

**STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street, 24th Floor
San Francisco, California 94105**

FINAL STATEMENT OF REASONS

**PROVIDER NETWORK ACCESS STANDARDS
FOR HEALTH INSURANCE POLICIES AND AGREEMENTS**

(also known as **Network Provider Provisions
In Health Insurance Policies And Agreements**)

OAL Notice File Number: Z-06-1114-04

CDI File Number: RH05043720

November 21, 2007

PROCEDURAL HISTORY

On November 22, 2006, the Department of Insurance gave notice of the proposed adoption of amendments to California Code of Regulations (“CCR”) Title 10, Chapter 5, Subchapter 3, Article 6, sections 2240, 2240.1, 2240.2, 2240.3, and 2240.5, as well as the proposed adoption of a new section, section 2240.5. Notice of the proposed regulatory action was published in the California Regulatory Notice Register on November 24, 2006.

The notice stated that the proposed changes and new section would implement the provisions of Insurance Code section 10133.5, as amended by Assembly Bill 2179, by requiring that health insurers that contract with providers for alternative rates pursuant to Insurance Code section 10133 demonstrate compliance with accessibility and availability standards regarding access to covered health care services, including continuity of care, and further requiring these insurers file network access measurement documents that demonstrate compliance with the proposed standards in these regulations with the Department of Insurance along with other related documents including sample provider contracts.

On September 21, 2007, and again on October 24, 2007, after considering public comments on regarding the proposed regulation, the Department of Insurance made available for public inspection changes to the regulation text as initially proposed. The changes were sufficiently related to the rulemaking as originally noticed such that a reasonable member of the directly affected public could have determined from the original notice that these changes could have resulted. (Cal.Code Regs., tit. 1, §42.)

The specific purpose of each change to the proposed regulation and the rationale for the Commissioner’s determination that each change is reasonably necessary to carry out the purpose for which it is proposed is set forth below.

TITLE 10, CHAPTER 5, SUBCHAPTER 3, ARTICLE 6

SUBSTANTIVE CHANGES

Title of Section

PURPOSE

The title of these regulations was changed from “Network Provider Provisions In Health Insurance Policies And Agreements” to “Provider Network Access Standards For Health Insurance Policies And Agreements,” for greater clarity.

NECESSITY AND RATIONALE

The Commissioner determined that the revised name was clearer, and made more specific reference to “access,” which is at the core of Insurance Code section 10133.5(a).

SECTION 2240. Definitions

This proposed section modified the pre-existing definitions of the EPO regulation, broadening the definitions so as to make them applicable to all provider network arrangements, including PPOs.

2240(a): “Basic Health Care Services”

PURPOSE

The introductory paragraph was modified to clarify that the definition applied to “covered health care services provided for in the applicable insurance contract.” In addition, the word “issued” was deleted from 2240(a)(8), as superfluous.

NECESSITY AND RATIONALE

This amendment was made in response to concerns reflected in comments received from interested parties that the definition might include services not covered by the insurance contract. The Commissioner has determined that this amendment is necessary to clarify that the definition applies only to covered health services.

The word “issued” in proposed paragraph (8) is superfluous, and has no meaning in the context of the sentence. It is necessary that it be deleted in order to enhance the clarity and readability of the paragraph.

AUTHORITY AND REFERENCE

Insurance Code section 10133.5.
2240(b): “Certificate”

PURPOSE

“Group” was added to the phrase “a group insurance contract.”

NECESSITY AND RATIONALE

Deletion of the term “group” was necessary to ensure clarity, as there could be contracts other than group contracts to which this definition could apply. “A” was changed to “an” to conform to standard grammar.

AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

2240(f): “Network Provider”

PURPOSE

This regulation applies to all network provider arrangements, including “leased networks” in which insurers may contract with entities that have separately contracted with providers and aggregated the providers into a network. To clarify that this regulation applies to a “leased network,” and other contractual arrangements involving an intermediary, the term “with the insurer” was stricken from the proposed regulation.

NECESSITY AND RATIONALE

The Commissioner has determined that the legislative intent in enacting Insurance Code section 10133.5, that “all enrollees of health care service plans and health insurers have timely access to health care” (emphasis added), requires that these amended regulations apply to both networks established through direct contracts between the insurer and providers, as well as to networks in which the insurer contracts with an intermediary. Accordingly, this change is necessary in order to clarify that the amended regulation applies to all such contracts, in order to achieve the intent of Insurance Code section 10133.5.

AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

2240(g): “Network Provider Services”

PURPOSE

The amendment to this paragraph of the existing regulation removed additional words

(“only” and “an exclusive”) that applied only to “exclusive providers” and therefore only Exclusive Provider Organizations, and replaced them with the term “network provider” in order to clarify that the definition applied to all network provider services.

NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires the Commissioner to promulgate regulations that apply to health insurers that contract for services at alternative rates, creating provider networks. The proposed amendments clarified the scope of the definition, consistent with the broad scope of section 10133.5.

AUTHORITY AND REFERENCE

Authority: Insurance Code section 10133.5.

2240(j): “Insurer”

PURPOSE

As a result of the first 15-day public comment period, the term “who provides health insurance” was added to clarify the reference to Insurance Code section 106(b).

NECESSITY AND RATIONALE

This amendment is necessary for clarity because Insurance Code section 106(b) defines “health insurance,” not “health insurer.”

AUTHORITY AND REFERENCE

Authority: Insurance Code section 10133.5. Reference: Insurance Code sections 106(b) and 10133.5.

(former) 2240(k): “Material Modification”

PURPOSE

As a result of public comment, this definition was deleted, because it was not subsequently used in the regulation and was, therefore, surplusage.

NECESSITY AND RATIONALE

“Material modification” was defined in the existing regulation, but was not subsequently used in the substantive portion of the regulation. It is necessary that it be deleted in order to achieve greater clarity.

AUTHORITY AND REFERENCE

Authority: Insurance Code section 10133.5.

2240(l): “Primary covered person”

PURPOSE

The term “under a group contract because of his or her membership in a group” in existing EPO regulation was inadvertently not deleted in the first amended text of the regulation. This amendment to the definition broadened the definition to extend beyond group coverage.

NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires the Commissioner to promulgate regulations that apply to health insurers that contract for services at alternative rates, creating provider networks; it is not limited to group coverage. Therefore, it is necessary to modify this definition in order for the scope of the definition to be consonant with the broader scope of section 10133.5. It is necessary to delete the prior phrase, limiting the scope of the definition to group only, in order to accomplish this.

AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

2240(m): “Service Area”

PURPOSE

Comments received during the public comment periods expressed concern that the revised definition of “service area” could include network arrangements outside of California, or to services not covered by the insurance policy in question. To address these concerns, the definition was modified to clarify that the term “service area” includes only the state of California, or smaller geographic areas within California, and does not apply to network arrangements outside California. Further, the definition was amended to clarify that it applied only to benefits covered under the insurance policy.

NECESSITY AND RATIONALE

This change in the definition of “service area” is necessary in order to clarify that the definition of “service area” applies only to networks within California, as the Department does not have jurisdiction over networks outside the state.

AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

SECTION 2240.1. Adequacy and Accessibility of Provider Services.

PURPOSE

Amendment adding 2240.1 (a)

In response to comments received, the Commissioner amended the proposed regulation to clarify that the regulation applied to “health insurance” policies as defined by Insurance Code section 106(b). Further, based on comments regarding the impact of the proposed regulation on dental-only and vision-only plans, the proposed regulation was amended to exclude such plans from its requirements.

Amendments to 2240.1(b)

The proposed amendment to this subdivision was modified to clarify that the regulation applied to “network” provider services [2240.1(b)], and to eliminate the surplus phrase “physicians or other” from 2240.1(b)(2). Also, former section 2240.1(b)(6), which applied to institutional exclusive providers and had nonspecific language pertaining to expectations, was deleted, as it has been superseded by the more specific requirements of 2240.1(c). Further, former 2240.1(b)(7), now proposed (b)(6), has been modified to clarify that the subdivision requires that insurers must assure that basic health care services are accessible through network providers, consistent with the access requirements of Insurance Code section 10133.5(a).

Amendments to 2240.1(c)

As originally proposed, the amendments to this section included provisions to address the situation faced by insureds that do not have timely access to needed health care services due to the lack of a contracted provider offering the health care needed by the insured. These amendments included requirements that insurers provide care through non-network providers at network rates if the standards could not be met, as well as an exemption for “physical impossibility.” In response to comments, these proposed sections (sections 2240.1(b)(7) and (8)) were deleted because of concerns that such a provision would serve as a disincentive for providers to contract with insurers, thereby frustrating the intent of Insurance Code section 10133.5, which seeks to assure access to needed health care through those insurers which contract with providers for alternative rates. Instead, a discretionary waiver provision was substituted [now, 2240.1(c)(7)], to provide for a discretionary review and exemption from the provisions of this regulation if an insurer is unable to meet these standards.

Amendments to 2240.1(d)

The proposed amendment was revised to clarify that the regulation applied to all network provider services, not just exclusive provider services. The amendment was also revised to make the reference to the Commissioner gender-neutral, and to correct an existing error in the citation to the Knox-Keene Health Care Service Plan Act.

NECESSITY AND RATIONALE

Amendment adding 2240.1 (a)

Based on comments regarding the impact of the proposed regulation on dental-only and vision-only plans, the Commissioner determined that the imposition of the minimum hour requirements and time and distance standards applicable to policies that offer comprehensive hospital, medical, and surgical coverage would impact dental-only and vision-only policies, and the providers with whom they contract, to an extent that could adversely affect the availability of these services, contrary to the intent of Insurance Code section 10133.5. The Commissioner therefore determined to exempt vision-only and dental-only policies of supplemental health insurance from the requirements of the proposed regulation, with the intent to revisit the issue of access standards for such policies at the time of the triennial review of these regulations, pursuant to Insurance Code section 10133.5(g).

Amendments to 2240.1(b)

The proposed amendments to this subdivision are necessary in order to achieve improved clarity.

Amendments to 2240.1(b)

The proposed amendment to this subdivision was modified to clarify that the regulation applied to “network” provider services [2240.1(b)], and to eliminate the surplus phrase “physicians or other” from 2240.1(b)(2). This amendment is necessary for clarity. Also, former section 2240.1(b)(6), which applied to institutional exclusive providers and had nonspecific language pertaining to expectations, was deleted, as it has been superseded by the more specific requirements of 2240.1(c). This amendment is necessary for clarity. Further, former 2240.1(b)(7), now proposed (b)(6), has been modified to clarify that the subdivision requires that insurers must assure that basic health care services are accessible through network providers, consistent with the access requirements of Insurance Code section 10133.5(a). This amendment is necessary in order to bring the existing section into conformance with the broader scope of Insurance Code section 10133.5.

Amendments to 2240.1(c)

As originally proposed, the amendments to this section included provisions to address the situation faced by insureds that do not have timely access to needed health care services due to the lack of a contracted provider offering the health care needed by the insured. These amendments included requirements that insurers provide care through non-network providers at network rates if the standards could not be met, as well as an exemption for “physical impossibility.” In response to industry comments, these proposed sections (sections 2240.1(b)(7) and (8)) were deleted because of concerns that such a provision would serve as a disincentive for providers to contract with insurers, thereby frustrating the intent of Insurance Code section 10133.5, which seeks to assure access to needed health care through those insurers which contract with providers for alternative rates. Instead, a discretionary waiver provision was

substituted [now, 2240.1(c)(7)], to provide for a discretionary review and exemption from the provisions of this regulation if an insurer is unable to meet these standards. The Commissioner has determined that such a discretionary waiver alternative is necessary to accommodate those circumstances where the time and distance standards cannot be met for a justifiable reason, as is particularly necessary regarding networks in sparsely populated rural areas, a consideration mandated by Insurance Code 10133.5(c).

Amendments to 2240.1(d)

The proposed revisions, clarifying that the regulation applied to all network provider services, not just exclusive provider services, to make the reference to the Commissioner gender-neutral, and to correct an existing error in the citation to the Knox-Keene Health Care Service Plan Act, are necessary for clarity.

AUTHORITY AND REFERENCE

Authority Section 10133.5, Insurance Code. Reference: Sections 106(b), 10133, 10133.5, Insurance Code.

SECTION 2240.3: Provisions of Certificates.

PURPOSE

Comments received during the public comment period noted that the requirement in existing section 2240.3(c)(2) that requires certain disclosure be made in red print would impose a burden on insurers who do not presently use color in the production of their group contracts. The requirement for red font was deleted. Also, the surplus word “state” was deleted from 2240.3(c)(2).

Also, public comments regarding 2240.3(d) noted that this existing provision would only apply to EPOs, not PPOs and other network types. Accordingly, it was modified so that such a disclosure provision would only be needed if it were applicable to the network type of the policy in question. Further, the term “exclusive” was deleted, and replaced by “network.”

An extraneous reference citation was also deleted.

NECESSITY AND RATIONALE

Comments received during the public comment period noted that the requirement in existing section 2240.3(c)(2) that requires certain disclosure be made in red print would impose an burden on insurers who do not presently use color in the production of their group contracts. The requirement for red font was deleted. The Commissioner determined that this change was necessary, in order to avoid costs that would not result in a commensurate increase in health care access. Deletion of the surplus word “state” was necessary for clarity.

Section 2240.3(d) was modified to make clear that it had limited application. Also,

deletion of “exclusive” and the substitution of “network” were necessary for clarity and consistency.

AUTHORITY AND REFERENCE

Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133, 10133.5, and 10133.56, Insurance Code.

SECTION 2240.4: Contracts with Providers.

PURPOSE

The modifications to the proposed amended regulation provided for an effective date (June 30, 2008), in response to comments received during the public comment period. Further, 2240.4(a) was modified to include contracts between network providers and the agents of insurers; this revision was made to clarify that the provisions of this section apply to arrangements such as leased networks, as well as to direct contracts between insurers and providers. The term “provider” was removed from 2240.4(a)(2), as it did not add meaning to the sentence. The term “network” was added to 2240.4(a)(3) to make it clear that the provision applied to network services, consistent with the remainder of the revised regulation. The term “any basis” was removed from 2240.4(a)(5), as it was extraneous in that usage. Sex and health insurance coverage were added to the non-discrimination provision of 2240.4(a)(5), as discrimination on the basis of these factors would also impair the ability of insureds to access needed health care services in a timely manner. The term “handicap” was removed in favor of “disability,” the preferred usage.

An extraneous reference citation was also deleted.

NECESSITY AND RATIONALE

The modifications to the proposed amended regulation provided for an effective date (June 30, 2008), in response to comments received during the public comment period. Further, 2240.4(a) was modified to include contracts between network providers and the agents of insurers; this revision was done to clarify that the provisions of this section apply to arrangements such as leased networks, as well as to direct contracts between insurers and providers. The term “provider” was removed from 2240.4(a)(2), as it did not add meaning to the sentence. The term “network” was added to 2240.4(a)(3) to make it clear that the provision applied to network services, consistent with the remainder of the revised regulation. The term “any basis” was removed from 2240.4(a)(5), as it was extraneous in that sentence. All of these modifications were necessary for clarity.

The Commissioner determined that sex and health insurance coverage should be added to the non-discrimination provision of 2240.4(a)(5), as discrimination on the basis of these factors would also impair the ability of insureds to access needed health care services in a timely manner. Adding these factors was therefore necessary in order to effectuate the intent of Insurance Code section 10133.5. The term “handicap” was removed in favor of “disability,” a

preferred usage.

AUTHORITY AND REFERENCE

Authority: Section 10133.5, Insurance Code. Reference: Sections 10133, and 10133.5 Insurance Code.

SECTION 2240.5. Filing and Reporting Requirements

PURPOSE

The proposed new section originally required that all accessibility reports be in the form of a “GeoAccess” report, is a report generated by the proprietary software of a particular company. The proposed section was thereafter revised to instead describe what the report should include (number and location of all network providers, demonstration of compliance), rather than specifying the particular software to be used. In order to provide an example of a report type that would be acceptable, GeoAccess GeoNetworks software is mentioned as an example. However, this software product is no longer described as a means of compliance, and any report, generated by any software or method that complies with the specified requirements is clarified to be acceptable.

In response to comments received during the public comment period, a requirement of the filing of an affidavit or attestation acknowledging compliance with this regulation was added.

The proposed new section originally required insurers to report annually regarding both complaints received by the insurer and complaints received by providers. Upon consideration of comments received during the public comment period, the language of the section was modified to delete the requirement of provider complaints. As amended, the regulation now requires that insurers provide the complaints that they receive. Also, the section originally proposed that insurers report data regarding complaints based on a number of categories, including services for persons with limited English abilities, diagnostic services, and others. Based on comments received during the public comment period, the Department determined that different criteria were necessary.

NECESSITY AND RATIONALE

The proposed new section originally required that all accessibility reports be in the form of a “GeoAccess” report, a report generated by the proprietary software of a particular company. The proposed section was thereafter revised to instead describe what the report should include (number and location of all network providers, demonstration of compliance), rather than specifying the particular software to be used. In order to provide an example of a report type that would be acceptable, GeoAccess GeoNetworks software is mentioned as an example. However, this software product is no longer described as a means of compliance, and any report, generated by any software or method that complies with the specified requirements is clarified to be acceptable. The Commissioner has determined that this change is necessary in order to facilitate insurer compliance with Insurance Code section 10133.5 by not limiting the insurers to a single means of preparing compliance reports.

In response to comments received during the public comment period, a requirement of the filing of an affidavit or attestation acknowledging compliance with this regulation was added. The Commissioner determined that this addition was necessary in order to facilitate review of the submitted materials by the Department.

The proposed new section originally required that insurers report annually regarding both complaints received by the insurer and complaints received by providers. Upon consideration of comments received during the public comment period, the language of the section was modified to delete the requirement of provider complaints. As amended, the regulation now requires that insurers provide the complaints that they receive. This change is necessary in order to bring the reporting requirement into alignment with the requirements of Insurance code section 10133.5, which specifies that complaints received by the insurer need be provided. Also, the section as originally proposed required that insurers report data regarding complaints based on a number of categories, including services for persons with limited English abilities, diagnostic services, and others. Based on comments received during the public comment period, the Commissioner determined that different criteria were necessary, criteria, as set forth in the amended regulation, more closely aligned with the focus in 10133.5 on needed health care services, while still specifying categories of data that will facilitate the Department's reporting under Insurance Code section 10133.5(e).

AUTHORITY AND REFERENCE

Authority cited: Section 10133.5, Insurance Code Reference: Section 10133, 10133.5

NON-SUBSTANTIVE CHANGES

Section 2240(g) was amended to delete the characters "f1", which were a typographical misprint without substantive significance. In proposed section 2240.5 (c), the citation to section 2240.1(c) (1), (2), and (3) incorrectly listed the citation as 2240.1(b)(1)(2)(3), the designation that the section had before an additional section was added to 2240.1. The citation has been corrected to reflect the updated numbering system in 2240.1. Also, 2240.5(c) incorrectly had the words "Insurance Code" prior to the citation of the regulatory section, 2240.1(c) (1),(2), and (3).

In the context of the paragraph, the citation is plainly a reference to a section of the regulation. There is no Insurance Code section 2240.1. Accordingly, this extraneous phrase "Insurance Code" was removed.

In certain of the proposed regulations, some citations to Insurance Code sections (other than to section 10133.5 and 10133) appear in the text of the regulation, but were not referred to in the "Authority and Reference" line. This omission was corrected.

UPDATED INFORMATIVE DIGEST

An Updated Informative Digest has been filed concurrently, as a separate document, with this Final Statement of Reasons.

UPDATE OF MATERIAL RELIED UPON

No material other than that presented in the initial statement of reasons has been relied upon by the Department of Insurance.

MANDATE ON LOCAL AGENCIES OR SCHOOL DISTRICTS

The Department has made a determination that adoption, amendment or repeal of the regulation does not impose a mandate on local agencies or school districts. The regulation has nothing to do with local agencies or school districts; it neither requires nor prohibits action on their part.

REASONABLE ALTERNATIVES TO THE REGULATIONS; IMPACT ON SMALL BUSINESS

The Commissioner has identified no reasonable alternatives to the presently proposed regulations, nor have any such alternatives otherwise been identified and brought to the attention of the Department of Insurance, that would be more effective in carrying out the purpose for which the amended regulations are proposed, or which would lessen any impact on small business, than the proposed regulation.

ALTERNATIVES:

The Commissioner must determine that no reasonable alternative considered by the Commissioner or that has otherwise been identified and brought to the attention of the Commissioner would be more effective in carrying out the purposes for which the regulations are proposed or would be as effective as and less burdensome to affected private persons than the proposed regulations. The Commissioner invited public comment on alternatives to the regulations with the November 22, 2006 Notice of Proposed Action and Notice of Public Hearing. These regulations are mandated by Insurance Code section 10133.5. While many comments submitted during the rulemaking resulted in revisions to these regulations, no alternatives to the regulation (including alternative to lessen any adverse economic impact on small businesses), other than those reflect in the comments during the rulemaking proceeding, were presented to or considered by the Commissioner.

After a review of the alternatives presented, the Commissioner has determined that no alternative would be more effective in carrying out the purpose for which the regulations are proposed, or would be as effective and less burdensome to affected private persons or small businesses than the proposed regulations. (Government Code section 11346.9(a)(4).)

SUMMARY OF AND RESPONSE TO OBJECTIONS OR RECOMMENDATIONS

A verbatim recital of each written and oral comment, objection, and/or recommendation received during the public comment period and the response to each is attached hereto.

The following descriptive codes are used to describe the written comments:

- “L” denotes “Letter.” Each piece of correspondence bears a unique “L” number.
- “C” denotes “comment.” Each category of comment topic within each letter is identified.
- The numeric sequence for comments starts a “1” for each letter.

To ease review, the comments have been grouped in the following descriptive categories. The section numbers in the category headings are those used in the most recent version of the proposed regulation, the version that accompanied the October 24, 2007 notice:

- 1) Overall Concerns Relating to EPO vs. PPO Policies
- 2) 2240(a) Definition of “Basic Health Care Services”
- 3) 2240(b) Definition of “certificate”
- 4) 2240 Definition of “covered benefits”
- 5) 2240(c) Definition of “covered person”
- 6) 2240(e) Definition of “Emergency Health Care Services”
- 7) 2240(f) Definition of “Network Provider
- 8) 2240(g) Definition of “Network Provider Services”
- 9) 2240(h) Definition of “Non-Network Provider Services”
- 10) 2240(j) Definition of “Insurer”
- 11) (former) 2240(k) Definition of “Material Modification”
- 12) 2240(k) Definition of “Primary Care Physician”
- 13) 2240(l) Definition of “primary covered person”
- 14) 2240(m) Definition of “Service Area”
- 15) 2240(n) Definition of “Network”
- 16) 2240 additional comments re: definitions
- 17) 2240.1 Adequacy and Accessibility of Provider Services
- 18) 2240.2 Insurance Contract Provisions
- 19) 2240.3 Provisions of Certificates
- 20) 2240.4 Contracts with Providers
- 21) 2240.5 Filing & Reporting Requirements
- 22) Comparison with DMHC regulation
- 23) Other Concerns

Subsequent 15-day Notice Periods

Subsequent to the initial 45-day notice period, the proposed regulation was subsequently amended over two 15-day comment periods.

First 15-day notice:

The first 15-day comment period began September 21, 2007 and ended October 9, 2007. The proposed amendments were limited to the following:

- Title: Changing title of regulation (“Provider Network Access Standards”)
- 2240(a) definition of “basic health care services”
- 2240(a)(8) elimination of extraneous word (“issued”)
- 2240(b) elimination of reference to “a group”
- 2240(f) definition of “network provider”
- 2240(g) definition of “network provider services”
- 2240(j) definition of “insurer”
- 2240(k) [former proposed section] deletion of definition of “material modification”

2240(l) definition of “primary covered person”
2240(m) regarding the definition of “service area”
2240: changing subdivision lettering to conform to changes, correcting Authority note.
2240.1 (a) incorporating definition of “health insurance” [Ins.C.§ 106(b)], excluding vision-only, dental-only
2240.1 (b) clarifying applies to network services, and, in subdiv.(2), clarifying scope of supervision
2240.1(b)(6) deleting references to “exclusive”
2240.1(c)
 (1),(2) grammatical changes
 (5) change from “needed” to “covered” services
 (7) revised discretionary waiver provision
2240.1(d) change to “network” to reflect scope of regulation, grammatical and gender-neutral changes, correction of Health & Safety citation
2240.1 changing subdivision lettering to conform to changes, correcting Authority note
2240.2(d) add “insurance” to clarify nature of contract
2240.3(c) grammatical change
2240.3(c)(2) deleting surplus word (‘state’), delete requirement of red print
2240.3(d) clarifying applies to network providers
2240.3 correcting Authority note
2240.4 clarifying effective date, contract requirements, Authority note
2240.5(a) clarifying reporting requirement, adding affidavit of compliance
2240.5(b) grammar correction
2240.5(e) revision of categories for complaint reporting

Second 15-day Notice:

The second 15-day comment period began October 24, 2007 and ended November 8, 2007. The proposed amendments were limited to the following:

2240(m) regarding the definition of “service area”
2240.1(b)(6) regarding administrative/professional staffing ratios
2240.1(b)(6) [formerly (b)(7)], regarding access to basic health care services through network providers
2240.1(c) regarding network provider services
2240.3(d) regarding service areas restricted to network providers
2240.5(a)(3) correction of citation
2240.5(e) regarding reporting of consumer complaints

Regulations for Provider Network Access Standards for
Health Insurance Policies and Agreements

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
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Topic 1: Overall Concerns Relating to EPO vs. PPO Policies

<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment letter January 11, 2007 (L1, C1)</p>	<p>2240</p>	<p>One of our chief concerns is that the Department has chosen to amend existing regulations that currently apply to Exclusive Provider Organizations to instead apply to all provider network arrangements. However, the Department has not recognized key differences between open access networks, such as Preferred Provider Organizations (PPOs), and closed network arrangements, such as EPOs.</p> <p>...a chief difference is that PPOs do not limit insureds to a service area. Instead, insureds not only can access in-network providers anywhere in California, but many plans provide limited networks outside of California as well. Many of the provisions of the proposed regulations impose requirements that would only make sense within a closed provider network / service area construct. Many other provisions appear to incorporate health care service plan concepts that may be appropriate and authorized by the Knox-Keene Act (Section 1340 et seq. of the Health and Safety Code) but are outside the authority of the Insurance Code. With this in mind, we would offer the following specific comments:</p>	<p>The Commissioner respectfully rejects this comment. The statute authorizing these regulations applies to all health insurers who contract with providers for alternative rates. See §10133.5(a). All health insurers define a service area in the policies they issue, even if it's the State of California, as in most PPO products. As a result, all geographic areas within the State of California where a health insurer offers and sells coverage will be subject to the timely access regulations., unless the insurer has described a different service area in the issued policy. In addition, if an insurer has no insureds in a service area that is a sub-set of California and/ or they do not sell health insurance in certain sub-set geographic areas of California, those insurers do not have any obligation to meet these regulatory requirements in those defined service areas.</p> <p>For the calendar year 2005, EPO policies covered only 10,000 people out of a total of 2.7 million people covered by health insurance policies regulated by CDI in California. EPO insureds lives continue to decline each year in California as so-called closed network arrangements are discontinued.</p>
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RH 05043720
 Regulations for Provider Network Access Standards for
 Health Insurance Policies and Agreements

