain regular and meaningful oversight of each of its delegates to ensure every such delegate is in compliance with the Act's network plan requirements, including but not limited to the following:

1. For any portion of the health care entity's network plan activity that is delegated, in part or whole, the health care entity shall be responsible for oversight and be held accountable for all activity delegated and for any non-compliance of its delegate with the Act and these regulations.

2. Should the Commissioner determine that any delegated activity is non-compliant with the rules herein or other state and/or federal laws, the health care entity may be required by the Commissioner to re-assume or reassign the performance of the activity delegated.

3. The health care entity shall ensure through its delegation agreement or contract that it and the Office will have direct access to all the information

held by the delegate that in its or the Office's determination could contribute to determining compliance with the Act and these regulations.

9.6 Network Plan General Requirements

A. For each network plan the health care entity must maintain and submit to the Office its most current grievance and complaint process that adheres to and includes the following minimal requirements:

1. Written processes whereby the beneficiary, a beneficiary's authorized representatives, or health care providers may seek resolution of complaints and other matters of which the health care entity has received oral or written notice;

2. Reasonable timeframes for the resolution of beneficiary, authorized representative of beneficiary, and provider complaints, grievances inquiries of not more than thirty (30) calendar days from the date the health care entity receives the oral or written notice unless granted an extension by the Commissioner;

3. At a minimum, an annual communication from the applicable health care entity to the network plan's beneficiaries and providers that explains the grievance and complaint process for the applicable network plan(s) and provides guidance for distinguishing between a complaint/grievance and a benefit determination appeal and the rights associated with each; and

4. Internal monitoring of complaints and grievances and reporting to the Office on categories of complaints in form and content consistent with instructions issued by the Office for that purpose.

B. As to each network plan, a health care entity shall be required to submit to the Office a mechanism designed to ensure beneficiaries and providers, including local providers participating in the network plans, provide meaningful input into the plan's health care polices, including without limitation:

1. A process to evidence that beneficiary and provider input is reasonably assessed for use by the health care entity; and

2. A process that ensures that issues brought to the attention of the health care entity regarding its network plans via the entity's complaint processes are regularly considered and addressed by the health care entity in the context of developing, reviewing and evaluating each network plan's health care policies.

C. For each network plan, health care entities must evidence to the Office its adherence to the following formulary requirements:

1. Network plan providers shall have input to formulary changes;

2. "Formulary changes" include but are not limited to the following:

a. Medications covered on the formulary;

b. Medication tiering; and

c. Cost sharing.

3. Prior to making any formulary changes for a network plan, a health care entity must provide thirty (30) calendar days direct notice to prescribers of the affected medications and adversely affected beneficiaries must be given at least thirty (30) calendar days direct notice prior to effective date of change;

4. All formulary change notifications to beneficiaries must include the following:

a. The familiar name of the medication(s);

b. A description of the change being made in easy to understand language; and

c. An explanation of the formulary exception process, in accordance with R.I. Gen. Laws § 27-18.9, in easy to understand language; and

D. To the extent a network plan has requirements relating to referrals, the network plan and or health care entity must institute and maintain a procedure for providers to make and authorize in-network referrals, which procedure shall include, without limitation:

1. A reasonable process for communicating the referral process to its beneficiaries in a manner that is easily understood; and

2. An administrative appeal process for denials for failure to obtain a referral consistent with R.I. Gen. Laws § 27-18.9.

E. Each health care entity shall develop, implement and maintain a quality assurance program that: includes the health care entity's oversight of all activities, whether or not delegated, subject to the Act and these regulations; that includes a process to regularly evaluate and determine whether its activities are being performed in a manner that maintains the quality of services delivered to its beneficiaries; and that assures that these activities do not adversely affect the delivery of covered services.

F. Each health care entity shall evidence to the Offices its compliance with state and federal behavioral health parity statues and any applicable regulations.

Comment [W3]: Could it be noted that dental and vision plans are out of scope for this requirement?

Comment [W4]: Will Rhode Island require a separate Rhode Island-specific quality committee or can carriers rely on our national committee? If so, can language to that effect be added?

Comment [W5]: Would Rhode Island clarify whether submission of an Attestation would be sufficient, if it is signed by appropriate Medical Director or officer of the legal entity?

Comment [W6]: Can language be added to clarify that dental and vision plans are out of scope for this requirement?

G. Each health care entity shall cooperate with all compliance reviews and investigations conducted by the Office which may include but not be limited to the following:

1. A review by the Office of the certified health care entity's operations as often as the Commissioner in his or her sole discretion deems appropriate to determine whether a health care entity may be in violation of the Act and these regulations.

9.7 Network Adequacy Requirements

A. For each Network Plan a health care entity must submit to the Office the Network Adequacy policies and procedures that evidence adherence to the following:

1. Each health care entity shall have an ongoing process in place to monitor and assure that its provider network, for each of its network plans, ~~are~~is sufficient in scope and volume to assure address and monitor its population needs such that all covered services ~~for beneficiaries, including children, adults and low-income, medically underserved beneficiaries, children and adults with serious chronic and/or complex health conditions or physical and/or mental disabilities and persons with limited English proficiency~~ are accessible in a timely manner without unreasonable delay.

2. Beneficiaries have access to emergency services twenty-hours (24) hours a day, seven (7) days a week.

3. The health care entity has clear procedures in place that assure its network plan beneficiaries access to a provider in the event that the health care entity fails to maintain sufficient provider contracts or a network provider is not available to provide covered services to beneficiaries in a timely manner. These procedures must include:

   a. A description of the circumstances in which the member is held harmless in the event that a network provider is not available to provide the covered benefit without unreasonable travel or delay;

   b. A process to address network inadequacies when the Commissioner has determined that the network plan has not maintained sufficient provider contracts;

   c. A process to appeal a denial of access to an out of network provider and/or any additional cost shares imposed beyond the beneficiary's in-network coverage, in accordance with R.I. Gen. Laws § 27-18.9.

4. A documented method to inform and assist beneficiaries on how to:

   a. Choose and/or utilize a Network Plan;

Comment [W7]: Can standards be added to define what constitutes sufficient scope and volume? The regulation as written does not allow a carrier to assess whether it is compliant.

Comment [W8]: Can you clarify what is meant there?

Comment [W9]: We suggest deleting the list of populations from this long sentence. If you require all covered services to be accessible, it goes without saying that any person eligible for the covered service would benefit from that access.

Comment [W10]: Could you add the metrics the Commissioner will use to make a determination of "sufficiency?" Carriers should know that in advance, if they are to comply.

b. Select and change a provider;

c. Access an updated provider directory in each network plan; and

d. Inform the beneficiary on the use of tiered networks within a network plan to include changes in beneficiaries' financial liability.

B. Each health care entity shall establish a process to monitor its network plan's network adequacy on quarterly basis. Information to substantiate this process shall be made available to the Office upon request.

C. Health care entities must provide evidence to the Office of adherence to the following transition of care requirements:

1. The network plan has established and maintains a transition of care policy and procedure for use in the event of a network plan change that affects beneficiaries including but not limited to the following types of network plan changes:

a. Narrowing of an existing network plan;

b. Network tiering or changes in network tiering of an existing network plan;

c. Termination of providers in a network plan with beneficiaries in active treatment; and

d. New beneficiaries in active treatment.

D. Health care entities shall evidence and maintain the following, to the satisfaction of the Commissioner, regarding network plan provider directories for each network plan.

1. A mechanism to submit provider directories to the Office for review.

2. A process to make the provider directories easily available by the health care entity to consumer and providers in an understandable and reasonably comprehensive format:

a. Location(s) by city, town and county;

b. Providers' Service Category (e.g. physician practice, urgent care, radiology, behavioral health, laboratory, pharmacy, telehealth etc.);

c. For professional provider directories;

(1) Specialty practice/practice type;

(2) If provider is accepting new patients;

Comment [W11]: Comment W7 above is applicable here as well.

Comment [W12]: Whether or not a member can access telehealth benefits is dependent on their coverage documents. If we identify telehealth providers specifically in the directory, members may misunderstand and assume such services are covered.

Comment [W13]: Please consider revising the list and removing “etc” so that entities know what to list.

(3) Hospital admitting privileges (if applicable) or affiliation and if those facilities are in-network;

(4) Network plan identification and tiering (if applicable) in language easy to understand;

3. That provider directories are available to beneficiaries, providers, and the public according to the following formats:

a. Electronically with search functions;

b. Printed and paper to be made available upon request to a beneficiary or a prospective beneficiary; and

c. All formats must accommodate individuals with limited English proficiency and/or those with disabilities.

4. Electronic and paper directories must be updated at least monthly with daily updates available telephonically.

5. Contact information in order to obtain an updated directory must be clearly evidenced on the health care entity website and on the beneficiary's insurance/health plan card.

Comment [W14]: Consider changing the reference to "obtain" to "access." The best and most accurate directory is the online version, which is already clearly identified on and accessible through the carrier's website. We want to encourage members to access it, rather than to obtain a paper directory.

Comment [W15]: There is no space on the ID card to add this type of information. The phone number on the back of the card should be the member's resource for any question, including how to access the online directory (or get a paper copy).

9.8 Professional Provider Credentialing and Re-credentialing

A. Each health care entity's professional provider credentialing and re-credentialing requirements, policies and processes must be submitted to the Office and must adhere, at a minimum, to the following.

1. Each professional provider credentialing application shall be reviewed by the health care entity's credentialing body; however, the credentialing body may delegate to one or more of its members decision making authority.

