BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION *
200 ST. PAUL PLACE, SUITE 2700 *
BALTIMORE, MARYLAND 21202 *

vs.

AETNA HEALTH AND LIFE INSURANCE COMPANY *
151 FARMINGTON AVE *
HARTFORD, CT 06156 *

NAIC# 78700 *

CASE NO: MIA-2023-01-001

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CONSENT ORDER

This Consent Order is entered into by the Maryland Insurance Commissioner and AETNA HEALTH AND LIFE INSURANCE COMPANY ("AHLIC" or "Respondent") pursuant to §§ 2-108, 2-204, and 4-113 of the Insurance Article, Maryland Code Annotated, to resolve the matter before the Maryland Insurance Administration ("Administration").

I. RELEVANT REGULATORY FRAMEWORK

1. Each insurer that uses provider panels for health benefit plans offered in the State must assure that its provider panels meet certain adequacy standards. On July 1 of each year each insurer is required to file a report with the Administration demonstrating the insurer's compliance with those standards.

2. Section 15-112 of the Insurance Article provides, in pertinent part:

(a) (1) In this section the following words have the meanings indicated.

* * *

(5) (i) "Carrier" means:

* * *

1. an insurer;

(b) (1) Subject to paragraph (3) of this subsection, a carrier that uses a provider panel shall:

> (i) if the carrier is an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization, maintain standards in accordance with regulations adopted by the Commissioner for availability of health care providers to meet the health care needs of enrollees;

* * *

(c) (1) This subsection applies to a carrier that:

> (i) is an insurer, a nonprofit health service plan, or a health maintenance organization; and
>
> (ii) uses a provider panel for a health benefit plan offered by the carrier.

(2) (i) On or before July 1, 2018, and annually thereafter, a carrier shall file with the Commissioner for review by the Commissioner an access plan that meets the requirements of subsection (b) of this section and any regulations adopted by the Commissioner under subsections (b) and (d) of this section.

3. The regulations referenced in § 15-112(c)(2)(i) of the Insurance Article are set forth in COMAR 31.10.44.

4. The network adequacy standards are set forth in COMAR 31.10.44.04 -.06 and consist of travel distance standards (COMAR 31.10.44.04), appointment waiting time standards (COMAR 31.10.44.05), and provider-to-enrollee ratio standards (COMAR 31.10.44.06) (collectively, the "Standards").

5. The access plan content and filing requirements are set forth in COMAR 31.10.44.03, which provides, in pertinent part:

> .03 Filing of Access Plan.
>
> C. Each annual access plan filed with the Commissioner shall include:

(1) An executive summary in the form set forth in Regulation .09 of this chapter;

(2) The information and process required by Insurance Article, §15-112(c)(4), Annotated Code of Maryland, and the methods used by the carrier to comply with the monitoring requirement under §15-112(c)(5);

(3) Documentation justifying to the Commissioner how the access plan meets each network sufficiency standard set forth in Regulations .04—.06 of this chapter; and

(4) A list of all changes made to the access plan filed the previous year.

6. COMAR 31.10.44.07 allows a carrier to apply for a temporary waiver from compliance with one or more of the Standards provided that certain criteria are met.

7. The criteria that must be met in order to qualify for a waiver of a Standard are set forth in COMAR 31.10.44.07, which states, in pertinent part:

.07 Waiver Request Standards

A. A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement listed in this chapter.

B. The Commissioner may find good cause to grant the network adequacy waiver request if the carrier demonstrates that the physicians, other providers, or health care facilities necessary for an adequate network:

(1) Are not available to contract with the carrier;

(2) Are not available in sufficient numbers;

(3) Have refused to contract with the carrier; or

(4) Are unable to reach agreement with the carrier.

C. A carrier seeking a network adequacy waiver shall submit a written request to the Commissioner that includes the following information:

* * *

(2) A list of physicians, other providers, or health care facilities within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(3) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(4) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(5) Steps the carrier will take to attempt to improve its network to avoid future network adequacy waiver requests.

II. FINDINGS

8. AHLIC holds a Certificate of Authority to act as an insurer in the State and uses provider panels for health benefit plans offered in the State. As such, it is subject to § 15-112 of the Insurance Article and the network adequacy standards set forth in COMAR 31.10.44.04 - .06. In addition, AHLIC is required to file a network adequacy plan in accordance with COMAR 31.10.44.03.

9. On July 1, 2021, AHLIC submitted a Network Adequacy Plan (the "AHLIC 2021 Access Plan") to the Administration, supplemented with additional information and documentation on November 24, 2021, January 21, 2022, March 1, 2022, April 13, 2022, July 29, 2022, and October 5, 2022.