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
			<p>Current regulations require every insurance contract to include a provision defining the service area. See §2240.2(e). The Commissioner has determined that adopting different timely access standards for different health insurance products covering basic health care services would be inconsistent with the intent of Insurance Code section 10133.5.</p> <p>See the most recent change to the proposed regulations in Definitions §2240 (m) which defines “Service Area” .</p>
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (7:20-10:3)</p>	<p>2240</p>	<p>Well, good morning. It's been a couple of years since we first started discussing these regulations, and it's good to have an opportunity to put those final touches on them with you.</p> <p>What I've submitted to you today, Mr. Hinze, and Ms. Asturias and Ms. Rosen, is a comment letter of 0008 ours as well as some proposed changes to the regulations to address some of the things we mention in our letter. What we're hoping to do is use this as a constructive time to talk about some things that we've been working on this issue too.</p> <p>Ever since AB2179 went into effect and we supported that regulation, or that law, we've looked at trying to figure out how best to implement that for PPOs.</p> <p>The concept of adequacy of network has been primarily associated with closed network systems like HMOs, and in fact the EPO regulations that have been amended to incorporate changes made by AB2179 of 2002 attempt to try and take the EPO regulations and add other types of network arrangements to them.</p>	<p>The Commissioner respectfully rejects this comment by adopting the response to Ms. Eowan’s written comment, located in the response cell immediately above.</p>

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		<p>What we'd like to do is maybe propose an alternative to that.</p> <p>We recognize that the Department is attempting and making a very good faith effort in trying to figure out how to implement AB2179 within an indemnity system, within a PPO network system, and so we hope that our comments today will be helpful in trying to figure that out together, because frankly PPO networks have not had that kind of focus in terms of adequacy of network. They tend to have 70,000 to 100,000 providers in them, and so adequacy of network has not so much been an issue, and in fact few states have even addressed this</p> <p>0009 issue when it comes to PPO networks.</p> <p>So, we're all kind of taking a stab at this in California, and so we hope that our letter as well as our proposed changes to the regulations will be helpful in that regard.</p> <p>What I have here is three documents in front of me. One is our letter, one is the regulations as they're being proposed, and then also our proposed revisions to those regulations. And you'll notice that what we've done is tried to carve out for these regulations a separate regulation from the EPO regulations that were put into effect, I don't know, it was before my time, so it was probably 20 years ago or more.</p> <p>EPO's exclusive provider organizations as you know are a closed system, you can't go outside the network of providers, and so when those regulations were adopted by the Department, it -- although they're not the same as capitated medical group HMO systems, they are limited to a closed network, and so</p>	

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		<p>our concern about the regulations that simply amend those EPO regulations is that there are certain things related to a closed system that are not appropriate for an open network system like a PPO where you can go in or out of the network depending on whether or not, you 0010 know, it's up to the insured to figure out whether or not they want to do that based on whether or not they want to pay in network or out of network cost sharing.</p>	
Topic 2: 2240(a) Definition of “Basic Health Care Services”			
<p>Anne Eowan, Association of California Life & Health Insurance Companies. Comment letter January 11, 2007 (L1, C2)</p>	2240(a)	<p><u>Defining “basic health care services” lacks authority.</u> Section 2240 (a) defines “basic health care services” for purposes of requiring insurers to make such services available during prescribed hours (see Section 2240.1 (a) (4). We would note that there is no authority to define “basic health care services” in the authorizing statute, nor is there any provision in the Insurance Code relating to health insurers which provides this authority. By defining “basic health care services,” the Department has exceeded its authority and has potentially created a presumption that additional benefits must be provided to insureds that are not always covered benefits. For example, California law limits the type and kind of preventive care that must be covered under a health insurance contract to prescribed children’s immunizations and screenings and adult cancer screenings. The regulation appears to require coverage for all types of</p>	<p>The Commissioner respectfully rejects this comment. The proposed regulations do not create any presumption of what services will or will not be covered and they do not address any of the issues regarding mandated or optional benefits. This regulation defining basic health care services existed prior to the proposed amendments implementing the timely access to health care statute. To further clarify that the timely access to health care standards in the proposed regulations only apply to covered health care services, the definition of basic health care services in §2240(a) has been modified to specify that basic health care services is limited to covered health care services as provided for in the insurance contract. The authorizing statute requires that access standards be</p>

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		<p>preventive care. Home health care is a mandatory <u>offer</u> in statute, and not a mandatory benefit. The Department has included <u>all</u> mental health services, not just those that are required by Insurance Code 10144.5. Finally, the Department has included any other benefit or services that are covered under a health insurance contract, which could include services not required by law, but are optional for the purchaser.</p>	<p>specified and applied to health care services covered by a health insurance contract.</p>
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (10:4-11:25)</p>	<p>2240</p>	<p>Some of our comments are a lot -- are high priority and some of them are not, so, but it might be helpful to you, particularly since I may be the -- one of the few commenters today, to maybe take the time to go through and talk about what our issues are, and maybe form a dialogue and see if we're understanding the regulations correctly and that sort of thing.</p> <p>Starting with the definition section, you'll notice in our proposed regulations we don't have a definition of "basic health care services"; that's because there is no term such as "basic health care services" in the Insurance Code. That was an HMO term out of the Knox-Keene Act that seemed to have been pulled over into the original EPO regs.</p> <p>I think what you mean to say here rather than "basic health care services" is just the health care services that they're talking about in 10133.5 where you have to ensure access for needed health care 0011 services. The way we're seeing this used here though and how it's used in the rest of the document, it appears as if it's requiring coverage for these basic services and setting a standard called "basic services" and regulation when there isn't any statutory authority to do that.</p> <p>So, what we're suggesting instead is using the</p>	<p>The Commissioner respectfully rejects this comment by adopting the response to Ms. Eowan's written comment, located in the response cell immediately above.</p>

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		<p>term "covered benefits" because your covered benefits are what the health care services that you would be using, but there's no definition of "covered benefits," that's what gives us some pause here, because without this relating to just those services that are covered under your contract, it appears as if we're expanding the mandated benefits in the Code; for example home health services, that's a mandated offer, not everybody buys it.</p> <p>Mental health services, you've attached it to the requirements of the Insurance Code there, but later in the document it's any mental health services, so there's some confusion that's related without that caveat that we're talking about, covered benefits, so that's something that we did, is you'll notice I have a definition of "covered benefits" in this, and that kind of takes into effect all your health care services, so that's why we use that term.</p>	
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (12:9-13:4))	2240	<p>Just looking at the definitions here, if you decide to use some definitions for "health care services" in there, and we would hope that you would connect that with covered benefits, we're not sure in (a)(8) what "supportive services" are, so you may want to be clearer about that, but I would point out that the term "basic" is a real concern for us.</p> <p>Then we've kind of tried to put some of the definitions together because we have "covered persons," we have "dependent covered persons" which are already included in subdivision (c), and we have "primary covered persons." I'm not sure since we're changing it from a group, actually you'll probably want to amend that up at the top too, changing this from</p>	<p>The Commissioner respectfully rejects this comment by adopting the response to Ms. Eowan's written comment, located two response cells above.</p>

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		group to just individual and group, not limited just to group, which is the original EPO law or regs were limited to group. 0013 I don't know if you need "certificate holders" anymore because certificate holders are the enrollees under a group contract, and so there may be some terms here you don't need and I haven't included them here.	
JP Wieske, The Council for Affordable Health Insurance, Comment Letter January 11, 2007 (L3, C2)	2240(a)	<p>Basic Health Care Services While definition of “basic health services” only requires “any” of the following specific items to meet the definition, we still feel the definition is overly broad. Included in the definition are services that are not mandated and may not be covered by some health plans. For example, while many network plans cover some preventative services, others plans do not. Home health care services are a mandated offer, rather than a mandated coverage and some plans provide no coverage at all. The problem with the overly broad definition is that it appears to require networks to offer access to providers, whether the services are covered or not.</p> <p>We would suggest replacing later references to “basic health care services” with “covered basic health care services.”</p>	<p>The Commissioner respectfully rejects this comment, for the reasons set forth regarding the comment of Ann Eowan, ACLHIC, above (L1,C2) regarding the definition of basic health services, which reasons are here adopted by reference.</p> <p>Basic health care services has been further specified to refer only to covered health services. The issue of mandated v. offered benefits is outside the scope of these regulations and not relevant.</p>

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<p>Eric C. DuPont MetLife Comment letter January 11, 2007 Public Hearing (L4, C1)</p>	<p>2240(a)</p>	<p>MetLife offers the following suggestions with regard to the proposed amendments to §2240 – Definitions:</p> <ol style="list-style-type: none"> 1. <u>“Basic health care services” - §2240(a)</u>. MetLife Dental believes that the proposed definition of “basic health care” is overly broad and its use is lacking in statutory authority, as it does not appear to be used in the authorizing statute or elsewhere in the Insurance Code. As currently defined in the proposed amendments, the use of the term “Basic health care services” will result in limited benefit insurance plans being required to provide coverage for services that are outside of the scope of the insurance contract. Further, this proposed definition is inconsistent with Sec. 10133.5(b)(2), which directs the department to “consider the nature of the speciality in determining the adequacy of professional providers.” For example, §2240(a)(8), as presently written, with the phrase “any other health care or supportive services that are covered issued pursuant to an insurance contract,” would likely require that a standalone dental plan or “accident only” insurance policy cover ambulance services. Should the Department determine it has the statutory authority to define “Basic health care services” and include the term in the final regulation, MetLife Dental suggests that §2240(a)(8) be amended. If §2240(a)(8) were amended to read “any other health care services that are covered and issued pursuant to a basic health care services insurance contract,” it would tighten the definition to recognize that some insurance policies do not cover all “health care or supportive services.” 	<p>The Commissioner respectfully rejects this comment. The Department’s definition of basic health care services does not address the question of required or mandated benefits. Mandated coverage is outlined elsewhere in the Insurance Code. Further, the Department has limited this definition to covered services. Further, the Department has excepted limited benefit plans such as vision only and dental only from these regulations. Please see proposed 2240.1(a).</p>

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Leanne Gassaway, CIGNA Companies Testimony at public hearing January 11, 2007 (51:16-25)	2240(a)	Secondly, I would like to emphasize the definition of "basic health care service," and that has -- Anne commented very extensively on that, and we would ask that that be removed as it has no statutory basis, and in fact there are significant things in that definition that are not mandated benefits, and so we would ask that that term be moved to "covered services" or "covered benefits" or something that is aligned with the kind of contract that is required under the Insurance Code.	The Commissioner has adopted this comment in part and modified the definition of "basic health services" to clarify that it refers to "covered health services."
	Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007		
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007	2240(a)	We recommend that the definition for "basic health care services" be deleted and replaced with a definition for "covered benefits" "Covered benefits" means health care services for medical and/or behavioral health benefits covered under the policy or contract for network providers. <u>Rationale:</u> The statute (Section 10133.5 (b) requires that there is accessibility of provider services for benefits covered under the contract. To provide clarity and prevent misinterpretation as to what services may or may	The Commissioner respectfully rejects this comment, having determined that the revised definition, which utilizes the term " <u>covered health care services</u> " (emphasis added) addresses these concerns, and also satisfies the requirements of Insurance Code section 10133.5.

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(L6A, C1)		not be covered benefits, the definition utilized needs to be unambiguous and refer to the policy or contract.	
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C2)	2240(a)	Summary: <i>PacifiCare recommends deleting subdivisions (a)(1)-(a)(8)</i>	The Commissioner respectfully rejects this comment, as the subdivisions (1) are already a part of the existing regulation, and (2) give greater specificity and clarity to the definition.
Topic 3: 2240(b) Definition of “certificate”			
Anne Eowan, Association of California Life & Health Insurance Companies. Attachment to Comment letter January 11,	2240(b)	<i>(alternative language proposed by comment author)</i> (a) "Certificate" means an individual or family certificate of coverage issued pursuant to a health insurance contract.	The Commissioner respectfully rejects this comment, which seeks to include “health” prior to the word insurance, because this proposed regulation already explicitly states that it pertains to health insurance, as defined by Insurance Code 106(b), at proposed 10 CCR 2240.1(a).

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2007 (L1A, C1)			
Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007			
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C3)	2240(b)	We recommend the following revised language: "Certificate" means an individual or family certificate of coverage issued pursuant to <u>a health</u> insurance contract. <u>Rationale:</u> To provide clarity and ensure consistency with the term "health insurance" as defined in section 106 (b) of the insurance code.	The Commissioner respectfully rejects this comment, which seeks to include "health" prior to the word insurance, because this proposed regulation already explicitly states that it pertains to health insurance, as defined by Insurance Code 106(b), at proposed 10 CCR 2240.1(a).
Topic 4: 2240 Definition of "covered benefits"			
Anne Eowan, Association of California Life & Health Insurance	No corres- ponding section in	<i>(alternative language proposed by comment author)</i> (b) "Covered benefits" means health care services for medical and/or behavioral health benefits covered under the policy or contract for network providers.	The Commissioner respectfully rejects this comment, as the definition of "basic health care services" in 2240(a) incorporates a definition of covered services.

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Companies. Attachment to Comment letter January 11, 2007 (L1A, C2)	regulation		
Topic 5: 2240(c) Definition of “covered person”			
Anne Eowan, Association of California Life & Health Insurance Companies. Attachment to Comment letter January 11, 2007 (L1A, C3)	2240(c)	<i>(alternative language proposed by comment author)</i> (c) "Covered person" means either a primary covered person or a dependent covered person eligible to receive benefits under the health insurance contract providing network provider services for medical benefits.	The Commissioner respectfully rejects this comment, having determined that the definition provided in the proposed regulation, which incorporates the “basic health services” definition of 2240(a), more appropriately addresses the mandate of Insurance Code section 10133.5(b).
Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007			

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Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C4)	2240(c)	We recommend the following revised language: (c) "Covered person" means either a primary covered person or a dependent covered person eligible to receive <u>benefits</u> under the <u>health</u> insurance contract providing network provider services <u>for medical benefits</u> . <u>Rationale:</u> We recommend deleting the definition of "basic health care services" and any reference to in the regulation and add "health" to ensure consistency with section 106(b).	The Commissioner respectfully rejects this comment, which seeks to include "health" prior to the word insurance, because this proposed regulation already explicitly states that it pertains to health insurance, as defined by Insurance Code 106(b), at proposed 10 CCR 2240.1(a).
Topic 6: 2240(e) Definition of "Emergency Health Care Services"			
Sheree Kruckenberg, , California Coalition of Mental Health Comment letter January 11, 2007 L2, C3)	2240(e)	(e)We have added language to the definition of "emergency health care services" so that it adequately reflects the current community definitions used for individuals suffering from acute mental illnesses.	The Commissioner respectfully rejects this comment. The proposed regulations are not intended to expand the existing general definition of emergency health care services nor is this necessary to accomplish the purpose of the timely access regulations. The purpose of the proposed regulations is to establish timely access to health care standards. The Department has added §2240 (a)(7) to further specify that mental health care services are now included in the definition of basic health care services and will be subject to timely access standards as defined.

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Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007 (L5A, C1)	2240(e)	(e) "Emergency health care services" means health care services rendered for any condition in which the covered person is in danger of loss of life or serious injury or illness or is experiencing severe pain and suffering. <u>This includes any person who, as a result of a mental disorder, is a danger to him/herself or others, or is gravely disabled.</u>	
Topic 7: 2240(f) Definition of “Network Provider”			
Anne Eowan, Association of California Life & Health Insurance Companies. Attachment to Comment letter January 11, 2007 (L1A, C4)	2240(f)	<i>(alternative language proposed by comment author)</i> (d) “Network provider" means an institution or a health care professional that renders covered benefits to covered persons pursuant to a contract with the health insurer to provide such services at alternative rates.	The Commissioner respectfully rejects this comment. This comment seeks to define “network provider” in terms of “covered benefits” for “covered persons.” The Commissioner has determined that defining the term in terms of “health care services” for “covered persons” is more appropriate in terms of the focus of Insurance Code section 10133.5 on “insureds” and “needed health care services.”

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Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007 (L5A, C2)	2240(f)	<i>(alternative language proposed by comment author</i> (f) " Exclusive <u>Network</u> provider" means an institution or a health care professional which renders exclusive provider <u>health care</u> services to covered persons under a group contract pursuant to a <u>current</u> contract with the insurer to provide such services at alternative rates.	The Commissioner respectfully rejects this comment, having determined that adding "current" is superfluous to this definitional section.
Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007			
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C5)	2240(f)	We recommend the following revised language: "Network provider" means an institution or a health care professional that renders <u>covered benefits</u> to covered persons pursuant to a contract to provide such services at alternative rates. <u>Rationale:</u> To ensure consistency with the statute (Section 10133.5 (b) which requires that there is accessibility of provider services for <u>benefits covered</u> under the contract.	The Commissioner respectfully rejects this comment. This comment seeks to define "network provider" in terms of "covered benefits" for "covered persons." The Commissioner has determined that defining the term in terms of "health care services" for "covered persons" is more appropriate in terms of the focus of Insurance Code section 10133.5 on "insureds" and "needed health care services."

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	Comments received during second 15-day comment period October 24, 2007 – November 8, 2007		
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Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13, C2)	2240(f)	Specifically, with the new definition of “service area,” the following inconsistencies and challenges arise: Section 2240 (f) & (g) - While the definition of "network provider" is not limited to providers in the "service area", "network provider services" means only those covered services that are rendered by network providers <u>within the service area</u> . That implies that there may be network providers that provide in-network services outside of the service area that are <u>not</u> "network provider services". There are options for insureds to get in-network rates outside of California under many health insurance policies. Thus, the definition of “network provider” should mean a provider that renders <u>covered</u> health care services to covered persons <u>within a service area</u> pursuant to a contract to provide such services at alternative rates. <u>However, this requirement should only apply to network providers within California.</u>	
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Topic 8: 2240(g) Definition of “Network Provider Services”

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<p>Anne Eowan, Association of California Life & Health Insurance Companies. Attachment to Comment letter January 11, 2007</p> <p>(L1A, C5)</p>	2240(g)	<p><i>(alternative language proposed by comment author)</i> (e) "Network provider services" means covered benefits that are covered under a health insurance contract only when rendered by a network provider within the service area.</p>	<p>The Commissioner respectfully rejects this comment. This comment seeks to define "network provider services" in terms of "covered benefits." The Commissioner has determined that defining the term in terms of "health care services" is more appropriate in terms of the focus of Insurance Code section 10133.5 on "insureds" and "needed health care services."</p>
<p>Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>			
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p> <p>(L6A, C6)</p>	2240(f)	<p>We recommend the following revised language: "Network provider services" means <u>covered benefits</u> that are covered under a <u>health insurance</u> contract when rendered by a network provider within the service area. <u>Rationale:</u> To ensure consistency with the statute (Section 10133.5 (b) which requires that there is accessibility of provider services for <u>benefits covered</u> under the contract and add "health" to ensure consistency with section 106(b) of the insurance code.</p>	<p>The Commissioner respectfully rejects this comment. This comment seeks to define "network provider services" in terms of "covered benefits." The Commissioner has determined that defining the term in terms of "health care services" is more appropriate in terms of the focus of Insurance Code section 10133.5 on "insureds" and "needed health care services." Further, because this proposed regulation already explicitly states that it pertains to health insurance, as defined by Insurance Code 106(b), at proposed 10 CCR 2240.1(a).</p>

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	Comments received during second 15-day comment period October 24, 2007 – November 8, 2007		
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Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13, C2[repeated])	2240(g)	Specifically, with the new definition of “service area,” the following inconsistencies and challenges arise: Section 2240 (f) & (g) - While the definition of "network provider" is not limited to providers in the "service area", "network provider services" means only those covered services that are rendered by network providers <u>within the service area</u> . That implies that there may be network providers that provide in-network services outside of the service area that are <u>not</u> "network provider services". There are options for insureds to get in-network rates outside of California under many health insurance policies. Thus, the definition of “network provider” should mean a provider that renders <u>covered</u> health care services to covered persons <u>within a service area</u> pursuant to a contract to provide such services at alternative rates. <u>However, this requirement should only apply to network providers within California.</u>	
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Topic 9: 2240(h) Definition of “Non-Network Provider Services”

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COMMENTER	SECTION	<p style="text-align: center;">VERBATIM COMMENT</p> <p style="text-align: center;">(All mistakes in text appear in original)</p>	<p style="text-align: center;">CDI RESPONSE</p>
<p>Anne Eowan, Association of California Life & Health Insurance Companies. Attachment to Comment letter January 11, 2007</p> <p>(L1A, C6)</p>	2240(h)	<p><i>(alternative language proposed by comment author)</i> (f) "Non- network provider services" means covered benefits delivered by a health care provider who is not contracted with the insurer either directly or indirectly.</p>	<p>The Commissioner respectfully rejects this comment. This comment seeks to define "network provider services" in terms of "covered benefits." The Commissioner has determined that defining the term in terms of "health care services" is more appropriate in terms of the focus of Insurance Code section 10133.5 on "insureds" and "needed health care services."</p>
<p>Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>			
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p> <p>(L6A, C7)</p>	2240(h)	<p>We recommend the following revised language:</p> <p>"Non- network provider services" means covered <u>benefits</u> delivered by a health care provider who is not contracted with the insurer either directly or indirectly.</p> <p><u>Rationale:</u> To ensure consistency with the statute (Section 10133.5 (b) which requires that there is accessibility of provider services for <u>benefits covered</u> under the contract</p>	<p>The Commissioner respectfully declines to respond to this comment, as it falls outside the scope of the proposed amendment. There was no amendment to 2240(h) proposed during the comment period that ended October 9, 2007.</p>

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Topic 10: 2240(j) Definition of “Insurer”

<p>Anne Eowan, Association of California Life & Health Insurance Companies. Attachment to Comment letter January 11, 2007</p> <p>(L1A, C7)</p>	2240(j)	<p><i>(alternative language proposed by comment author)</i> (g) "Insurer" means a health insurer as defined in Section 106 (b) that provides network provider services for covered benefits to covered persons under health insurance contracts.</p>	<p>The Commissioner respectfully rejects this comment, noting that the proposed regulation already incorporates the definition of “health insurance” defined in Insurance Code section 106(b). This comment seeks to define “insurer” in terms of “covered benefits.” The Commissioner has determined that defining the term with reference to Insurance Code 10133 is more appropriate, as Insurance Code section 10133.5(a) makes specific reference to this section.</p>
<p>Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>			
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter</p>	2240(j)	<p>We recommend the following revised language:</p> <p><u>"Insurer" means a health insurer as defined in Section 106 (b) that provides network provider services for covered benefits to covered persons under health insurance contracts.</u></p> <p><u>Rationale:</u> To ensure consistency with section 106 (b) of</p>	<p>The Commissioner respectfully rejects this comment. The proposed provision was modified to include “who provides health insurance as defined in Section 106(b)”. This more accurately achieves consistency with Insurance Code section 106(b) than does the alternative suggested by the correspondent, as Section 106(b) defines “health <u>insurance</u>”, not “health insurer.”</p>

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COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
October 9, 2007 (L6A, C8)		the insurance code.	
Topic 11: (former) 2240(k) Definition of “Material Modification”			
Anne Eowan, Association of California Life & Health Insurance Companies. Comment letter January 11, 2007 (L1, C4)	Former 2240(k)	<u>The term “Material Modification” lacks authority / clarity / necessity.</u> Section 2240 (k) defines “material modification” to mean those changes – presumably to a contract - that a reasonable covered person would consider important regarding timely access to appropriate health care. Again, there is some construct under HMO regulations for “material modifications” to health care service plan contracts. However, there is no parallel definition or statutory reference for health insurers. It is unclear how this definition is necessary in the regulation, or how such a vague standard could be applied with any predictability or consistency.	The Commissioner has considered this comment, and has adopted it in part. As a result, this provision has been stricken from the proposed regulations.
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing	Former 2240(k)	I've skipped over "material modification," that's a term that is -- has a meaning on the Knox-Keene side, but there's no definition and statute for it, and then it's not used in the regulation at all. You use the term "material changes" to a contract, and I think we understand what that means, but material modification is not used, and you may want to get rid of that as a redundant thing.	The Commissioner has considered this comment, and has adopted it in part. As a result, this provision has been stricken from the proposed regulations.

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COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
January 11, 2007 (14:14-21)			
Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007			
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C9)	[former 2240(k)]	Agree with deletion.	The Commissioner acknowledges this agreement with the deletion of this clause.
Topic 12: 2240(k) Definition of “Primary Care Physician”			
Anne Eowan, Association of California Life & Health Insurance	2240(k)	<i>(alternative language proposed by comment author)</i> (h) "Primary care physician" means a physician who is responsible for providing initial and primary care to patients, for maintaining the continuity of patient care or for initiating referral for specialist	The Commissioner respectfully rejects this comment, as the language proposed by the commenter is identical to the language in the proposed regulation, which in turn is unchanged from the existing regulation, save and except that as proposed it now

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COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
Companies. Attachment to Comment letter January 11, 2007 (L1A, C8)		care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.	has a different letter designation.
Topic 13: 2240(l) Definition of “primary covered person”			
Eric C. DuPont MetLife Comment letter January 11, 2007 (L2, C3)	2240(l)	MetLife offers the following suggestions with regard to the proposed amendments to §2240 – Definitions: “ <u>Primary covered person</u> ” - §2240(m). MetLife Dental believes that this definition of “Primary covered person” is overly broad, with the result that, in a group policy context, the definition would include dependents as well as the covered employee or group member. This would cause problems with providing notice under the policy, in that group insurers would be required to provide notice to every “person eligible for coverage under an insurance contract or certificate.” This is of concern, as it is not clear how an insurer could determine who every person eligible for coverage is. Further, the expense of making such a determination, as well as the increased production and delivery of notices will impact administrative costs and ultimately premium. MetLife Dental suggests that the proposed amendment to §2240(m) be eliminated and that the current definition in the regulation under §2240(l) (“Primary covered	The Commissioner respectfully rejects this comment. Section 2240.2(c) requires that “primary covered persons” be provided with the substance of any notice given to the group contract holder: this means that notice must be given to those covered under the group contract.