2. Professional provider credentialing and re-credentialing criteria shall include:

a. Input from providers credentialed in the entity's network plans and the criteria developed shall be available to applicants;

b. That any economic considerations taken into account by the health care entity factor in and/or adjust for applicant's specialty, applicant's utilization and practice patterns, comparison of the applicant to peers in same specialty, applicant's case mix, severity of illness and/or age of the applicant's patients, and any features of an applicant's practice that may account for higher or lower than expected costs; and

c. That any economic profiling used as part of credentialing or re-credentialing be made available to those provider's profiled.

3. Each health care entity shall evidence to the Office compliance with R.I. Gen. Laws §§ 27-18-83, 27-19-74, 27-20-70, and 27-41-87 that include the following:

a. Communication to the applicant of its credentialing and re-credentialing decision as soon as practical, but no later than forty-five (45) calendar days after the date of receipt of a completed application.

b. For minor changes to the demographic information of a professional provider who is already credentialed with a health care entity, evidence that the health care entity shall complete such change within seven (7) business days of receipt of the health care provider's request. Minor changes shall include, but not be limited to, changes of address and changes to a health care provider's tax identification number.

c. Each health care entity or network plan shall establish a written standard acceptable to the Commissioner defining what elements constitute a complete credentialing and re-credentialing application and shall distribute this standard with the written version of the credentialing application and make such standard available on its website.

4. During the applicable re-credentialing process, network plans must have an established mechanism to assure effective communications with in-network professional providers, including without limitation:

a. A two-way communication to assure that the health care entity has directly informed the provider of the need for re-credentialing;

b. Adequate due diligence by the health care entity in obtaining the current and correct mailing address or other provider-preferred mode of communication to directly communicate with the network provider;

c. A mechanism to adequately follow up with network providers who have not responded to the initial re-credentialing communications with a diligent effort to validate the provider's current physical and/or electronic address used as the mode of communication and confirm receipt of the initial re-credentialing communication; and

d. Health care entities and/or network plans shall not de-credential a network provider if the health care entity has failed to properly adhere to these re-credentialing requirements.

Comment [W16]: Can language be added to provide flexibility so health plans can use the Council for Affordable Quality Healthcare (CAQH) process? Health care entities no longer create their own credentialing applications. The national application and database established by the (CAQH) is where practitioners submit their credentialing information for access by various health care entities – health plans and hospitals. CAQH determines complete/incomplete status of an application. UHC may request supplemental information, as listed in section 4.2 of the UHC Credentialing Plan which was filed and approved by the Commissioner.

Comment [W17]: Can language be added to provide flexibility so health plans can use the Council for Affordable Quality Healthcare (CAQH) process? Health care entities access the CAQH application electronically. The recredentialing process is invisible to the provider and happens automatically. There is only a need to communicate with the provider if any required information is missing or out of date. The provider doesn't have multiple carriers bothering him or her but can deal directly with CAQH.

Comment [W18]: Carriers that do this through CAQH accept the mailing address and e-mail address included on the provider's CAQH credentialing/recredentialing application.

Comment [W19]: If insufficient information is available from the CAQH database, UHC sends a communication to the practitioner once every 30 days, for up to three communications in 90 days, to notify the practitioner that the information is needed.

Comment [W20]: Can language be added to provide flexibility so health plans can use the Council for Affordable Quality Healthcare (CAQH) process? Practitioners should not remain in the network unless his/her recredentialing is current. It puts the member at risk and would cause the health plan to be out of compliance with NCQA accreditation credentialing requirements.

5. Each health care entity or network plan shall promptly respond to inquiries by the applicant regarding the status of a credentialing or re-credentialing application as well as provide the applicant with an automated application status update at least once every fifteen (15) calendar days to inform the applicant of any missing application materials until the application is deemed complete; and

6. Within five (5) business days of deeming an application complete each health care entity or network plan shall inform the applicant that the credentialing or re-credentialing application is complete.

7. The effective date for billing privileges shall be the next business day following the date of approval of a credentialing application.

B. Evidence to the Office that if the health care entity denies a credentialing or re-credentialing application, the health care entity or network plan shall notify the health care provider in writing and shall provide the health care provider with any and all reasons for denying the application.

C. A health care entity shall establish a transitional or conditional credentialing approval processes in any provider category where there is an established "need" (geographic "need" or "need" by specialty type such as resident graduates, primary care providers, behavioral health providers or certain specialist providers), and shall include:

1. "Need" shall be determined by the Commissioner considering continuity of care for beneficiaries, insufficient network by provider type and/or the inability of the entity to provide timely access to covered services to its beneficiaries.

2. To be considered for a transitional or conditional credentialing approval, the provider must have:

   a. Submitted an otherwise completed credentialing application and met all other credentialing criteria;

   b. Successfully graduated from the training program; and

   c. Includes a mechanism to ensure that providers with transitional, conditional or temporary credentialing approval receive an effective date for billing privileges of the first business day after the transitional, conditional and/or temporary credentialing approval.

D. A credentialing and re-credentialing application shall be considered complete when all the following requested material has been submitted and the health care entity or network plan may not require the submission of additional material for an application to be considered complete unless any such additional requirement is approved by the Commissioner:

Comment [W21]: Can language be added to provide flexibility so health plans can use the Council for Affordable Quality Healthcare (CAQH) process? CAQH notifies an applicant if his/her credentialing application is complete or incomplete. A carrier may request supplemental information from the provider but relies on CAQH to handle most of the processing.

Comment [W22]: Existing Utilization Management processes address how the health plan works with members in instances of Network Gaps. When a Network Gap is identified, the member can be approved to receive services from an out of network provider at the in-network benefit level. There can be risk to members and health plans to add providers to the network before complete credentialing has been completed.

Comment [W23]: This list is incomplete, and omits essential credentialing information required by NCQA (the National Committee for Quality Assurance) for health plan accreditation. Please see below for additions to this list that are required in order for health plans to comply with NCQA credentialing requirements.

1. Provider demographics to include name, current mailing address;

2. Current valid license, registration or certificate required in order for professional provider to practice in Rhode Island or other state as applicable;

3. History of any revocation, suspension, probationary status or other disciplinary action regarding provider's license, registration or certificate noted in 2 above;

4. Clinical privileges at a hospital, as applicable;

5. Valid Drug Enforcement Agency and Controlled Substance certificate/registration and/or other state or federal verification to prescribe controlled substances (if applicable);

6. Evidence of board certifications if the professional provider states that he/she is board certified;

7. Evidence of malpractice/professional liability insurance; and

8. History of professional liability claims and description of any settlements or judgements paid to a claimant in connection with a professional liability claim.

9. Completion of medical or professional education and training;

10. Evidence of post-graduate training (e.g. – residency training);

11. Medicare and Medicaid Program Participation Eligibility;

12. Work History, with explanation of gaps more than six months; and

13. Review of affirmative responses to Disclosure Questions on the CAQH Credentialing Application.

~~8.~~14.

E. A health care entity may utilize an alternative credentialing program approved by the Commissioner.

9.9 Provider Contracting and Due Process

A. The health care entity must include the following in its network provider contracts:

1. A provision protecting beneficiaries to include:

a. Ensuring the beneficiary is held harmless from any liability attributable to the failure of a referring provider to adhere to the referral process, including by failing to submit the required referral documents to the health care entity when there is evidence that the beneficiary sought and received a referral from this provider;

b. That in no event, including but not limited to non-payment by the health care entity or intermediary, insolvency of the health care entity or one of its delegates or breach of the health care entity's agreement with a network plan provider, shall the network plan provider bill, charge, collect a deposit from, or seek compensation, remuneration or reimbursement from a beneficiary to include but not limited to facility or administrative fees added to a beneficiary for covered services by the provider; and

c. That no beneficiary shall be liable to any provider for charges for covered benefits, except for the amounts due for co-payments, deductibles and/or coinsurance, when provided or made available to enrolled participants by a licensed health maintenance organization, as that term is defined in R.I. Gen. Law § 27-41-2(t), during a period in which premiums were paid by or on behalf of the enrollee.

2. Language to describe that in the event of a provider contract termination:

a. The beneficiary is held harmless for covered benefits except for amounts due for co-payments, coinsurance, and deductibles, for the duration of an active course of treatment or up to one year, whichever is earlier, subject to all the terms and conditions of the terminated provider contract, unless the provider is able to safely transition the patient to a network provider; and

b. For this period of active treatment, the beneficiary shall only be responsible for in-network cost shares provided for under the beneficiaries' coverage documents and not otherwise prohibited by state or federal laws or regulations.

3. A requirement that in the event where a non-network provider delivers services in a network facility to include a network laboratory, radiology or diagnostic site of service, the health care entity must contractually assure that:

a. When there is no reasonable time to inform the beneficiary in advance of receipt of a covered service from a non-network facility in these instances, that the network plan has a mechanism in place to assure that the beneficiary's financial liability does not exceed the in-network coinsurance, copayment and/or deductibles; and

b. When there is reasonable time to inform the beneficiary that a specific provider is out-of-network in a network facility, it will be the responsibility of the network facility to inform the beneficiary in writing of this out-of-network status and any financial implications to the beneficiary within a reasonable period of time and in advance of any related out-of-network provider services.

c. Reasonable timeframes shall be established by the health care entity and presented to the Commissioner for approval.

B. In the event a health care entity or network plan modifies a professional provider contract the health care entity shall comply with the following:

1. A health care entity or network plan may materially modify the terms of a participating agreement it maintains with a professional provider only if it

disseminates, in writing, by mail or by electronic means to the professional provider, the contents of the proposed modification and an explanation, in non-technical terms, of the modification's impact and any change or modification meets all requirements herein.

2. The entity or network plan shall give the professional provider an opportunity to amend or terminate the contract within sixty (60) calendar days of receipt of the notice of a contractual modification.

