BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION 200 ST. PAUL PLACE, SUITE 2700 BALTIMORE, MARYLAND 21202	*	
VS.	*	
MAMSI LIFE AND HEALTH INSURANCE COMPANY 9800 HEALTH CARE LANE MN006-W500 MINNETONKA MN 55343	*	MIA FILE NO: MIA-2021-04-031
NAIC# 60321	*	

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CONSENT ORDER

This Consent Order is entered into by the Maryland Insurance Commissioner and MAMSI LIFE AND HEALTH INSURANCE COMPANY ("MLHIC" 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.

II. FINDINGS

7. MLHIC 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, MLHIC is required to file a network adequacy plan in accordance with COMAR 31.10.44.03.

8. On July 1, 2019, MLHIC submitted a Network Adequacy Plan (the "MLHIC 2019 Access Plan") to the Administration.

9. On August 8, 2019, MLHIC submitted information to supplement the MLHIC 2019 Access Plan. The information included a revised executive summary and several proprietary and confidential items, including access maps to document compliance with the travel distance standards, a listing of all Maryland essential community providers, and an explanation of the survey method that was used to document appointment waiting time standards.

10. On February 6, 2020, the Administration sent a letter to MLHIC requesting additional information and documentation necessary for the Administration to evaluate whether the MLHIC 2019 Access Plan was in compliance with the Standards.

11. On April 3, 2020, MLHIC submitted the additional information and documentation. The information included additional proprietary and confidential items, including justification to support MLHIC's compliance with the appointment waiting time standards and MLHIC's methodology for selecting essential community providers.

A. The Access Plan-Travel Distance Standards

12. The data submitted by MLHIC in connection with the MLHIC 2019 Access Plan failed to demonstrate compliance with the Travel Distance Standards.

13. 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:			

* * *

Allergy and Immunology	15	30	75
Dermatology	10	30	60
Gastroenterology	10	30	60
General Surgery	10	20	60
Gynecology, OB/GYN	5	10	30

* * *

Neurology	10	30	60
Oncology-Medical and Surgical	10	20	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	10	20	60
Pediatrics-Routine Primary Care	5	10	30
Pulmonology	10	30	60
Urology	10	30	60

* * *

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

Outpatient Dialysis	10	30	50
Outpatient Infusion/ Chemotherapy	10	30	60

* * *

Skilled Nursing Facilities	10	30	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
Other Behavioral Health/Substance Abuse Facilities	10	25	60

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

(a) Allergy and immunology providers met the required standard for 99.2% of suburban enrollees, leaving 305 members outside the travel distance standard of thirty miles.

(b) Dermatology providers met the required standard for 99.9% of urban enrollees, leaving 36 members outside the travel distance standard of ten miles.

(c) Gastroenterology providers met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of ten miles.

(d) General surgery providers met the required standard for 99.9% of urban enrollees, leaving 36 members outside the required travel distance standard of ten miles.

(e) Gynecology, OB/GYN providers met the required standard for 99.6% of urban enrollees, leaving 209 members outside the travel distance standard of five miles. The standard was met for 99.2% of suburban enrollees, leaving 310 members outside the travel distance standard of ten miles.

(f) Neurology providers met the required standard for 99.8% for urban enrollees, leaving 86 members outside the travel distance standard of tem miles.

(g) Oncology-Medical and Surgical providers met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of ten miles.

(h) Oncology- Radiation/Radiation Oncology providers met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of fifteen miles.

(i) Ophthalmology providers met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of ten miles.

(j) Pediatrics-routine primary care providers met the required standard for 99.8% of urban enrollees, leaving 102 members outside the travel distance standard of five miles. The standard was met for 99.7% of suburban enrollees, leaving members 125 outside the travel distance standard of ten miles.

(k) Pulmonology providers met the required standard for 99.9% of urban enrollees, leaving 36 members outside the travel distance standard of ten miles.

(l) Urology providers met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of ten miles.

(m) Acute inpatient hospital facilities met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of ten miles.

(n) Critical Care Services-Intensive Care Unit facilities met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of ten miles.