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		<p>person' means a person eligible for coverage under a group contract because of his or her membership in a group.") be retained</p>	
<p>Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>			
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p> <p>(L6A, C1o)</p>	2240(l)	<p>We recommend the following revised language:</p> <p>"Primary covered person" means a person eligible for coverage under a <u>health</u> insurance contract or certificate.</p> <p><u>Rationale:</u> To ensure consistency with section 106(b) of the insurance code add "<u>health</u>".</p>	<p>The Commissioner respectfully rejects this comment. In the context of this regulation, it is clear that this provision refers to health insurance.</p>
<p>Topic 14: 2240(m) Definition of "Service Area"</p>			
<p>Anne Eowan, Association of California Life & Health Insurance</p>	2240(m)	<p><u>Application of a "Service area" lacks clarity and authority.</u> Section 2240 (n) defines "service area" as a geographical area designated in the contract within which network provider services are rendered or some covered services are available. "Service area" is a concept that only has meaning under closed provider</p>	<p>The Commissioner respectfully rejects this comment in part and adopts it in part. Insurance Code section 10133.5 requires that these regulations "assure accessibility of provider services in a timely manner." The proposed definition provides that, if the contract</p>

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COMMENTER	SECTION	<p style="text-align: center;">VERBATIM COMMENT</p> <p style="text-align: center;">(All mistakes in text appear in original)</p>	<p style="text-align: center;">CDI RESPONSE</p>
<p>Companies. Comment letter January 11, 2007 (L1, C3)</p>		<p>panel health plans, such as HMOs, and to some extent, EPOs that can confine services to a particular geographical area. As mentioned earlier in this letter, insureds covered under a PPO policy can access services worldwide. To require PPOs to meet the requirements of these proposed regulations worldwide would be impossible to comply with, and would be an enforcement nightmare for the Department. Further, there is nothing in the authorizing statute that would apply the concept of "service area" to these network arrangements. ACLHIC would recommend that the concept of "service area" either be stricken or be defined to be limited to services within California (primary service area).</p>	<p>provides that covered benefits are provided within a particular geographic area within California, this area constitutes the 'service area.' Otherwise, the 'service area' for the purpose of this regulation is the state of California. Noting the concerns of commenters that the original proposed regulation could be construed to assert worldwide jurisdiction, the proposed regulation has been amended to clarify that this regulation applies only to service areas within California.</p>
<p>Anne Eowan, Association of California Life & Health Insurance Companies. Attachment to Comment letter January 11, 2007 (L1A, C9)</p>	<p>2240(m)</p>	<p><i>(alternative language proposed by comment author)</i> (i) "Service area" means covered benefits provided to covered persons within California.</p>	<p>As stated in the cell immediately above, the Commissioner has adopted this comment in part by amending the proposed regulation to clarify that the regulation applies only to covered benefits provided for covered persons within California.</p>
<p>Anne Eowan, Association of California Life & Health</p>	<p>2240(m)</p>	<p>Getting down to "service area," I think this is where the rubber kind of meets the road when we're talking about open access network systems and closed network systems. When you are</p>	

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Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (13:5-14:3)		<p>limiting your enrollees to particular providers and you don't allow them to go outside of that network, then it makes sense to have a service area; but under open access network arrangements like PPOs, there's no such thing as a real service area because you could get coverage -- you're indemnified against the loss wherever you go; if you go outside the network, you know, you pay out of network rates.</p> <p>But the concept of "service area" concerns us a lot because many of the provisions in here that would be appropriate for an EPO causes some concern with regards to a PPO.</p> <p>What we've suggested here is if you're going to use "service area" that you use, we basically say "covered benefits provided to covered persons within California," so at least we define that it's California. If you say it's worldwide, we can't</p> <p>0014</p> <p>possibly prove up networks worldwide. If we were to offer say some lease network in some other country as a service for our enrollees should they want to have a cheaper option outside, it would be very difficult to prove up that kind of network arrangement.</p> <p>So, we've suggested if you want to use the "service area," that we mean California, but just when I was looking at this this morning, I realized maybe you want to have separate EPO regulations and separate regulations that apply to open access</p>	

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		because service area for an EPO would not be out of California. I don't think, not necessarily; these little confusing things.	
JP Wieske, The Council for Affordable Health Insurance, Comment Letter January 11, 2007 (L3, C3)	2240(m)	<p>Service Area</p> <p>The definition of service area is also problematic – especially for PPO benefit plans. Since PPO plans provide out-of-network coverage for almost all covered services, the service area is at least the entire country, if not the entire planet. We would suggest deleting “or covered services are available for some level of coverage under the insurance contract.”</p>	The Commissioner respectfully rejects this comment, for the reasons set forth regarding the comment of Ann Eowan, ACHLIC, above (L1,C3) regarding the definition of a service area for purposes of applying the timely access standards, which reasons are here adopted by reference. The Department’s jurisdiction over the application of network access standards extends only to California and as such these network access standards would not apply to any network providers located outside the State even if they are serving insureds covered by a California policy.
<p>Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>			
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter October 9, 2007	2240(m), 2240(a)	<p><u>Application of a “Service area” lacks clarity and authority.</u> Section 2240 (m) defines “service area” as the State of California <u>or any other geographical area</u> designated in the contract within which network provider services are rendered <u>or some covered services are available.</u> Under a PPO contract, an insured can be indemnified against a loss anywhere in the world, thus some covered benefits, albeit not in a network, can be available anywhere. Thus the regulations exceed the authority of the department</p>	The Commissioner has adopted this comment in part: subsection 2240(m) has been amended to clarify that the regulation applies only to covered benefits provided for covered persons within California. Subsection 2240(a) has been amended to clarify that the regulation applies to covered health services.

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(L7,C1)		<p>to impose geographical access standards on non-network benefits.</p> <p>Secondly, the regulations as written would serve to reduce provider network options for insureds, which is counter to the stated intent of the law. Currently as a convenience to enrollees, there are insurers that have arranged some in-network services outside of California for insureds that have medical needs when traveling. However, it would be impossible to prove up the adequacy requirements that are in Section 2240.1, or the mapping requirements of Section 2240.5 for non-proprietary networks for providers in other states. Should these regulations take effect as is, these options could no longer be available to insureds. Not only would it be more difficult to find a provider they could trust when out of state, they will pay more for their portion of medical services.</p> <p>In addition, some insurers have made agreements with medical centers of excellence outside of California, such as Dana Farber, Sloan Kettering, and the Mayo Clinic to provide services at in-network rates. It is of great value to insureds to be able to access these centers of excellence at in-network rates, as the cost could be prohibitive if they had to pay out-of-network rates for what could be very</p>	

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		<p>expensive treatment. Again, it would be impossible to meet the access and filing/reporting requirements for these centers of excellence. Further, it would be impossible for the Department to monitor compliance out of state which would go beyond state regulation. Thus, ACLHIC strongly recommends that Section 2240 (m) be amended as follows:</p> <p>(m) "Service area" means the State of California or any other geographic area <u>within the state</u> designated in the contract within which network provider services are rendered to covered persons for <u>covered benefits</u> or covered services are available for some level of coverage under the insurance contract.</p>	
Andrea DeBerry Blue Shield of California, Comment Letter October 9, 2007 (L8,C1)	2240(m)	<p><u>SERVICE AREA:</u></p> <p>Our biggest issues all generally arise out of and relate to the concept of "service area", how that is defined in the draft regulation and what the carrier is obligated to do within that service area. The regulations continue to propose to impose the concept of a service area on a PPO and to define service area in such a way that ANYWHERE the policy provides ANY coverage is deemed to be <u>in</u> the service area. As we read the regulations, for example, if a carrier tried to limit its "service area" to California, but then covered emergency services anywhere in the US or the world, then the attempted limit wouldn't work; the service area</p>	<p>The Commissioner has adopted this comment in part; subsection 2240(m) has been amended to clarify that the regulation applies only to covered benefits provided for covered persons within California.</p>

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		<p>would be the US or the world.</p> <p>Insureds in a PPO have traditionally been free to go anywhere they want for care - they have not been limited to California (or any single state). If the policy provides ANY level of benefits for services receive elsewhere - through network or non-network providers - that would be part of the "service area" for the policy under this regulation. Carriers have historically tried to make arrangements so that insureds can access at least some "in-network" providers in other</p> <p>states. For examples, insureds of BSC Life have the ability to access the huge BlueCard network of providers of all of the other Blue Cross and Blue Shield plans and receive in-network levels of benefits. Insureds in California have the ability to seek care from specialists, like Dana Farber, Sloan Kettering, Mayo Clinic, etc. and get those services at an in-network level of benefits. We submit this is all clearly in the best interest of our insureds. But, under these draft regulations, anywhere those services are covered would be in the service area/part of the service area of the insurer, thus requiring the carrier to comply with the stated obligations in the "service area".</p> <p>It is because of the features above that PPOs have not historically included the concept of service area. There really isn't "in-area" and "out-of-area". It is in-network or out-of-network, wherever the services are received. See, e.g., Section 2240.3(c)(1) on the top of page 7 of the draft regulations – the stated requirement</p>	

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		<p>doesn't make sense precisely because of this conundrum: i.e., if the policy provides coverage (in-network or out-of-network) where the particular service is rendered, then it is always "in" the service area - there could never be the situation where there is coverage and it is "out-of-area". Thus, even this provision of the regulations conflicts with the way the definition is written.</p> <p>Under the proposed regulation, within the service area (whatever it is), the carrier would be obligated to comply with a number of requirements regarding network providers, must monitor access, must map and file providers, etc. This simply could NOT be done for the world or all of the US. BSC Life couldn't do it for all of the BlueCard providers in the US. From a practical standpoint carriers could only perform these functions with respect providers in California (i.e., within the physical jurisdiction of DOI).</p> <p>Thus, in response to the regulation as currently drafted, PPO carriers would likely find themselves in the position of having to absolutely limit coverage to a defined service area, such as California. Carriers would then be telling insureds they have NO coverage outside of California, <u>including</u> emergency services and urgent services. [Note, the requirement on availability of emergency care applies only within the service area.] And a carrier wouldn't be able to cover anyone that didn't live/work in California (including retirees).</p> <p>We would submit that is a horrible result and would make the coverage significantly more restrictive</p>	

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		<p>than Knox-Keene plans.</p> <p style="padding-left: 40px;">According, BSC Life strongly recommends that the proposed regulations be modified to eliminate the concept of “service area” and to limit the stated requirements to services covered and network providers within the State of California.</p> <p style="padding-left: 40px;">Note, we view this as the single most significant problem with the proposed regulation.</p>	
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C11)	2240(m)	<p>We recommend the following revised language:</p> <p>“Service area” means the State of California or any other <u>the geographic area in the State of California designated in the contract</u> within which network provider services are rendered to covered person or covered services <u>benefits</u> are available for some level of coverage under the <u>health</u> insurance contract.</p> <p><u>Rationale:</u> The language as currently drafted could be interpreted to require coverage outside of California as insureds covered under a PPO policy can access services worldwide.</p>	The Commissioner has adopted this comment in part; subsection 2240(m) has been amended to clarify that the regulation applies only to covered benefits provided for covered persons within California.
Comments received during second 15-day comment period October 24, 2007 – November 8, 2007			

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Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13,C1)	2240(m)	Section 2240 (m) defines “service area” as “the State of California or any geographical area within the state designated in the contract within which network provider services are rendered to covered persons for covered benefits.” We agree with this definition and are appreciative of this clarification.	The Commissioner acknowledges this comment.
Topic 15: 2240(n) Definition of “Network”			
Anne Eowan, Association of California Life & Health Insurance Companies. Comment letter January 11, 2007 Public Hearing (L1, C5)	2240(n)	<u>Unintended consequences of applying regulations to leased provider networks counter to legislative intent.</u> Section 2240 (o) defines a “network” to include direct contracting arrangements between the insurer and providers in a network and also includes a leased provider network arrangement. There are important distinctions between leased network arrangements and directly contracted arrangements. Insurers that lease provider networks do so from a contracting agent that has in turn contracted with providers to be in a network. The contract is usually limited to reimbursement rates per procedure for all clients utilizing the network. The contracting agent will then lease the network to a variety of payors, including insurers.	The Commissioner respectfully rejects this comment. The authorizing statute requires CDI to set and consistently apply timely access to health care standards. It does not permit CDI to discriminate between insurers whose health insurance products include directly contracted provider networks from those who utilize leased networks. All California insureds should have consistent protection by having timely access to health care regardless of how an insurer chooses to include a provider network in an insurance product and are protected by the same statute. Based on the Department’s survey of health insurers conducted prior to development of these

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		<p>The application of all the requirements in the proposed regulations to leased network arrangements could only be complied with if the contracting agents were willing to amend all their individual contracts with providers to address all the compliance needs of all their insurer clients. Obviously, contracting agents would be unwilling to make those costly changes, and providers would be unwilling to take on a number of new requirements (such as hours of operation, etc.) per type of benefit for each of the contracting agents' clients. Thus, carriers that lease provider networks would be unable to meet all the requirements of the proposed regulations.</p> <p>The net result will be that those carriers that utilize lease arrangements to improve network adequacy for insureds will find them untenable to maintain. While the intent of the legislation is to expand access to providers for timely health care, <u>this provision will serve to shrink networks of providers</u>. This is counter to legislative intent and public interest. Section 10133.5 (b) requires the Department to assure accessibility of provider services in a timely manner. This provision would undermine that mandate.</p> <p>ACLHIC would recommend that the requirements not be applied to leased networks, as there is no explicit authority in the statute to make that application, but that leased networks may continue to be used as a tool to improve network adequacy.</p>	<p>regulations, companies who lease networks to California insurers will not have trouble complying with these fairly conservative timely access standards. As a general practice, the same health care providers who contract directly with many California insurance companies also contract with leased networks.</p> <p>The regulation's requirements for hours of operations do not apply to each individual network provider; rather to the network as a entity. It is the insurer's responsibility under the proposed regulations to make sure that some but not all of its network providers are open during the required hours of operation to meet the needs of their insureds and the timely access standards set by these regulations.</p> <p>CDI has no authority to differentially apply timely access standards to provider networks used by California insurance companies to serve their insureds. The intent of the legislation is to assure timely access to health care for all insureds by establishing and consistently applying quantitative standards to measure and monitor such access for all California insureds.</p> <p>There is no statutory authority for applying the timely access network requirements to some health insurers and not others who might choose to lease networks in lieu of direct contracting.</p>

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<p>Anne Eowan, Association of California Life & Health Insurance Companies. Attachment to Comment letter January 11, 2007</p> <p>(L1A, C10)</p>	<p>2240(n)</p>	<p><i>(alternative language proposed by comment author)</i> (j)"Network" means all institutions or health care professionals that are utilized to provide medical services to covered person pursuant to a contract with an insurer to provide such services at alternative rates as described in Insurance Code Section 10133. A network as defined herein can be directly contracted with by an insurer or leased by an insurer.</p>	<p>The Commissioner respectfully rejects this comment, noting, particularly in the context of the comments made by this commenter in the cell immediately above, that the proposed alternative language is identical to the language proposed by the Department.</p>
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (15:1-18:10))</p>	<p>2240(n) [formerly 2240(o)]</p>	<p>Now, in subdivision (o) you've added lease networks to that. And the problem with lease networks, at least in the construct of the regulations as you've proposed them, is there are a number of things that you're asking provider contracts be amended to do. You've got hours of operation, you've got a number of things that have to be included in a provider contract.</p> <p>And I think it's worthwhile to maybe explain what a lease network is as opposed to a direct contract between a provider and the health insurer. A lease network is a network that you don't put together yourself as an insurer; some third party like Beech Street or some other type of PPO company contracts with providers to develop a very large, lots of times, or a very, you know, geographic area network arrangement, and then they lease that network to a number of payors.</p> <p>So the providers that agree to be on that lease network know that they're going to be leased to a number of payors, and so they go into those contracts</p>	<p>The Commissioner respectfully rejects this comment by adopting the extensive responses to Ms. Eowan's written comment and proposed alternative regulation, located in the two response cells immediately above.</p>

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		<p>knowing I'm going to make -- I'm going to negotiate one contract and it's going to be full reimbursement rate, that's generally the terms of the agreement kind of contract per service, and then I know I'll be reimbursed for that every time they lease it. And the contracting agent, as I said, will lease that to a 0016 number of payors. An insurer would just be one of those payors, it would be like a client.</p> <p>Lease networks are used by a number of insurance companies. If they happen to be multi-state insurance companies and they have a very small amount of business in California, it's really not cost effective for them to directly contract with providers, they get like 70,000 to 100,000 providers. They might use a lease network for a very small enrollee population. Other carriers might use a lease network to beef up their network, to provide more access to network arrangements, so I have one company that will lease networks outside of California, they directly contract in California, but they'll lease some networks outside California so if you're traveling, you have a lower cost option when you go outside.</p> <p>The problem with applying some of the stuff that you have in the regulations where you have to amend the contract backwards is that the contracting agent is not going to be willing to take all of your requirements as an insurer that may be different based on your needs to develop access and back load them onto the providers and renegotiate the provider contracts individually with each of their 70,000 to 100,000 0017 insured.</p>	

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		<p>And so what happens is is that you've got two parties that were the original contracting parties that would be unwilling to do that for the insurer because you're just one of their clients.</p> <p>So what we're suggesting here is that if you use a lease network, or you have that it would be something that would increase access, because what our concern is is that the intent of the law is to create adequate access for networks. If you make it untenable for insurance companies to use lease networks, you'd really shrink the networks.</p> <p>And I would say that that's a real concern in the rural areas. We have rural areas where you only have a PPO option because HMOs can't have a service area up there, they can't get enough providers who are willing to contract with them, and I'd say that's close to 50 percent of the state is what I'm hearing in these little pockets of rural Northern California.</p> <p>And so if you have an opportunity to use a lease network where providers have already contracted in that area and you can beef up your network, we don't want to create a situation where you can no longer use these lease networks. you know, we raised these same suggestions on</p> <p>0018</p> <p>the language assistance regulations because they apply o lease networks and require you to go back and try and get the contract agent to amend all of their contracts for each individual little insurer, it's untenable, so that's the same issues that we have here. And so our concern is the way the regulations are drafted, it would actually intend to shrink the networks considerably and take away a lot of options for folks,</p>	

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		particularly in the rural areas, to have anything other than indemnity coverage.	
JP Wieske, The Council for Affordable Health Insurance, Comment Letter January 11, 2007 (L3, C4)	2240(n)	<p>Network</p> <p>Here again, the definition of network is overly broad. In some cases, health insurers may offer access to discount medical plans by definition it would become a network. A value-added discount plan, which may be incidental to the insurance plan, should not be treated as a full network.</p>	The Commissioner respectfully rejects this comment. The Department has jurisdiction over insurance policies and their included provider networks if they are offered as part of the policy’s coverage. If an insurer offered a “ discount medical plan “ as an option to the insured to access covered basic health care services, the authorizing statute requires the Department to include such providers in a timely access analysis.
Topic 16: 2240 Additional comments re: definitions			
Sheree Kruckenberg, , California Coalition of Mental Health Comment letter January 11, 2007 (L5, C4)	2240	(p)You will note we have included a definition for “urgent care” as this is a critical standard for individuals suffering from serious mental illnesses.	The Commissioner respectfully rejects this comment. The Department believes that urgent care is included in the other components of basic health care services defined in §2240 (a) including but not limited to physician services, hospital inpatient services, ambulatory care services and mental health care services and as such an additional definition is not necessary.

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Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007 (L5A, C2)	2240	<p><u>(p) "Urgent care means health care for a condition which requires prompt attention within 24 hours."</u></p>	The Commissioner respectfully rejects this comment, for the reasons set forth in the cell immediately above.
<p style="text-align: center;">Topic 17: 2240.1, Adequacy and Accessibility of Provider Services</p>			
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment letter January 11, 2007 (L1, C1)	2240.1(c)	<p>2240.1. ADEQUACY AND ACCESSIBILITY OF PROVIDER SERVICES</p> <p><u>Geographic accessibility standards / service area standards inconsistent with open access network arrangements.</u> There are provisions in this section that utilize a closed network HMO/EPO geographic construct that is not appropriate for open access PPO plans. Since HMOs and EPOs can limit their service areas, it is necessary to have a geographic standard apply to them to ensure that their service area is comprised of adequate providers to service that geographically defined area. This is not the case with PPO plans. An insured can literally go anywhere, and is not limited to seeing a primary care physician before accessing specialists. Thus, having geographic</p>	The Commissioner respectfully rejects this comment in part and adopts it in part. Insurance Code section 10133.5 requires that these regulations "assure accessibility of provider services in a timely manner." The regulations provide that if the insurer's policy covers the entire State of California and not a smaller geographic area that the geographic access requirements only apply within the insurer's designated service area. The fact that an insured may access any PPO Network provider within the designated service area does not relieve the Commissioner of the obligation to set a quantitative minimum access standard for covered health care services that an insured should have access to under

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		<p>accessibility standards is not only unnecessary but also unauthorized by the statute. Unlike a closed network under which a primary care physician manages all the care and determines which specialists an insured is referred to, open access networks let the insured choose. It would be impossible, except upon receipt of a claim or complaint, to know which provider an insured wishes to access. To then have to ensure that each provider is within 30 minutes of an insured's home or workplace, accessible by public transportation (subdivision (a)(3)), and that their facility is open at least 40 hours a week and weekends until 10:00 p.m. would be impossible and would place a far greater burden on health insurers than their HMO competitors, on whose standards these were modeled. In addition, it is important to remember that a PPO network may have as many as 70,000 to 100,000 providers in it, which greatly reduces the access concern present in a conventional limited HMO or EPO network.</p> <p>Further, subdivision (b (7) would provide an incentive for providers to drop their contracts with insurers, since there would be no downside against doing so. Insureds would get in-network rates and providers could get something akin to billed charges rather than their contracted rate. This would be counter to the intent of the legislation to improve access to network providers, and would result in increased premiums to cover higher claims amounts.</p> <p>ACLHIC would instead suggest the attached criteria as an alternative to Section 2240.1 of the proposed regulations. We feel there is authority in the statute for this alternative and hope this will provide a better option to ensure greater and more meaningful compliance by insurers and</p>	<p>their policy.</p> <p>This comment misstates the standard: it's not that each provider is within 30 minutes of an insured's home or workplace; instead the standard correctly stated is that at least ONE Network provider with sufficient capacity to see the insured must be within the geographic distance specified in this regulation.</p> <p>Subdivision (b)(7) comment is adopted and this entire paragraph was deleted.</p>

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		result in better and more timely consumer access to providers.	
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Attachment to Comment letter January 11, 2007 (L1A, C11)	2240.1	<p><i>(alternative language proposed by comment author)</i> 2240.1 Availability of Network Provider Services</p> <p>Every health insurer subject to this article shall maintain an adequate network of providers and monitor how effectively the network meets the needs and preferences of individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract.</p> <p>Every insurer shall develop a methodology to determine the size and adequacy of the provider network necessary to serve the insured population.</p> <p><u>Number and Distribution of Providers</u> The methodology shall include quantifiable and measurable standards for the number and geographic distribution of:</p> <ul style="list-style-type: none"> (1) Primary care physicians (2) High-volume behavioral health care providers (3) High-volume specialty care providers (3) Hospitals (4) Other ancillary providers, if applicable 	<p>The Commissioner respectfully rejects the proposed alternative language by this commenter as it would not meet the requirements of the statute being implemented by these regulations. To allow each and every health insurer to arbitrarily set their own individual time and distance standard for maintaining an adequate network of providers accessible to insureds would be tantamount to no standard at all and would invite an unacceptable level of variability in network access for California insureds. The Commissioner would be required to determine what constitutes a “ valid “ methodology on a case by case basis for each individual insurer which could result in dramatically different network access standards within California.</p>

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		<p><u>Assessment of Performance</u> Every health insurer shall annually assess its performance against the standards established for the availability of providers. The health insurer shall use a valid methodology that allows direct comparison of performance to standards. There must be evidence of a formal assessment of organization-wide performance against standards.</p>	
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Attachment to Comment letter January 11, 2007 (L1A, C12)	2240.1	<p><i>(alternative language proposed by comment author)</i> 2240.2 Accessibility of Network Provider Services</p> <p>Every health insurer shall establish mechanisms to assure the accessibility of covered benefits. The insurer shall provide and maintain appropriate access to covered benefits.</p> <p><u>Assessment Against Access Standards</u> The health insurer shall use a valid methodology that allows direct comparison of performance to standards. There must be evidence of a formal assessment of organization-wide performance against standards.</p> <p>Using valid methodology, the health insurer shall collect and perform an annual analysis of data to measure its performance against standards for access to covered benefits for the following: (1) Routine care appointments</p>	Please see response to comment above which applies to this comment as well.

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		<p style="text-align: center;">(2) Urgent care appointments (3) After-hours care</p>	
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (18:11-20:21)</p>	<p>2240.1</p>	<p>Okay. In the next section, "Adequacy and Accessibility of Provider Services," we kind of separate this into two sections, you know, it's just our way of doing it. You've got some very specific things here, some of which are really EPO related like I said, but if we could define the service area as just California, I think that that would make it a little bit better.</p> <p style="padding-left: 40px;">That I would point out is in subdivision (a)(3), you've got a situation here where this is really a closed network issue. When you have -- and particularly in the HMO side where you have to go to a primary care physician, pick a primary care physician, and that primary care physician is generally in a medical group, and then you are limited generally to 0019 just those providers and specialty providers that contract with that medical group. And so when you close your system down to that extent, it's really important to make sure that there are adequate providers within the geographic distance.</p> <p style="padding-left: 40px;">What we are concerned about is that we don't know, because we don't require under a PPO that you use a primary care physician, we have no idea which provider you're going to access since you can access any provider in the state of California.</p> <p style="padding-left: 40px;">So you may decide, let's say for example you get some sickness or illness, you may decide that you want to go see some specialist in Northern California,</p>	<p>The Commissioner respectfully disagrees with the comment concerning the regulation proposing that facilities used to render basic health services are reasonable accessible by public transportation and accessible to the physically handicapped.</p> <p>There is nothing in the regulation that suggests that every single facility in an insurer's PPO Network must meet these physical access requirements; only that basic health services that are covered by the insurer's policy are physically accessible. If an insurer has a PPO Network that lacks physical access for those who must use public transportation or those who are physically handicapped, those insureds clearly lack timely access to covered health care services to which they are entitled under their insurance policy.</p> <p>Please refer to earlier comment that the fact that an insured in a PPO plan may access any network provider in the service area has no bearing on the statute's demand for minimum geographic access standard to be established by the Commissioner.</p> <p>With respect to the comment regarding (4) Basic Health Services, the regulation requiring 40 hour/</p>

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		<p>you live in Southern California, that's your provider; but we're going to try and figure out somehow that we're getting providers for you close to where you live and close to transportation.</p> <p>We're proposing some alternatives where we figure out -- and you'll see in our proposed regulations that we don't use these kind of standards because they're really appropriate for closed networks.</p> <p>Instead we have to make sure that we have an adequate number of providers for you to use and that they're accessible to you, and that these kind of service area, closed service area specific provisions, like we 0020 wouldn't really know if they're accessible to physically handicapped if we don't know which provider you're going to go to.</p> <p>If you're going to go to a primary care physician first, then we can make sure that that's what you're doing. Does that make sense? Stop me if you have any questions at all, please.</p> <p>Again, in sub (4) we have "basic health care services," I mentioned that before, and then they have to be available at least 40 hours per week. We weren't sure when we saw this what you meant by that. Is this all providers? Is it just some providers? You know what I mean? If you can go anywhere in the state, these kind of provisions don't make a whole lot of sense.</p> <p>We're assuming this is just -- this would be very important if you were limited to your medical group and you want to make sure they had an urgent care or somebody open for you, but if you can go to anybody, and we have some services that will be open and that</p>	<p>week availability does not mean that every single Network provider must be available 40 hours/ week. Instead it means that the insurer's network- collectively- must have covered basic health services available 40 hours/ week. If an insurer chooses to have some physician offices who are open part time combined with an urgent care clinic offering longer hours, the requirement for basic health services to be available for 40 hours/ week would be met. Given the open PPO panel, this is an easy requirement to meet when an insured is not limited to a single primary care physician as is often the case in an HMO plan.</p>

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		<p>should be okay.</p>	
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (20:22-22:4)</p>	<p>2240.1</p>	<p>You've got "emergency health care services" here too in sub (5), "accessible within the service area." Well, you know, 70,000 to 100,000 providers and a lot of hospitals, I'm assuming this is something, a 0021 holdover from the old HMO days where emergency services outside your network weren't being covered, but a lot of changes have happened to the statute on the Knox-Keene side where emergency services and whether or not you can access them have been taken care of, and that's certainly not an issue within PPO coverage.</p> <p>I think what I'll do at this point is maybe look a little bit, now that I've explained some of the differences between closed networks and the needs that you have for that related to an open access network, is maybe just go to our proposed regulations and just show you what we've done under availability and accessibility.</p> <p>Because if you go to the next page of the Department's regulations, we're now getting down to an equivalent of at least one full-time physician per 1200 covered persons and at least the equivalent of one time -- or one full-time primary care physician per 2,000 covered persons. You know, it's kind of like how do you measure when you can go to anyone and you don't know until you get the claim.</p> <p>So what we're concerned with is we want to comply with this, and so we want to make sure that</p>	<p>The requirement that sub(5) offer network emergency health care services be available and accessible at all times within the service area is an existing regulation and is equally applicable to insureds who have a PPO insurance plan.</p> <p>The regulatory requirement of at least one full time physician per 1200 covered insured persons is easy to measure by insurer use of network access software. CDI contacted most health insurers prior to development of these regulations and learned that it was industry standard to measure network access by comparing provider and insured's relative locations. The insured' free choice of PPO providers has no bearing on what the minimum capacity or access requirements must be in order to achieve the statutory mandate of timely access to health care services.</p>