3. Any termination of a professional provider contract made as a result of a modification shall be effective fifteen (15) calendar days from the mailing of a written notice of termination by a professional provider to the health care entity.

4. The termination due to a modification in a professional provider contract shall not affect the method of payment or reduce the amount of reimbursement to the provider by the health care entity for any beneficiary in active treatment for an acute medical condition at the time the beneficiary's provider terminates until the active course of treatment is concluded or, if earlier, one year after the termination.

C. For all adverse decisions resulting in a change of professional provider privileges or a change in the terms of a provider contract, health care entities shall afford due process that includes, without limitation, the following:

1. Option for a voluntarily waiver by the professional provider;

2. Written notification by the health care entity to the affected professional provider(s) of the proposed action(s) and the reasons for the proposed action(s);

3. Meaningful opportunity for the provider to contest the proposed action(s);

4. An appeals process that has reasonable time limits for the resolution of the appeal; and

5. That all due process decisions are made by an objective, unbiased, and qualified individual or group.

D. A health care entity shall not refuse to contract with or compensate for covered services an otherwise eligible participating or non-participating provider solely because that provider has, in good faith, communicated with one or more or his/her patients regarding the provisions, terms, or requirements of the health care entity’s network plan at it relates to the needs of a patient.

E. A health care entity shall not exclude a professional provider of covered services from participation in its network plans solely based on the professional provider’s:

1. Degree or license as applicable under state law; or

2. Lack of affiliation with, or admitting privileges at, a hospital, if that lack of affiliation is due solely to provider's type of license.

3. Discussion with a beneficiary specific treatment options or for advocating to the health care entity treatment options for a beneficiary.

F. A health care entity shall not discriminate against providers when establishing its provider networks or when establishing provider network tiers using, but not limited to, the following selection criteria:

1. The provider treats a substantial number of patients who require expensive or uncompensated care; or

2. Are located in geographic areas that contain population or providers presenting a risk of higher than average utilization.

G. Health care entities shall not be allowed to include clauses in a provider's contract that allow for the health care entity's termination of the contract "without cause"; provided however, "cause" shall include lack of need due to economic considerations.

H. A health care entity or network plan shall not include a most-favored-rate clause in a provider contract.

9.10 Reporting

A. Each health care entity shall compile and maintain reports in form and content consistent with instructions issued as a bulletin by the Office for that purpose and these reports shall:

1. Include but not be limited to a report that includes all complaints received by the health care entity and its delegates (if applicable) by complaint categories set forth by the Office, which categories may change from time to time at the discretion of the Commissioner; and;

2. Be filed with the Office at least annually on or before March 1st of each calendar year.

B. Each health care entity shall promptly comply with periodic requests by the Commissioner and/or the Office for information, data and/or reports requested by the Commissioner for the purpose of determining compliance with the Act and these regulations.

9.11 Denial, Suspension, or Revocation of Certification

Denial, suspension, or revocation ~~or~~ of certification is governed by R.I. Gen. Laws § 27-18.8-8.

9.12 Penalties and Enforcement

Penalties and enforcement is governed by R.I. Gen. Laws § 27-18.8-9.

9.13 Rules of Governance

All hearings and reviews required under the provisions of the Act, as amended, shall be held in accordance with the provisions of Part 10-00-2 of this Title.

9.14 Severability

If any section, clause, or provision of the Act or these regulations shall be held either unconstitutional or ineffective in whole or in part, to the extent that it is not unconstitutional or ineffective, it shall be valid and effective and no other section, clause or provision shall on account thereof be termed invalid or ineffective.

National
Multiple Sclerosis
Society

October 5, 2018

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1511 Pontiac Ave
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Alyssa.Metivier@ohic.ri.gov

RE: Network Plans Draft Regulations, Rule 230-RICR-20-30-9

Dear Ms. Metivier,

Thank you for the opportunity to provide comments regarding the Rhode Island Department of Business Regulation's proposed network plans regulations. I am writing on behalf of the National Multiple Sclerosis Society - an organization that supports individuals living with multiple sclerosis (MS), their caregivers, and their larger support system in the state of Rhode Island.

MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and symptoms in any one person cannot yet be predicted. Network inadequacy raises particular concerns for people living with MS and others with specialized and complex healthcare needs. People living with MS may require care from neurology, rehabilitation, radiology, mental health and other specialists, as well as treatments, services and products from pharmacies, durable medical equipment (DME) providers, home care agencies and more to live their best lives.

The Society recognizes that mid-policy term changes to an insurer's drug formulary, especially for those living with chronic illnesses such as MS, can have negative effects on their lives and health outcomes. These formulary changes, known as non-medical switching, occur when health insurers remove a prescription drug or move it to a higher cost-sharing tier during the plan year for reasons unrelated to patients' health or safety. When these changes happen, patients are often switched from one disease modifying therapy (DMT) to another. DMTs are used in modifying the disease course, treating relapses, and managing symptoms in MS; they are the best way to prevent the accumulation of disability and protect the brain from permanent damage. Identifying the right medication for each patient can be a long a difficult process, and when the right medication is identified a patient should remain on it for as long they and their physician see fit; movement from one DMT to another should only occur for medically-appropriate reasons as DMTs are not interchangeable. When a person living with MS loses access to the treatment that best controls their disease progression, they may experience loss of function and a possible irreversible increase in disability.

National
Multiple Sclerosis
Society

When patients enroll in a health plan, they sign a contract for an entire year. People with chronic conditions like MS base their decision to enroll in a particular health plan on the available information about the medications they need. MS DMTs are very costly. As of 2017, the average wholesale cost of MS DMTs was $83,688. Placing any medication that is part of a DMT on a higher cost-sharing tier during a policy term can create either unmanageable expenses or worsening symptoms and side effects for individuals living with MS. As a result, instances have occurred where individuals have stopped taking medication, leading to worsening health care outcomes.

It is for these reasons that the MS Society urges the amending of Part 9.6, Section C, Subsection 3. A 30-day notice period is in no way sufficient for what a patient would need, especially one suffering from a complex disease and cognitive issues such as MS. We encourage a change to reflect that insurers must cover a medication for the remainder of a patient's policy term – without moving it to a higher cost-sharing tier - in addition to notifying them at least 90 days in advance that it will no longer be covered should the policy be renewed.

The MS Society supports the Network Adequacy requirements of Part 9.6 of these proposed regulatory changes, including the development and implantation of a process that assures network plans are sufficient in both scope and volume for the needs of individuals with chronic and/or complex health conditions. The guarantee of emergency services twenty-four hours, seven days a week and the assurance that access to a provider must be maintained regardless of the sufficiency of in-network providers means that those living with MS will not see a lapse in care. Within the proposed regulations of Section A, Subsection 1, we would encourage a clearer definition of what is adequate in terms of scope and volume.

Given the high cost of treating MS, Part 9.9, Section A, Subsection 3 is especially important. The average cost of living with MS, including both direct and indirect costs, is upwards of $70,000 per year, per person. Individuals living with MS may suffer relapses, falls, or other health concerns that lead them to seek emergency services. It is vital that these patients can access treatment without the fear of surprise billing that will add to the already burdensome cost of this disease. In Subsection b of Subsection 3, the proposed changes outline a scenario in which there is time to notify a beneficiary that a specific provider is out-of-network even though they are within a network facility. In this scenario beneficiaries are guaranteed a "reasonable period of time" for notice of the out-of-network status and financial implications. When deciding on what is considered a "reasonable period of time", this timeframe must take into account both the lengthy process of the patient consulting their physician to find an alternative and the extra time that may be needed as many patients have cognitive issues. With this in mind we urge this required notification period to be at least 90 days whenever possible.

Proper network adequacy and access to affordable, quality healthcare is essential to the wellbeing of Rhode Island residents living with MS. The National MS Society looks forward to the final regulations and

National
Multiple Sclerosis
Society

we appreciate the opportunity to participate in the process. If I can be of further assistance, please contact me at (860) 913-2550 X52521 or laura.hoch@nmss.org.

Sincerely,
Laura Hoch
Manager, Advocacy
National MS Society

Peggy Rupp
Compliance Manager
Enterprise Compliance
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Sent via electronic mail

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October 5, 2018

Alyssa R. Metivier
Department of Business Regulation
Office of the Health Insurance Commissioner
1511 Pontiac Ave
Cranston, RI 02920

RE: 230-RICR-20-30-9, Proposed Network Plans Regulation – Comments

Dear Ms. Metivier,

On behalf of Cigna Health and Life Insurance Company ("CHLIC" or "Company"), I write to comment on the proposed regulation 230-RICR-20-30-9. The Company submits its comments and questions below for your review and consideration.

Definitions:

#16 Material change – Can clarification be provided on the definition of the following statement: "for a significant number of beneficiaries of a health care entity" – would it be a percentage or fixed number?

9.5 Delegate Requirements

What types of delegation is covered under this particular act. Is it just Medical Management or does it include Claims and Credentialing?

B. 3. The health care entity shall ensure through its delegation agreement or contract that it and the Office will have direct access to all the information held by the delegate that in its or the Office's determination could contribute to determining compliance with the Act and these regulations.

We would request clarification on what "direct access" means. If it means access directly into our systems to obtain this information we have concerns with privacy. If it is just providing necessary information so that the Office can determine we are compliant then we have no concerns.

9.6 Network Plan General Requirements

A. 3. At a minimum, an annual communication from the applicable health care entity to the network plan's beneficiaries and providers that explains the grievance and complaint process for the applicable network plan(s) and provides guidance for distinguishing between a complaint/grievance and a benefit determination appeal and the rights associated with each

For Dental: if we post this information on our Dental Office Reference Guide which is posted on our provider portal will that be sufficient for meeting the requirement for notifying the Dental providers?