(o) Diagnostic radiology facilities met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of ten miles.

(p) Outpatient dialysis facilities met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of tem miles.

(q) Outpatient infusion/chemotherapy facilities meet the required standard for 99.8%% of urban enrollees, leaving 86 urban enrollees outside the travel distance standard of ten miles.

(r) Skilled nursing facilities met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of ten miles.

(s) Surgical services (outpatient or ambulatory surgical center) facility providers met the required standard for 99.8% of urban enrollees, leaving 86 members outside the travel distance standard of ten miles.

(t) Other behavioral health/substance abuse facilities met the required standard for 99.3% of urban enrollees, leaving 331 members outside the travel distance standard of ten miles. The standard was met for 99.4% of suburban enrollees, leaving 212 members outside the travel distance standard of twenty-five miles.

B. The Access Plan-Essential Community Providers

15. COMAR 31.10.44.04C(1) provides that each provider panel of a carrier, that is not a group model HMO provider panel, shall include at least 30 percent of the available essential community providers in each of the urban, rural, and suburban areas.

16. MLHIC submitted an executive summary form as a part of the MLHIC 2019 Access Plan. The executive summary form states that 62 essential community providers are participating in the network, which represents 46% of the total available essential community providers. MLHIC reported that they have essential community providers and health departments in their network throughout Maryland including, but not limited to Baltimore and surrounding counties, suburban and western Maryland. MLHIC did not provide documentation to establish the percentages of essential community providers that are participating providers in each urban, rural, and suburban area within the MLHIC service area.

17. The data self-reported by MLHIC in connection with the MLHIC 2019 Access Plan failed to demonstrate that at least 30 percent of the available essential community providers in each of the urban, rural, and suburban areas are included in the network.

C. The Access Plan-Appointment Waiting Time Standards

18. The data submitted by MLHIC in connection with the MLHIC 2019 Access Plan failed to demonstrate compliance with Appointment Waiting Time Standards.

19. 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

20. The data self-reported by MLHIC in connection with the MLHIC 2019 Access Plan disclosed that Urgent care services (including medical, behavioral health, and substance use disorder services) met the 72-hour standard for 92% of enrollees, representing a deficiency of three percentage points.

21. MLHIC has acknowledged the deficiency in its self-reported data regarding appointment waiting time standards for urgent care services. MLHLIC advised that every Maryland Urgent Care Clinic they surveyed was able to provide care within 72 hours and that there are a sufficient number of Urgent Care Clinics within their Maryland network to provide care for 100% of enrollees. MLHIC also surveyed Maryland physician offices for urgent care appointment wait time, and 92% are able to provide urgent care within 72 hours.

III. CONCLUSIONS OF LAW

22. The Administration concludes that MLHIC 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 travel distance standards and appointment waiting time standards and by failing to demonstrate that at least 30 percent of the available essential community providers in each of the urban, rural, and suburban areas are included in the network.

23. 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 MLHIC of $40,000 for the violations of § 15-112 of the Insurance Article and COMAR 31.10.44.03C identified here;

B. The obligation of MLHIC to pay the aforesaid administrative penalty is hereby suspended pending the Administration's (i) review of the access plan submitted by MLHIC in 2021; (ii) determination as to whether the 2021 access plan substantiates representations made by MLHIC related to its intent to improve its compliance with the Standards; (iii) review of all evidence submitted by MLHIC demonstrating good faith efforts to meet all applicable standards; and (iv) based on such review and determination, decision on whether the administrative penalty should be paid, reduced, or rescinded.

C. The Administration's review of MLHIC's 2021 access plan shall include consideration of any waiver requested by MLHIC as permitted by COMAR 31.10.44.07.

A waiver granted to MLHIC by the Administration may be considered a demonstration of MLHIC's improvement of the same standard when the Administration makes its decision on whether the administrative penalty should be paid, reduced, or rescinded.

OTHER PROVISIONS

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. 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.

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

Kathleen A. Birrane
INSURANCE COMMISSIONER

signature on original

By: David Cooney
Associate Commissioner, Life & Health

Date: 4/29/21