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		<p>whatever information we give you is meaningful and measurable, and so a lot of these things that are put 0022</p> <p>in here under (1), (2) and (3), (4), (5), all of these things where you have to have it within so many miles; again, when you can go to anybody, we're not sure how to do that.</p>	
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (22:5-23:24)</p>	2240.1	<p>But if you see here, what we've done is this is very similar. I know that the Department has to have some sort of standards against which they can measure the filings that are being filed with you to make sure that there's adequate networks.</p> <p>The difficulty we have is for PPOs, this is we're going into some new territory in terms of what makes it adequate. The NCQA has developed their accreditation standards for adequacy and availability of provider networks, and so what we're proposing here is kind of based on that, where the companies have to file something with you that is -- that they monitor, they develop a methodology, there's a number and distribution of providers, there's an assessment of the performance, and then there's an assessment against the access standards that they have.</p> <p>Of course, like I said, this would probably be enforced a lot by finding out if people are calling up and saying I can't get in or, you know, that would be the way that you would monitor this on the back end</p> <p>25 which you already have in your regulations in terms of</p> <p>0023</p> <p>complaint data filing and what have you. But this is based on the NCQA, and a lot of companies have spent a lot of money to get NCQA accredited for</p>	<p>Agree with the comment that the Department has to have some sort of standards against which we can measure filings from the insurers to make sure that there are adequate networks (with access for insureds).</p> <p>The Commissioner respectfully rejects the commenter's suggestion that the Department should sit back and wait to receive complaints about lack of timely access to health care from insureds before setting minimum time and distance access standards.</p> <p>NCQA is a private corporation which is primarily focused on quality of care and their standards are not developed pursuant to any statutory authority and have no bearing on these regulations. Further CDI has no statutory requirement that its certificate holders seek or attain NCQA accreditation and as such, the Commissioner determined not to substitute a private organization's standards for publicly set network access standards.</p>

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		<p>quality assurance and this accessibility availability is included, so you might want to consider -- and I've got a copy of the NCQA guidelines, I don't know if you've seen them or not, but --</p> <p style="padding-left: 40px;">MS. ROSEN: We have them.</p> <p style="padding-left: 40px;">MS. EOWAN: You have, okay. That's what this is kind of based on because they're already trying to meet those standards, and there is monitoring and reporting related to that. And so you may want to think about either using that as the standard, that's kind of what we're using here, using what we proposed, or at least maybe deeming those that have already got NCQA accreditation to save you from having to do a lot of review and what have you.</p> <p style="padding-left: 40px;">I would suggest this rather than the concepts here that are really HMO concepts where you're so limited. When I say so limited, I mean that the HMO networks are broad, but once you choose your primary care physician, then that narrows down, you know, your specialists and whatnot in most cases, and that's not the case here.</p>	
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11,	2240.1	<p style="padding-left: 40px;">The concern we have in number (7) here, and I 0024 think it's, what is it, (b)(7), yeah, (b)(7) in the section, what we don't want to have happen, and that's one of the concerns that we have with saying you have to have so many physicians per person kind of thing, and particularly in (7) we don't want to create an incentive, particularly in the rural areas, for providers to opt out of their contracts because that would have the opposite result of the regulation and the intent of the law.</p> <p style="padding-left: 40px;">What we're concerned with here in this language saying that where there's no network provider</p>	<p>The comment regarding (b) (7) has been adopted by the Department and this subparagraph is deleted.</p>

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2007 (23:25-25:4)		<p>available to a covered person, the access standards can't be met, and this is something that's in the regulations, then the insured is held harmless. And the -- what we're concerned is the network provider will say then there's no reason for me to contract, because in regulation here it says that the insured has to be held harmless, so they won't be complaining to me and I'll get my bill charges.</p> <p>We're having a lot of problems right now. As you know, there's been a number of bills introduced to try and blow up network contracts, and so we're very concerned about having something in regulation.</p> <p>Now, this might be something that the Department may decide to look at should there be 0025 complaints or a market conduct or what have you, but having it in regulation like that we think is incentive to not contract because there would just be no incentive to contract.</p>	
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007	[former 2240.1(c) (8)]	<p>We like subdivision (8) obviously, but we're not quite sure, I think the sentence got separated in half, I think you'll probably want to amend that, but we're not quite sure what "physical impossibility" means. If that means that no providers in all of Northern California will contract with you, that's one thing, but we're not quite sure what "physical impossibility" means, so you might want to clarify that or maybe you could let us know what you mean by that.</p>	<p>The Commissioner adopts this comment in part, inasmuch as subdivision (8) has been stricken.</p>

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(25:5-13)			
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (27:17-29:9)	2240.1	<p>MS. EOWAN: But, when we tried to figure out -- the reason that we came up with something that was based on what you're required to do with the NCQA is to give companies that have not gone through that process or may have limitations to that process an option to submit something. The NCQA could be an alternative where you could deem approval. I don't know what the limitations to having</p> <p>0028 absolutely everybody have NCQA accreditation, but my concern is that if companies were unable to get that done by a certain time period or for other reasons, then they basically lose their network, and the enrollees that are under that are the ones that are harmed.</p> <p>So, we were trying to come up with some kind of standards that would be complementary to what you're already required to do with NCQA, so we weren't coming up with two sets of standards that the folks who spend a lot of time and money doing NCQA now have to meet these standards too, so we were trying to find something that would be complementary, but not limited just to NCQA.</p> <p>That's kind of how we approached this because again, I do know and I did see a copy of the letter that you sent out to the companies, the Department sent out to the companies asking them for their standards, and I think some of them do use those standards.</p> <p>I think what we are hoping with our proposal is</p>	<p>The Commissioner respectfully rejects this comment. Please see comment above regarding NCQA as a private organization that is not universally utilized by health insurers in California. In addition, NCQA uses standards which are more “ process” oriented and do not establish a measurable quantitative time and distance standard to certain types of network providers.</p>

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		<p>that companies would be able to figure out what works best for them and make sure that for their enrollees and based on their providers and where they're located and their benefits, they could submit something that was a little less stringent than the</p> <p>0029 absolute requirements that were in here.</p> <p>MS. ROSEN: Okay.</p> <p>MS. EOWAN: So that's kind of where we're coming from. And in terms of the HMO and the EPO issue, we saw some issues in here related, because EPOs are closed networks, that by trying to put them both together we thought maybe there was some problems in the service area or just, you know, location according to where you were located.</p>	
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (29:10-34:2)</p>	<p>2240.1</p>	<p>MS. ROSEN: Now, the 2240.1 that you propose has no quantitative measurement whatsoever, there's no time standards, there's no distance standards.</p> <p>MS. EOWAN: I know.</p> <p>MS. ROSEN: There's actually no real, something that you could call a standard that's measurable. Oh, okay.</p> <p>And then I was wondering if you could give an example of -- oh, you're right, sorry -- what you said that you could give some examples of the types of standards that might meet 2240.1.</p> <p>MS. EOWAN: Well, I don't know if I said I could give you some examples, but I said I have the NCQA guidelines. I know that the NCQA guidelines allow companies to submit something, and then they look at them to determine whether or not they would be adequate</p>	<p>The Commissioner respectfully rejects this comment. The Department has surveyed health insurers in California prior to development of these regulations and learned that all of them use some version of time and distance standards to measure adequate access for their insureds. In all cases, insurers were using quantitative time and distance standards that were more restrictive and demanding than those adopted by the Department in these regulations. Moreover, all were using the GeoNetworks software to analyze their PPO Network's performance.</p> <p>NCQA uses non quantitative goals that the Department finds would not meet the statutory requirement of assuring adequate availability and</p>

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		<p>0030 to meet it. I realize there's no absolute strict numbers in what we're suggesting.</p> <p>MS. ROSEN: Okay. And, you know, I apologize, I actually don't -- this isn't the forum for commenting on yours. I just wanted to also state that when we did the solicitation of information before we even wrote one word, we did get time and distance standards back from every responder.</p> <p>MS. EOWAN: And I would imagine they probably would and they might submit that to you because that may be the way that they've attempted to do it to meet NCQA guidelines.</p> <p>MS. ROSEN: Right, and they were all much more stringent quantitatively than what we are proposing. Just we were impressed frankly at how well they monitor the networks and how high their standards were for measuring access, very sophisticated and much more, much more quantitatively rigorous even than what we have proposed.</p> <p>MS. EOWAN: And we would hope that would be the type of filings that you would get. I think we were -- where my company's looked at the proposed regulations, I think they were concerned that some things they would not be able to measure or some things</p> <p>0031 might not be always appropriate, like they'd have to have lots of exceptions to some of these things depending on where people decided they wanted their provider, so I think that's why they wanted more flexibility in terms of, and I know for the Department it's difficult because you would like to have some set</p>	<p>access to covered health care services.</p>

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		<p>standards against which you could measure the filings. But we were kind of hoping that the filings would be of the caliber that you're suggesting, that it would work for each company based on the same set; and then of course if you got a filing that was absolutely inadequate, that's something, you know, that they go to the Department for review, and you could certainly say this is inadequate in terms of your monitoring and compliance.</p> <p>For lease networks, again I would have to ask them how they would do that because I don't know whether or not that's something that the contracting agent would give them or something they could do on their own with their leased network of providers.</p> <p>I know the statute says that it's insurers that contract with the providers for alternative rates of payment, but I know that the Department's interested in making sure that they get as broad a scope as possible with this. And we want to comply on the lease 0032 networks, but I think that was one of the reasons why we put, other than just exactly this, some standards that if you have a lease network, you could prove it up in a potentially different way that you could prove it up. I hope that makes sense.</p> <p>The point is is that we want to make sure that we can comply and that it's something that's enforceable and realistic. Anything else under that section? You guys are being very patient.</p> <p>MS. ROSEN: I just wanted to clarify your comments on 2240.1 then to make sure that we understand it. Then you would envision that we would have -- we regulate, I don't know, Bruce, how many,</p>	

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		<p>150, 200 different health insurers? I just looked at the list the other day -- that we could conceivably have different time and distance standards for each insurer under what you're proposing, I just want to make sure I understand it.</p> <p>MS. EOWAN: Well, you know, I don't think that many are actually doing business as health insurers some of them sell ancillary products like visual only dental only, that sort of thing, and then cash only policies, but they're still licensed as a disability insurer.</p> <p>MS. ROSEN: Just for the ones who are offering 0033 a health insurance product in the medical network.</p> <p>MS. EOWAN: Right. Most of the ones that are big companies are members of ACLHIC, and I would say maybe there are 15, and I don't know how many folks you get responses from for your other data calls that are -- it's just that I looked at the -- I've looked at your accident and covered lives report.</p> <p>MS. ROSEN: Right, that's what I looked at.</p> <p>MS. EOWAN: Yeah, and it seemed like there were fewer health insurers, they were more in the subcategories of the other kind of products.</p> <p>MS. ROSEN: But even strictly within the health insurers then is what you're envisioning is that everyone could conceivably have different standards and still comply with the access requirements?</p> <p>MS. EOWAN: Conceivably, but as you saw from the filings that you already got, most of them are -- I mean we do have some standards here that they would have to -- I mean there is some criteria here that they would have to file, but in answer to your question, potentially yes.</p>	

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		<p>MS. ROSEN: Okay MS. EOWAN: Potentially, although I would think that most of them, many of them, the bigger ones in particular are trying to do NCQA or are close to it. 0034 You'll probably find more agreement than you'll find disagreement in your process.</p>	
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (48:5-49:2))</p>	<p>2240.1</p>	<p>MS. EOWAN: I guess what I'm trying to – what we're trying to do here is to the extent -- I don't know how many companies responded, I don't know if you had 150 companies respond as you said that there were out there or not, but I'm assuming some of the larger companies are doing that because perhaps it's hard to parcel part of their NCQA or maybe as just part of their own internal quality assurance. What we're trying to do is come up with standards that are flexible enough for companies that might be smaller and might not have the enrollee base, may not -- you know, that's what we're attempting to do. MS. ROSEN: Okay. MS. EOWAN: So while it's good to know that a good portion of the industry is far exceeding some of these standards, we're just trying to find something that won't put some companies perhaps out of business in California, not be able to comply or put them in a position where it may not be appropriate given their enrollee size; there may be a more cost-effective 0049 alternative for them, and that's what we're trying to do is just give them that flexibility.</p>	<p>The Commissioner respectfully rejects this comment, for the reasons set forth in the two response cells immediately above.</p>

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<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (12:1-8)</p>	2240.1	<p>I'm assuming though that we're not talking about dental only or vision only coverage here because we use the term "medical" and we use "physician services" and that sort of thing in here, particularly dental, so we may want -- and I have not included that in our proposed regulations, but you may want to make that clear too because I think that follows the intent of the Act.</p>	<p>The Commissioner adopts this comment in part, inasmuch as the Department has determined that the legislative intent and the authorizing statute are aimed at health insurance policies that generally cover medical care and the basic health services as defined in §2240(a). The Department has changed the proposed regulations in §2240.1(a) by excluding supplemental policies that provide coverage for vision care expenses only or dental care expenses only.</p>
<p>Eric C. DuPont MetLife Comment letter January 11, 2007 (L2, C1)</p>	2240.1	<p>As a general comment, we note that the application of the standards in these proposed amendments to limited scope plans, such as standalone dental insurance, will, at the least, be challenging due to the nature of the dental insurer-dentist network relationships. Therefore, MetLife Dental respectfully suggests that the Department consider a more flexible approach for limited scope plans, such as standalone dental insurance. For example, the regulations could except such limited scope plans from inclusion in the requirement that basic health care services be available until 10:00 p.m. one night per week, as contained in §2240.1(4). Over 64% of dentists are solo practitioners, with the rest mainly in small group practices. Further, most dental care is delivered in an office setting – in contrast to medical care, which is often delivered in a hospital or office affiliated with a hospital, which are generally open around the clock. Compliance with this requirement for most dentists,</p>	<p>The Commissioner adopts this comment in part, inasmuch as the Department has determined that the legislative intent and the authorizing statute are aimed at health insurance policies that generally cover medical care and the basic health services as defined in §2240(a).</p> <p>The Department has changed the proposed regulations in §2240.1(a) by excluding supplemental policies that provide coverage for vision care expenses only or dental care expenses only.</p>

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		<p>particularly the solo practitioners, will likely be quite expensive, as well as create a great deal of inconvenience – with little likely benefit to patients.</p>	
Eric C. DuPont, MetLife Comment letter January 11, 2007 (L2, C4)	2240.1	<p>In addition, MetLife Dental offers the following comments concerning insurer responsibilities under §§2240.1 - .4:</p> <ol style="list-style-type: none"> 1. The proposed amendments to the Regulation would make insurers responsible for the monitoring and performance of their providers and contract holders. In particular the following sections are of concern to MetLife Dental: <ol style="list-style-type: none"> a. <u>Section 2240.1(a)(2)</u> - relating to decisions of health care services. The words “and appropriate” require the insurer, at time of claim payment, to make a determination of “appropriateness.” MetLife Dental does not believe that the proposed requirement that insurers make the determination of “appropriateness” is statutorily authorized and suggests that it be removed from the amendments to the Regulation. 	<p>The Commissioner respectfully rejects this comment. The term appropriate in front of health care professionals is intended to replace “ physicians and other “ health care professionals and has nothing to do with an insurer’s decision about the appropriateness of care to support a claim payment. This is clarification of an existing regulation.</p>
Eric C. DuPont, MetLife Comment letter January 11, 2007 (L2, C8)	2240.1(b) (7)	<ol style="list-style-type: none"> 2. <u>Section 2240.1(b)(7)</u> – relating to the unavailability of network providers in a specific geographic area. The proposed amendments would require network benefits to be paid for non-network services if access standards are not met because “no network provider” is available. MetLife Dental is concerned with the impact this proposed requirement will have 	<p>The Commissioner accepts this comment in part. This section has been stricken.</p>

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		<p>on pricing and the ability of insurers to contract with providers. Specifically, we are concerned that this may create a disincentive for providers to contract with insurers. Under this proposed requirement, a provider would be able to receive a network rate and still charge regular fees and avoid regulatory contractual requirements, such as the recently promulgated Language Assistance Program requirements. It is doubtful that this is the result the Department seeks and we urge the Department to eliminate this proposed amendment.</p>	
<p>JP Wieske, The Council for Affordable Health Insurance, Comment Letter, January 11, 2007 (L3, C5)</p>	<p>2240.1</p>	<p>This section has numerous problems. While specific issues are listed below, in general, we believe the regulation should clarify that insurers may contractually delegate responsibility to a leased network. Insurers should retain ultimate responsibility, but many of the specific functions are commonly performed by leased networks. The contractual delegation of authority ensures both an appropriate level of responsibility and cost-effective administration.</p> <p>Secondly, PPO networks provide discounted fee-for-service coverage. They do not manage care in the same way that many HMO's do. As a result, they do not have the leverage to control the operations of hospitals or doctor's office and should not be required to do so.</p> <p>Section a(3) This section requires the insurer to ensure providers are in reasonable proximity to the insured persons worksite, and that providers are accessible through public transportation. These are standards which are impossible</p>	<p>The Commissioner respectfully rejects this comment. The Department agrees with the commenter that insurers may contract with a leased network but not that they may delegate responsibility. The insurer is always ultimately responsible for compliance with statutory requirements including the timely access regulations.</p> <p>Most of the same providers who contract to provide services to HMO patients also contract to provide services to insured PPO patients. Thus the operations of these providers, including their hours, will be the same or similar for both sets of patients.</p> <p>(a)(3) is an existing regulation and requires the insurer to select network providers which are reasonably proximate to either the insured's workplace or principal residence. It also recognizes, as providers</p>

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		to meet. PPO networks have no control over provider locations, or public transportation routes. We would suggest deletion of this section.	do, the value of being accessible to insureds using public transportation when possible. This is a longstanding requirement and a widespread goal of both providers and insurers.
<p>JP Wieske, The Council for Affordable Health Insurance, Comment Letter, January 11, 2007 (L3, C6)</p>	2240.1	<p>Section a (6) This section appears to require PPO networks to monitor the staffing level of providers and hospitals. This is impossible. PPOs do not have the market power to force these changes contractually, and there is no legislative authority. This section should be deleted.</p>	<p>The Commissioner respectfully rejects this comment. (a) (6) is an existing regulation and expects insurers to ensure that network providers possess sufficient administrative and support staff to allow patients to be timely admitted for hospital care, for example. If insureds cannot be processed for admission to a hospital or an emergency room, they do not have timely access to a network provider.</p>
<p>JP Wieske, The Council for Affordable Health Insurance, Comment Letter, January 11, 2007 (L3, C7)</p>	2240.1(c)	<p>Section b (2-5) These sections specify specific time and distance standards for providers. The problem is that these standards can not be applied in many situations. For example, rural areas may not be served by many specialists and a hospital may be some distance away. In urban areas, traffic may certainly result in travel times that exceed the required standards. Many states have adopted a more flexible standard requiring distances and travel times to meet the standards of the region. This standard ensures rural areas are able to access a full range of health insurance options, and encourages providers to locate in the region.</p>	<p>The Commissioner respectfully rejects this comment. The quantitative access standards to network health care providers set in these sections require the application of EITHER a time OR distance standard and such flexibility accommodates traffic problems that might exist as well as some areas where providers are more sparsely located.</p> <p>Please see (c)(7) which is intended to accommodate any geographic area, including a rural area, where providers are located at distances further from the covered persons than the access standards require. In a rural area where there are insufficient number of providers or insureds must travel longer distances to</p>

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			reach them and that fact prevents the insurer from meeting the required access standard, this section allows the Commissioner to waive the access standards based on the information provided by the insurer.
JP Wieske, The Council for Affordable Health Insurance, Comment Letter, January 11, 2007 (L3, C8)	240.1(c)(7)	Section b (7) This section requires insurers to cover all care at in-network rates when providers are not available. Unfortunately, this will only ensure the problem becomes worse. First, providers already in the region will lose all incentive to join the network. Second, the cost of the proposal will likely force the insurer to abandon the region entirely. We suggest striking this section.	The Commissioner adopts this comment. Accordingly, this section was stricken in the revised text issued October 24, 2007.
Leanne Ripperger, Pacific Care, A United Health Company, Comment letter January 11, 2007 (L4, C1)	2240.1(c)	We believe the regulations should move beyond the status quo of adopting prescriptive requirements (i.e., prescribed geographic distances – 30 minutes or 15 miles of each covered person’s residence or workplace) that have been embedded in the regulatory scheme for many years but over time have not proven to improve access to health care services. The regulation that is constructed needs to allow for a quality improvement approach, and set forth minimum standards with which health insurers shall comply to ensure that insured’s have access to needed health care services. Health insurers would be required to establish standards which	The authorizing statute requires the Department to insure that adequate numbers and types of institutional and professional providers are accessible to insureds with health insurance coverage in California. Adopting a non quantitative standard would not meet the requirements of the statute and would allow widely varying access standards to be used across the State. Nothing in these proposed regulations prohibits insurers from adopting a quality improvement approach or process nor inhibits them from monitoring their provider network access on a systematic basis.

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		<p>would be incorporated into a quality improvement process and monitored on a systematic basis.</p>	
<p>Leanne Ripperger, Pacific Care, A United Health Company, Comment letter January 11, 2007 (L4, C2))</p>	<p>2240.1(c)</p>	<p>Availability and accessibility standards would address the following:</p> <ul style="list-style-type: none"> • Health insurer uses a quality improvement approach, and sets forth minimum standards with which health insurer shall comply to ensure that insured's have access to needed health care services. • Health insurer offers an adequate number and type of contracted or participating institutional facilities and professional providers to meet the health needs of its insured's. • Health insurer offers a network of contracted or participating institutional facilities and professional providers that are geographically accessible to insured's. • Health insurer monitors the insured's experience through satisfaction survey and complaints received regarding timely access to care. 	<p>The Commissioner respectfully rejects this comment. The Department believes that the quantitative standards contained in the proposed regulations will, for most companies, serve as the minimum standard as the Department has been informed that most of the active health insurance companies in California operate provider networks with much more robust access than required by the proposed regulations. Nothing in the proposed regulations prohibits a health insurer from setting its own internal network access standards at a higher level and monitoring access through its own internal tracking systems.</p>

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<p>Sheree Kruckenberg, , California Coalition of Mental Health Comment letter January 11, 2007 (L5, C1)</p>	<p>2240.1</p>	<p>Insurance Code Section 10133.5 mandates that, in developing access regulations, the department shall consider “the accessibility to provider services in rural areas.” As we interpret this directive, it requires the Department to mandate that insurers develop rural access plans. In the field of mental healthcare, there are rural areas within California that do not have a single appropriate mental health provider for certain populations and 30 of California’s 58 counties currently have not acute in-patient psychiatric beds. We strongly suggest that, rather than providing plans with an escape clause in these situations, plans must be required to develop specific plans for rural access. The implementation of telemedicine has proven successful in rural areas and might be considered as a viable solution for non acute in-patient and outpatient mental health care.</p> <p>To ensure accessibility of services in both rural and urban areas, the Department should distinguish between the adequacy of the supply of qualified providers, including specialist and subspecialist mental health providers, and the distribution of these providers in particular areas as well as generally across the state. The Department must assess whether appropriate ethnic, race, and language capabilities exist for those who would benefit most from them. Further, the Department should also assess and report the economic factors that discourage the recruitment and retention of qualified providers in specific areas.</p>	<p>The Commissioner respectfully rejects this comment. This comment proposes a health care provider supply analysis that is outside the scope of the authorizing statute §10133.5. This statute does not require the Department to assess the adequacy of the supply of certain kinds of providers in any particular geographic area. The Dept has promulgated separate regulations regarding language capabilities of providers providing care covered by health insurers. Please see the Health Care Language Assistance Program regulations, 10 CCR 2538.1, et seq.. Department acknowledges that an inadequate supply of certain types of providers will make it difficult for health insurers to demonstrate timely access for insureds to providers who are in low supply in certain areas; accordingly, the proposed regulation includes a provision for a discretionary waiver of these requirements (see proposed section 2240.1(c)(7)). The misdistribution of qualified mental health providers and the economic factors that may be contributing to this problem is beyond the scope of the authorizing statute.</p>

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<p>Sheree Kruckenberg, Chair, Mental Health Parity Workgroup, California Coalition of Mental Health (L2, C5)</p>	2240.1	<p>(a)(1) We applaud the department for acknowledging that the “projected demand for services by type of service” is a critical component when determining the adequacy of provider services.</p> <p>(a)(6) This section is vague and not clear to the readers. We ask that you provide clarity to this section.</p>	<p>The Commissioner adopts this comment as it pertains to section (a)(1) [now denominated (b)(1)], and as to section (a)(6), which has been stricken.</p>
<p>Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007 (L5A, C3)</p>	2240.1(a)	<p><i>(alternative language proposed by comment author)</i></p> <p>(4) Basic health care services (excluding emergency health care services and urgent care) covered as exclusive provider services are available at least 40 hours per week, except for weeks including holidays. Such services shall be available until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday, except for Saturdays falling on holidays.</p>	<p>The Commissioner respectfully rejects this comment. The Department believes that urgent care is included in the other components of basic health care services defined in §2240 (a) including but not limited to physician services, hospital inpatient services, ambulatory care services and mental health care services and as such an additional definition is not necessary.</p>
<p>Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter</p>	2240.1	<p><i>(alternative language proposed by comment author)</i></p> <p>(5) Emergency health care services are available and accessible within the service area at all times, and <u>urgent care services shall be available within one hour.</u></p>	<p>The Commissioner respectfully rejects this comment, for the reasons set forth in the response cell immediately above, and for the further reason that accessibility based on time and distance standards are provided in proposed section 2240.1(c).</p>

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January 11, 2007 (L5A, C4)			
Sheree Kruckenberg, Chair, Mental Health Parity Workgroup, California Coalition of Mental Health (L2, C6)	2240.1(b) (7) [formerly 2240.1 (a)(7)]	(a)(7) The term “accessible” should be defined, as these regulations do not establish wait times. Additionally this requirement appears to place the burden for compliance on providers and not the health plan.	The Commissioner respectfully rejects the remaining comments. As to section (a)(7) [now section (b)(7)], the Commissioner determined that the requirements of Section 10133.5 would best be met by using measures in addition to the waiting times criterion previously provided in 2240.1(b)(7). Accordingly, accessibility is determined using the standards set forth in subdivision (c).
Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007 (L5A, C5)	2240.1(a) (7)	<i>(alternative language proposed by comment author)</i> (8) Exclusive Network Provider services are rendered pursuant to written procedures which include a documented system for monitoring and evaluating accessibility of such of care. The monitoring of waiting time appointments, <u>wait lists, number of providers based on full time equivalents, the number of providers accepting new patients and elapsed time standards</u> shall be a part of <u>such</u> a system.	The Commissioner respectfully rejects this comment, having made the determination that the requirements of Insurance Code section 10133.5 are satisfied by the criteria established in proposed section 2240.1(c).