9.7 Network Adequacy Requirements

A. 1. Each health care entity shall have an ongoing process in place to monitor and assure that its provider network for each of its network plans are sufficient in scope and volume to assure address and monitor its population needs that all covered services for beneficiaries, including children, adults and **low-income, medically underserved beneficiaries,**

We are concerned with this requirement specific to "low-income, medically underserved beneficiaries". How would carriers determine which RI beneficiaries are considered low-income or medically underserved in order to include that in our analysis of the adequacy of our network.

D. 3. c. That provider directories are available to beneficiaries, providers, and the public according to the following formats:

c. All formats must accommodate individuals with limited English proficiency and/or those with disabilities.

We have disclosures that direct members to a phone number where they can receive assistance with translation. Do we need to have the actual directory translated or will the disclosure be sufficient?

9.9 Provider Contracting and Due Process

A. 3. a. A requirement that in the event where a non-network provider delivers services in a network facility to include a network laboratory, radiology or diagnostic site of service, the health care entity must contractually assure that:

a. When there is no reasonable time to inform the beneficiary in advance of receipt of a covered service from a non-network facility at a network facility?

Should the highlighted section say non-network provider?

B. 3. Any termination of a professional provider contract made as a result of a modification shall be effective fifteen (15) calendar days from the mailing of a written notice of termination by a professional provider to the health care entity.

We have concern with this short timeframe to make a termination effective. We often will try to resolve the issue with the provider to avoid termination.

G. Health care entities shall not be allowed to include clauses in a provider's contract that allow for the health care entity's termination of the contract "without cause"; provided however, "cause" shall include lack of need due to economic considerations.

We would like to recommend this requirement be removed or revised. It would be difficult to prove, but the proof necessary to show "lack of need due to economic consideration" would likely involve the

disclosure of competitively sensitive pricing information that would make the environment susceptible to antitrust conduct.

9.10 Reporting

A. 1. Include but not be limited to a report that includes all complaints received by the health care entity and its delegates (if applicable) by complaint categories set forth by the Office, which categories may change from time to time at the discretion of the Commissioner; and;

2. Be filed with the Office at least annually on or before March 1st of each calendar year.

We recently received a new notice and form from OHIC that included a form that says "All entities must file an annual report with OHIC on or before January 31, 2020, for calendar year 2019." Please clarify the date the report on complaints needs to be filed.

Thank you for the opportunity to provide comments regarding the proposed regulation.

Please do not hesitate to contact me at 860.902.6864 or at Peggy.Rupp@Cigna.com if you should have questions.

Respectfully,

Peggy Rupp

C: Deb Hutton, State Government Affairs Director, Cigna
Christine Cooney, State Government Affairs Manager, Cigna
Mike Kolosky, Managing Counsel, Cigna

Alyssa R. Metivier
Office of the Health Insurance Commissioner (OHIC)
By Electronic Mail: Alyssa.Metivier@ohic.ri.gov

October 5, 2018

Re: **Proposed Regulation 230-RICR-20-30-9 (Network Plans)**

To Whom It May Concern:

Thank you for the opportunity to provide these comments that pertain to proposed regulation 230-RICR-20-30-9. The Mental Health Association of RI (MHARI), an affiliate of Mental Health America, welcomes the opportunity to provide input into these rules which have the potential to greatly impact the care and treatment of people who live with behavioral health disorders.

This year, MHARI has been preparing to launch its project, the RI Parity Initiative (RIPI). As part of RIPI, over this past summer we facilitated a series of focus groups—some for patients and family members, and some for providers. Many of the comments that appear below reflect the experiences that have been shared by participants in both provider and patient/family groups.

COMMENTS:
Please note that a double underline indicates language that we are proposing.

9.3 Definitions

9.3 (A) (1) (b):
The term *behavioral health* is not defined. It is usually defined as mental health/mental illness/substance use disorders (often referred to as addiction disorders).

9.5 Delegate Requirements

9.5 (A):
The following language should be added:
A health care entity must provide notice to each beneficiary of its delegation of any activity as defined in R.I. Gen. Laws Chapters 27-18.9 and/or 27-18.8. The health care entity shall provide to the beneficiary the name of the delegate and its contact information that may be used for direct communication with the delegate. If the delegate has authorization or denial authority over any service that is available on a 24 hours basis, including pharmacy, there shall be available 24-hour live assistance available by phone and online.

If there is a change, removal, or addition of a delegate, that information shall be provided to the beneficiary thirty (30) days or more before the effective date.

Health care entities shall evidence and maintain the following to the satisfaction of the Commissioner:

1. A mechanism to provide a proposed Notice of Change of Delegate to the Office for review.

2. A process to make the Notice of Change of Delegate available to beneficiaries and providers, including to those without online access.

9.6 Network Plan General Requirements

9.6 (C) (1):
Requires input from providers to formulary changes. What constitutes input? What is the process? What are the criteria used to adopt or reject provider input?

9.6 (C) (2):
A common practice utilized by health insurers is referred to as *non-medical switching*. Non-medical switching occurs when insurers force a switch to a different drug by either dropping coverage or increasing the out-of-pocket cost of the drug after the plan year has begun. Patients who live with a mental illness may have tried several medications before finding one that works. To adjust to a new medication could mean a deterioration in one's condition, serious reduction in one's level of functioning, hospitalization or, in some cases, even worse (e.g., unemployment, homelessness, or interaction with the criminal justice system).

It is fundamentally unfair to allow individuals to choose a health plan and enter into a contract, only to have this component of the contract change in the middle of the contract year. While insurers want to maintain the ability to switch medications during the term of the contract, fairness and safety concerns should remain paramount and should prohibit dropping coverage or increasing the out-of-pocket cost of the drug after the plan year has begun.

Further, adequate notice should be provided to a beneficiary to inform him/her/they that, if and when the policy is renewed, the beneficiary will be impacted by changes, as described, below.

The following language should be added:
During the health plan year, a health care entity providing health care services, and providing coverage for prescription drugs shall not:

(1) Remove any covered prescription drug from its list of covered drugs unless the United States food and drug administration has issued a statement about the drug that calls into question the clinical safety of the drug, or the manufacturer of the drug has notified the United States food and drug administration of any manufacturing discontinuance or potential discontinuance as required by § 506C of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 356c);

(2) Reclassify a drug to a more restrictive drug tier or move a drug to a higher cost-sharing tier; or

(3) Reduce the maximum coverage of prescription drug benefits.

(4) This section does not prohibit the addition of prescription drugs to a policy's list of covered drugs during the health plan year.

(5) At least 90 (ninety) days prior to renewal date, if any current medication will no longer be covered, will be classified to a more restrictive drug tier, moved to a higher cost-sharing tier, or if there will be any reduction in the maximum coverage of prescription drug benefits, the health care entity shall directly notify prescribers of the affected medications and adversely affected beneficiaries of the aforementioned anticipated changes should the policy be renewed.

9.6 (C) (3):
If our suggested change to 9.6 (C) (2), which would prohibit non-medical switching, is not promulgated, then 9.6 (C) (3) shall provide at least ninety (60) calendar days' notice of the formulary change to prescribers and adversely affected beneficiaries, instead of thirty (30), as currently stated in the proposed rules.

9.6 (C) (4) (c):
An explanation of the formulary exception process, in accordance with R.I. Gen. Laws §27-18.9, in easy to understand language. This shall also be provided to the beneficiary when initially enrolling in a plan and at the time of renewal; and

9.6 (B)(3) Suggested new section:
Health care entities shall convene consumer advisory boards, comprised of patients, family members, and patient advocates, for the purpose of obtaining information about, and responding to, areas of concern pertaining to any and all aspects of the health plan and its coverage. The consumer advisory boards shall meet at least every two months. This does not replace any of the processes developed under 9.6 (B)(1) and (2).

9.7 Network Adequacy Requirements

9.7 (A). For each Network Plan a health care entity must submit to the Office the Network Adequacy policies and procedures that evidence adherence to the following:

1. Each health care entity shall have an ongoing process in place to monitor its population needs and assure that its provider network for each of its network plans are up-to-date and sufficient in scope and volume to assure ~~address and monitor its population needs~~ that all covered services for beneficiaries, including children, adults and low-income, medically underserved beneficiaries, children and adults with serious chronic and/or complex health conditions or physical and/or **mental disabilities[emphasis added]** and persons with limited English proficiency are accessible in a timely manner without unreasonable delay.

   What is the definition of mental disabilities?

9.7 (C). Health care entities must provide evidence to the Office of adherence to the following transition of care requirements:

1. The network plan has established and maintains a transition of care policy and procedure for use in the event of a network plan change that affects beneficiaries including but not limited to the following types of network plan changes:
   a. Narrowing of an existing network plan;
   b. Network tiering or changes in network tiering of an existing network plan;
   c. Termination of providers in a network plan with beneficiaries in active treatment; and
   d. New beneficiaries in active treatment

2. Health care entities must provide notice to its adversely affected beneficiaries of any network plan change including, but not limited to, items 9.7 C (1) (a through d).
   a. Health care entities shall evidence and maintain the following to the satisfaction of the Commissioner:

      (1) A mechanism to provide proposed Notice of Network Change to the Office for review.
      (2) A process to make the Notice of Network Change available to beneficiaries and providers, including to those without online access.

9.7 (D)(2)(c): For professional provider directories:

For behavioral health providers, additional information should be provided.

