The League of Life and Health Insurers of Maryland

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For information, contact:
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Lisa Larson
Regulations Manager
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Re: Amended Regulations 31.10.44 Network Adequacy

Dear Ms. Larson:

Thank you for the opportunity to provide comments on amending Regulations 31.10.44 regarding Network Adequacy on behalf of the League of Life and Health Insurers of Maryland, Inc. (League). The League is the state trade association representing life and health insurance companies in Maryland. The League appreciates the work the Maryland Insurance Administration (MIA) has done on this issue from 2016 to date and also appreciates the collaborative process throughout.

The League would like to thank the MIA for its consideration of the comments made throughout the 2020 Session and corresponding workgroups including the industry. While the process has addressed some of the questions and concerns we raised, the discussion still leaves a number of concerns for League members.

One general comment to the overall discussion is with respect to the omission of telehealth. Telehealth is an important mechanism for access to health care and the utilization has exploded as we all have adapted to the fluid situation of a global pandemic. Maryland has invested significant time creating a legislative framework for telehealth as a means to increase access to a variety of health care services in the state. As such, the League believes it is important that telehealth be incorporated in the Travel Distance Standards and Wait Time Standards under the regulations.

The League's specific concerns with and questions of regulations are as follows:

31.10.44.02 Definitions

31.10.44.02B(27) "Waiting time"

While the League appreciates the MIA's leadership around the discussion of the analyzation of "Waiting time," this definition continues to raise concerns. The League believes that should wait times be used in the regulation, the "waiting time" for appointments that require prior authorization should not begin until after prior authorization has been granted. Current law already provides for timing relating to determinations for prior authorization requests. To combine the time for those determinations with the "waiting time" will result in a shorter time period for an enrollee or enrollee's treating provider to obtain an appointment for services requiring prior authorization. This is also a proper area in which to incorporate telehealth as a way to meet the standards.

31.10.44.04 Travel Distance Standards

With respect to the Sufficiency Standards and Group Model HMO Plans Sufficiency Standards, the League is uncertain as to what type of provider is included under "Other Provider Not Listed" and what type of facility is included in "Other Facilities." Carriers need clarity as to these categories so as to ensure compliance with this requirement and the League believes that providers and facilities subject to the standards should be listed. In addition, "Applied Behavioral Analysis" and "Outpatient Infusion/Chemotherapy" are neither providers nor facilities and should be stricken from the charts.

The League further recommends that the measure used for travel distance standards be changed to the percent of members who received care within the stated timeframe and recommends the threshold be the Medicare standard of 90% of members having access to a provider.

As indicated earlier, the standards should take into consideration access through telehealth. In addition, access through reciprocal networks in neighboring states, and other tools carriers use to provide access within the network to patients should also be considered. The regulations do not articulate how these and other approaches to access utilized by carriers will be considered as part of the travel distance standards. It is important that the MIA allow plans to make use of telehealth and other tools effectively and fully integrate these options into the Time and Distance Standards. It is even more crucial as Marylanders are hesitant to leave the home, telework has expanded exponentially, and Governor Hogan recommends that Marylanders are far safer at home.

31.10.44.05 Appointment Waiting Time Standards

The League believes that wait times are not appropriately defined in the regulation as quantitative standard for the entire Maryland market. Nationwide, less than a quarter of states use wait times as a network adequacy metric and we are struggling to find states in which their standards are not being reevaluated. While carriers endeavor to have a network with enough providers to minimize the time an enrollee must wait in order to access care, the measurement and enforcement of wait times is complex. Wait time standards assume there are adequate providers in a practice area or specialty such that, if a carrier contracts with the available, qualified and willing providers, the wait times are reasonable under the regulation. However, without a clear understanding of the provider supply in the state, it is difficult to determine if longer wait times are attributable to a lack of participating providers or a more general lack of available providers. This naturally varies by geography and specialty. We were starting to make progress on this front during the 2020 Maryland General Assembly but had to be shelved due to the COVID-19 outbreak as the state shortened the General Assembly Session for the first time since the Civil War.