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<p>Sheree Kruckenberg, Chair, Mental Health Parity Workgroup, California Coalition of Mental Health (L2, C7)</p>	2240.1	<p>(b)(1) We have concerns that separate standards for mental health providers have not been established and feel they should be established and articulated in these regulations as you have done for physical health providers.</p>	<p>The Commissioner respectfully rejects this comment, inasmuch as the proposed regulations establish separate standards for mental health providers as stated in §2240.1(c)(4).</p>
<p>Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007 (L5A, C6)</p>	2240.1(c) (7)	<p><i>(alternative language proposed by comment author)</i> <u>(7) In any geographic area where no network provider is available to a covered person, and as a result the applicable network access standards cannot be met without using non-network providers, the insurer shall provide network benefits for on the same terms and conditions to covered persons receiving needed care from a non-network provider. This requirement shall continue until the insurer provides substantially similar health care services through network providers.</u></p>	<p>The Commissioner respectfully rejects this comment, noting that this subdivision has been stricken.</p>
<p>Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter</p>	2240.1(c) (8)	<p><i>(alternative language proposed by comment author)</i> <u>(8) If no providers described in these geographic access standards are practicing or available within the time or distance standards required by these regulations for any part of an insurer's service area., Those geographic access standards that cannot be physically met, shall not apply as to those covered persons residing or working within the portion of the service area that is out of compliance with these</u></p>	<p>The Commissioner respectfully rejects this comment, noting that this subdivision has been stricken. Further, that the Commissioner has determined that the requirements already specified in 2240.1(c) meet the requirements of Insurance Code section 10133.5.</p>

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January 11, 2007 (L5A, C7)		<p><u>regulations due to physical impossibility. It shall be the responsibility of the Department to require insurers to demonstrate to the Department that lists of network providers contain consenting providers, and that such lists are subject to Department verification. Such networks may not be composed in part or in whole of purchased or rented lists of providers derived from other sources. The purpose of these Department responsibilities is to ensure that no provider is held out to be a member of a network without their knowledge and affirmative consent in the form of a currently signed contract.</u></p>	
Sheree Kruckenberg, Chair, Mental Health Parity Workgroup, California Coalition of Mental Health (L2, C8)	2240.1(c) (8)	<p>(b)(8) The first sentence in this section is incomplete and does not make sense. We were unable to determine the intent of this paragraph. The current concerns with phantom panels prompted our recommended additions to the language in this section. We acknowledge that it may be desirable to provide flexibility in those situations for which the insurer has an inability to perform due to factors beyond their control. The term “physical impossibility” may not be broad and inclusive enough to indicate the range of conditions that are beyond the control of either insurers or providers and we recommend it be struck, with a more suitable replacement word or phrase inserted.</p>	<p>The Commissioner respectfully rejects this comment. Subdivision (b)(8) [in the portion of the proposed regulation now designated as subdivision (c)]has been struck. Revisions to (b)(7) are designed to address the situation where there is insufficient supply of certain types of providers in a geographic area which results in the health insurer being unable to meet the timely access standards through no fault of their own.</p>
Sheree Kruckenberg, Chair, Mental Health Parity	2240.1(d)	<p>(c) We have stricken the language “to the extent he deems necessary” as there is clear intent in the statutes that there be coordination and comparable standards between DOI and DMHC plans. This language would cause inconsistency between the two departments and appears to act as a “get out of jail free” card for insurers</p>	<p>The Commissioner respectfully rejects this comment. Subdivision (d) [formerly, subdivision (c)] is existing language from current regulations and recognizes the Commissioner’s discretion to recognize structural differences between health insurers and Knox-Keene</p>

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Workgroup, California Coalition of Mental Health (L2, C9)		and a “tough luck” clause for patients.	plans in how they make arrangements for network provider services, and is consistent with Insurance Code section 10133.5(c) and(d)..
Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007 (L5A, C8)	2240.1(d)	<i>(alternative language proposed by comment author)</i> (c) In determining whether an insurer's arrangements for exclusive network provider services comply with these regulations, the Commissioner shall consider to the extent he deems necessary, the practices of comparable health care service plans licensed under the <u>Knox-Keene Law, Health Care Service Plan Act of 1975 Health and Safety Code Section 1340, et seq.</u> Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133, 10133.5 and 11512, Insurance Code.	The Commissioner respectfully rejects this comment for the reasons set forth in the response cell immediately above.
Leanne Gassaway, CIGNA Companies Testimony at public hearing January 11, 2007 (49:11-50:16)	2240.1	MS. GASSAWAY: Yes, Leanne Gassaway with Cigna Companies. Connecticut General Insurance Company is our California Department of Insurance licensed entity. I just wanted to emphasize we fully support ACLHIC's letter and the alternative proposal that's been presented to the Department for their consideration as providing needed flexibility to improve strategies measuring access. This has been probably one of the biggest challenges for health care companies is how do we improve the very service that we've promised to deliver to our enrollees. And I think one thing that you will notice in the ACLHIC alternative proposal is the fact	The Commissioner respectfully rejects these comments, for the reasons set forth in the responses, above to the letter and alternative proposal of Ms. Anne Eowan, ACLHIC, above. Ms. Gassaway endorses ACLHIC's letter and proposal.

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		<p>that we don't know -- today how we're measuring access is vastly different than how we measured it ten years ago.</p> <p>0050</p> <p>ago.</p> <p>And what we don't want to do is put something into regulation today that will become out of date ten years from now. As we improve our strategies and our protocols and our understanding of measuring and improving access to care and maintaining an affordable product for the consumer, we want to keep all of that in balance.</p> <p>I do need to put out one disclaimer. I represent a company that has NCQA accreditation for both HMO and PPO lines of business, so we are hitting a very high bar voluntarily. I should say voluntarily in quotes due to the fact that many of our purchasers demand that we be NCQA accredited, and so we incorporate that into our overall business philosophy.</p>	
<p>Leanne Gassaway, CIGNA Companies Testimony at public hearing January 11, 2007 (52:1-53:13)</p>	<p>2240.1(c)</p>	<p>The third thing that I would like to highlight is the "Adequacy and Availability of Provider Services." We have stringent requirements in our policies and procedures that do exceed that, that's in the regulation today; however, we cannot guarantee that on a statewide basis.</p> <p>We cannot guarantee that there will be a hospital within 30 miles because there are some areas of the state where there is not a hospital within a hundred miles of where one of my insureds may reside.</p> <p>And what this will require us to do is if it becomes a regulatory standard is to reevaluate how where we do business in the state. Right now we are a statewide</p>	<p>The Commissioner respectfully rejects this comment. The Commissioner understands that insurers may not be able to guarantee a network hospital within 30 miles everywhere in the state; the proposed regulations anticipate this situation in the waiver provision in Section 2240.1(c) (7). There in nothing in the proposed regulations that would cause a PPO to reduce coverage in areas where there are insufficient practicing health care providers since this reality is taken into account in the above cited discretionary waiver section.</p>

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		<p>approved insurance company.</p> <p>And what we have seen on the HMO side and what we should all learn from is that when requirements are in place and you cannot meet those requirements, an insurance company or a health plan has to make a very difficult decision about do I simply leave that part of the state because I can't comply or do I try to make it work, and it may be far too expensive to make it work in that community.</p> <p>As you know, in the rural areas they're already typically of lower income, they already have fewer choices for their health plan opportunities, and 0053</p> <p>if stringent standards are put in place, PPOs will be required to do what HMOs did, which is simply leave the suburban and rural parts of the state, shrink their service areas to the areas in the state where they can make the requirements, and that is a huge unintended consequence I don't think any of us want to see.</p> <p>So, I would ask the Department keep that in mind as you do your review about how those standards are structured and how they're conveyed in the regulation in order for them to be -- so that we can comply with them and continue to offer coverage to all parts of the state regardless of where someone may live.</p>	
	<p>Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>		

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<p>Leanne Ripperger, Pacific Care, A United Health Company, Comment letter October 9, 2007 (L6, C1)</p>	<p>2240.1</p>	<p>We believe the focus should be on developing appropriate and meaningful methods of addressing <i>identified</i> access issues. The health care landscape has changed since the passage of AB 2179 and continues to change. With that in mind the regulation needs to allow for flexibility and accommodation for forward thinking and innovation in the health care system.</p> <p>The regulation should allow for insurers to establish quantifiable and measurable standards for the number and geographic distribution of network providers and conduct an assessment of organization-wide performance against standards. Simply amending existing regulations that currently apply to Exclusive Provider Organizations to instead apply to all provider network arrangements is not appropriate nor will it allow for the development of meaningful methods to monitor and improve access to care and service.</p>	<p>The Commissioner respectfully disagrees that only “identified “access issues should receive attention under the proposed regulations. The statute fully authorizes the Commissioner to require an affirmative showing by insurers that their PPO networks that are included as part of the policy benefits are built and maintained to provide adequate and timely access to covered health care benefits. Relying on insurers to identify access issues before applying an access standard would prevent the Commissioner from complying with the statutory mandate.</p>
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter October 9, 2007 (L7,C2)</p>	<p>2240.1(c) (7)</p>	<p><u>Discretionary Waiver Option Unclear.</u> Section 2240.1 (c) requires carriers to apply for a waiver if a specific geographic area lacks adequate numbers of providers to meet the requirement for geographic proximity. We appreciate that this change was added because of the lack of sufficient providers in certain rural areas in particular, and we agree that there should be some recognition in the regulations of this problem. However, it is not clear if such a waiver would be required for each type of physician or specialist that may not be adequate. There should be some type of clarification, or the department may find themselves buried under reams of filings for waivers. Would such a lack of a particular specialty</p>	<p>The Commissioner agrees with the comment that this Section of the proposed regulations is intended to address the “ lack of sufficient providers in certain rural areas in particular” and in fact this section offers the insurers the ability to demonstrate where in California they are physically unable to comply with the time and distance standards due to the unavailability of providers to include in their networks. The filings are only required initially or when a new policy form is submitted for approval to the Department. If a new provider moves into an underserved rural area and chooses to become part of the PPO Network and there is no longer a need for the Commissioner’s waiver, there would not be a need to</p>

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		<p>be indicated in the initial filing? What happens if a particular specialist no longer contracts, or leaves a rural area? Would companies be filing for a waiver, and then refile for removal of the waiver once the situation is resolved? What sort of demonstration would the department require? Again, we appreciate the department recognizing the problems of finding adequate contracting providers in certain areas of the state, but we would ask the department to implement such a waiver system in a workable manner that alleviates unnecessary workload on both the department and insurers.</p>	<p>contact the Department.</p>
<p>Andrea DeBerry Blue Shield of California, Comment Letter October 9, 2007 (L8,C2)</p>	<p>2240.1(c) (7)</p>	<p>Section 2240.1(c)(7) of the proposed regulation now seems to require the carrier to apply to DOI for a "waiver" if a specific geography doesn't have any providers (or sufficient providers?) to meet the geographic access standards. That could result in a HUGE number of filings for the DOI, especially for all of the states rural areas. Would the DOI expect that, in the very first filing after enactment of the regulations, the carrier would just identify the areas where there aren't providers to meet the standards? What level of demonstration/evidence will be required? This needs to be cautiously approached or the carriers and the DOI will find themselves buried in filings. Consider, for example:</p> <p style="padding-left: 40px;">If the 1 orthopedic surgeon in an area retires or dies such that the stated strict access standard can't be met, then I assume each carrier would have to file for a waiver and present whatever is needed to</p>	<p>The Commissioner respectfully rejects this comment. Section 2240.5 spells out the filing and reporting requirements which are rather limited. An insurer is only required to provide a timely access report for their PPO Network at the time of requesting approval for a new policy form and only if the network was not previously approved or by June 2008 whichever time occurs first. When an insurer's PPO Network is initially filed with the Commissioner, any waivers needed to cover underserved areas can be requested at that time. After an insurer's PPO Network has been filed and analyzed for compliance only material changes from that compliance are required to be filed. Given that most of the State's population are not in rural areas but in areas well served by doctors and hospitals, this should not result in an overly burdensome situation. Further, the statute does</p>

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		<p>justify the waiver. Then, if a new orthopedic surgeon is later successfully recruited and the ability to meet the standards changes, I assume that means all of the carriers would then have to do a filing to vacate the exemption. This is going to result in an enormous burden on carriers and the Department. While it may be a theoretical approach to this matter, we would submit that may not be a practical workable solution.</p> <p>Section 2240.3(d) was left in from the EPO regulations and won't apply to a PPO. At a minimum, it should say "if any" - since in a PPO there is no area where services are restricted ONLY to network providers.</p>	<p>mandate that the Commissioner set quantifiable time and distance standard for timely access and it is only reasonable that compliance with access standards should be monitored once adopted.</p> <p>The changes regarding Section 2240.3(d) are accepted and were made accordingly.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C12)</p>	<p>2240.1(b) (1)</p>	<p>We recommend the following revised language:</p> <p>Network providers <u>maintain licensure, accreditation, and credentials sufficient to meet the insurer's credential verification program requirements</u> are duly licensed or accredited and that they are sufficient, in number or size, to be capable of furnishing the health care services <u>benefits</u> covered by the <u>health</u> insurance contract. , taking into account the number of covered persons, their characteristics and medical needs including the frequency of accessing needed medical care within the prescribed geographic distances outlined herein and the projected demand for services by type of services.</p> <p><u>Rationale:</u> To ensure consistency with the statute (Section 10133.5 (b) which requires that there is accessibility of provider services for <u>benefits covered</u></p>	<p>Comment accepted in part; rejected in part. Section 2240.(a) definition of basic health care services was changed to clarify that only covered health care services as defined in the insurance contract are the subject of these regulations.</p> <p>The number of insureds and their utilization patterns (number of visits, etc) must be addressed in any time of geographic access to health care analysis.</p>

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		under the contract and add “ <u>health</u> ” to ensure consistency with section 106(b) of the insurance code.	
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C13)	2240.1(b) (2)	We recommend the following revised language: Decisions pertaining to health care services covered <u>benefits</u> to be rendered by <u>network</u> providers to covered persons are based on such persons' medical needs and are made by or under the supervision of licensed and appropriate health care professionals. <u>Rationale:</u> To ensure consistency with the statute (Section 10133.5 (b) which requires that there is accessibility of provider services for <u>benefits covered</u> under the contract and add <u>network</u> to ensure consistency with the defined term.	Accepted in part; see above comment.
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C14)	2240.1(b) (3)	We recommend the following revised language: Delete the current proposed language and replace with – <u>There is adequate provider network capacity to serve the insured population in a timely manner.</u> <u>Rationale:</u> Section 10133.5 (b)(1) requires adequacy of number and locations of institutional facilities and professional providers, and consultants in relationship to the size and location of the insured group and that the services offered are available at reasonable times. The statute does not require that insurers assume responsibility for accessibility to public transportation.	The comment is respectfully rejected. The Commissioner has determined that the statutory mandate would not be met by a simple non quantitative network access standard that would not be consistent across insurers.

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<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C15)</p>	<p>2240.1(b) (4)</p>	<p>We recommend the following:</p> <p>Delete the current proposed language. The recommended revised language under (b)(3) will require adequate capacity in a timely manner.</p> <p><u>Rationale:</u> Section 10133.5(b)(1) requires - Adequacy of number and locations of institutional facilities and professional providers, and consultants in relationship to the size and location of the insured group and that the <u>services offered are available at reasonable times.</u> In addition there is no evidence-based data to support the proposed prescriptive timeframes.</p>	<p>The comment is respectfully rejected. The statute calls for “timely” access to health care which implies not only a sufficient number of providers with capacity to provide care but also that the services be available enough hours per week to allow insureds to be seen timely.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C16)</p>	<p>2240.1(b) (5)</p>	<p>We recommend deletion of this language.</p> <p><u>Rationale:</u> Insurers are responsible for coverage of such services and for ensuring that there is adequate provider network capacity to serve the insured population. Therefore this language is unnecessary and redundant.</p>	<p>Comment respectfully rejected. Please see response regarding need for quantitative measures of network health services capacity to comment re: 2240.1(b)(3).</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to</p>	<p>2240.1(b) (6)</p>	<p>We recommend deletion of this language.</p> <p><u>Rationale:</u> The proposed language is beyond the requirement of the statute which requires adequacy of number of professional providers. In addition there is no evidence-based data to support a requirement for insurers to monitor staffing ratios for professional and</p>	<p>The Commissioner has adopted this comment in part, and has deleted this provision.</p>

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Comment letter October 9, 2007 (L6A, C17)		administrative staff of <u>institutional providers</u> and such ratios have no relation to whether or not professional staff is available.	
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C18)	2240.1(b) (7)	We recommend the following revised language: Health care professionals are accessible to covered persons through staffing, contracting or referral <u>network providers, or other network arrangement.</u> <u>Rationale:</u> The language as drafted implies a staff model type arrangement. Insurers are going to use networks to arrange for delivery of covered benefits.	The Commissioner has adopted this comment in part by revising the proposed subdivision to include the phrase “network providers, or other network arrangement.”
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C19)	2240.1(b) (8)	We recommend the following revised language: <u>Mechanism are in place for monitoring how effectively the network meets the needs and preferences of individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract.</u> <u>Rationale:</u> The statute does not require that insurers monitor wait time for appointments.	The Commissioner respectfully rejects this comment. While the existing regulation provides for the <u>monitoring</u> of waiting times, 2240.1(c) requires that arrangements for network services meet seven specified criteria, none of which involve waiting times. Thus, while the existing regulation provides for monitoring of waiting times, waiting times are not a factor in determining adequacy and accessibility of services under Insurance Code 10133.5. Further, the proposed reporting requirements of 2240.5 do not include waiting times.

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<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C20)</p>	<p>2240.1(c)</p>	<p>We recommend deletion of this entire subsection and replace with the following:</p> <p><u>Insurers shall establish quantifiable and measurable standards for the number and geographic distribution of network providers.</u></p> <p><u>Number and Distribution of Providers</u> The methodology shall include quantifiable and measurable standards for the number and geographic distribution of:</p> <ul style="list-style-type: none"> (1) Primary care physicians (2) High-volume behavioral health care providers (3) High-volume specialty care providers (3) Hospitals (4) Other ancillary providers, if applicable <p>Every health insurer shall annually assess its performance against the standards established for the availability of providers. The health insurer shall use a valid methodology that allows direct comparison of performance to standards. There must be evidence of a formal assessment of organization-wide performance against standards.</p>	<p>The Commissioner respectfully rejects this comment and finds that in order to meet the statutory requirement of ensuring timely and adequate access to covered health care services, quantitative access standards which are measurable, consistent across insurers and provide some baseline access protections for insureds are required. The bulk of the comments in this section advocate deletion of a consistently applied, quantitative measurable geographically based access standard. The Commissioner believes that a simple requirement that an insurer have some kind of standard would by itself fail to meet the statutory mandate of Section 10133.5 (b) (1) and (2) which expressly refers to the number of providers in relationship to both the size (covered insureds) and location (their zip code). The proposed geographic time and distance standards meet this statutory mandate.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to</p>	<p>2240.1(c)</p>	<p>We recommend deletion of this entire subsection and replace with the following:</p> <p><u>Insurers shall establish quantifiable and measurable standards for the number and geographic distribution of network providers.</u></p>	

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<p>Comment letter October 9, 2007 (L6A, C20)</p>		<p><u>Number and Distribution of Providers</u> The methodology shall include quantifiable and measurable standards for the number and geographic distribution of:</p> <ul style="list-style-type: none"> (1) Primary care physicians (2) High-volume behavioral health care providers (3) High-volume specialty care providers (3) Hospitals (4) Other ancillary providers, if applicable <p>Every health insurer shall annually assess its performance against the standards established for the availability of providers. The health insurer shall use a valid methodology that allows direct comparison of performance to standards. There must be evidence of a formal assessment of organization-wide performance against standards.</p>	
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C21)</p>	<p>2220.4(c) (1)</p>	<p>We recommend deletion of the current proposed language and replace with the language recommended in (c) above. <u>Rationale:</u> Proposed standards or indicators should be evidence-based and provide for meaningful measurement and improvement. It is unclear as to what would constitute a full-time physician and insured covered persons are not assigned to a primary care physician as they are allowed to self-direct.</p>	<p>Comment respectfully rejected. As noted several times in these responses, the fact that an insured is in a PPO plan and is not assigned to a primary care physician has no bearing on the statute's requirement that an insured have timely access to a network doctor-whether they choose to go to a primary care doctor or specialist.</p>

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Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C21)	2220.4(c) (1)	We recommend deletion of the current proposed language and replace with the language recommended in (c) above. <u>Rationale:</u> Proposed standards or indicators should be evidence-based and provide for meaningful measurement and improvement. It is unclear as to what would constitute a full-time physician and insured covered persons are not assigned to a primary care physician as they are allowed to self-direct.	
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C22)	2240.1(c) (2)	We recommend deletion of the current proposed language and replace with the language recommended in (c) above. <u>Rationale:</u> Proposed standards or indicators should be evidence-based and provide for meaningful measurement and improvement. An example would be taking into account urban, suburban, rural differences.	Comment respectfully rejected. These regulations do not prevent insurers from demonstrating that the minimal quantitative access standards set in these regulations are applied differently in urban, suburban and rural areas. In fact, the regulations anticipate that in rural areas where network providers are more sparse requests for waivers of the standard will be made.
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter	2240.1(c) (2)	We recommend deletion of the current proposed language and replace with the language recommended in (c) above. <u>Rationale:</u> Proposed standards or indicators should be evidence-based and provide for meaningful measurement and improvement. An example would be taking into account urban, suburban, rural differences.	

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October 9, 2007 (L6A, C22)			
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C23)	2240.1(c) (3)	We recommend deletion of the current proposed language and replace with the language recommended in (c) above. <u>Rationale:</u> Proposed standards or indicators should be evidence-based and provide for meaningful measurement and improvement. An example would be taking into account urban, suburban, rural differences. In addition the recommended revised language in (b)(8) would address the requirement in Insurance Code 10133.5 (b)(3) as it would require an insurer to maintain an adequate network of providers and <u>monitor how effectively the network meets the needs and preferences of individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract.</u>	Comment respectfully rejected. Please see response above regarding the need for established quantitative geographic access standard.
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C23)	2240.1(c) (3)	We recommend deletion of the current proposed language and replace with the language recommended in (c) above. <u>Rationale:</u> Proposed standards or indicators should be evidence-based and provide for meaningful measurement and improvement. An example would be taking into account urban, suburban, rural differences. In addition the recommended revised language in (b)(8) would address the requirement in Insurance Code 10133.5 (b)(3) as it would require an insurer to maintain an adequate network of providers and <u>monitor how effectively the network meets the needs and preferences of individuals comprising the insured or</u>	

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		<u>contracted group, pursuant to benefits covered under the policy or contract.</u>	
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C25)	2240.1(c) (5)	We recommend deletion of the current proposed language and replace with the language recommended in (c) above. <u>Rationale:</u> Proposed standards or indicators should be evidence-based and provide for meaningful measurement and improvement. An example would be taking into account urban, suburban, rural differences.	Comment respectfully rejected. Please see response above regarding the need for established quantitative measurable geographic access standard.
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C24)	2240.1(c) (4)	We recommend deletion of the current proposed language and replace with the language recommended in (c) above. <u>Rationale:</u> Proposed standards or indicators should be evidence-based and provide for meaningful measurement and improvement. An example would be taking into account urban, suburban, rural differences.	

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<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C25)</p>	<p>2240.1(c) (5)</p>	<p>We recommend deletion of the current proposed language and replace with the language recommended in (c) above. <u>Rationale:</u> Proposed standards or indicators should be evidence-based and provide for meaningful measurement and improvement. An example would be taking into account urban, suburban, rural differences.</p>	<p>Comment respectfully rejected. Please see response above regarding the need for established quantitative measurable geographic access standard.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C25)</p>	<p>2240.1(c) (5)</p>	<p>We recommend deletion of the current proposed language and replace with the language recommended in (c) above. <u>Rationale:</u> Proposed standards or indicators should be evidence-based and provide for meaningful measurement and improvement. An example would be taking into account urban, suburban, rural differences.</p>	
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter</p>	<p>22240.1(c)(6)</p>	<p>We recommend deletion of this language. <u>Rationale:</u> Covered persons are not limited to a service area.</p>	<p>The Commissioner respectfully rejects this comment. Whereas some insurance contracts may not limit the service area, this portion of the regulation applies to those contracts that do.</p>

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October 9, 2007 (L6A, C26)			
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C27)	2240.1(c) (7)	We recommend the following revised language: If an insurer is unable to meet <u>their standards for number and geographic distribution of network providers</u> due to the absence of practicing providers located within sufficient geographic proximity of the insurer's covered persons, the insurer may apply to the Commissioner for a discretionary waiver. Such application should include, at a minimum, a description of the affected area and covered persons in that area and how the insurer determined the absence of practicing providers. <u>an alternative standard including reasons justifying the standard.</u> <u>Rationale:</u> Insurers should establish quantifiable and measurable standards for the number and geographic distribution of network providers. If the insurer is unable to meet the standards due to a shortage of practicing physicians than an alternative standard should be developed and accessed.	Comment respectfully rejected. The Commissioner does not believe insurers should be setting their own “ alternative “ standards for geographic and timely access to covered health services and the suggestion here would result in just that. It is preferable to give insurers the option to explain why they can’t meet a particular geographic standard in a specific geographic area and if the explanation is valid, true and acceptable, the Commissioner can waive the regulatory standard.
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter	2240.1(c) (7)	We recommend the following revised language: If an insurer is unable to meet <u>their standards for number and geographic distribution of network providers</u> due to the absence of practicing providers located within sufficient geographic proximity of the insurer's covered persons, the insurer may apply to the Commissioner for a discretionary waiver. Such application should include, at a minimum, a description	

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October 9, 2007 (L6A, C27)		<p>of the affected area and covered persons in that area and how the insurer determined the absence of practicing providers., <u>an alternative standard including reasons justifying the standard.</u></p> <p><u>Rationale:</u> Insurers should establish quantifiable and measurable standards for the number and geographic distribution of network providers. If the insurer is unable to meet the standards due to a shortage of practicing physicians than an alternative standard should be developed and accessed.</p>	
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C28)	2240.1(d)	<p>We recommend deletion of this language:</p> <p><u>Rationale:</u> The language proposed is beyond the requirements of the statute. Section 10133.5 (d) requires the department in <u>designing</u> the regulations to consider the regulations in Title 28, of the California Administrative Code of Regulations, commencing with Section 1300.67.2, which are applicable to Knox-Keene plans, and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. The department shall consult with the Department of Managed Health Care concerning regulations developed by that department pursuant to Section 1367.03 of the Health and Safety Code and shall seek public input from a wide range of interested parties.</p> <p>Section 10133.5 (d) does not require the department to consider the practices of plans licensed under the Knox-Keene Act who must comply with a completely different set of regulation in order to determine compliance by insurers.</p>	<p>Comment respectfully rejected. The Commissioner always has the discretion to evaluate the practices of comparable health care service plans licensed as a Knox Keene Health Care Service Plan in determining if the comparable insurance statutes and regulations are being met by an insurer who operates both insurance policy products and health care service plans which is often the case. This is the intent of this regulation and it is envisioned by the authorizing statute Section 10133.5 (d).</p>

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<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C28)</p>	<p>2240.1(d)</p>	<p>We recommend deletion of this language:</p> <p><u>Rationale:</u> The language proposed is beyond the requirements of the statute. Section 10133.5 (d) requires the department in <u>designing</u> the regulations to consider the regulations in Title 28, of the California Administrative Code of Regulations, commencing with Section 1300.67.2, which are applicable to Knox-Keene plans, and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. The department shall consult with the Department of Managed Health Care concerning regulations developed by that department pursuant to Section 1367.03 of the Health and Safety Code and shall seek public input from a wide range of interested parties.</p> <p>Section 10133.5 (d) does not require the department to consider the practices of plans licensed under the Knox-Keene Act who must comply with a completely different set of regulation in order to determine compliance by insurers.</p>	<p>The Commissioner respectfully rejects this comment. While Insurance Code section 10133.5(d) requires that the Commissioner consider the regulations promulgated by DMHC in developing these regulations, the same section does not prohibit the Commissioner continuing to consider the DMHC's regulations on an ongoing basis in the interests of ensuring that insureds have the opportunity to access needed health care services in a timely manner.</p>
<p>Jason Levine Assurant Government Relations Late Comment Letter, October 15, 2007 (comment closed October 9)</p>	<p>2240.1(c)</p>	<p>We apologize for the late comment on PROVIDER NETWORK ACCESS STANDARDS FOR HEALTH INSURANCE POLICIES AND AGREEMENTS (also known as Network Provider Provisions In Health Insurance Policies And Agreements) RH-05043720, September 21, 2007.</p> <p>We would like to suggest that a separate time/distance adequacy standard from the proposed 30 minute/15 mile standard for primary care givers be established for rural areas. A 60 minute/30 mile standard for rural areas would</p>	<p>The Commissioner respectfully declines to respond to this comment, as it was received on October 15, 2007, after the first 15-day comment period closed on October 9, 2007. Notwithstanding that, the Department notes that a determination was made that issues regarding accessibility in rural areas would best be dealt with through a waiver process.</p>

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(L 11, C 1)		make more sense and would prevent over-utilization of the waiver process in the proposed rule.	
<p>Comments received during second 15-day comment period</p> <p>October 24, 2007 – November 8, 2007</p>			
Mary Riemersma, California Association of Marriage and Family Therapists, Comment Letter October 31, 2007 (L12, C1)	2240.1(b)	First, §2240.1(b) was designed to assure accessibility of network provider services in a timely manner to the contracted consumer. The current language does not require insurers or plans to provide up-to-date information about the contracted providers. <i>Phantom panels</i> are notorious throughout the insurance industry, creating situations wherein the consumer is forced to waste hours, if not days, sorting through the numerous providers whom are no longer contract providers, no longer accepting patients or their numbers have changed. It is incumbent upon the Department of Insurance to protect the consumer from such a lack of up-to-date provider information. Included within §2240.1(b) should be a requirement that “An insurer, or plan, shall update their contact information for the contracted providers at least every 30 days.”	The Commissioner respectfully rejects this comment. It is beyond the scope of the statutory authority that the Department should require insurers to update their contact information for network providers every 30 days. The operational approach that insurers take to keeping their provider data current is outside the scope of these regulations. Further, the consumer complaint reports required to be filed at the end of the year would reveal if this issue is a problem for an insurer at which point, the Department could take action to more closely monitor compliance by an insurer’s whose PPO Network information is seriously out of date.
Mary Riemersma, California Association of Marriage and Family Therapists, Comment Letter October 31, 2007	2240.1(c) (7)	Second, the original §2240.1(c)(7)’s language ensured that covered persons had appropriate access to covered health care services, within an acceptable geographic location. However, the Department’s striking of that language now allows an insurer, or plan, to easily waive that requirement rather than send a consumer to a non-network provider. This absolutely violates the spirit of the legislative intent to ensure accessibility of health care to the Californian consumer and	The Commissioner respectfully disagrees with this comment; in fact this section- 2240.1(c) (7) is intended to reflect the reality of underserved, mostly rural, areas in California where the standards are physically impossible to meet. If the insurer cannot demonstrate that this is the primary reason why the access standards are not met, the Commissioner will

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(L12, C2)		solely benefits the insurer.	not grant the waiver.
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13, C3)	2240.1(b)	Section 2240.1(b) – Again, this subsection should be limited to network provider services within California to be consistent with the intent of the definition of “service area.” While network options may occur outside California in some cases, it would be virtually impossible to monitor these requirements.	The Commissioner respectfully rejects this comment. These regulations apply to network provider services within California, only.
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13, C4)	2240.1(b)(4)	Section 2240 [sic] (b) (4) – Requires “basic health care services” to be available at least 40 hours a week, available until at least 10:00 p.m. at least one day a week or for at least four hours each Saturday. Since “basic health care services” include specialists, it would be virtually impossible to ensure that certain specialists have office hours within these after hours parameters. After hour services should be limited to urgent care, or in some instances primary care.	The Commissioner respectfully declines to respond to this comment, as it comments on matters outside of the scope of amendments proposed during the second 15-day notice period. There were no amendments proposed to section 2240.1(b)(4) during the second comment period.