10. On July 1, 2021, AHLIC requested a temporary waiver from compliance with the travel distance standards (the "Travel Distance Waiver request") for outpatient dialysis facilities and for outpatient infusion/chemotherapy facilities.

11. On January 21, 2022, AHLIC requested a temporary waiver from compliance with the appointment waiting time standards (the "Waiting Time Waiver Request") for urgent care (including medical, behavioral health, and substance use disorder services) and for non-urgent behavioral health/substance use disorder services.

12. On March 1, 2022, July 29, 2022, and October 5, 2022, AHLIC submitted additional information to the Administration supplementing the Travel Distance Waiver Request.

13. On July 29, 2022 and October 5, 2022, AHLIC submitted additional information to the Administration supplementing the Waiting Time Waiver Request.

A. <u>The Access Plan-Travel Distance Standards</u>

14. The data submitted by AHLIC in connection with the AHLIC 2021 Access Plan failed to demonstrate compliance with the Travel Distance Standards.

15. COMAR 31.10.44.04 provides, in pertinent part:

> .04 Travel Distance Standards
>
> A. Sufficiency Standards.
>
> (1) Except as stated in §B of this regulation, each provider panel of a carrier shall have within the geographic area served by the carrier's network or networks, sufficient primary care physicians, specialty providers, behavioral health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed

in the chart in §A(5) of this regulation for each type of geographic area. The distances listed in §A(5) of this regulation shall be measured from the enrollee's place of residence.

(2) When an enrollee elects to utilize a gynecologist, pediatrician, or certified registered nurse practitioner for primary care, a carrier may consider that utilization as a part of its meeting the primary care provider standards listed in §A(5) of this regulation.

* * *

(5) Chart of Travel Distance Standards

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
* * * *			
Facility Type:			
Outpatient Dialysis	10	30	50
Outpatient Infusion/Chemotherapy	10	30	60

* * *

16. The data self-reported by AHLIC disclosed the following deficiencies based on distance of a provider to an enrollee's address:

(a) Outpatient dialysis facility providers met the required standard for 99.3% of rural enrollees, leaving one member outside the travel distance standard of fifty miles in one zip code, 21502.

(b) Outpatient infusion/chemotherapy facility providers met the required standard for 99.5% of urban enrollees, leaving 17 members outside the travel distance standard of ten miles in one zip code, 21044.

B. <u>The Travel Distance Waiver Request</u>

17. The Travel Distance Waiver Request included a statement that AHLIC was in negotiations to contract with an outpatient dialysis facility provider within the required distance standard in the specific zip code where there was a deficiency. The Travel Distance Waiver Request also included data and information demonstrating that there were no available outpatient infusion/chemotherapy facility providers to contract with AHLIC within the required distance standard in the specific zip code where there was a deficiency. AHLIC included a description of unsuccessful efforts to locate any additional outpatient infusion/chemotherapy facilities within the required distance standards in specific zip codes using both internal reporting, such as claims data and demographics, and external resources; including internet research and CMS data. AHLIC also provided GeoAccess analysis and maps to demonstrate that the deficient travel distance metrics for outpatient dialysis facilities were within 6 miles of the required distance standard of fifty miles, and for outpatient infusion/chemotherapy facilities were within less than one mile of the required distance standard of 10 miles; written confirmation of continued monitoring of deficient areas for available providers to recruit from both internal and external sources; and an affirmation by AHLIC that that the carrier imposes no limitations based on specialty type or location for providers seeking to contract with AHLIC..

18. The Administration has found good cause to grant AHLIC's travel distance standard waiver request. The waivers for the travel distance standards for outpatient

dialysis facility providers and for outpatient infusion / chemotherapy facility providers are granted for one year.

C. The Access Plan-Appointment Waiting Time Standard

19. The data submitted by AHLIC in connection with the AHLIC 2021 Access Plan failed to demonstrate compliance with Appointment Waiting Time Standards.

20. COMAR 31.10.44.05 states, in pertinent part:

> .05 Appointment Waiting Time Standards
>
> A. Sufficiency Standards.
>
> (1) Subject to the exceptions in §B of this regulation, each carrier's provider panel shall meet the waiting time standards listed in §C of this regulation for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel.
>
> (2) When it is clinically appropriate and an enrollee elects to utilize a telehealth appointment, a carrier may consider that utilization as a part of its meeting the standards listed in §C of this regulation.
>
> * * *
>
> C. Chart of Waiting Time Standards

Waiting Time Standards	
Urgent care (including medical, behavioral health, and substance use disorder services)	72 hours
Routine Primary Care	15 Calendar Days
Preventive Visit/Well Visit	30 Calendar Days
Non-Urgent Specialty Care	30 Calendar Days

Non-urgent behavioral health/substance use disorder services	10 Calendar Days

21. The data self-reported by AHLIC disclosed the following deficiencies:

(a) Urgent care (including urgent medical and urgent behavioral health/substance use disorder services) met the required 72-hour standard for 82% of enrollees, representing a deficiency of 13 percentage points.