The ability of a carrier to effectively manage wait times is also impacted by the delivery model. The relationship between a carrier operating a staff model HMO with a dedicated physician practice serving

enrollees has far more influence over wait times and scheduling practices of providers than a more traditional PPO based delivery model. Traditional network models allow providers to control their office hours, scheduling practices, and patient mix. To impose specific wait time requirements assumes that carriers have control over these provider decisions, beyond contractual requirements included in provider contracts. Further, Maryland law already extends protections to patients who are unable to access an appointment without unreasonable travel or delay in a manner that allows the necessary case by case assessment each patients needs should warrant.

It is also unclear how this measure is to be assessed. Wait times may be sufficient over a broad category of services, yet still fall short for a particular patient at a particular moment in time. How will the MIA continue to determine compliance across all providers for compliance reviews? The difficulty carriers experience with enforcement of wait times will also continue to be a review challenge for the department.

The standard for wait times is "the time from the initial request for health care services by an enrollee or by the enrollee's treating provider to the earliest date offered for the appointment for services." However, the wait time experienced by a patient is often dictated by their acceptance of an appointment rather than an offer of an appointment. It's also a challenge for carriers to track these differences. Carriers are often able to meet wait time standards established in regulation by offering an appointment to a patient; however, ultimately, the patient must accept an appointment. If a patient declines the appointment, a carrier should not be penalized. These instances of a patient declining the offer of an appointment occurs when a patient requests a specific provider due to a myriad of factors including a preferred provider type as well as other considerations such as the provider's race/ethnicity and/or gender. Sometimes specific providers are not readily available due to scheduling or lack of supply.

It seems apparent to the League that even after years of working on this important part of the network adequacy puzzle that we have yet to see the desired progress. The current regulation places an undue burden on provider, consumer, and carriers alike. We have inquired with our colleagues in other states for their approaches to try to zero in on a best practice, and we do not believe that we have yet to find an approach that would satisfy the intention of the wait time standards.

31.10.44.07 Waiver Request Requirements

It is well known that certain parts of the state lack certain types of facilities and providers. For example, Western Maryland has experienced a shortage of Obstetrician-Gynecologists for years. Even if carriers would be able to contract with every single child psychologist statewide we would still not be able to meet the standards. The League would like to request that the MIA deem that certain geographic areas of the State lack specific types of facilities and/or providers and that carriers need not file a waiver request for the areas and facilities or providers indicated. This practice would allow the MIA and carriers to focus efforts on improving access.

As you know, there was significant time spent during the shortened 2020 Maryland General Assembly Session to address the carriers ongoing concerns that it was almost impossible for carriers to establish the universe to expand networks without having access to an updated and accurate list of providers in which the carriers could contact. Significant progress and dedication to improving this key factor was being made through the legislative process spearheaded by Delegate Ariana Kelly before the COVID-19 crisis derailed the efforts being made with provider boards to assist carriers. The League would like to continue this important work to make progress – which carriers are committed to and have been making strides in recent years. With up-to-date lists and provider buy-in more progress will be achieved.

31.10.44.09 Network Adequacy Access Plan Executive Summary Form

These regulations require carriers to report network sufficiency results based on certain metrics. For Travel Distance Standards, carriers must list the percentage of the participating providers by provider type for which the carrier met the travel distance standard listed. Instead, we request that the standard be measured by the percent of members that have access to a stated provider type. This approach is consistent with the National Committee for Quality Assurance (NCQA) national standards that carriers are already collecting. To change to a different standard will be unnecessarily burdensome and difficult.

We suggest that there was progress being made on establishing the universe for carriers to contact to expand networks that was unfortunately cut short due to the pandemic. We should pick up that legislative effort as soon as the legislature reconvenes. We also hope that with the new reality we all face together due to COVID-19 that telemedicine be adopted as part of the network adequacy regulations on multiple fronts to capture the world that is now commonplace for carriers. Frankly, as we adjust to the new "abnormal," and prepare for ongoing periods of shutdown, it is more important than ever to incorporate telehealth as a standard measure to which to balance network adequacy needs and benchmarks.

Thank you, again, for the opportunity to provide this feedback on the current regulations. Should you have any questions, please do not hesitate to contact me.

Sincerely,

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