BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION	*	
200 ST. PAUL PLACE, SUITE 2700	*	
BALTIMORE, MARYLAND 21202	*	
	*	
vs.	*	
	*	
	*	
KAISER PERMANENTE INSURANCE CO	*	
4480 HACIENDA DR., BUILDING B	*	
PLEASANTON, CA 94588	*	**CASE NO: MIA-2023-09-007**
	*	
NAIC# 60053	*	
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ORDER

Pursuant to the authority granted in §§ 2-108 and 2-204 of the Insurance Article, Maryland Code Annotated, the Insurance Commissioner for the State of Maryland ("the Commissioner") has determined that KAISER PERMANENTE INSURANCE COMPANY ("KPIC") has failed to comply with the network sufficiency standards as provided in § 15-112 of the Insurance Article and Code of Maryland Regulations ("COMAR") 31.10.44.[1] KPIC has the right to request a hearing regarding the above violation under § 2-210 of the Insurance Article.

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.

[1] Note that the text of COMAR 31.10.44 was revised, effective May 15, 2023. The 2022 network adequacy access plans were filed and reviewed for compliance under the version of COMAR 31.10.44 that was effective prior to May 15, 2023. Unless otherwise specifically noted, all references to COMAR 31.10.44 are to the regulations that were effective prior to May 15, 2023, as the revisions are not retroactive and were not in effect at the time the 2022 network adequacy access plans were filed.

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. KPIC currently holds a Certificate of Authority to act as an insurer in the State and uses a provider panel 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, KPIC is required to file a network adequacy plan in accordance with COMAR 31.10.44.03.

9. On May 12, 2022, the Commissioner issued Bulletin 22-05, reminding carriers of the due date and specifying the submission method for the 2022 access plan filings required by § 15-112 of the Insurance Article.

10. On, July 1, 2022, KPIC submitted a Network Adequacy Plan (the "KPIC 2022 Access Plan") to the Administration, supplemented with additional information and

documentation on July 7, 2022, September 28, 2022, November 1, 2022, November 18, 2022, March 17, 2023, May 16, 2023, June 1, 2023, June 9, 2023, August 8, 2023, and August 17, 2023.

11. On July 1, 2022, supplemented with additional information and documentation on March 17, 2023, June 1, 2023, June 9, 2023, and August 8, 2023, KPIC requested a temporary waiver from compliance with the travel distance standards (the "Travel Distance Waiver Request") for the following provider types: Gynecology, OB / GYN, Neurology, Pediatrics – Routine / Primary Care, and Psychiatry; and for the following facility types: Acute Inpatient Hospitals, Critical Care Services-Intensive Care Units, Inpatient Psychiatric Facility, Other Behavioral Health / Substance Abuse Facilities, and Skilled Nursing Facilities.

12. On July 1, 2022, supplemented with additional information and documentation on November 18, 2022, March 17, 2023, and June 9, 2023, KPIC requested a temporary waiver from compliance with the appointment waiting times standards (the "Waiting Time Waiver Request") for urgent care (including medical, behavioral health, and substance use disorder services), routine primary care, and non-urgent behavioral health/substance use disorder services.

A. Travel Distance Standards

13. The data submitted by KPIC in connection with the KPIC 2022 Access plan failed to demonstrate compliance with the Travel Distance Standards.

14. 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)
Provider Type:			
* * *			
Gynecology, OB/GYN	5	10	30
* * *			
Neurology	10	30	60
* * *			
Pediatrics-Routine/Primary Care	5	10	30
* * *			
Psychiatry	10	25	60

* * *

Facility Type:			
Acute Inpatient Hospitals	10	30	60
Critical Care Services-Intensive Care Units	10	30	100

* * *

Inpatient Psychiatric Facility	15	45	75

* * *

Skilled Nursing Facilities	10	30	60

* * *

Other Behavioral Health/Substance Abuse Facilities	10	25	60

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

(a) Gynecology, OB/GYN providers met the required standard for 99.5 % of urban enrollees, leaving 6 enrollees outside the travel distance standard of five miles in two zip codes.

Urban zip codes

(i) Zip code 20746 has 2 enrollees outside the standard.

(ii) Zip code 21403 has 4 enrollees outside the standard.

(b) Neurology providers met the required standard for 99.3% of urban enrollees, leaving 8 enrollees outside the travel distance standard of ten miles in one zip code, 20745.

(c) Pediatrics – Routine / Primary Care providers met the required standard for 99.4% of urban enrollees, leaving 8 enrollees outside the travel distance standard of five miles in one zip code, 21403.

(d) Psychiatry providers met the required standard for 99.4% of urban enrollees, leaving 7 enrollees outside the travel distance standard of ten miles in one zip code, 21114. The required standard was met for 99.9% of suburban enrollees, leaving 1 enrollee outside the travel distance standard of twenty-five miles in one zip code, 21842.

(e) Acute Inpatient Hospitals met the required standard for 99.9% of urban enrollees, leaving 1 enrollee outside the travel distance standard of ten miles in one zip code, 21114.