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<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13, C8)</p>	<p>2240.1(b) (c)(d)</p>	<p>There are a number of provisions in the regulation for which it is not clear if they apply only within the service area or anywhere there are network providers. For example:</p> <p>Section 2240.1(b), (c) & (d) - These should <u>not</u> apply <u>at all</u> with respect to network providers outside of the state - but, that limit isn't stated</p>	<p>The Commissioner respectfully rejects this comment. The provisions of this regulation do not apply to network providers outside of California. This is clearly delimited by the change made to Definitions in Section 2240 (m).</p>
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13, C10)</p>	<p>2240.1(b) (6)</p>	<p>In addition to the above, there are a few other provisions that need clarification that may benefit from a discussion with the Department as to intent:</p> <p>Section 2240.1(b)(6) - What does "other network arrangement mean"?</p>	<p>“Other network arrangements” means arrangements other than an insurer directly providing with providers to provide services to members at alternative rates pursuant to section 10133. Leased networks are an example of “other network arrangements.”</p>
<p>Anne Eowan, Association of California Life & Health Insurance</p>	<p>2240.1(b) (7)</p>	<p>Section 2240.1(b)(7) – Has the department determined that carriers are going to have a system to monitor access that includes monitoring appointment wait time? It is not clear how that can be accomplished, given that insureds are not required to go through a primary care physician's office that might be able to report or track</p>	<p>The Commissioner respectfully rejects this comment. The proposed regulations in this Section only require the insurer to have written procedures in place regarding how the insurer plans to monitor access including appointment waiting times. Tracking complaints and responding accordingly to geographic</p>

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Companies (ACLHIC) Comment Letter November 7, 2007 (L13, C11)		these times. This probably could only be done retroactively through complaints or surveys. How does the Department view compliance with this requirement?	areas highlighted by complaints would be such a system. The insurer has been left with considerable discretion to develop, and implement an internal system for monitoring access by their insureds to their PPO Network providers.
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13, C12)	2240.1(c) (7)	Section 2240.1(c)(7) - This continues to be a challenge, as per our previous comments. It would be really helpful to have a discussion with the Department to see what it expects would occur under this waiver provision. <u>One change we would strongly recommend that would alleviate a number of requests for waiver would be to allow carriers to have more flexible requirements under Section 2240.1 for rural areas vs. urban areas, similar to the distinction made in the NCQA guidelines.</u>	The Commissioner respectfully rejects this comment. The waiver provision in this section is very flexible and is designed to accommodate multiple reasons for a PPO Network's inability to meet the state time and distance standard, including the differences between urban and rural areas.
Diane Przepiorski, California Orthopedic Association Comment Letter November 6, 2007 (L14, C2)	2240.1	1. Plans should be required to demonstrate adequate access to specialists within their networks. Plans often cite a total number of providers within their network, but fail to cite the number of specific specialists within the network. For example, it provides little benefit to patients if they have access to a dermatologist if they actually need availability to an orthopaedic surgeon, etc. Plans should be required, based on their historical claims data, to demonstrate to the Department that they have an adequate number of medical specialists to provide care to their beneficiaries.	The Commissioner respectfully rejects this comment. While it is common for insurers to set and measure their PPO Network against internal access standards set for each individual specialist type, it is not feasible for the Department to receive this many reports for each insurer's PPO Network. The Department can monitor protracted lacks of specialists in certain geographic areas through consumer and provider complaints filed annually and through complaints received by the Department's Consumer Services Division.

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<p>Teresa Favuzzi, Disability Health Coalition, November 8, 2008, L15, C1</p>	<p>2240.1</p>	<p>The revised text of section 2240.1(b)(6) concerns the maintenance of healthcare professional and administrative staffing ratios so “provider services will be accessible to covered persons without delays detrimental to the health of each the [sic] covered persons.” Section 2240.1(b)(7) concerns ensuring that “basic health care services are accessible to covered persons.”</p> <p>We support the Department’s proposal to regulate health insurers to ensure the accessibility of health care services provided through network providers, and seek to clarify that “accessible” as raised in the revised text of section 2240.1 and throughout the proposed provision includes accessibility for covered persons with disabilities.</p> <p>People with various disabilities encounter numerous barriers when seeking health care that impede their access to timely access to care. These barriers include architectural barriers (e.g., the lack of a needed ramp or elevator, entry doors that are too narrow, no or inadequate Braille signage, lack of maneuverability for wheelchair users), as well as programmatic barriers (e.g., clinical and office procedures and policies that result in a refusal to admit service animals, a failure to provide sign language interpreters, or the lack of trained transfer assistance or accessible medical screening</p>	<p>The Commissioner respectfully rejects the request to restate that the Unruh Civil Rights Act applies to health care providers. A restatement of existing law does not increase its import or applicability. It applies currently; prior to adoption of these regulations. Further, the Commissioner relies on the strength of the Section 2240.1(3) wherein facilities used by providers are required to be reasonably accessible to the physically handicapped. Further detailed requirements should be negotiated with other state departments that regulate the physical plant of health care providers.</p> <p>Details about how a doctor’s office or hospital should be required to make certain examination equipment more physically accessible for persons with disabilities are outside the scope of these regulations. There is no statutory authority here for regulating the type or size of examination tables and imaging equipment a network provided must have; that would fall to another state department which regulates facilities and physical access to and within facilities and health care providers.</p>

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		<p>and diagnostic equipment such as adjustable exam tables and imaging equipment). People with disabilities who encounter architectural and programmatic barriers inevitably receive delays in their care and a lesser quality of care as examinations cannot be completed, critical health information cannot be communicated, and appointments must be re-made.</p> <p>According to the Department of Insurance’s original November 24, 2006 Notice of Proposed Action, the proposed access standards, as well as the new insurance reporting and complaint procedures, are “designed to ensure that all covered persons have timely access to care including assuring continuity of care.” For covered persons with disabilities, architectural and programmatic accessibility is critical to achieving timely access to care and continuity of care and is therefore implicit in the revised provision’s references in section 2240.1(b) to staffing ratios and the need to ensure “accessible” basic health care. Nonetheless, given the importance of this issue to our members, we ask for the explicit inclusion of language which clarifies that in the Provider Network Access Standards of Article 6, “accessible” includes:</p> <ul style="list-style-type: none"> (i) architectural compliance with the requirements of the Unruh Civil Rights Act, California Government Code 11135, the Americans with Disabilities Act of 1990, and Section 504 of the Rehabilitation Act; and (ii) reasonable modification of provider policies, practices and procedures to the extent 	<p>It is noteworthy that the Department recently adopted new regulations requiring language interpreters as needed by patients which could include sign language.</p> <p>The Commissioner respectfully rejects the addition of a general statement regarding the necessity of access regulations to the health, safety or welfare of the state as unnecessary and overly broad.</p>

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		<p>necessary for appropriate care and services, including the provision of accessible medical screening and diagnostic equipment such as lift equipment, adjustable high/low exam tables, wheelchair scales, and imaging equipment.</p> <p>Such an explicit clarification is entirely consistent with the requirements of federal and state law that the Department of Insurance is required to consider in section 10133.5(c) of the Insurance Code. Since the Department is proposing these Provider Network Access Standards as regulations under its authority to promulgate regulations under section 10133.5, we believe that our requested clarification and language is within both the Department's rule-making power and its responsibility. The Department's requirement in section 2240.1(b)(3), that insurers shall ensure "facilities used by providers to render basic health care services are . . . reasonably accessible to the physically handicapped," recognizes the fact that access to healthcare necessarily encompasses architectural accessibility. However, physical access to facilities is only a necessary first step in ensuring that timely access to health care is received once one gets in the door.</p> <p>...</p> <p>Once again, the Disability Health Coalition reiterates our support for the Department's enactment of Provider Network Access Standards. We also strongly advocate that the Commissioner's finding that these proposed program access amendments to the Insurance Code regulations, <i>with</i> the clarification that we have proposed above, "is necessary for the health, safety, or welfare of</p>	

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		the people of the state.”	
Topic 18: Section 2240.2 Insurance Contract Provisions			
Anne Eowan, , Association of California Life & Health Insurance Companies (ACLHIC). Comment letter January 11, 2007 (L1, C7)	2240.2	<p><u>Notice Requirements Lack Authority.</u> Section 2240.2 (b) requires written notice to a contractholder if any provider is terminated from the network if such termination would materially and adversely affect the contract holder or covered persons. Since it would be impossible to determine if termination of any provider in a 70,000 provider network would adversely affect any one covered person (since they are not limited by geographic area to access the providers) this is in effect a mandate to send to each insured a written notice any time a provider terminates. There is no authority in IC Section 10133.5 for such a notice. Section 10133.56 of the Insurance Code is also cited as authority for this section. We would note that Section 10133.56 only requires notice of the opportunity to request continuity of care <u>upon request by the insured.</u> There is no requirement to proactively send notices every time a provider terminates their contract with an insurer.</p> <p>Further, this section continually cites “service area” of the insurer. We would note the objections raised earlier about the inappropriateness and the inapplicability to open network PPO plans. This is highlighted by</p>	<p>The Commissioner respectfully rejects this comment. Notice regarding provider termination is essential to assure accessibility of provider services in a timely manner, as required by Insurance Code section 10133.5. As the commenter notes, most commercial provider networks utilized by health insurers in California are large and provide robust access to insureds. Since the authorizing statute, §10133.5(b) requires the CDI to ensure that insureds have timely access to care, in the event that an insured no longer has the required access to a network provider as a result of the provider’s termination, this notice requirement is triggered. A simple geonetworks style report which is routinely performed by managers of the insurer’s provider networks will reveal whether or not the loss of a key provider type or provider group in a particular geographic area will or will not have a material adverse impact on covered insureds who are accessing the now terminated provider. The notice requirement is only triggered if there actually is a material and adverse impact on those insureds and this</p>

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		subdivision (b), which requires health insurance contracts to allow payment of a service rendered on an emergency basis outside the service area. Again, there would be no limitation as to reimbursement regardless of the locale of the emergency treatment.	is easily determined by the insurer who is monitoring network strength on an ongoing basis. This is not a mandate to provide notice to every insured whenever a provider is terminated from a provider network. It is constructed much more narrowly in its application. Please see responses on service area comments provided earlier, above, at Topic 14.
Anne Eowan, , Association of California Life & Health Insurance Companies (ACLHIC). Comment letter January 11, 2007 (L1A, C13)	2240.2	<i>(alternative language proposed by comment author)</i> 2240.3 Insurance Contract Provisions Health insurance policies or contracts containing provisions covering network provider services shall contain the following: (a) A provision that, pursuant to Insurance Code Section 101 33.56, upon termination of an network provider contract, the insurer shall be liable for covered benefits rendered by such provider to a covered person under the care of such provider at the time of termination until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such services by another network provider are made. This provision need not provide that the insurer shall be liable for any services rendered to a covered person after such person ceases to be eligible for coverage under the group insurance contract.	The Commissioner respectfully rejects this comment, for the reasons set forth in the response cell immediately above, incorporated here by reference.

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		<p>(b) A prominent disclosure pursuant to Insurance Code Section 510 stating that covered persons who have complaints regarding their ability to access needed health care in a timely manner may complain to the insurer and to the California Department of Insurance. The disclosure shall include the address and the customer services telephone number of the insurer and the name address and toll free telephone number of the Consumer Services Division of the Department of Insurance.</p> <p>(c) A provision or attachment identifying all network providers or describing how a copy can be obtained or found on the internet.</p>	
Eric C. DuPont, MetLife Comment letter January 11, 2007 (L2, C5)	2240.2(b)	<p>b. <u>Section 2240.2(b)</u> - relating to the requirement that insurers notify their contractholders of any “termination or permanent breach of contract by, or permanent inability to perform of, any network provider.” While MetLife Dental believes it is in the best interests of their contractholders and covered persons for MetLife Dental to maintain an up-to-date network provider list, it is inappropriate to require insurers to notify contractholders that a network provider has breached its agreement with MetLife Dental. An unintended effect of this provision is to subject insurers to potential legal liability.</p>	<p>The Commissioner respectfully rejects this comment. §2240.2(b) is an existing regulation and addresses the very limited situation when a patient’s network provider is no longer included in the provider network AND the provider’s termination would materially or adversely affect the insured. In most instances, an insured could access an alternative network provider to avoid a material and adverse impact in which case no notice is required by the regulation.</p>

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		<p>Instead, MetLife Dental suggests that a provision regarding the timely maintenance of network provider lists is more appropriate.</p>	
<p>Eric C. DuPont, MetLife Comment letter January 11, 2007 (L2, C6)</p>	<p>2240.2(c)</p>	<p>c. <u>Section 2240.2(c)</u> – relating to the requirement that insurers include a provision in their contract with their contractholders requiring contractholders to deliver notices of 2240.2(b) within 30 days. In addition to the reasons stated under comments on 2240.2(b), MetLife Dental is concerned that, if an insurer is aware that notices are not distributed, the insurer could be responsible for enforcing contract provisions. If not, the insurer could have liability with regard to the certificate holder or the Department. Further, this requirement is not consistent with the practices of insurers today; that is, most insurers maintain websites where covered persons may access up-to-date lists of providers. Instead MetLife suggests that a requirement to maintain an up-to-date list of network providers in a manner, as determined by the insurer, to assure availability of the list to covered persons should suffice to fulfill any notice of changes in network providers.</p>	<p>§2240.2 (c) is existing regulation and ensures that persons covered under a group insurance contract would receive notice that had been given to the contract holder if the covered person would be materially and adversely affected by the termination of a network provider being utilized by the covered person. This existing regulation imposes the notice requirement on the contract holder of a group policy, not the insurer.</p>
	<p style="text-align: center;">Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>		

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<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p> <p>(L6A, C29)</p>	2240.2	<p>We recommend the following revised language:</p> <p><u>Health</u> insurance <u>policies</u> or contracts containing provisions covering network provider services shall contain the following:</p> <p><u>Rationale:</u> To ensure consistency with section 106 (b) of the insurance code.</p>	<p>The Commissioner respectfully rejects this comment. Based on proposed section 2240.1(a), which references Insurance Code section 106(b), this regulation plainly applies to health insurance. Further, the term “insurance contracts” encompasses insurance policies.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p> <p>(L6A, C30)</p>	2240.2(a)	<p>We recommend deletion of this language.</p> <p><u>Rationale:</u> Insurers are responsible for coverage of such services and for ensuring that there is adequate provider network capacity to serve the insured population. Therefore this language is unnecessary and redundant.</p>	<p>The Commissioner respectfully declines to respond to this comment, as it is outside of the scope of the changes to the to the regulation proposed during the first 15-day comment period (which began September 21, 2007, and ended October 9, 2007). There was no amendment of 2240.2(a) proposed.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to</p>	2240.2(b)	<p>We recommend deletion of this language.</p> <p><u>Rationale:</u> There is no authority in Section 10133.5 for such a notice. Section 10133.56 of the Insurance Code is also cited as authority for this section. Section 10133.56 only requires notice of the opportunity to request continuity of care <u>upon request by the insured</u>. There is</p>	<p>The Commissioner respectfully declines to respond to this comment, as it is outside of the scope of the changes to the to the regulation proposed during the first 15-day comment period (which began September 21, 2007, and ended October 9, 2007). There was no amendment of 2240.2(b) proposed.</p>

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<p>Comment letter October 9, 2007 (L6A, C31)</p>		<p>no requirement to proactively send notices every time a provider terminates their contract with an insurer.</p>	
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C32)</p>	2240.2(c)	<p>We recommend deletion of this language.</p> <p><u>Rationale:</u> There is no authority in Section 10133.5 for such a notice.</p>	<p>The Commissioner respectfully declines to respond to this comment, as it is outside of the scope of the changes to the to the regulation proposed during the first 15-day comment period (which began September 21, 2007, and ended October 9, 2007). There was no amendment of 2240.2(c) proposed.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C33)</p>	2240.2(d)	<p>We recommend the following revised language:</p> <p>A provision that, pursuant to Insurance Code Section 10133.56, upon termination of a network provider contract, the insurer shall be liable for covered <u>benefits</u> rendered by such provider to a covered person under the care of such provider at the time of termination until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such services by another network provider are made. This provision need not provide that the insurer shall be liable for any services rendered to a covered person after such person ceases to be eligible for coverage under the contract.</p>	<p>The Commissioner respectfully rejects this comment, because section 10133.5(b) provides that “these regulations shall be assigned to assure accessibility of provider services,” and the definition of “basic health care services” proposed in 2240(a) includes the qualifier “covered health services provided for in the applicable insurance contract or certificate of coverage.”</p>

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		<u>Rationale:</u> The statute (Section 10133.5 (b) requires that there is accessibility of provider services for benefits covered under the contract.	
Comments received during second 15-day comment period October 24, 2007 – November 8, 2007			
Mary Riemersma, California Association of Marriage and Family Therapists, Comment Letter October 31, 2007 (L12, C3)	2240.2(b)	Lastly, §2240.2(b) fails to define what “a reasonable period of time” means in context of provider termination notice to the contractor holder. What is reasonable? 10 days? 30 days? 1 year? Without clarification, this creates an ambiguous situation for the insurer, or plan, and creates a loophole with which to delay notice.	The Commissioner respectfully declines to respond to this comment, as it is outside the scope of the proposed amendment to the regulation. No amendment to 2240.2 was proposed during this second 15-day notice period.
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007	2240.2(e)	Section 2240.2(e) – “Service area” is required to be defined in the policy. This should only be required if there is a service area or areas within California that are smaller than the entire State. Otherwise, it would be confusing for insureds.	The Commissioner respectfully declines to respond to this comment, as it is outside the scope of the amendments proposed during the second 15-day comment period (which began October 24, 2007 and ended November 8, 2007). No amendment to 2240.2(e) was proposed during that comment period, or at any time.

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(L13,C5)			
Topic 19: Section 2240.3 Provisions of Certificates			
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (34:4-37:24)	2240.3	<p>MS. EOWAN: All right. "Insurance Contract Provisions," this is another one where some of the old language from the EPOs may be, or maybe we've moved on past that statutorily, I'm thinking; and again, we kind of put this together in one section because since we're taking out group contracts, we didn't see a need to have something different for certificate holders but, you know, maybe the Department has a reason for that that we didn't see because any insured would probably want to have whatever you're doing in here, so their contract would have this in here, but perhaps there's something in there that we're not getting.</p> <p>You'll see that we just kind of picked the ones that we thought were appropriate for now. We -- today, for example, point 2 (a), provision of coverage on indemnity or provision of service basis for emergency health care services to be rendered to covered persons outside the service area, that would be something you'd want for an EPO, but for a PPO you always get services outside the network area, so, you know, that's what I'm saying. And we didn't include that in ours because we're doing this kind of more in 0035 terms of a PPO.</p>	<p>The Commissioner respectfully rejects the comments regarding the notice requirement. The continuity of care regulations referred to by the commenter are in place and function independently of the proposed regulations. There is no additional notice to the insured requirement if a provider terminates from a PPO Network created by these regulations.</p> <p>As noted during the testimony, most of this commenter's testimony addressed existing EPO regulations and not the proposed changes or additions. The rulemaking process was not intended to change the requirements for EPO policies as outlined in the original regulations.</p>

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		<p>And then subdivision (b), this is a -- we're not quite sure where the authority for this is. It was in the old, as I said, the existing EPO regulations, but with the -- since then we've had the, we've had the continuity of care laws passed and a number of other things; and when you take (b) and (d) together, the notice requirements to the insured under the continuity of care statute is specific.</p> <p>It says that you only have to provide -- you have to put it in your disclosure documents, but like your EOBs and that sort of thing, but -- not EOBs, I'm sorry, but evidence of coverage. But you only have to notify them of their rights to have continuity of care if they asked for that policy, and this requires that every single person that you insure, every time a provider terminates from the network that you have to send them a notice; and that goes beyond the statute in terms of what you're required to provide notice for for continuity of care.</p> <p>So, bringing (b) and (d) together, that would be extraordinarily expensive because, you know, you've got 70,000 to 100,000 providers in a network, and one might come in or go out or what have you, and so what you do have to do is provide them continuity of care.</p> <p>0036</p> <p>As you know, the -- you've read the statute -- should the provider be willing to take the in network reimbursement rates, and it's only for certain services, so this we thought went beyond statute and so we didn't include it in our regulations.</p> <p>You've got a lot of warnings in here that are under point three. I think this is stuff that is already covered under existing law now in other notice</p>	<p>As noted, these regulations do not alter the requirements of the current continuity of care regulations.</p>

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		<p>requirements, and a lot of this has to do with emergency services. And again, since you don't -- you've got emergency services statewide, it may not be as applicable as it might have been 20 years ago, so you might want to just look at that in terms of whether or not it's appropriate anymore.</p> <p>In subdivision (e) we've proposed a slightly different change to this where you, you either offer them a provider directory in writing or tell them where they can get it, but there's no requirement that you have to have it on the Internet, so we've amended that slightly that you either tell them how they can get a copy or how they can access it on the Internet; most of the larger companies though do have Internet access.</p> <p>We're just concerned that that seemed to be going beyond what's required in your statute. And we included subdivision (f) that you have 0037 here in our proposed regulations. Are there any questions about that?</p> <p>MS. ROSEN: The continuity of care, do you have a citation on that?</p> <p>MS. EOWAN: I do, I think it's in my letter, it's in my letter.</p> <p>MS. ROSEN: Okay.</p> <p>MS. EOWAN: Yeah, it's one of the issues that I raised in my letter.</p> <p>MS. ROSEN: You feel that the continuity of care legislation that was passed after the -- because a lot of your comments are on the existing regs, not on the changes.</p> <p>MS. EOWAN: I know, I know, but see, since that would -- I understand completely, but I guess my</p>	<p>There is nothing in the proposed regulations that alters the insurer's obligations with respect to making a PPO Network directory available to insureds.</p> <p>The proposed regulations do not expand former EPO requirements to PPO Networks since that is generally not necessary as PPO Networks typically use the entire State of California as their service area and they do not limit covered benefits to network providers. Therefore, the key regulatory provisions that apply to EPOs perforce do not apply to PPO insurance policies since their terms and conditions are so dramatically different due to their open access network feature and the right of insureds to access out of network providers and get some, albeit limited, policy coverage.</p>

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		<p>point is is that some of the things that -- this now currently only applies to EPOs, but now we're taking the existing regs and we're applying them more broadly to PPOs, and so I wasn't around to comment on the EPO regs; now that they're going to apply more widely, I think it's really important that they reflect all the changes in the existing law that have been made since then. I think a number of us haven't looked at the EPO regs in years.</p>	
<p>Sheree Kruckenberg, Chair, Mental Health Parity Workgroup, California Coalition of Mental Health (L5, C10)</p>	<p>2240.3</p>	<p>(f) Neither this regulation package in general, nor these sections specifically, contain provisions for providers of services to complain. We would recommend a provider grievance and complaint resolution system be developed and included in these access regulations.</p>	<p>The Insurance Code already provides specific provisions allowing provider complaints to be filed with insurers and with the Department. See CIC §10123.137.</p>
<p>Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007</p>	<p>2240.3</p>	<p><i>(alternative language proposed by comment author)</i> (e) A provision or attachment identifying-all network providers or describing <u>where a current directory of network providers can be found on the Internet- which is continuously updated.</u></p>	<p>The Commissioner respectfully rejects this comment. This subsection provides for information that is required to be included in certificates of insurance. It requires that the certificate contain information regarding where a directory of providers may be found on the internet (such as, for example, a website address). Given the nature of this section, it would not be appropriate to describe requirements for the content of such a website in this context.</p>

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(L5A, C9)			
Leanne Gassaway, CIGNA Companies Testimony at public hearing January 11, 2007 (53:14-24)	2240.3	I have kind of a technical issue that Anne did not raise because it seems like it's something completely so silly that I shouldn't even have to mention it, but there's a section in 2240.3 that would require us under (c)(2) to print certain disclaimers in red font. We don't do red font, we do our contracts in black and white, and I think most of us try to keep our materials in a cost-effective manner, and any time that you add color or font requirements or things to that extent, it raises the cost of those materials, and so if you can take the red out, that would be great.	The Commissioner has adopted this comment and deleted the requirement that the disclaimer be printed in red font.
	Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007		
Andrea DeBerry, Blue Shield of California, Comment letter, October 9, 2007 (L8, C3)	2240.3(d)	Section 2240.3(d) was left in from the EPO regulations and won't apply to a PPO. At a minimum, it should say "if any" - since in a PPO there is no area where services are restricted ONLY to network providers.	The Commissioner adopts this comment. Section 2240.3(d) was changed to read "if applicable."