- What is the professional license of the provider (e.g., psychiatrist, psychiatric nurse specialist, licensed clinical social worker, etc.)?
- If the provider is authorized to prescribe, is his/her practice limited to medication maintenance?
- Does the provider provide psychotherapy? Perhaps even greater detail is needed. Individual? Couples? Group? Type of psychotherapy (e.g., cognitive behavioral therapy)
- Does the provider limit his/her practice to certain areas/diagnoses of mental health? (e.g., substance use? Depression/anxiety)?
- Does the provider provide out-patient services and/or inpatient services? This needs to be clarified.

Additional suggested **Network Adequacy** language:

The networks of mental health providers are frequently much smaller than networks of other provider networks. This is not parity. We urge the creation of the following requirement:

Plans must demonstrate to the Commissioner that credentialing requirements and provider reimbursement rates are fair and competitive so that network adequacy is achieved and maintained. The rates of payment for services rendered by an individual provider shall be the same regardless of: 1. where the services are provided; or, 2. for whom the individual provider is employed; or, 3. with whom the individual provider has a contractual agreement to provide such services.

9.9 Provider Contracting and Due Process

9.9 (A) (1) (b):
We strongly support this section which prohibits the imposition of facility or administrative fees upon the beneficiary by the provider

Suggest creating 9.9 A (4), and adding:
If a member can document that he/she/they confirmed a provider's network status through the carrier's online directory, print provider directory or member services call center, relied on that confirmation and that confirmation was, in fact, erroneous, then the member should be held harmless beyond ordinary cost sharing.

Thank you very much fo the opportunity to provide this input.

Sincerely,

Ruth Feder, Esq., MSW
Executive Director

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October 5, 2018

Alyssa R. Metivier
Department of Business Regulation
Office of the Health Insurance Commissioner
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RE: 230-RICR-20-30-9, Proposed Network Plans Regulation – REQUESTING AMENDMENTS

Dear Ms. Metivier:

I write today on behalf of America's Health Insurance Plans (AHIP) to express our concerns with proposed rule 230-RICR-20-30, which moves jurisdiction over the regulation of network plans from the Rhode Island Department of Health (DOH) to the Office of Health Insurance Commissioner (OHIC). The proposed rule also updates network adequacy requirements and establishes supplementary standards and procedures for the certification and recertification process of network plans, as well as requiring internal monitoring processes for such plans.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, AHIP improves and protects the health and financial security of consumers, families, businesses, communities and the nation. AHIP is committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

To these ends, AHIP believes that the hold harmless provisions in network adequacy requirements should be amended and strengthened to protect consumers from surprise billing. Also problematic are provider directory updating requirements which are administratively burdensome, likely to cause consumer confusion and potentially raise health care costs.

Hold Harmless Provisions Should Include Payment Specifications

The proposed rule requires health insurers offering network plans to have procedures in place to ensure a member is "held harmless," or is not liable for a surprise bill, when: 1) the plan's

network is unable to provide a covered benefit "without unreasonable travel or delay"[1]; 2) a referring provider fails to "adhere to the referral process"[2]; or 3) in the event of a provider contract termination.[3] This also applies to health maintenance organization members.[4]

Out-of-network (OON) providers bill the patient for any amounts not paid by the health plan, a practice called balance (or "surprise"), billing, which is defined as payment demanded by an OON provider directly from the patient to collect the difference between the provider's charge and the allowed amount paid by the health insurance plan, but does not include the copayment, deductible, or coinsurance owed by the insured patient.

AHIP supports laws and regulations that require providers who are not contracted with a health plan to accept the assignment of benefits from an enrollee and agree not to balance bill the enrollee for any amounts owed beyond copayment, coinsurance, or deductible amounts that the patient might owe related to covered services. However, approaches for limiting surprise bills must also include payment provisions for the OON provider, which may include establishing the rate of payment to OON providers for services. Reimbursement provisions should: 1) be set at a level that does not destabilize provider contracts in the state but instead encourages health plans and providers to enter into mutually beneficial contracts, and 2) be based on accepted rates, contracted rates, or government payment fee schedules and not billed charges. Adding such provisions would strengthen financial protections for consumers and help keep the cost of health care in Rhode Island low.

Provider Directory Updating Requirements are Administratively Burdensome

Under the proposed rule, health insurers must make three versions of a network plan's provider directory available to consumers: electronically, by paper and by telephone. Electronic and paper directories must be updated "at least monthly," while directories by telephone must provide "daily updates."[5]

It is important for consumers to get timely, up-to-date information, but the proposed language may cause undue confusion and frustration for consumers since the information could potentially be asymmetric – a consumer requesting a paper directory by mail may receive it after the monthly electronic update; or the information from the call may be different from both the electronic and paper directories since it is updated daily instead of monthly. Thus, it is possible for a consumer to get provider directories containing three different sets of information at a given time.

Furthermore, requiring provider directory information to be delivered three different ways under two different timeframes is also overly burdensome and costly, especially with regards to the daily updates via telephone. Insurers need time to implement changes to the directories, whether

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[1] 230-RICR-20-30-9.7.A.3.a.
[2] 230-RICR-20-30.9.9.A.1.a.
[3] 230-RICR-20-30.9.9.A.2.a.
[4] 230-RICR-20-30.9.9.A.1.c.
[5] 230-RICR-20-30.9.7.D.4.

it be online, in print or its call system. The turnaround time for telephone updates is extremely and unreasonably short when compared to the other methods and will be very costly to maintain. The proposed rule also appears unclear whether insurers are required to print new provider directories every month or whether they only must be available upon request. Such burdensome requirements would negatively impact the price of health care for consumers in Rhode Island.

AHIP proposes the rule language be amended to promote informational uniformity across all three sources and to clarify that paper directories do not have to be printed every month, only upon request. We suggest aligning all three methods to be updated monthly. These changes will give insurers greater flexibility to implement changes so that consumers receive up-to-date provider directory information that is consistent

AHIP and its members applaud the state's efforts to address these important consumer issues and appreciate the opportunity to provide comments on 230-RICR-20-30-9. Thank you for taking our views into consideration and we look forward to continued discussions with you on these important issues.

Sincerely,

Terrance S. Martiesian

By: TL

Terrance S. Martiesian

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October 5, 2018

Alyssa R. Metivier
Office of the Health Insurance Commissioner
1511 Pontiac Ave Cranston, RI 02920

RE: Proposed Regulation 230-RICR-20-30-9

Dear Ms. Metivier:

Blue Cross & Blue Shield of Rhode Island (BCBSRI) appreciates the opportunity to provide comments on proposed regulation 230-RICR-20-30-9, which is being promulgated pursuant to R.I. Gen. Laws § 27-18.8-1 *et seq.*, entitled the Health Care Accessibility and Quality Assurance Act. While we provide comments on individual sections below, we have broader concerns that the proposed regulation attempts to address issues both beyond the statutory delegation of authority, and in conflict with the stated aims of the statute. The proposed regulation creates substantive new notice and procedural requirements for issuers and providers, without sufficient attention to the administrative burdens they represent, and the potential for unintended harms they cause. We are committed to working with the Office on the concerns that motivated the proposed regulation, and are hopeful that with input from all stakeholders, the final regulation will reflect a more balanced and measured approach.

9.3 Definitions

9.3 (A) (1) (d) Active Treatment
BCBSRI objects to the proposal to expand the definition of "active treatment" to include "an ongoing course of treatment for a health condition which a treating provider attests that discontinuing care by that provider would worsen the condition or clinical outcome of that beneficiary." While the Affordable Care Act (ACA) regulations include this provision, they specifically apply it only to Qualified Health Plans on the Federally Facilitated Exchange. *See* 45 CFR § 156.230(d). In fact, the broad provision is a significant expansion of the concept of "active treatment." It does not require the member's condition to be serious or acute, and relies solely on a provider statement that his/her care is important to the member outcome. The concern is not only that there is no check against a provider's self-serving attestation. Because "active treatment" is the basis of a subsequent requirement to continue paying a non-network provider, this portion of the definition has serious consequences for a plan's ability to maintain quality standards for its provider network, manage its network size, and maintain affordability. While the intent is to be protective of members, the effect overall is to encourage members to continue seeking services from non-network providers who may not meet quality standards and may balance bill members.

9.3 (A) (10) Covered Service or Covered Benefit
To clarify the definition, BCBSRI recommends adding "subject to the contractual limitations on beneficiary benefits as may apply, including, for example deductibles, waiting period or frequency limitations" to the end of the definition, similar to the provision in R.I. Gen. Laws §27-18.8-4.

9.3 (A) (16) Material Change
BCBSRI recommends deleting "and/or" from the end of bullets (d) and (f) and deleting "and" from the end of bullet (e).

9.3 (A) (24) Substantial Systemic Change
BCBSRI believes the proposed definition of "substantial systemic change" is inconsistent with, and is an impermissible expansion of R.I. Gen. Laws § 27-18.8-3(b)(3). Because the proposed definition references "any modification" to policies and procedures, it includes policy and operational changes by the plan that are not part of its certification application on file, and brings within the scope of OHIC review the day-to-day management of an insurance company. The appearance that the OHIC, through this definition and its application in Section 9.4 of the proposed regulation, may determine that an operational change or policy is subject to OHIC approval, is an unwarranted intrusion into the management functions of insurers. As the Rhode Island Supreme Court has held consistently, a regulator's powers "do not include the authority to dictate managerial policy."[1]

Such regulatory overreach creates an unworkable burden on plans, potentially subjecting even minimal administrative changes to regulator review. For example, BCBSRI currently has about 400 medical and reimbursement policies that are reviewed and updated throughout the year, with new policies added as needed. Providers have the opportunity to comment on policy changes and are provided with at least 60 days' advance notice if the changes impact them, as required by law. It would be a significant administrative work effort if even a fraction of these were determined to be a material modification to our Network Health Plan certificates, and required OHIC review. The General Assembly provided separately for a public input process to plan policy changes in R.I. Gen. Laws § 27-18.8-3(b)(5), but did not provide OHIC with the authority (as they could have) to review or approve such changes.