(f) Critical Care Services-Intensive Care Units met the required standard for 99.9% of urban enrollees, leaving 1 enrollee outside the travel distance standard of ten miles in one zip code, 21114.

(g) Inpatient Psychiatric Facilities met the required standard for 96.5% of urban enrollees, leaving 28 enrollees outside the travel distance standard of fifteen miles in four zip codes.

Urban zip codes:

(i) Zip code 20706 has 2 enrollees outside the standard.
(ii) Zip code 20743 has 14 enrollees outside the standard.
(iii) Zip code 20785 has 2 enrollees outside the standard.
(iv) Zip code 21040 has 10 enrollees outside the standard.

(h) Other Behavioral Health / Substance Abuse Facilities met the required standard for 87.5% of urban enrollees, leaving 115 enrollees outside the travel distance standard of ten miles in fifteen zip codes. The required standard was met for 99.9% of suburban enrollees, leaving 1 enrollee outside the travel distance standard of twenty-five miles in one zip code, 21842.

Urban zip codes

(i) Zip code 20706 has 22 enrollees outside the standard.
(ii) Zip code 20710 has 3 enrollees outside the standard.
(iii) Zip code 20737 has 10 enrollees outside the standard.
(iv) Zip code 20740 has 8 enrollees outside the standard.
(v) Zip code 20743 has 15 enrollees outside the standard.
(vi) Zip code 20781 has 2 enrollees outside the standard.
(vii) Zip code 20783 has 2 enrollees outside the standard.
(viii) Zip code 20784 has 12 enrollees outside the standard.
(ix) Zip code 20785 has 3 enrollees outside the standard.
(x) Zip code 20904 has 13 enrollees outside the standard.
(xi) Zip code 21040 has 5 enrollees outside the standard.
(xii) Zip code 21061 has 11 enrollees outside the standard.
(xiii) Zip code 21114 has 4 enrollees outside the standard.
(xiv) Zip code 21222 has 4 enrollees outside the standard.
(xv) Zip code 21224 has 1 enrollee outside the standard.

(i) Skilled nursing facilities met the required standard for 98.6% of urban enrollees, leaving 16 enrollees outside the travel distance standard of ten miles in two zip codes.

Urban zip codes:

(i) Zip code 20879 has 1 enrollee outside the standard.
(ii) Zip code 20886 has 15 enrollees outside the standard.

B. The Travel Distance Waiver Request

16. The Administration has found good cause to grant KPIC's Travel Distance Waiver Request because the Travel Distance Waiver Request included data and information demonstrating that for certain deficiencies there were no available providers and health care facilities to contract with KPIC within the required distance standard, and for other deficiencies KPIC has been unable to reach an agreement with available providers or the providers have refused to contract with KPIC.

17. KPIC included in the Travel Distance Waiver Request a description of its unsuccessful efforts to locate any additional providers and health care facilities within the required distance standards in specific zip codes using both internal reporting, such as non-participating provider claims data, and external resources, including CMS data, online searches, and analytic services. KPIC also included documentation of continued good faith efforts to contract with providers identified as recruitment targets in certain zip codes to resolve the deficiencies for the enrollees outside the travel distance standard.

18. The KPIC Travel Distance Waiver Request included data demonstrating that the maximum distance of enrollees outside of the travel distance standard to the nearest provider or facility was one mile or less for the following:

(a) In zip code 21114, the maximum distance for the furthest enrollee was .1 miles outside the 10-mile urban standard for Acute Inpatient Hospitals and Critical Care Services – Intensive Care Units; .8 miles outside the 10-mile urban standard for Psychiatry providers; and .3 miles outside the 10-mile urban standard for Other Behavioral Health / Substance Abuse Facilities.

(b) In zip code 20746, the maximum distance for the furthest enrollee was .1 miles outside the 5-mile urban standard for Gynecology – OB / GYN providers.

(c) In zip code 20745, the maximum distance for the furthest enrollee was 1 mile outside the 10-mile urban standard for Neurology providers.

(d) In zip code 21403, the maximum distance for the furthest enrollee was .6 miles outside the 5-mile urban standard for Pediatrics – Routine / Primary Care providers.

(e) In zip code 20879, the maximum distance for the furthest enrollee was .5 miles outside the 10-mile urban standard for Skilled Nursing Facilities.

(f) In zip code 21842, the maximum distance for the furthest enrollee was .8 miles outside the 30-mile suburban standard for Skilled Nursing Facilities.

(g) In zip code 20781, the maximum distance for the furthest enrollee was 1 mile outside the 10-mile urban standard for Other Behavioral Health / Substance Abuse Facilities.

(h) In zip code 20783, the maximum distance for the furthest enrollee was .4 miles outside the 10-mile urban standard for Other Behavioral Health / Substance Abuse Facilities.

(i) In zip code 21040, the maximum distance for the furthest enrollee was .3 miles outside the 10-mile urban standard for Other Behavioral Health / Substance Abuse Facilities.