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<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p> <p>(L6A, C34)</p>	2240.3(a)	<p>We recommend deletion of this language.</p> <p><u>Rationale:</u> Insurers are responsible for coverage of such services. Therefore this language is unnecessary and redundant.</p>	<p>The Commissioner respectfully declines to respond to this comment, as it is outside of the scope of the changes to the to the regulation proposed during the first 15-day comment period (which began September 21, 2007, and ended October 9, 2007). There was no amendment of 2240.3(a) proposed.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p> <p>(L6A, C35)</p>	2240.3(e)	<p>We recommend the following revised language:</p> <p>A provision or attachment identifying all network providers or describing where a current directory of network providers <u>how a copy can be obtained or found</u> on the internet.</p> <p><u>Rationale:</u> There is no authority in Section 10133.5 for requiring directories of network providers on the Internet.</p>	<p>The Commissioner respectfully rejects this comment. Insurance Code section 10133.5 directs the Commissioner to promulgate regulations “to ensure that insureds have the opportunity to access needed health care services in a timely manner.” The Commissioner has determined that availability of provider directories on the internet is necessary in order to ensure the opportunity for insureds to have timely access to health care services.</p>
	<p style="text-align: center;">Comments received during second 15-day comment period October 24, 2007 – November 8, 2007</p>		

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Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13,C6)	2240.3(a)	Section 2240.3(a) – This provision requires a description of the coverage provided by the contract for emergency services outside the service area. Does this mean in-network versus out of network rates that might apply? Otherwise, it seems to imply that emergency services could not be covered.	The Commissioner respectfully rejects this comment regarding the implication that emergency services could not be covered. The section requires a description of the emergency services covered outside the service area (or outside California, if the service area encompasses the entire state). If there is a network vs. non-network coverage differential for this out-of-area care, a description of this aspect of the coverage should be included.
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13,C7)	2240.3(b) and (c)(1)	Section 2240.3(b) and (c) (1) – In our first comment letter to you on these regulations, we noted several provisions taken from existing regulations that at that time applied only to Exclusive Provider Networks which do not have an out of network option. Since PPOs do not limit services to within a network, some of these requirements were nonsensical. These two subdivisions would fall into the category of requirements that would be more applicable to EPOs rather than PPOs and should be modified or deleted. For example, under subdivision (b), is this description required if the coverage is the same within the "service area" as it is anywhere else: i.e., the coverage is the same for network and non-network providers both within the service area and elsewhere? The same question were pertain to (c) (1).	The Commissioner respectfully rejects this comment. The regulations apply to both EPO and PPO policies and the terms of coverage for all services for both network and non network providers are governed by the terms of those insurance contracts. These regulations do not affect coverage decisions and as such the comment is not applicable. The answer to the commenter’s question : is the coverage the same for network and non-network providers within the service area and elsewhere is addressed by the insurance contract terms of coverage not these regulations.

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Topic 20: Section 2240.4 Contracts with Providers

<p>Anne Eowan, , Association of California Life & Health Insurance Companies (ACLHIC) Comment letter January 11, 2007 (L1, C8)</p>	2240.4	<p><u>Provider contract requirements exceeds authority.</u> Subdivision (a) imposes enforcement requirements on insurers to ensure that their contracted provider does not discriminate in the provision of contracted services on a number of bases, many of which exceed even what is required of insurers under law (note that in addition to the long list of discriminatory activities, “any basis” is included, as undefined). There is no authority in any of the Insurance Code Sections cited that require insurers to enforce anti-discrimination requirements on providers. Section 10133.5 simply requires that provider contracts be fair and reasonable. There is no authority to require a prohibition against balance billing in the contract, regardless of its laudable virtue (see (a) (2), nor is there any authority (except for EPOs) to require quality of care (see (a) (3)).</p> <p>We would ask that this section be limited to a requirement that provider contracts be fair and reasonable.</p>	<p>The Commissioner respectfully rejects this comment. The Department is directed by §10133.5(b)4. to assure that contracts with providers that result in provider networks are fair and reasonable. The purpose of the regulation is to implement and make specific this statutory requirement. Non discrimination provisions, anti-balance billing requirements and quality of care requirements are well known to be industry standard provisions in PPO provider contracts. Insurers have a very strong interest in protecting their insureds who are accessing a network provider in order to receive covered network benefits and are interested in making sure the contracted network providers do not discriminate against their insureds, do not balance bill their insureds and adhere to community standards of quality of care.</p>
<p>Anne Eowan, , Association of California Life & Health Insurance Companies (ACLHIC)</p>	2240.4	<p><i>(alternative language proposed by comment author)</i> 2240.4 Contracts with Providers</p> <p>Contracts between providers and insurers shall be in writing and be fair and reasonable as to the parties to such contracts.</p>	<p>The Commissioner respectfully rejects this comment. This recommended language includes a limitation “as to the parties to such contracts,” not found in Insurance Code section 10133.5(b)(4), and inconsistent with 10133.5(b).</p>

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Attachment to Comment letter January 11, 2007 (L1, C13)			
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (37:25-39:25)	2240.4	<p>Okay. Under point four, "Contracts with 0038 Providers," the main comment that we're making here in this section is the only thing that's in statute that the Department's authorized to put in the regulations is that they have to be in writing and have to be fair and reasonable, that's in section 10133.5.</p> <p>But you guys have included a number of additional things here, and some of which we think would probably be a good idea, there's just no statutory authority for doing it. For example, (a)(2), this looks like it's an anti-balance billing provision that you'd have to amend into your provider contracts. That's something that is required under the Knox-Keene Act, but there's nothing in the Insurance Code that does it. It's not that we don't think it's a good idea, but we just -- if you require the contracts to be amended to do that, there's no statutory authority we don't think to do that.</p> <p>And even four, making sure the provider's primary consideration shall be the quality of care, we think that's a very good idea, but there's no authority in statute to do that. And particularly we're concerned about five, I may have cited that wrong, it's four I just meant before about the quality of care.</p> <p>Five, this is ensuring, including provisions ensuring that providers shall not discriminate. You've 0039</p>	<p>The Commissioner respectfully rejects the comments. Specifically, 2240.4 (a) (2) is not an anti-balance billing provision. Rather it simply states that additional charges charged by the provider to the patient or insurer for network services are not allowed. This does not address charges that may be owed by the patient when not paid by the insurer (e.g. balance billing) which is allowed under the Insurance Code as the commenter notes. This provision refers to charges above and beyond the basic charges for the network services encompassed by the provider agreement.</p> <p>The provision pertaining to the provider's primary consideration being primary care is in the existing regulation and is not new.</p> <p>It is industry standard to have anti-discrimination provisions in provider contracts used by insurers and in a very basis sense it would fall within the Commissioner's discretion to determine that a fair and</p>

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		<p>not only, you've said -- we don't see that there's any authority in statute to require us to regulate them through contract. I mean our only thing we could do is cancel their contract if there was ever a complaint about discrimination, but you've gone beyond even what the statute has as bases for discrimination, anti-discrimination it says "hereunder, on any basis including," and so we're very concerned about that.</p> <p>So we're -- if you just look at our proposed language, it's very simple, it says they have to be -- we stick to the statute, they have to be fair and reasonable as to the parties of such contracts.</p> <p>Again too, this is a lot of changes to provider contracts, and under a lease network you'd have to, you'd have to have the contracting agent go back and amend it to include a lot of bases for discrimination that aren't even included in state law, so -- and if the providers refused to do that, they're just not going to open up 70,000 contracts for renegotiation to do this, so you see what I mean, I want to raise the lease issue with you on this kind of stuff too.</p> <p>I think it would be easy enough to prove up that they're in writing and fair and reasonable if they were leased, but not this other criteria.</p>	<p>reasonable contract would assure that network providers were expressly prohibited from discriminating against insureds based on the grounds listed in the regulation.</p> <p>The purpose of these limited interpretations of what constitutes a fair and reasonable contract between a provider and an insurer formed and maintained to provide covered health care benefits to insureds is to make specific and clarify what this general provision means.</p> <p>With respect to the commenter's concern about leased networks, it's worth noting that when an insurer rents access to a PPO Network, as the client, they are entitled to demand and expect that the owner of the leased network will develop and maintain their PPO Network in a manner that would make it viable in California. For example, doctors who don't meet CA licensing standards are not allowed to practice in this state. California's determination of what constitutes fair and reasonable contracting should not vary based on ownership vs. leasing of a PPO Network designed to serve insureds. There is no authority for making this distinction.</p>

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<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (42:15-45:8)</p>	<p>2240.4</p>	<p>Are there any questions? MS. ROSEN: I do, I've got one. I just – and maybe we haven't written this clearly enough, but the intent of (a)(2) under 2240.4 on the network provider shall not -- that's actually not a new, that's part of the old regulation, it's not part of the new – that network providers shall not make any additional charges for rendering network services, except as provided for in their contract between themselves and the insurer, that was referring to network providers. And unless I'm not understanding balance billing, I thought balance billing only applied when we 0043 were talking about non-network providers. How does balance billing apply for network providers who have a rate, presumably have a rate of reimbursement in their contract? Obviously the insured is required to pay co-pays, deductibles, non-covered services, but all the provider contracts that I've seen have a very express provision that the rate that's negotiated between the insurer and the network provider, that the network provider is to be paid that rate. MS. EOWAN: Right. MS. ROSEN: Except for -- MS. EOWAN: And that's a requirement in the Knox-Keene Act that they put that in there, that they put that in their contract, but I don't think there's a similar provision in the Insurance Code. One would hope that there wouldn't be any balance billing beyond what they have already agreed to be reimbursed. MS. ROSEN: Well, I guess my question is what is balance billing for a network provider in a PPO, what does that mean? I don't understand that.</p>	<p>Please see earlier comment regarding balance billing. These regulations do not address balance billing as this is covered by the terms of coverage in the insurance contract and is not affected by these regulations.</p>

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		<p>MS. EOWAN: That would be that if they get reimbursed an amount and then they would be able to balance bill what they didn't get reimbursed. There you have a contract to be reimbursed a certain amount by the insurer, but to the extent that it's the insured</p> <p>0044 that goes in to get the coverage, they would balance bill. We don't think that they should do it, we're just questioning the authority here.</p> <p>Now, that's in the EPO regs, you know, it's -- we've crossed out "exclusive network providers," but I think that you, I think you --</p> <p>MS. ROSEN: Actually we just have that -- I think that acknowledges the way PPO provider contracts work which is they set a rate, then the provider is to be reimbursed that rate, that's part of the agreement, whatever, \$150 for an office visit --</p> <p>MS. EOWAN: That's what the insurer would pay them, right.</p> <p>MS. ROSEN: Right. So, you're envisioning PPO contracts --</p> <p>MS. EOWAN: I don't think it happens very often. I guess what we're just raising here is that in terms of all of these provisions, and that -- we're only pointing out that there's nothing in statute; if the Department decided to continue that, that's not a bad idea. But in terms of what is in statute in terms of what you can require in regulation based on the statute is just very unreasonable, and we're just pointing that out.</p> <p>Our biggest concern with this section is the</p> <p>0045 last one where we're becoming the enforcer to anti-discrimination provisions to network providers, that's</p>	<p>Please see responses regarding the Commissioner's discretion regarding fair and reasonable contracts between providers and insurers with respect to</p>

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		<p>our biggest concern is the language that you added. MS. ROSEN: Okay. MS. EOWAN: We were just pointing out that, you know, it's what the statute authorizes, but that's not our biggest priority.</p>	<p>protecting insureds from unlawful and unreasonable discrimination by PPO Network providers.</p>
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (45:22-47:11)</p>	<p>2240.4</p>	<p>MS. EOWAN: On any basis? I mean that was one of the issues that was raised to us. MS. ROSEN: I'm sorry? MS. EOWAN: Well, but the issues that were 0046 raised to me that I'm including in this is that while they may put those things in their provider contracts, and it's a good idea, in terms of what the statute allows the Department to require, we don't know what statute that's being based on. And secondly, we're concerned about "on any basis," it goes beyond what the bases are for discrimination that are already in the statute, so it's those two things. MS. ROSEN: Okay. So, the "on any basis" is the main concern? MS. EOWAN: Well, I'd have to go through each one of these, but I think there are a few in here that you have that go beyond, like source of payment maybe, there are some that go beyond what are even in the statute as bases of discrimination, but again we would point out that regulation should be -- as you know, I'm not telling you anything you don't know -- but our concern is that the regulation should be based on the underlying statute. And then while some of these things are really good things to do and a lot of them a lot of companies</p>	<p>The Commissioner has adopted this comment in part, and has stricken "any basis" from 2240.4(a)(5).</p>

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		<p>may be doing it anyway, requiring it in regulation we would point out we don't know what the statute is that you're basing that on. 0047</p> <p>MS. ROSEN: Thank you.</p> <p>MS. EOWAN: All good questions. And if there's anything that, you know, I haven't explained very well in the letter or some of our language is unclear, anything else that we can present to you to clarify this, I know it won't be -- whatever we can do to help.</p> <p>Because we -- as I said, our companies are committed to complying with this and in a way that we feel can be measurable standards in a timely basis, so thanks so much for your time.</p>	
<p>Leanne Gassaway, CIGNA Companies Testimony at public hearing January 11, 2007 (54:25-58:188)</p>	<p>2240.4</p>	<p>MS. GASSAWAY: Oh, can I ask -- I can actually 0055 answer the question about the balance billing that happens on the network side.</p> <p>MS. ROSEN: Great, and your questions were great too. Yes, I am baffled by that.</p> <p>MS. GASSAWAY: One thing that we are starting to see, and actually unfortunately we've had to take some action on recently, is what's called boutique or concierge medicine in which a network provider will start to begin to charge his enrollees a thousand dollars a year to have 24-hour access, telephone access to him personally.</p> <p>We are starting to outlaw that in our contracts. We appreciate that the Department -- we think that that would address some of those situations, but again, I think -- I don't want you guys to be put into a situation that that becomes challenged on a statutory basis, but</p>	<p>The Commissioner respectfully rejects these comments. The comments offered here support the regulations expressly requiring a contract provision that disallows the imposition by providers of additional charges outside the terms of the provider contract.</p> <p>This commenter confirms that any balance not paid by the insurer to a network or non-network provider under the terms of coverage of the insurance contract</p>

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		<p>that is one area that we are starting to see kind of percolate up in some very small areas of the state where we have physicians who are looking to improve their income by offering an enhanced service to their patients, and they're doing it through these boutique arrangements.</p> <p>Secondly is in some contracts that I may have with an enrollee, balance billing actually may be a perfectly legitimate thing, differently than in the HMO 0056 context. In the HMO context, you have a fixed dollar amount that you pay to that provider, \$10 co-pay, \$25 co-pay, whatever it may be, and then the plan's going to pay whatever the balance of that bill is to the provider and the provider gets nothing more.</p> <p>In the PPO environment, my contract may actually say that I am allowed to pay -- that the plan will pay 80 percent of the usual and customary charge, and the enrollee would be responsible for the 20 percent of the usual and customary charge, but that provider may have a higher rate than a usual and customary charge, and that is allowed under certain contracts.</p> <p>And they're starting to become less and less frequent, but that is allowed balance billing because that member has chosen to go to a more expensive provider basically, and they've chosen to do that. So, we will look at our data and we'll say an average charge for this is \$100, we all pay \$80, we would expect that the enrollee would pay \$20, but that provider may charge \$120, and so the enrollee then would have to pay the additional \$20. Does that make sense?</p> <p>MS. ROSEN: Yes, I think the light bulb is finally going on here. I've never seen a PPO provider</p>	<p>will be the responsibility of the insured. These regulations do not address this practice which is allowed if the provider agreement and the insurance contract don't expressly forbid it.</p> <p>This is not a provider contracts matter; it is a coverage question.</p>

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		<p>0057 contract that's based on UCR, but what I'm hearing is -- MS. GASSAWAY: Yes, they exist sometimes in the dental area. 5 MR. HINZE: Just try to keep one to speak at a 6 time. 7 MS. ROSEN: So, just so I'm understanding this right, there are PPOs in California, or Cigna has some contracts for example where the basis for the rate is not a fixed schedule of some sort, but it's triggered from usual and customary charges, and so therefore you set a limit on what you consider UCR, and anything above UCR or above your percentage of your payment, the patient, the insured could be responsible for. MS. GASSAWAY: Could be, yes. MS. ROSEN: So, it could be 20 percent of what CIGNA says is the UCR, and then the provider under your contract has the right to charge the difference between Cigna's UCR and their bill charge. MS. GASSAWAY: Yes, they're very rare, they're very small amounts that are like that anymore because we like to have some more finite expectations for both the plan and the enrollee, but in the dental arena where there's a little bit more of a UCR fee schedule that's acceptable, unlike the medical arena, you do see 0058 some things like that. I will also comment I do represent Cigna Dental Insurance Company as well, and we do have some concerns about the applicability of these regulations to</p>	<p>This discussion pertains to pricing of services within a PPO contract which is not addressed by these regulations.</p> <p>These regulations have been changed to exclude their application to dental only and vision only insurance policies.</p>

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		<p>the dental only, vision only, behavioral health only plans, so to the extent that we could find a way to address that these -- for example, you talk about medical services repeatedly through this, and that doesn't really apply to a dental plan, they don't cover medical services.</p> <p>So, to the extent that we could add possibly a paragraph to address how this affects something like a limited -- I hate that term -- limited benefit plan, that would be helpful so that we have some clarity around that.</p>	
<p>Eric C. DuPont, MetLife Comment letter January 11, 2007 (L2, C7)</p>	<p>2240.4</p>	<p>c. <u>Section 2240.4(a)(5)</u> - relating to non-discrimination by providers in the provision of contracted services. MetLife Dental supports the purposes of this section – to prohibit discrimination – and commends the Department for seeking to assure that insureds are not discriminated against. However, MetLife Dental respectfully suggests that this requirement is not statutorily authorized and is beyond the role of an insurer contracting with a provider.</p>	<p>The Commissioner respectfully rejects this comment. The authorizing statute that applies to this proposed regulation is §10133.5(b) 4. It requires that an insurer’s contracts with providers be fair and reasonable. The Department, in meeting its obligations to interpret and make specific this statute believes that the non-discrimination parameters outlined in §2240.4(a) (5) are reasonable and meet the intent of the authorizing statute.</p>
	<p style="text-align: center;">Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>		

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COMMENTER	SECTION	<p style="text-align: center;">VERBATIM COMMENT</p> <p style="text-align: center;">(All mistakes in text appear in original)</p>	<p style="text-align: center;">CDI RESPONSE</p>
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter October 9, 2007 (L7,C3)</p>	2240.4	<p><u>Requirements on Insurers to Regulate Agents Lacks Authority.</u> Section 2240.4 requires insurers to meet various requirements related to a provider contract. The revised text imposes the requirement on the agents of insurers, and appears to make insurers the regulator of these private contracts. It is not clear what is meant by “agent.” Presumably the department means unrelated companies that enter into agreements with providers and then lease the networks to other entities, such as insurers. These agents are not employees of the insurer, and thus not under the control of the insurer. The department would be exceeding their authority to extend the requirement to agents, however that might be defined. It would impose a liability on insurers for private contracts</p> <p>between two unrelated parties, which also would exceed the authority of the statute and general contract law.</p>	<p>The reference in Section 2240.4(a) to “agents of the insurers” addresses the insurers who do not directly own or maintain their own provider contracts but instead access a PPO Network for their insurance programs through an agent. In this situation, the agent owns, holds and controls their contracts with PPO Network providers.</p> <p>Please see earlier comment with respect to the requirement that insurers select agents whose provider contracts meet the regulatory requirements with respect to fair and reasonable contracts. There is no reason why an agent operating a for-lease PPO Network should not be held to the same fair and reasonable provider contracting standard as insurers who operate their PPO Network directly. If these agents want to operate in California and continue to lease their networks, they will amend their provider contracts, if necessary, to make sure they are fair and reasonable according to the requirements set out in these regulations.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter</p>	2240.4	<p>We recommend the following revised language:</p> <p>Effective June 30, 2008, <u>On or after July 1, 2008, for new or renewing</u> contracts between network providers and insurers or their agents shall: 1) be in writing and be fair and reasonable as to the parties to such contracts; 2) provide that network providers shall not make any</p>	<p>The Commissioner respectfully rejects this comment. Because Insurance Code section 10133.5 requires regulations that insure that <u>all</u> insureds have the opportunity to access needed health care services in a timely manner, the Commissioner has determined that these regulations must apply to existing, as well as new, policies.</p>

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October 9, 2007 (L6A, C36)		additional charges for rendering network services except as provided for in the contract between the insurer and the insured; 3) include all the agreements between the parties pertaining to the rendering of network provider services; 4) recite that the provider's primary <u>concern</u> consideration shall be the quality of the health care services rendered to covered persons.; 5) include provisions ensuring that providers shall not discriminate against any insured in the provision of contracted services on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage , utilization of medical or mental health services or supplies, or other unlawful basis including without limitation, the filing by such insured of any complaint, grievance, or legal action against a provider.	
Comments received during second 15-day comment period October 24, 2007 – November 8, 2007			
Diane Przepiorski, California Orthopedic Association Comment Letter November 6, 2007 (L14, C3)	2240.4	2. Plans should be required to have a direct contract with providers they claim are part of their network. Too often, a provider is listed as part of a network, but they have no knowledge they are in the network. Sometimes the provider is no longer practicing or has moved out-of-state, but yet their name still appears on a list of providers. This distorts the accuracy of the list and could have a significant impact on patients' access to care. This problem can be resolved, if carriers are required to have a direct contract with providers on their list.	The Commissioner respectfully declines to respond to this comment, as it is outside the scope of the amendments proposed in the second 15-day notice.

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Topic 21: Section 2240.5 Filing & Reporting Requirements			
Anne Eowan, , Association of California Life & Health Insurance Companies (ACLIHC). Comment Letter January 11, 2007 (L1, C9)	2240.5	<p>Our general concern with this section of the proposed regulations is the unintended consequences of delaying the approval of policy forms by imposing a concurrent filing requirement of all provider networks to accompany the form filing (see subdivision (a)). We have suggested an alternative in the attached document which would separate the filing requirements and allow the carrier to identify which networks will be used with each policy form filing. This will decrease the already overwhelming workload of the Department's reviewers in the Policy Approval Bureau, while giving them the information they would need in reviewing the policy form.</p> <p>We are also concerned that the requirement to develop a full "GEOACCESS" report would be costly and overwhelming to comply with, particularly within the caveat that such regulations must be appropriate for a "cost efficient" system of indemnification (Section 10133.5 (d)).</p>	<p>The commenter incorrectly assumes that submission of the required report demonstrating an insurer's compliance with timely access standards will delay the approval of policy forms by the Dept. Further the Department cannot escape its statutory responsibility to assure timely access to provider services, as required by §10133.5 (b) due to the possibility of delay.</p> <p>As part of the process of developing these regulations, the CDI researched the kind of reports currently used by health insurers to evaluate the strength of their provider networks and to market their provider networks to employers. The CDI discovered that Geonetworks/ geoaccess reports are virtually universally used by health insurers. As a result, the CDI found no evidence that this would present a cost burden to insurers since these reports are already in widespread use in the industry for a variety of business purposes.</p>

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(continued from cell above)	2240.5	Further, the statute only requires that insurers report on complaints received on timely access to care. The proposed regulations would require that health insurers break down this information into every type of service, include limited English speaking persons. This goes well beyond any authority granted in statute.	The Commissioner has considered this comment and adopted it in part, particularly regarding concerns pertaining to reporting of services for limited English speakers and disabled access. Accordingly, proposed §2240.5(e) of the regulations, which calls for a report summarizing receipt and resolution of complaints regarding access to covered health care has been simplified by reducing the categories of complaints to four types of health services. A survey conducted by the Department prior to development of these regulations revealed that this type of information is gathered as a standard practice by health insurers.
Anne Eowan, , Association of California Life & Health Insurance Companies (ACLIHC). Attachment to Comment Letter January 11, 2007 (L1A, C14)	2240.5	<p><i>(alternative language proposed by comment author)</i></p> <p>2240.5 Filing and Reporting Requirements</p> <p>(1) On or after July 1, 2007, whenever an insurer seeks approval from the department for any policy form that relies upon or includes the option of utilizing contracted network providers to deliver covered benefits, the insurer shall advise the Policy Approval Bureau of the provider networks that shall apply to those filings.</p> <p>(2) On or after July 1, 2007, a health insurer shall file with the Policy Approval Bureau of the California Department of Insurance:</p> <p style="padding-left: 40px;">(A) Standards established for the availability and accessibility of providers</p>	The Commissioner respectfully rejects this comment for the reasons set forth in the response cell above, incorporated here by reference.