The proposed definition also extends beyond what has been required historically under previous legislation and what was intended by the new statute. The use of "substantial systemic change" in R.I. Gen. Laws § 27-18.8-3(b)(3) reflects a concern with comprehensive changes to the health care entity, the plan, or relevant provisions of its certification application on file, not the ordinary changes an organization makes to its everyday operations. While we understand the importance of keeping OHIC informed of changes to our medical and reimbursement policies that could impact beneficiaries and providers, these are ultimately business decisions reserved to management that ensure that we can continue to provide access to high-quality affordable healthcare. Subjecting such changes to the material modification process could significantly impede our ability to make necessary changes to our operations. We recommend using the definition as it appears in R.I. Gen. Laws § 27-18.8-3(b)(3).

[1] Providence Water Supply Board v. Public Utilities Commission, 708 A.2d 537, 543 (R.I. 1998). The Court differentiates between exercising permissible authority (regulating an industry in order to ensure that its rates are fair and reasonable) and exercising impermissible authority (managing the regulated entity by actually "exercis[ing] the prerogatives of ownership") (citing Blackstone Valley Electric Co. v. Public Utilities Commission, 543 A.2d 253, 255 (R.I. 1988). See, also, United Transit Co. v. Nunes, 209 A.2d 215, 222 (R.I. 1965); New England Telephone and Telegraph Co. v. Public Utilities Commission, 358 A.2d 1, 13 (R.I. 1976).

9.4 General Requirements – Certification, Recertification, and Material Change

To be consistent with R.I. Gen. Laws § 27-18.8-3(a)(2), BCBSRI recommends adding that the Commissioner will act upon the healthcare entities' completed application for certification of network plans within ninety (90) days of receipt of the application for certification.

9.6 Network Plan General Requirements

9.6 (A) (3)

The requirement for an annual communication proposed in this section is not included in any part of R.I. Gen. Laws § 27-18.8, and creates a mailing that would be burdensome, costly and irritating to most members and providers, who already complain about the volume of notices they receive from plans. The information this notice is intended to provide is distributed in numerous other ways, subject to multiple other requirements. For example, the ACA requires issuers to provide members with a Summary of Benefits and Coverage (SBC), which includes high-level language explaining how to file grievances and complaints, at enrollment, renewal, and upon request. The same information is also required to be included in the member's subscriber agreement/certificate of coverage. Detailed information regarding appeals is also required to be provided to members with every adverse benefit determination. Providers separately have access to this information in numerous ways, including provider manuals and policies online. Because we provide the required information in other notices, which arrive when the information is relevant, this proposed annual notice is duplicative and unnecessary. Members and providers continue to voice concerns about the costs of unnecessary mailings, and this proposed requirement would cost approximately $48,000 annually for a mid-size issuers.

We recommend that this provision be removed, or if retained, that it be revised to require that the information be posted on the insurers' website in an easily accessible location for both beneficiaries and providers, and available in writing upon request.

9.6 (C)

BCBSRI requests that the definition of formulary changes in this section be revised to remove section (C)(2)(c), cost sharing. As written, this proposal appears to expand the definition of formulary changes to include any change in cost sharing, which expands the requirements as to provider input and notice of formulary change.

While providers are responsible for important input into formulary tiering, they should not be involved in decisions around cost sharing. The cost sharing assigned formulary tiers is determined by multiple, non-medical factors, including the requirement that individual and small group market plans meet specific actuarial value (AV) levels. Requiring that plans allow providers input into cost sharing brings them into final plan design, which is outside their medical subject matter expertise.

In addition, in requiring 30-day notice for formulary cost share changes, the proposed regulation suggests that plans are expected to provide notification at renewal if the member's prescription cost sharing changes. Today, members get a required notice of benefit change at renewal, which identifies the change to their cost sharing on all of their benefits, including the prescription drug benefit. Additionally requiring a separate notice for drug cost sharing changes would result in a significant cost and administrative burden for a mailing which duplicates other required notifications.

For these reasons, we recommend removing cost sharing from the definition of formulary changes.

9.7 Network Adequacy Requirements

9.7 (A) (3) (a)

BCBSRI understands that there are times when a member may need to see a non-network provider as the services are not available through a participating provider, and in those cases, we authorize the service, and apply the member's in-network benefit.

We nonetheless object to the proposed requirement in Section 9.7(A)(3)(a) to hold the member harmless in those situations. As the Commissioner is aware, this subject has been a topic of significant attention and debate at the General Assembly for several years, without any enactment resulting. No authority has been specifically granted to OHIC to implement such a significant policy, and doing so in this regulation is a significant expansion of the network adequacy requirements in R.I. Gen Laws § 27-18.8-3(b), which address access to providers, not member cost sharing.

In fact, this requirement has the potential for significant unintended consequences that harm both members and providers. It could result in substantially increased medical costs, which drive up premiums. Specifically, it incents providers ***not*** to contract with insurers since they can demand higher rates under a hold harmless policy. Insurers will have no leverage to negotiate with a non-network provider, who understands the insurer is required to hold the member harmless. And it provides no controls as to what a non-network provider can charge, which is why if this kind of policy is to be implemented, it should be done through a legislative enactment that applies equally to insurers and providers. While the intent of this provision appears to be consumer protection, we believe the unintended consequence will be to the detriment of consumers through loss of affordability and choice.

BCBSRI requests that this requirement be modified to require that the service be covered as an in-network service in these situations, but without further requiring that the member be held harmless. Without clear guidelines for payment rate and to whom the payment obligation runs, such hold harmless requirements would have tremendous negative impacts to members and providers, and essentially subject issuers to non-network providers' demands, no matter how unreasonable.

9.7 (C) (1) (d)

BCBSRI objects to this provision, which purports to impose on a new insurer the obligation to provide continuity of care to a new enrollee. This is a significant expansion of the provision in R.I. Gen. Laws § 27-18.8-3(d)(10), which only applies when an existing member is affected by a provider terminating his or her contract with an insurance company. There is no statutory authority for such a provision that addresses situations far more comprehensive than provider contract terminations; therefore, BCBSRI requests that bullet (d) be deleted from this section.

9.7 (D) (2) (c) (3)
The provider directory and online provider finder are consumer tools designed to identify providers who are participating in a plan's network. The language of this section presents significant administrative challenges to the extent it appears to require that a plan identify admitting privileges to non-network facilities. This information is not currently available, is impractical to collect and maintain, and would lead to customer confusion, as these tools are explicitly for the purpose of identifying in-network providers. We request this be amended to reflect that the directory need only identify admitting privileges at in-network facilities.

9.7 (D) (3) (c)
BCBSRI requests that the words "all formats" be removed from the beginning of this section. We agree fully that provider directory information must be made available in a format accessible to individuals with limited English proficiency and/or those with disabilities; however, it may be impractical to make both paper and electronic formats available in such a manner. We recommend that this be accomplished upon the request of a member in a format designed to ensure that the member is able to access the information he/she needs in order to make a provider selection.

9.7 (D) (4)
BCBSRI recommends deleting "paper directories" from this section. Provider directories are quite voluminous, and, almost instantly upon printing are out of date. We share the goal of ensuring that members are provided up-to-date provider information; however, we suggest that requiring that paper copies of the directory be updated monthly would add significant and unnecessary costs to the system. Practically speaking, in the modern world, individuals are looking for more immediate support for their provider selections. Waiting for a paper copy of a complete provider directory is impractical for them. Instead, we suggest that this provision provide that the network plan must provide an up-to-date paper copy of the directory upon request. We note that consumers and members are generally looking for a particular provider and or type of provider and customer service representatives are able to assist them with the requested information in the area they are looking for in a paper or an electronic format. This approach ensures that they are getting the information they need and the most up-to-date information.

9.7 (D) (5)
BCBSRI agrees that it is important for members to understand how to obtain information about participating providers. However, we object to the requirement to include this information on a member's identification (ID) card. The ID card is not an effective tool for providing this information. First, the ID card is small, and has numerous required elements under existing law already crowding its margins. Second, detailed information about how to find providers is conveyed during enrollment and at renewal through the summary of benefits and coverage and the subscriber agreement. Third, the primary source for information regarding the provider network as well as information on all aspects of a member's plan is customer service, and the ID card provides clear information on how to access our representatives. In the interest of keeping ID cards simple and easy to use, we ask that the requirement to include information about how to obtain a provider directory be removed.

9.8 Professional Provider Credentialing and Re-Credentialing

For the reasons further described in these comments, BCBSRI believes that expanding the credentialing requirements to include re-credentialing processes has the unintended consequence of adding administrative burden for insurers and providers. We also note that while R.I. Gen. Laws § 27-18.8-3(d) does address the credentialing process, statutory construction requires that the more specific provisions of R.I. Gen. Laws §§ 27-18-83; 27-19-74, and 27-41-87, which directly describe requirements for provider credentialing, control. Therefore, we recommend that this section be revised to ensure consistency with R.I. Gen. Laws §§ 27-18-83, 27-19-74, and 27-41-87.