(j) In zip code 21222, the maximum distance for the furthest enrollee was .2 miles outside the 10-mile urban standard for Other Behavioral Health / Substance Abuse Facilities.

19. KPIC provided a description of its network adequacy process to ensure that enrollees are not financially disadvantaged by an existing travel distance deficiency. Those residing in areas where KPIC has identified deficiencies are informed that related out-of-network claims will be treated proactively as in-network and no action is required of the enrollee. Claims for covered services will be processed at the enrollee's participating/in-network benefit level and the enrollee will be held harmless from any balance billing from the non-participating/out-of-network provider. New enrollees are informed of the network adequacy policy as part of the on-boarding process.

20. The waivers for the travel distance standards for the following provider types: Gynecology, OB / GYN, Neurology, Pediatrics – Routine / Primary Care, and Psychiatry; and for the following facility types: Acute Inpatient Hospitals, Critical Care Services-Intensive Care Units, Inpatient Psychiatric Facility, Other Behavioral Health / Substance Abuse Facilities, and Skilled Nursing Facilities are granted for one year.

C. Appointment Waiting Time Standard

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

22. 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

23. The data self-reported by KPIC disclosed the following deficiencies:

(a) Urgent care (including medical, behavioral health, and substance use disorder services) met the required standard of 72 hours for 75.3% of enrollees, representing a deficiency of 19.7 percentage points.

(b) Routine primary care met the required standard of 15 calendar days for 90.22% of enrollees, representing a deficiency of 4.78 percentage points.

(c) Non-urgent behavioral health/substance use disorder services met the required standard of 10 calendar days for 83.46% of enrollees, representing a deficiency of 11.54 percentage points.

D. <u>The Waiting Time Waiver Request and Additional Mitigating Factors</u>

24. The Administration has not found good cause to grant the Waiting Time Waiver Request because it failed to demonstrate that the providers necessary for an adequate network were not available to contract with KPIC, were not available in sufficient numbers, refused to contract with KPIC, or were unable to reach an agreement with KPIC. KPIC failed to provide sufficient evidence to demonstrate that KPIC engaged in adequate provider recruitment efforts to address the extent of the deficiencies in waiting time standards.

25. The Waiver Request did not include a list of providers that KPIC attempted to contract with to address the specific deficiencies for each appointment waiting time category for which the waiver was requested. KPIC submitted a provider recruitment list in response to the Administration's request, however the list provided was the same list that KPIC submitted to support the Travel Distance Waiver Request, which only included providers identified as recruitment targets to address specific travel distance deficiencies in particular zip codes.

26. Instead of demonstrating that the conditions described in COMAR 31.10.44.07B were applicable, the Waiting Time Waiver Request focused on limitations in KPIC's measurement methodology for the waiting time standard, efforts to improve the amount and quality of appointment waiting time data, and efforts to assist enrollees who have difficulty scheduling an appointment. For example, KPIC explained that its appointment waiting time surveys currently measure the time elapsed between the enrollee requesting the appointment and having the appointment, instead of the time from the initial request for a service to the earliest date offered for the appointment for services (as required by COMAR 31.10.44.02B(27). KPIC also described its remediation plan that processes claims for covered services at the in-network benefit level and holds the

enrollee harmless from any balance billing from the out-of-network provider when an enrollee is unable to obtain covered services from an in-network provider due to deficiencies regarding the waiting time standards. However, the plan does not currently include a process for proactively identifying enrollees who were unable to obtain a timely appointment, and instead relies on enrollee complaints.

III. CONCLUSIONS OF LAW

27. The Administration concludes that KPIC 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.

28. 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, and subject to your right to request a hearing, it is this 11th day of September 2023, **ORDERED:**

a) That, pursuant to § 4-113 of the Insurance Article, based on consideration of COMAR 31.02.04.02 and the significant remediation efforts voluntarily

undertaken by KPIC, within thirty (30) days of the date of this Order, KPIC pay an administrative penalty of $10,000 for the violations of § 15-112 of the Insurance Article and COMAR 31.10.44.03C identified here.

Kathleen A. Birrane
INSURANCE COMMISSIONER

By: David Cooney
Associate Commissioner, Life & Health

Date: September 11, 2023

RIGHT TO REQUEST A HEARING

Any person aggrieved by this Order has the right to request a hearing. A request for a hearing must be made in writing and received by the Maryland Insurance Administration within thirty (30) days of the date of this Order. The request must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Attention: Angelique Jones. Failure to request a hearing in a timely fashion, or to appear at a scheduled hearing, will result in a waiver of your right to contest the Commissioner's action, and the Order will be final on the effective date. If a hearing is requested within ten (10) days of the date of the letter accompanying this Order, the effective date of the Order will be stayed until the matter is adjudicated. Should an aggrieved party request a hearing, the hearing officer may reduce, increase, or affirm the penalty amount sought by the Commissioner.

All administrative penalties should be made payable to the Maryland Insurance Administration and sent to the attention of Angelique Jones, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202-2272. Please include the MIA Order number on all correspondence to the Administration.