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		<p>(B) A report describing the number and location of all network providers utilized by the insurer to provide services to covered persons and an affidavit or attestation acknowledging compliance with all the requirements of these regulations.</p> <p>(C) Copies of the most commonly utilized network provider contracts for each type of provider the insurer includes in the provider network, including but not limited to hospital, individual physician, group physician, mental health rehabilitation and ancillary service contracts.</p> <p>(3) A health insurer seeking approval for a new product which will utilize a provider network that has previously been described to or filed with the department may file an affidavit or attestation stating that the network to be utilized for the new product is substantially the same as one previously filed, and that there have been no material changes to the network that would result in failure to comply with any of the provisions of this regulation. Such affidavit shall clearly identify the previous filing, and shall, if appropriate, recalculate the number and geographic distribution of providers taking into account projected new covered lives.</p> <p>(3) A health insurer must notify the department as soon as practical at any time that a material change to any of its provider networks results in the insurer being out of compliance with the provisions of these regulations and, at the same time submit a corrective plan specifying all actions that the insurer is taking, or will</p>	

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		<p>take, to come into compliance with these provisions, and estimating the time required to do so.</p> <p>(4) Health insurers that contract for alternative rates of payment with providers shall report within one year of the effective date of these regulations, and annually thereafter to the Consumer Services Division of the Department of Insurance on complaints received by the insurer regarding accessibility of medical and/or behavioral covered benefits. This report shall include a summary of receipt and resolution of complaints regarding access to or availability of any services by primary, specialty or institutional providers.</p> <p>(5) The department shall review these complaint reports and any complaints received by the department regarding accessibility of covered benefits and shall make this information public.</p>	
<p>Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Testimony at public hearing January 11, 2007 (40:1-42:13)</p>	<p>2240.5</p>	<p>Okay. Under point five, "Filing and Reporting Requirements," what we've done is we've separated out -- you've got a requirement that when you put in a policy form filing at the same time you file this other stuff, and we were concerned that that would create even potentially more delays in terms of approval of policies, and for the Policy Approval Bureau that's already overworked -- I've spent a lot of time with them, they're already overworked and overburdened -- we've come up with an alternative where they get the information and there's not this same time filing requirement, so we would ask you to kind of look at what we've suggested there as to how the Policy Approval Bureau would be able to get the information</p>	<p>The Commissioner respectfully rejects this comment. The PPO Network is an integral part of the health insurance product offered under the policy forms submitted for approval. It is reasonable that an insurer be required to affirmatively demonstrate that the PPO Network they intend to incorporate into a particular policy they wish to offer. Submission of the network access reports as part of the policy form filing approval process achieves this statutory mandate. Allocation of staff as needed to review such network access reports is within the purview of the Department's administration and is not part of this rulemaking process.</p>

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		<p>that they need, but it wouldn't be a filing at the same time requirement.</p> <p>I see here that you have a full GEOACCESS or comparable report, and you probably got that maybe some of our companies are doing that, maybe they're sophisticated enough to do that, but we were concerned that we're not quite sure what that is and many of them may not be able to provide that, so we kind of went with the same sort of standards that I think are required by the NCQA.</p> <p>And the rest of that I think you'll see we've 0041 just got -- proposed some alternative language for you. We've got some timelines in here that we've changed in terms of coming up with some, when we have to give the complaint reports and whatnot. I think we did a year after the regulations go into effect give you the first one and then a year after, but we do need some time to provide you that information.</p> <p>One of the things we did have a concern with is in subdivision (e). We think we have to -- obviously the statute requires that we provide you with a complaint report, but you've got a lot of things in here: "Ancillary care, inpatient and outpatient hospital care, outpatient or hospital ambulatory surgery center services for limited English speakers, handicap access to any health care provider, emergency services," and then finally "contracted network providers."</p> <p>We think that goes obviously beyond statute, but we're not even sure we could parse it out to that extent, nor do we understand why we would need special services for limited English; in the language act as you know we have to provide some translation for them.</p>	<p>The comment regarding the annual report summarizing consumer complaints regarding access problems has been adopted; a simplified set of categories (4) has been adopted. The Department believes this reporting requirement is well within the authority of the statute.</p>

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		<p>But that's related to their threshold languages and this seems to go beyond even that statute, so we do 25 have a lot of concerns there.</p> <p>0042</p> <p style="padding-left: 40px;">And we've suggested that you limit it to the types of services that are in the statute which would be I think providers and institutional providers, and I think we have ancillary providers if necessary.</p> <p style="padding-left: 40px;">We have primary specialty or institutional providers, and so you can parse it out to see if you've got a problem in any one of those areas, but we think you're narrowing it down a little bit too far.</p> <p style="padding-left: 40px;">So, in general those are our comments. We hope that the suggestions we're making are constructive to the process. We want to be able to comply and have measurable standards, but we do think that there needs to be some changes related to PPOs as we've outlined.</p>	
<p>JP Wieske, The Council for Affordable Health Insurance, January 11, 2007 Comment Letter (L3, C9)</p>	<p>2240.5</p>	<p>We believe this section should be reconsidered to ensure appropriate standards that can be met by most PPO networks. We suggest that the Department take some additional time to survey PPO networks to ensure they can meet the reporting standards.</p>	<p>The Commissioner respectfully rejects this comment. The Department has already conducted a survey of the State's most active health insurers to determine if they can supply the reports required in §2240.5 and in fact all of the health insurers included in the survey supplied such reports to illustrate how they internally evaluate the strength of their provider network access.</p>

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<p>Sheree Kruckenberg, , California Coalition of Mental Health Comment letter January 11, 2007 (L5,C11)</p>	<p>2240.5(a)</p>	<p>(a) This section lacks clarity. We are unsure what constitutes a “policy form”.</p> <p>(a)(3) We believe that the publishing of rates and/or rate schedules promotes transparency and fairness and would increase competitive performance of insurers generally. However, we can understand the reluctance on the part of insurers to do so. We believe the Department should require those rates to be publicly available to help demonstrate linkages with causal factors when patterns of violation of accessibility standards emerge.</p>	<p>A policy form for disability policies affected by these regulations is defined in Insurance Code 10290 et seq.</p> <p>The Commissioner respectfully rejects this comment. The Department does not believe the authorizing statute extends to requiring health insurers to supply rate schedules that are part of their provider contracts. Health insurers normally consider their rate schedules that are part of the provider contracts to be proprietary. The statutory requirement of Insurance Code section 10133.5(b)(4) that the Department assure that provider contracts are fair reasonable arguably does not extend to the Department’s review of rate schedules negotiated between providers and health insurers.</p>
<p>Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007 (L5A, C10)</p>		<p><i>(alternative language proposed by comment author)</i> <u>2240.5 Filing and reporting requirements</u> <u>(a)Whenever an insurer seeks approval from the department for any policy form that relies upon or includes the option of utilizing contracted network providers to deliver basic health care services, the insurer shall at the same time file with the Policy Approval Bureau of the California Department of Insurance:</u> <u>(1) A full " GEOACCESS" or comparable annual report describing the number and location of all network providers based on fulltime equivalents utilized by the insurer to provide services to covered persons and demonstrating that the insurer is in compliance with all the accessibility and availability requirements of these regulations, including elapsed time standards,</u></p>	<p>The Commissioner respectfully rejects this comment, having made the determination that the requirements of Insurance Code section 10133.5 are satisfied by the submission of a report at the time a policy form is submitted for approval, demonstrating compliance with the criteria of proposed section 2240.1. Further, the Department has determined that using FTE as a measure of provider availability is not feasible. A single PPO network could have thousand of mental health providers in it any given point in time. If some portion of those providers decide to cut back their practice to less than FT, say to 80% for a month or six months, it would be difficult for an insurer to track each individual provider’s availability. This part</p>

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		<p><u>waiting lists, and number of providers actively accepting patients.</u> <u>(2)A copy of written procedures required by Section 2240.1 (a) (8).</u> <u>(3) Complete copies, including all appendices, attachments and exhibits, of the most commonly utilized network provider contracts for each type of provider the insurer (or its agent if using a leased network) includes in the provider network, including but not limited to hospital, individual physician, group physician, laboratory, mental health, rehabilitation and ancillary service contracts. Rates or rate schedules need not be provided, unless a pattern of violations has been identified with respect to accessibility standards however. All material changes to provider contracts must be filed with the Policy Approval Bureau as they become effective.</u></p>	<p>of the regulation pertains to fair and reasonable contracting; not timely access. There is not a relationship between difficulty in timely access to network providers and rates or rate schedules in a provider contract.</p>
<p>Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007 (L5A, C11)</p>	<p>2240.5(e)</p>	<p><i>(alternative language proposed by comment author)</i> <u>(e) Health insurers that contract for alternative rates of payment with providers shall report annually to the Consumer Services Division of the Department of Insurance on complaints received by the insurer and providers regarding timely access to care. This report shall include a summary of receipt and resolution of complaints regarding access to or availability of any services, including but not limited to of the following services by type of service : ancillary care, inpatient and outpatient hospital care, outpatient or hospital ambulatory surgery center services for limited English speakers, handicap access to any health care provider, emergency services, urgent care services, diagnostic services, mental health services, rehabilitation services, physical</u></p>	<p>The Commissioner respectfully rejects this comment. Requiring reporting of complaints received by providers was considered, but was ultimately rejected due to the administrative burden that such reporting would entail.</p>

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		<p><u>therapy, contracted network providers, provider availability.</u></p>	
<p>Sheree Kruckenberg, , California Coalition of Mental Health Attachment to Comment letter January 11, 2007 (L5A, C12)</p>	<p>2240.5(f)</p>	<p><i>(alternative language proposed by comment author)</i> <u>(f)The department shall review these complaint reports and any complaints received by the department regarding timely access to care and shall make the this information public, pursuant to Section 2240.5 (e), available on the internet at least annually.</u></p>	<p>The Commissioner respectfully rejects this comment. The reference ‘pursuant to Section 2240.5(e)’ is uncertain, as subdivision (e) does not contain a requirement of public disclosure. Further, while the Department may consider posting the information in question on its internet site, it has been determined that Insurance Code section 10133.5 does not require that it do so.</p>
<p>Leanne Gassaway, CIGNA Companies Testimony at public hearing January 11, 2007 (53:25-54:21)</p>	<p>2240.5</p>	<p>And the last thing that I will comment on is 0054 the annual reporting in terms of the bifurcation of the various specialties that Anne spoke of under 2240.5. I would really ask for your reconsideration of that much slicing and dicing of our access and complaint data. If it gets sliced too small, it becomes unusable because we start to dismiss complaints because oh, well, there's only five of those and I've got 300,000 people. Well, it's because there's only five because we've sliced the data so thinly that we may actually have missed something that ought to be addressed. So I would ask that we really do keep it high level and allow the plans to delve into that detail where it makes sense within their own employee structure. That could</p>	<p>The Commissioner has adopted this comment in part, and has changed the types of service that must be reported in 2240.5(e).</p>

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		<p>be because they have a large LEP population or they have a large rural population or some other kind of unique facet in their plan that they would delve into that instead of being possibly that specific in the regulation. So, those are my comments today. Thank you 21 very much. Are there any questions?</p>	
<p>Leanne Gassaway, CIGNA Companies Testimony at public hearing January 11, 2007 (53:25-54:21</p>	<p>2240.5</p>	<p>23 MS. ROSEN: I just wanted to ask one question about the comment you made on the too fine slicing and dicing. We basically looked -- again, when we did our 0059 solicitation of information, we got a lot of very good responses from the health insurers on how they organize and evaluate their complaints and what categories they use, and we adopted one of the companies that we felt was representative of kind of the responses that we got. So I guess my question is if we change this part of the regulation to limit the number of categories, would you envision that -- I mean part of this is we didn't want to make more work for the insurers. Would you envision it being burdensome for them to take -- if you were an insurer, there are many insurers that have this many categories when they have their complaints. Would you envision that it would be more work for them to take those and collapse it, would that be acceptable for a company that does keep this many categories of their complaints? And I'm assuming they do that so that they know where they could -- if they're all of a sudden getting a whole lot of complaints in one category, it's an indicator to them that that's sort of an</p>	<p>The Commissioner has adopted this comment in part, and has changed the types of service that must be reported in 2240.5(e).</p>

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		<p>internal quality control thing, they can go back and fix some things, so I guess my question is if they wanted to send in a whole bunch of categories, would you object to that? 0060</p> <p>MS. GASSAWAY: No, I think rolling things up is always easier than rolling things down, so if you have a company that has say ten categories of complaints that they are evaluating in their access program today, they can clump those together into physicians, specialty, hospital and ancillary, much easier than a company who's got those four in their system and having to go through all of those and slice them into smaller bits.</p> <p>MS. ROSEN: Okay.</p> <p>MS. GASSAWAY: For example, if someone were to call into a call center at Health Plan and say I'm having problems with my physical therapist, getting a physical therapy appointment, if I had to track it by the eight or ten things that are here, I would have to program my call center system to track each one of those; whereas if someone has a system that does that today, great, they will be able to take that data and give it back to the Department so you can make an apples to apples comparison across all insurers, which I think is what you'd want to be able to do.</p> <p>Whereas for a company like mine that does not do this kind of specificity, we would have to go through a pretty big system rework, and we're already spending about \$18 million to rework our IT system for 0061</p> <p>the language assistance regs, so something I don't want to necessarily have to throw out there right now, but we will be able to do, say for example limited</p>	

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		<p>English speakers is something that we will be tracking because we're doing that under the language assistance regs, but something as specific as diagnostic services versus rehab services versus physical therapy, that is not something that would be typically programmed into a call center complaint system, grievance system where you'd want to be tracking and trending that information over a monthly and quarterly basis.</p>	
<p>Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>			
<p>Andrea DeBerry Blue Shield of California, Comment Letter October 9, 2007 (L8,C4)</p>	<p>2240.5(a) (3)</p>	<p>Finally, as a result of other revisions Section 2240.5(a)(3) now has a mistake; the citation should be to Section 2240.1(b)(8).</p>	<p>The Commissioner has adopted this comment. The citation has been corrected.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p>	<p>2240.5(a)</p>	<p>We recommend the following revised language: (a) <u>On or after July 1, 2008</u>, whenever an insurer seeks approval from the department for any policy form that relies upon or includes the option of utilizing contracted network providers to deliver <u>covered benefits</u>, the insurer shall <u>advise the Policy Approval Bureau of the provider networks that shall apply to those filings</u>.</p>	<p>The Commissioner respectfully rejects this comment. As noted earlier, the Commissioner has determined that use of the phrase “basic health care services” is consistent with the mandate of Insurance Code section 10133.5 that these regulations assure that insureds can access “needed health care services.” Further, the comment is rejected because the Commissioner has determined that assuring accessibility requires that insurers demonstrate actual compliance, rather than</p>

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(L6A, C37)		<p><u>(b) On or after July 1, 2008, a health insurer shall file with the Policy Approval Bureau of the California Department of Insurance:</u> <u>(b)(1) Standards established for the availability and accessibility of providers</u></p>	the mere existence of standards.
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C38)</p>	2240.5(a) (1)	<p>We recommend the following revised language:</p> <ul style="list-style-type: none"> • (b)(2) A report describing the number and location of all network providers utilized by the insurer to provide services to covered persons and demonstrating that the insurer is in compliance with all the accessibility and availability requirements of these regulations, such as a report produced using GeoAccess GeoNetworks® software offered by Ingenix Corporation <u>or an affidavit or attestation acknowledging compliance with all the requirements of these regulations.</u> <p><u>Rationale:</u> The regulation needs to allow insurers the flexibility of reporting in a cost efficient manner.</p>	The Commissioner respectfully rejects this comment. The Commissioner has determined that actual data demonstrating compliance is necessary in order that the Department may fulfill its obligation under Insurance Code section 10133.5 to assure accessibility, and also to periodically review the effectiveness of these regulations (10133.5(g)).
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter</p>	2240.5(a) (2)	We recommend deletion of this language as it is covered in the proposed revised language in 2240.5 (a)(1).	The Commissioner respectfully rejects this comment, for the reasons set forth in the response cell immediately above.

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October 9, 2007 (L6A, C39)			
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C40)	2240.5(a) (3)	We recommend the following revised language: <u>(b)(3) A description of mechanisms in place for monitoring the adequacy of the network.</u>	The Commissioner respectfully rejects this comment. The Commissioner has determined that the language used in the proposed regulation more closely reflects the intent of Insurance Code section 10133.5
Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C41)	2240.5(a) (4)	We recommend the following revised language: <ul style="list-style-type: none"> • <u>(b)(4) Copies of the most commonly utilized network provider contracts for each type of provider the insurer includes in the provider network, including but not limited to hospital, individual physician, group physician, mental health rehabilitation and ancillary service contracts.</u> <p><u>Rationale:</u> This goes well beyond any authority granted in statute and would impose additional administrative burden and cost.</p>	The Commissioner respectfully rejects this comment. Insurance Code section 10133.5 provides that these regulations shall insure that the policy or contract is not inconsistent with standards of good health care and clinically appropriate care, and that all contracts shall be fair and reasonable. The Commissioner has determined that fulfilling this mandate of the statute requires that contracts be submitted, as described in the proposed regulation section, in order to fulfill the Department's obligation to monitor compliance. (see, e.g., Chapter 797, 2002 Regular Session (Assembly Bill No. 2179) ,which provides in pertinent part, "It is the further intent of the Legislature in enacting this section that the department shall incorporate the

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			standards developed under this section in licensing, survey, enforcement, and other processes intended to protect the consumer.”)
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p> <p>(L6A, C42)</p>	2240.5(b)	<p>We recommend deletion of this language.</p> <p><u>Rationale:</u> See proposed revised language in 2240.5 which addresses all filing requirements.</p>	The Commissioner respectfully rejects this comment, for the reasons set forth in the response cell immediately above.
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p> <p>(L6A, C43)</p>	2240.5(c)	<p>We recommend the following revised language:</p> <p>An <u>A</u> health insurer seeking approval for a new product which will utilize a <u>provider</u> network that has previously been described to or filed with the department pursuant to subsections (a)(1) or (b); may file an affidavit or attestation stating that the network to be utilized for the new product is substantially the same as one previously filed, and that there have been no material changes to the network that would result in failure to comply with any of the provisions of this article <u>regulation</u>. Such affidavit shall clearly identify the previous filing, and shall, if appropriate, recalculate the rations required by Insurance Code Section 2240.1 (b) (1), (2), and (3)</p>	The Commissioner respectfully rejects this comment. As stated previously, the Commissioner has determined that satisfying the mandate of Insurance Code section 10133.5 that these regulations “shall be designed to assure accessibility,” and “ensure that insureds have the opportunity to access needed care” requires that the Department establish specific benchmarks, with which insurers must demonstrate compliance. The Commissioner has determined that merely establishing that insurers have developed their own internal standards is not sufficient to satisfy the requirements of section 10133.5

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		<p><u>number and geographic distribution of providers</u> taking into account projected new covered lives. <u>Rationale:</u> To ensure consistency with the proposed language changes reflecting that insurers shall establish quantifiable and measurable standards for the number and geographic distribution of network providers.</p>	
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C44)</p>	<p>2240.5(d)</p>	<p>We recommend the following revised language:</p> <p>A health insurer must notify the department <u>immediately as soon as practical</u> at any time that a material change to any of its <u>provider</u> networks results in the insurer being out of compliance with any of the provisions of these regulations and, at the same time submit a corrective plan specifying all actions that the insurer is taking, or will take, to come into compliance with these provisions, and estimating the time required to do so. <u>Rationale:</u> To stipulate a more appropriate timeframe for notification to the department.</p>	<p>The Commissioner respectfully rejects this comment. The Commissioner has determined that assuring accessibility of provider services in a timely manner, as required by Insurance Code section 10133.5(b), requires that this notification be given promptly.</p>
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007 (L6A, C45)</p>	<p>2240.5(e)</p>	<p>We recommend the following revised language:</p> <p>Health insurers that contract for alternative rates of payment with providers shall report annually to the Consumer Services Division of the Department of Insurance on complaints received by the insurer and providers regarding timely access to care accessibility of medical and/or behavioral covered benefits. This report shall include a summary of receipt and resolution of complaints regarding access to or availability of any of the following services by type of service: primary</p>	<p>The Commissioner has adopted this comment in part, as the regulation has been modified so that insurers need only report access complaints received by the insurers, and not those received by providers. The Commissioner has determined that the other changes proposed would reduce the effectiveness of the proposed regulation in assuring accessibility of provider services, as it would eliminate the “timely” reference which is drawn directly from Insurance Code section 10133.5(a).</p>

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		<p>care services, specialty care services, mental health professional services and hospital services.</p> <p><u>Rationale:</u> The proposed requirement goes well beyond any authority granted in statute and would impose additional administrative burden and cost on insurers to capture complaints received <u>by providers</u>.</p>	
<p>Leanne Ripperger, Pacific Care, A United Health Company, Attachment to Comment letter October 9, 2007</p> <p>(L6A, C46)</p>	2240.5(f)	<p>We recommend the following revised language:</p> <p>The department shall review these complaint reports and any complaints received by the department regarding timely access to care <u>accessibility of covered benefits</u> and shall make this information public.</p>	<p>The Commissioner respectfully rejects this comment, for the reasons set forth in the response cell immediately above.</p>
	<p>Comments received during second 15-day comment period October 24, 2007 – November 8, 2007</p>		
<p>Anne Eowan, Association of California Life & Health Insurance Companies</p>	2240.5	<p>Section 2240.5 - These requirements should <u>not</u> apply <u>at all</u> with respect to network providers outside of the state - but, that limit isn't stated.</p> <p>To rectify this lack of clarification, Section 2240.1 (a) should be amended to make it clear that the requirements of Section 2240.1 should only apply to</p>	<p>The provisions of these regulations apply only to network providers within California. See, e.g., revisions to 2240(m).</p>

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(ACLHIC) Comment Letter November 7, 2007 (L13, C9)		network services within California. The reason for this is that it would be virtually impossible to comply with the various requirements for network providers out of state.	
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13, C13)		Section 2240.5(a)(1) – What does the Department expect with regards to an appropriate level of detail with this mapping requirement? How would it be broken out by specialty or allied professionals?	This question is more one of implementation; that said, where these regulations require that access to a specific type of provider, such as hospitals, a Geoaccess style report would demonstrate that an insurer’s PPO Network provides a sufficient hospital network to serve their particular number of covered insureds. Similarly, a report showing that the PPO Network contains sufficient and properly located primary care physicians is required. These are routine reports easily and routinely produced by operators of PPO Networks.
Anne Eowan, Association of California Life & Health Insurance Companies (ACLHIC) Comment Letter November 7, 2007 (L13, C14)	2240.5(c)	Section 2240.5(c) - The references in the last sentence to "ratios in 2240.1(b) (1), (2) and (3) is now incorrect. As modified, only (b) (1) is a ratio.	The commenter is correct that the reference needed to be changed once the paragraphs were renumbered. This non-substantive change has been made.

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Topic 22: Comparison with DMHC regulation

<p>Sheree Kruckenberg, , California Coalition of Mental Health Comment letter January 11, 2007 (L5, C2)</p>	<p>Additionally, Insurance Code Section 10133.5(b)(4)(d) mandates that the Department consult with the Department of Managed Health Care (DMHC) regarding regulations developed by that Department pursuant to Health and Safety Code Section 1367.03. The DMHC has done a significant amount of work in developing draft regulations pursuant to this section, including significant requirements related to appointment waiting time, telephone waiting time, monitoring and compliance, and plan corrective action.</p> <p>Because people suffering from mental illness require the same care whether their insurer is regulated by the California Department of Insurance or the DMHC, we believe it is imperative that regulations developed by CDI contain the same protections as regulations developed by DMHC.</p> <p>We understand the fine balance required in developing regulations and the need to ensure that proposed regulations do not overburden the system. However, given the numerous studies which have shown that untreated mental health problems significantly correlate with increased costs and severity of co-occurring chronic medical and substance abuse disorders, we are confident that appropriate investment in mental healthcare will not overburden the system, but will actually prove to be cost-effective.</p>	<p>The Commissioner respectfully rejects this comment. In compliance with Insurance Code section 10133.5(d), the Department consulted with DMHC in preparation of these proposed regulations. However, the authorizing statute for DMHC's timely access regulations differs significantly from Insurance Code section 10133.5. For example, Health & Safety Code section 1367.03(a)(1) provides that CMHC is to use appointment waiting times as an indicator of timeliness to access of care. In contrast, Insurance Code section 10133.5 does not mention waiting times as a criterion. In developing the present regulations, the Commissioner has determined that measuring health access requires the use of metrics in addition to waiting times (as already provided in the existing regulation) in order to fully meet the requirements of section 10133.5. The differences between the DMHC regulation and the proposed regulation are thus based on the differences in the respective statutes applicable to each Department.</p>
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	<p>Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>		
<p>Keith Pugliese, Brown & Toland Medical Group, Comment Letter, October 9, 2007 (L9,C1)</p>	<p>General</p>	<p>Brown & Toland would like to applaud the Department of Insurance (CDI) regarding its proposed Provider Network Access Standards regulations, Title 10, Sections 2240, 2240.1, 2240.2, 2240.3, 2240.4 and 2240.5. As compared to regulations drafted by the California Department of Managed Health Care (DMHC), the CDI's regulations are practical and measurable. The CDI's version of access standards regulations will provide patient access to care while not overburdening the administrative capacities of physician groups. Still, Brown & Toland asks that the CDI be sensitive to the likelihood that providers might need to navigate through dissimilar and potentially conflicting access standards and monitoring obligations, considering the vast differences between the CDI's and DMHC's access regulations.</p>	<p>The Commissioner notes the concerns expressed in this comment, but respectfully rejects the comment inasmuch as it suggests that the CDI and DMHC regulations in this area must be identical. The differences between the CDI and DMHC regulations are the result of the different statutory schemes for provider access inherent in the Insurance Code and Health and Safety Code.</p>
<p>William Barcellona, California Association of</p>	<p>Generally</p>	<p>The present version of the proposed regulations differs sharply from the standards under consideration by the California Department of Managed Health Care, in length, scope and content. CAPG applauds the</p>	<p>The Commissioner notes the concerns expressed in this comment, but respectfully rejects the comment inasmuch as it suggests that the CDI and DMHC regulations in this area must be identical. The</p>

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Physician Groups, Comment Letter, October 9, 2007 (L10,C1)		<p>Department of Insurance for proposing a set of regulations that more closely resembles the current capability of the healthcare industry to comply. Your version of the regulation will provide a foundation to improve patient access to care but will not overburden the administrative capacity of California physicians in group practice.</p> <p>Should two differing versions of the regulation be adopted by the CDI and the DMHC, providers will be impacted as follows:</p> <ol style="list-style-type: none"> 1. The average California physician will have difficulty attempting to comply with the differing standards for DMHC-regulated PPO patients versus CDI-regulated PPO patients. 2. The average California physician will be unable to discern whether a Blue Cross or Blue Shield PPO patient has a plan that is regulated by the CDI or the DMHC, since both insurers have similar benefit plans filed with either regulator. 3. It will be difficult for each regulator to enforce violations of their respective regulation because of the difficulty in identification of the applicable regulator over these PPO plans in individual cases. Providers will not be able to create reports on their PPO patient access data by regulator, and with two different 	<p>differences between the CDI and DMHC regulations are the result of the different statutory schemes for provider access inherent in the Insurance Code and Health and Safety Code.</p>

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		<p>standards, the data will be muddled.</p> <p>4. Administrative costs are increased when trying to comply with conflicting and differing regulations on the same subject. Increased administrative costs detract from the primary mission of physician groups – to provide quality care in a timely and appropriate manner to patients.</p> <p>Thank you for the opportunity to comment on the pending regulation.</p>	
	<p align="center">Comments received during second 15-day comment period October 24, 2007 – November 8, 2007</p>		
<p>Diane Przepiorski, California Orthopedic Association Comment Letter November 6, 2007 (L14, C1)</p>		<p>3. For the last several years, we have seen insurance carriers change their marketing tactics. Previously, carriers were encouraging beneficiaries to choose their HMO products. The last several years, we have seen a shift to where carriers are now more aggressively marketing and encouraging employers and beneficiaries to select their PPO products. We believe that one reason this has occurred is that the Department of Managed Health Care has adopted stringent regulation of HMO plans and implemented more patient protection measures. We would urge your regulations to be consistent with those adopted by the DMHC to remove any incentive for health plans to move patients between their HMO and PPO products. These shifts are disruptive to patient care and could cause access to care problems as patients</p>	<p>The Commissioner respectfully declines to respond to this comment as it is outside the scope of the proposed amendments. However, as noted above, the differences between the CDI and DMHC regulations are the result of the different statutory schemes for provider access inherent in the Insurance Code and Health and Safety Code.</p>

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		are moved to different plans.	
Topic 23: Other Concerns			
<p>Sheree Kruckenberg, , California Coalition of Mental Health Comment letter January 11, 2007 (L2, C10)</p>		<p>Final Comment: The proposed regulations do not reference enforcement powers of the Department pertaining to these sections and must do so to ensure compliance of insurers.</p>	<p>The Commissioner respectfully rejects this comment. The authorizing statute is silent as to specific enforcement mechanisms. As such, enforcement of this statute and the associated regulations would default to general provisions in the Insurance Code governing compliance.</p>
<p>Leanne Gassaway, CIGNA Companies Testimony at public hearing January 11, 2007 (50:16-51:15)</p>		<p>But there are a couple of things that I would like to point out in the regulation as our priority issues. One is the effective date. To the extent that the changes that we will need to make within our company to comply with the regulations, and to the extent that those require us to either amend policies or to amend provider contracts, that is a very time-consuming experience.</p> <p>And as we read the regulations right now, and we could be reading them incorrectly, it looks like 0051 that would be expected to occur by June 30th of 2007, and that would be a pretty intense experience within the</p>	<p>The Commissioner has adopted this comment in part, and has moved the changed the effective dates in 2240.4 and 2240.5(b) to June 30, 2008.</p>

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		<p>plan to try to do that if that date does not change as we go through the OAL approval process, you know.</p> <p>Say even if you guys were to move at lightning speed and submit these to OAL by the end of the week for approval, we're still looking at sometime in mid February where those would be reviewed and 30 days after that would become effective, and we would be scrambling, scrambling to try to get everything in place in three or four months.</p> <p>So I would ask that consideration of an approximate 12-month period of time be allowed for exactly the provider contracting provisions that may be impacted by this.</p>	
	<p>Comments received during first 15-day comment period, September 21, 2007 – October 9, 2007</p>		
		<p><u>(none)</u></p>	
	<p>Comments received during second 15-day comment period October 24, 2007 – November 8, 2007</p>		
Teresa Favuzzi, Disability Health Coalition,		<p>While recognizing that section 2240.1(a)(b)(3) is not among the recent October 2007 revisions, we must point out that the language of “physically handicapped” in that section is completely outdated, and the person-</p>	<p>The Commissioner respectfully declines to respond to this comment, as it is outside the scope of the proposed amendment. “Disability” was already substituted for “handicap” in 2240.4(a)(5), and deleted</p>

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Comment Letter, November 8, 2007 (L15, C2)		first language of “persons with disabilities” is far preferable. Similarly, “disability” should replace the use of the word “handicap” throughout Article 6 (e.g., in section 2240.4(a)(5) and in section 2240.5(e)).	from 2240.5(e).

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