9.8 (A) (4)

The industry standard for insurers is to automatically re-credential providers without requiring them to re-apply. In this automatic re-credentialing process, insurers only outreach to providers when missing information is needed. As written, this section of the proposed regulation establishes required procedures inconsistent with such industry practices, which creates unnecessary work and potential interruption in participation for providers and insurers – ultimately putting network adequacy at risk. Industry standard processes generally, and in particular those processes currently employed by BCBSRI, may not require any action on the part of the provider in order to be re-credentialed. BCBSRI recommends that this section be revised to clearly indicate that if a plan has a re-credentialing process, network plans have an established mechanism to assure effective communications with in network professional providers. For example, this could be accomplished by stating that (4) (a) only applies when information from the provider is required during the re-credentialing process.

9.8 (C)

This provision appears to be an expansion of the statutory language at R.I. Gen. Laws § 27-19-74(f), which provides for transitional/conditional/temporary approval to resident graduates who otherwise submit a completed application, by adding OHIC authority to apply a similar obligation when OHIC determines there is a "need." This proposed extension lacks statutory support, and fails to establish criteria for such a determination. We request that this section be revised to adopt only transitional approval for resident graduates, consistent with the statute.

9.8 (D)

BCBSRI is concerned that this requirement, limiting what insurers can request from providers, impedes the ability of insurers to credential providers effectively and to ensure quality and safety for our members. We agree that the listed items are generally the types of information that may be required to credential a provider, but object to the prohibition (not supported by statute) against requesting additional information. We request that this requirement be deleted and that section 9.8 (A) (2) be expanded to require that criteria include, but not be limited to, the items identified.

9.9 Provider Contracting and Due Process

9.9 (A) (1) (a)

BCBSRI objects to this section in that it requires members be held harmless for failures in the referral process. No authority has been granted to OHIC under R.I. Gen Laws § 27-18.8 to address member cost sharing, where the purpose of the chapter is to "ensure accessibility and

quality for the state's patients." R.I. Gen. Laws § 27-18.8-1(1). In fact, it could be argued that this section is contrary to that objective, in that it could ultimately encourage specialists to turn patients away. Holding members harmless, while in appearance a member-protective rule, has unintended consequences that can harm both members and providers.

Referral-based plans are the norm in many jurisdictions across the country. To the best of our knowledge, in those jurisdictions, the member is held responsible for ensuring that he/she obtains a referral from his/her provider. While the expanded availability of referral-based plans in Rhode Island is new to providers here, that should not change the basic mechanisms of how they function within a plan. We must encourage the adoption of these plans as a mechanism to engage consumers in their care and to drive improved quality and affordability.

We request that this section be removed. If the section remains, we request that it be revised to specify that the member should only be responsible for their cost-sharing and not be held harmless from all costs due to the mistake of the referring physician.

9.9 (A)(3)

Consistent with our comments on section 9.7, BCBSRI objects to the proposed requirement in Section 9.9(A)(3) to hold the member harmless. As the Commissioner is aware, this subject has been a topic of significant attention and debate at the General Assembly for several years, without any enactment resulting. In addressing the issue through regulation, when legislation this past year was considered and debated by multiple stakeholders, OHIC not only oversteps the bounds of the enabling legislation, but it substantially discounts the complexities of the issue, and the potential for damaging unintended consequences for providers, payers, and patients. More work needs to be done to arrive at a solution that addresses the issue comprehensively, and BCBSRI is committed to doing that work with OHIC and other stakeholders through the legislative process. While we object to this section in its entirety, we offer the following specific comments.

This section purports to establish a standard to trigger obligations based on what is a "reasonable time" for communications to happen at the network facility. It is unclear how "reasonable time" may be assessed – that is, whether the measure should be taken by what would be reasonable to a patient, a family member, a facility administrator, a nurse, a physician, or others.

Part (a) is particularly problematic. Specifically, it incents providers ***not*** to contract with insurers since they can demand higher rates under a hold harmless policy. It has the potential of resulting in significant increased costs, which drive up premiums. Insurers will have no leverage to negotiate with a non-participating provider and there are no existing controls as to what an out of network provider can charge – which is why if this policy is to be implemented, it should be done through a legislative enactment that applies equally to insurers and providers. While the intention of this provision appears to be consumer protection, we believe the unintended consequence will be to the detriment of consumers through loss of affordability and choice.

Part (b) raises a concern about applicability. It purports to impose an obligation on network facilities to inform the beneficiary of the out-of-network status of the provider. It is unclear how this part would be applied or enforced against a facility that fails to provide this notice. While BCBSRI shares the goal of this role for network facilities, without an enforcement mechanism, the protection of the provision here seems to be illusory and it should be deleted.

Blue Cross shares the Commissioner's concerns regarding surprise billing and addressing the primary concerns: what scenarios constitute surprise billing, the obligation of facilities, the appropriate cost sharing, and what rate providers must accept to avoid balance billing members. We are concerned an OHIC regulation does not, and likely cannot, adequately resolve the full scope of the surprise billing situation.

***

I hope you find these comments useful. If you have any questions or require additional information, please contact Kim Holway at Kimberly.holway@bcbsri.org or 401-459-5502.

Sincerely,

Monica Neronha

Monica A. Neronha
Vice President, Legal Services

MetLife, Inc.
5 Park Plaza, Suite 1850
Irvine, CA 92620

Crystal McElroy
Assistant Vice President
Supplemental Product
Compliance and Regulatory

October 5, 2018

Ms. Alyssa R. Metivier,
Department of Business Regulation (includes the Office of the Heath Insurance Commissioner)
Office of the Health Insurance Commissioner
1511 Pontiac Ave.
Cranston, RI 02920

RE: Proposed Rule 230-RICR-20-30-9 Network Plans

Dear Ms. Metivier,

On behalf of Metropolitan Life Insurance Company ("MetLife"), I wish to inform you that we have reviewed the requirements of 230-RICR-20-30-9 and while we understand the need to require health care entities operating a network plan to submit a recertification application every two years, there are a number of requirements listed in the proposed rule that we must oppose and we ask the Department to consider alternatives to the way the rule is currently written.

9.6 Network Plan General Requirements

A. For each network plan the health care entity must maintain and submit to the Office its most current grievance and complaint process that adheres to and includes the following minimal requirements:

> 3. At a minimum, an annual communication from the applicable health care entity to the network plan's beneficiaries and providers that explains the grievance and complaint process for the applicable network plan(s) and provides guidance for distinguishing between a complaint/grievance and a benefit determination appeal and the rights associated with each.

It is important that both the network plan's beneficiaries and providers are made aware of the plan's grievance and complaint processes and are provided guidance for distinguishing between a complaint/grievance and a benefit determination appeal and the rights associated with each. However, we feel that requiring "an annual communication" even when none of the processes or guidance relating to grievances, complaints, and benefit determinations have changed would lead to confusion for our beneficiaries and providers.

MetLife requests that the Department considers revising the "annual communication" requirement to requiring health care entities to include this information in the plan disclosure documents provided to beneficiaries and providers when they initially join the network plan and then requiring that this information also be included with the Explanation of Benefits document that the parties receive when services are provided. We believe that providing this information when they initially join the plan and then when benefits are provided ensures that beneficiaries and providers are receiving information on complaints, grievances, and benefit determinations at the most impactful and necessary times rather than just with an annual required mailing.

9.8 Professional Provider Credentialing and Re-credentialing

A. Each health care entity's professional provider credentialing and re-credentialing requirements, policies and processes must be submitted to the Office and must adhere, at a minimum, to the following.

7. The effective date for billing privileges shall be the next business day following the date of approval of a credentialing application.

We believe that requiring the effective date for billing privileges to be the next business day following the date of approval of a credentialing application does not take into account the work effort and time it takes a dental office to update their internal systems to accommodate the new network relationship. Section 9.8 provision A.6 requires a health care entity to inform an applicant that their credentialing or re-credentialing application is complete within five business days of deeming it complete. We believe that revising the timeframe listed in A.7 to more closely match the timing requirements in A.6 would be more appropriate.

Thank you for considering our proposed alternatives to the above requirements. We look forward to discussing our concerns and comments with you and your staff. Please feel free to contact me at 949-437-2750 or cmcelroy@metlife.com.

Sincerely,

Crystal McElroy
Assistant Vice President
Supplemental Product Compliance and Regulatory

Neighborhood Health Plan OF RHODE ISLAND™

910 Douglas Pike, Smithfield, RI 02917 : 1-800-963-1001 : nhpri.org

October 5, 2018

Alyssa R. Metivier
Department of Business Regulation
Office of the Health Insurance Commissioner
1511 Pontiac Ave
Cranston, RI 02920

Dear Ms. Metivier:

Neighborhood Health Plan of Rhode Island (Neighborhood) appreciates the opportunity to provide comments to the Office of the Health Insurance Commissioner (OHIC) concerning the proposed rules for Network Plans. Neighborhood's comments center on the proposed approach to address the issue of surprise or balance billing. This is understood as a process in which out of network providers provide services through in-network facilities and bill consumers directly for the total cost of services provided. While Neighborhood is eager to protect consumers from this practice, we feel the proposed solution would fail to address the issue.

Neighborhood opposes the approach to surprise billing described under sections **9.7 Network Adequacy Requirements** and **9.9 Provider Contracting and Due Process** for the following reasons:

1. **Surprise billing is a limited issue in Rhode Island:** Numerous hearings and public testimony, including from OHIC, have reaffirmed the fact that to date, this issue has been reported on relatively few occasions in Rhode Island. Neighborhood as well as the other major insurers in the state work to resolve disputes with providers and protect consumers when these events occur.
2. **Language is an ineffective mechanism to protect consumers:** Neighborhood appreciates the discretion available to define the appropriate mechanism; however insurers have limited ability through contracting to enforce a mechanism with providers for which there is no contractual relationship. In-network providers such as hospitals also face limitations on their ability to enforce a prohibition of surprise billing depending on the nature of relationship with these providers.
3. **Potential for negative market impact:** The mechanism proposed in this legislation would create incentives for providers to remain out of network and demand higher rates. This demand for higher rates will undoubtedly increase the cost of premiums paid by consumers in the state.