(b) Non-urgent behavioral health/substance use disorder services met the required standard of 10 calendar days for 72% of enrollees, representing a deficiency of 23 percentage points.

D. <u>The Waiting Time Waiver Request</u>

22. The Waiting Time Waiver Request, including the supplemental information submitted on July 29, 2022 and October 5, 2022, failed to demonstrate that the providers necessary for an adequate network were not available to contract with AHLIC, were not available in sufficient numbers, refused to contract with AHLIC, or were unable to reach an agreement with AHLIC. AHLIC failed to describe efforts to recruit providers who offer in-person only or in-person and virtual services to address the deficient waiting time standards. AHLIC included a description of attempts to expand the network of providers who offer telemedicine services only to address the deficiency.

23. AHLIC failed to satisfy the criteria set forth in COMAR 31.10.44.07, therefore, the Administration has not found just cause to grant the request. The waivers from compliance with the appointment waiting time standards for urgent care (including medical, behavioral health, and substance use disorder services) and for non-urgent behavioral health/substance use disorder services must be denied.

III. CONCLUSIONS OF LAW

24. The Administration concludes that AHLIC violated § 15-112 of the Insurance Article and COMAR 31.10.44.03C by submitting an access plan that failed to comply with the required appointment waiting time standards.

25. Section 4-113 of the Insurance Article states in pertinent part:

> (b) The Commissioner may deny a certificate of authority to an applicant or, subject to the hearing provisions of Title 2 of this article, refuse to renew, suspend, or revoke a certificate of authority if the applicant or holder of the certificate of authority:
>
> > (1) violates any provision of this article other than one that provides for mandatory denial, refusal to renew, suspension, or revocation for its violation[.]
>
> (d) Instead of or in addition to suspending or revoking a certificate of authority, the Commissioner may:
>
> > (1) impose on the holder a penalty of not less than $100 but not more than $125,000 for each violation of this article[.]

ORDER

WHEREFORE, for the reasons set forth above, it is **ORDERED** by the Commissioner and consented to by the Respondent:

A. That, pursuant to § 4-113 of the Insurance Article, based on consideration of COMAR 31.02.04.02, the Administration imposes an administrative penalty on AHLIC of $50,000 for the violations of § 15-112 of the Insurance Article and COMAR 31.10.44.03C identified here.

OTHER PROVISIONS

B. The executed Order and any administrative penalty shall be sent to the attention of: David Cooney, Associate Commissioner, Life and Health, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

C. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondent, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about the Respondent made under the Maryland Public Information Act, or properly made by governmental agencies, this Order will be kept and maintained in the regular course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Order.

D. The parties acknowledge that this Order resolves all matters relating to the factual assertions and agreements contained herein and are to be used solely for the purposes of this proceeding brought by or on behalf of the Administration. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or civil action for violations not specifically identified in this Order, including, but not limited to, specific consumer complaints received by the Administration, nor shall anything herein be deemed a waiver of the right of the Respondent to contest other proceedings by the Administration. This Order shall not be construed to resolve or preclude any potential or pending civil, administrative, or criminal action or prosecution by any other person, entity or governmental authority, including but not limited to the Insurance Fraud Division of the Administration, regarding any conduct by the Respondent including the conduct that is the subject of this Order.

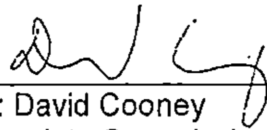
E. Respondent has had the opportunity to have this Order reviewed by legal counsel of its choosing, and is aware of the benefits gained and obligations incurred by the execution of the Order. Respondent waives any and all rights to any hearing or judicial review of this Order to which it would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Order.

F. This Order contains the entire agreement between the parties relating to the administrative actions addressed herein. This Order supersedes any and all earlier agreements or negotiations, whether oral or written. All time frames set forth in this Order may be amended or modified only by subsequent written agreement of the parties.

G. This Order shall be effective upon signing by the Commissioner or his designee, and is a Final Order of the Commissioner under § 2-204 of the Insurance Article.

H. Failure to comply with the terms of this Order may subject Respondent to further legal and/or administrative action.

Kathleen A. Birrane
INSURANCE COMMISSIONER



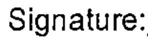
By: David Cooney
Associate Commissioner, Life & Health

Date: 12/20/22

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does in fact have the authority to bind Respondent to the obligations stated herein.

Name: James M. Bostian


Signature: ______________________________

Title: President, Aetna Capitol and MidSouth Markets

Date: 12/19/2022