Neighborhood suggests the following alternative courses of action:

1. **Incentives to participate in networks**: Neighborhood will support a solution that provides incentives for providers to remain or join health plan networks as opposed to creating permanent alternative avenues for payment that permit them to remain as high cost outliers.
2. **Seek to amend licensure requirements:** One potential suggestion would be to amend licensure requirements for large provider entities, enhancing their ability to prevent out of network providers from directly billing a consumer with health insurance.

3. **Await comprehensive legislation:** The language could be placed on hold until comprehensive surprise billing legislation makes its way through the Rhode Island General Assembly. Further guidance could be issued by the appropriate executive branch agency at this time.

Please contact me at (401) 459-6679 or EMcClaine@nhpri.org with any questions regarding these comments. Thank you for your consideration.

Sincerely,

Elizabeth McClaine
Director of Operations & Strategy, Commercial Products

RHODE ISLAND BUSINESS GROUP ON HEALTH

October 5, 2018

Alyssa R. Metivier
Department of Business Regulation
Office of the Health Insurance Commissioner
1511 Pontiac Avenue
Cranston, RI 02920

Dear Ms. Metivier,

I am writing on behalf of the RI Business Group on Health representing 90 companies with over 80,000 employees to express our opposition to proposed changes in regulations dealing with surprise billing that are contained in the draft regulation on Network Plans, 230-RICH-20-30-9, specifically section 9.9. This letter focuses on section 9.9 of the proposed regulation because we believe it has the greatest risk of disrupting networks and dramatically increasing premiums.

Over the last few years, the issue of surprise billing has grown to the point where national consumer organizations, such as Consumers Union, have launched programs to educate consumers and to help advise organizations at the state level on how to craft effective legislative and regulatory solutions. During 2017, RIBGH called attention to this growing problem by inviting Consumers Union to present on surprise billing at our Annual Healthcare Summit for that year. Many business and community leaders attended including Commissioner Ganim. During the 2018 session of the Rhode Island General Assembly, RIBGH partnered with Consumers Union to provide analysis of bills emanating from both houses of the RI General Assembly. Consumers Union wrote several memos in opposition, voicing strong concern with surprise billing legislation proposed by members of the Rhode Island House and Senate. In doing so, Consumers Union detailed common features necessary for creating a cost-effective solution for surprise bills. These should similarly be considered for any regulatory proposal:

1. A requirement that providers inform consumers whether they are in-network or out-of-network, in a way that preserves meaningful consumer choice.
2. A requirement that deductibles, co-payments, co-insurance, and other out-of-pocket costs are the same for unanticipated and emergency out-of-network care as they are for in-network care.
3. A provision creating a well-defined payment schedule for out of network surprise bills that does not increase premiums or undermine existing in-network contractual agreements. The surprise billing payment schedule should increase the pressure on out-of-network providers to be in-network.

4. A provision instituting a ban on "balance billing" that explicitly protects consumers from receiving or have to pay unavoidable or inadvertent out-of-network charges known as "balance bills."

The draft regulation on Network Plans, 230-RICR-20-30-9, specifically section 9.9 represents a faulty approach because it fails to address items 3 and 4. More specifically, the proposed regulation limits the subscriber's financial liability for a surprise medical bill to the amount that would be paid for a comparable in-network service without limiting the amount charged by the out-of-network provider. This change puts the insurer in the position of having to pay the charges of providers who are not influenced by the usual market pressures that create the incentive for most physicians to accept in-network fees. The insurers will have no leverage negotiating these fees which are significantly higher than negotiated rates. The net result will be a predictable increase in health insurance premiums.

The second highly problematic concern is that as out-of-network physicians and providers of other services are successful in using this regulation to get their high, out-of-network, fees paid by insurers, then we are at risk for other in-network groups trying to pursue the same course of action. This would be particularly catastrophic because more than 90% of physicians in this state accept in-network fees.

We respectfully request that you consider the wealth of research available detailing solutions that will not impact premiums or harm networks. I would be happy to share this material with you.

Thank you for providing the opportunity to comment on this proposed change in regulations.

Sincerely,

Albert Charbonneau
Executive Director

Alyssa R. Metivier
Department of Business Regulation
Office of the Health Insurance Commissioner
1511 Pontiac Avenue
Cranston, RI 02920

October 3, 2018

RE: Proposed Network Plan Regulations (230-RICR-20-30-9)

Dear Ms. Metivier,

The undersigned members of the Rhode Island Business Coalition (RIBC) would like to comments on the Network Plan Regulations proposed by the Office of the Health Insurance Commissioner (OHIC). The RIBC is a diverse group of business associations representing nearly every major company and industry sector within Rhode Island. As an organization, the RIBC is committed to the adoption and implementation of public policies that improve Rhode Island's economic competitiveness and overall business climate.

Overall, the proposed Regulations laudably complement the Health Care Accessibility and Quality Assurance Act's emphasis on patient and provider protection, network adequacy, and quality assurance. We note, however, that certain of their provisions address those objectives in ways that are less cost efficient than could be.

For example, the provisions of proposed Section 9.6.A(3) that effectively require health insurance carriers to make an annual paper mailing to their members explaining their grievance process could just as easily and effectively be accomplished by just a prominent, permanent display on the carrier's website. Redundant paper mailings are an outmoded – and unnecessarily expensive – approach to communicating this type of information.

The same is true with respect to the proposed requirement of Section 9.7.D.5 of the Regulations that health plan identification cards be utilized to communicate information to members concerning provider directories, in addition to being found on the carrier's website. The repetitive production and mailing of identification cards for health insurance purposes is increasingly falling out of favor in the health care industry altogether. And research relating to a health plan's participating providers is almost universally conducted by accessing the health plan's website.

Finally, we have concerns regarding the dramatically reduced time that health plans will have to research and properly resolve complaints, including quality of care complaints. Whereas the current regulations provide for this to be done within 60 business days after the receipt of necessary information, the proposed regulations would reduce that timeframe to 30 calendar days, without regard to the receipt of necessary information. The multi-layered nature of the health benefits delivery and financing system carries with it a similarly multi-layered process for getting to the bottom of quality issues. Our concern is that an unreasonably accelerated complaint resolution process for the investigation and disposition of quality complaints will itself suffer in terms of quality outcomes.

We appreciate OHIC's continued service to Rhode Island's employers and consumers, and for the opportunity to provide these comments.

Sincerely,

American Council of Engineering Companies, Rhode Island – Marcel A. Valois, Executive Director

Associated Builders and Contractors of Rhode Island – Maureen E. Grillo, President

New England Business Association (formerly SBANE) - Robin L. Main, Chair; Ralph Coppola, Chair RI Government Affairs Committee

Northern Rhode Island Chamber of Commerce – John C. Gregory, President/CEO

Rhode Island Business Group on Health – Donald Nokes, President

Rhode Island Mortgage Bankers Association – Dean Harrington, President

Rhode Island Small Business Economic Summit – Grafton Willey, Tax and Budget Committee Chairman

Rhode Island Society of Certified Public Accountants – Robert A. Mancini, President

RHODE ISLAND BUSINESS GROUP ON HEALTH

October 5, 2018

Alyssa R. Metivier
Department of Business Regulation
Office of the Health Insurance Commissioner
1511 Pontiac Avenue
Cranston, RI 02920

Re: Proposed Network Plan Regulations
(230-RICR-20-30-9)

Dear Ms. Metivier:

I am writing on behalf of the RI Business Group on Health representing 90 companies with over 80,000 employees to express our opposition to proposed changes in regulations dealing with surprise billing that are contained in the draft regulation on Network Plans (230-RICR-20-30-9).

RIBGH's mission is to assist Rhode Island employers of all industries and sizes in navigating the ever-changing health care marketplace, and in getting the most from their health care investment. We support initiatives that align with our members' goals of reducing overall health care costs while maintaining or improving quality.

Overall, the proposed Regulations laudably complement the Health Care Accessibility and Quality Assurance Act's emphasis on patient and provider protection, network adequacy, and quality assurance. We note, however, that certain of their provisions address those objectives in ways that are less cost efficient than could be.

For example, the provisions of proposed Section 9.6.A(3) that effectively require health insurance carriers to make an annual paper mailing to their members explaining their grievance process could just as easily and effectively be accomplished by just a prominent, permanent display on the carrier's website. Redundant paper mailings are an outmoded – and unnecessarily expensive – approach to communicating this type of information.

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industry altogether. And research relating to a health plan's participating providers is almost universally conducted by accessing the health plan's website.

Finally, we have concerns regarding the dramatically reduced time that health plans will have to research and properly resolve complaints, including quality of care complaints. Whereas the current regulations provide for this to be done within 60 business days after the receipt of necessary information, the proposed regulations would reduce that timeframe to 30 calendar days, without regard to the receipt of necessary information. The multi-layered nature of the health benefits delivery and financing system carries with it a similarly multi-layered process for getting to the bottom of quality issues. Our concern is that an unreasonably accelerated complaint resolution process for the investigation and disposition of quality complaints will itself suffer in terms of quality outcomes.

We appreciate OHIC's continued service to Rhode Island's employers and consumers, and for the opportunity to provide these comments.

Sincerely,

Albert D. Charbonneau
Executive Director

In The Matter Of:

DBR Hearing

Network Plan Regulation Public Hearing
September 24, 2018

ALLIED
COURT REPORTERS, INC.
AND
VIDEO CONFERENCE CENTERS