The
League
of
Life and
Health
Insurers
of
Maryland

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Annapolis, Maryland 21401
410-269-1554

May 8, 2017

Lisa Larson
Assistant Director of Regulatory Affairs
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Re: Draft Proposed Network Adequacy Regulations

Dear Ms. Larson:

Thank you for the opportunity to provide comments on Drat Proposed Regulations 31.10.44 on behalf of the League of Life and Health Insurers of Maryland, Inc. The League is the state trade association representing life and health insurance companies in Maryland. The League appreciates the work the Maryland Insurance Administration has done on this issue and the opportunity to participate in stakeholders meeting throughout 2016.

This letter will highlight specific concerns and questions with the draft proposed regulations. As a general suggestion, when the MIA begins to develop the access plan, the League suggests working with carriers on the development of the form. A user-friendly form that works well across the industry will minimize the expense of compliance, make completion more efficient for carriers who are filing multiple forms for various plans and ensure that there are no concerns that will make meeting a July 1, 2018 deadline difficult.

The League's comments on the draft proposed regulations are as follows:

**31.10.44.02 Definitions**

31.10.44.02B.(26) "Telemedicine"
The regulations include a definition of "Telemedicine" but the term is not used in the regulation. Telemedicine is an important mechanism for access to health care. Maryland has invested significant time creating a legislative framework for telemedicine as a means to increase access to a variety of health care services in the state. The League believes it is important that telemedicine be incorporated in the access standards under the regulation. Please also note that House Bill 983 (2017) replaces the term "telemedicine" with "telehealth" in § 15-139 of the Insurance Article, which appears to be the source of this definition.

31.10.44.02B(.29) "Waiting time"

The regulation includes within the definition of "waiting time," "the time for obtaining prior authorization from the carrier or the carrier's participating providers for the appointment."

1. It is unclear when the clock begins to run for the determination of the waiting time. In the mind of a patient or a provider, this could include time before the prior authorization request has actually been received by a carrier. Current Maryland law related to timing of determinations for prior authorization requests uses receipt of the request as a trigger. (See Insurance Article § 15-10B-06) For carriers who will be responsible with calculating the days for compliance, having a date certain from which to count is important. We suggest that should wait times be used in the regulation, the clock should be triggered by receipt of the request.
2. It is unclear why there is a reference to "the time for obtaining prior authorization from the …carrier's participating providers for the appointment." Participating providers do not make prior authorization determinations. Under Maryland law, such utilization review decisions must be made by a certified Private Review Agent. (See Insurance Article, Title 15, Subtitle 10B) It is possible this language was included to contemplate receipt of a referral from a participating provider. If that is the intent, the language creates concern. For plans that require referrals, the timing of a response by a participating provider may be governed by the contract between the participating provider and the carrier, but it difficult to control and monitor by a plan. Unless a member raises an issue or complaint, a carrier will not know that a particular provider is slow to respond to a referral request. Further, unlike the time it takes for a carrier to deliver a prior authorization decision which is in the carrier's control, it leaves a significant unknown variable in the calculation of the wait time while increasing the carrier's compliance risk. We suggest this reference be removed.

**31.10.44.03 Filing of Access Plan**

Again, the League suggests the MIA engage carriers in the development of the access plan and its specific content.

**31.10.44.04 Accessibility of Providers**

The regulations attempt to create definitions for varying geographic areas within the State, The League would suggest that the MIA add to the regulation a list of the counties that fall within each geographic area. This will ensure a consistent application of the geography across carriers and minimize confusion or unintentional variations in assessment of the application of the standard.

The League also suggests that the MIA consider adding flexibility to the requirements. Currently only 6 states require plans to meet geographic access, wait time and provider to enrollee ratios. Given that certain measures are more appropriate for different delivery systems, the League suggests the MIA considering requiring one common measure across all plans and allowing flexibility for plans to determine what additional measures are appropriate based on their business model.

The list for geographic access includes specific types of providers, services, specialty areas and facilities. The League was only able to identify one state that attempted to require such a stringent list for compliance in the area of geographic access. The majority of states in the country do not have geographic access standards. Of the states who do have geographic access standards, the majority enumerate standards for primary care providers and specialists,

with 10 states having standards related to mental health and substance abuse providers. A handful of states with geographic access standards have requirements for hospitals. The League urges the MIA to consider a more streamlined approach (PCP and specialists) for geographic access, more consistent with and in line with the 20 of the 21 states with existing standards. It would also be helpful for the MIA to address providers or services in the standard as opposed to the mix that exists in the proposal.

The list of specialties included for carriers generally and staff model HMO's are slightly different. It is not clear if this was intentional or an oversight.

CMS has recently altered the threshold for ECPs. The League urges the MIA to update the regulation to reflect a 20% standard consistent with the recently adopted Market Stabilization Rules.

The proposed regulations attempt to address tiered plans. Tiered networks may be "narrow" and offer fewer, but still high quality, provider choice for a reduced cost or more favorable cost sharing as an incentive. The provision in the regulation, however seems unnecessary. Nothing about the regulations suggests that any network could be sold in the state that fails to meet the regulations. If the regulations were effectively apply to plans utilizing a narrow network, the more appropriate approach would be for the regulations to allow an alternate, less stringent standard applicable to the plan with the lowest cost sharing in a tiered plan, provided the carrier demonstrates that network continues to meet the needs of enrollees and, per the NAIC Model Act, is not discriminatory.

The standards should take into consideration access through telehealth, access through reciprocal networks in neighboring states and other tools carriers use to provide access within in the network to patients. The regulations do not articulate how these and other approaches to access utilized by carriers will be considered as part of the access plans. It is important that the MIA allow plans to make use of telehealth and other tools effectively and fully integrate these options in to the standards.

**31.10.44.05 Wait times for Appointments**

The League believes that wait times are not an appropriate quantitative standard for the entire market Maryland. Nationwide, less than a quarter of states use wait times as a network adequacy metric. 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 understand 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. 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 determine compliance across all providers for compliance reviews? The difficulty carriers experience with enforcement of wait times will also be a review challenge for the department.

In addition to our general concerns with this metric, the League also wishes to note:

1. The references to the time frames with and without a prior authorization for urgent care have been reversed. (a longer time should be provided when there is a prior authorization request for processing)
2. It is unclear what some of the undefined, used terms mean. Additional definitions would be helpful.

**31.10.44.06 Provider to Enrollee Ratios**

Of the three metrics completed in the regulations, provider to enrollee ratios are the least utilized measure nationwide. Currently, only nine states use this metric. It is not clear why these provisions do not apply to staff model HMOs.

**31.10.44.07 Waiver Request Requirements**

The League appreciates the inclusion of a mechanism for a waiver request. In reviewing the process laid out in the regulations, it is not clear why there is a requirement that the waiver request be sent to specific providers. It seems that this would only heighten tensions between plans and providers. Further, given that there is no clear statement about the confidentiality of such requests, even the inclusion of specific providers' names in the request, this appears to create an unnecessary opportunity to publicly shame providers who refuse to contract. The League suggests removing these parts of the requirement.

**31.10.44.08 Confidential Information in Access Plans**

The draft, regulations appear to enumerate certain provisions on the access plan that will be treated as confidential but do not track the language in the statute where these elements of the plan are enumerated. To minimize confusion, the League believes that the statutory language should be used. Section 15-112 (C)(4) uses the following descriptors:

(II) THE CARRIER'S PROCESS FOR MONITORING AND ENSURING, ON AN ONGOING BASIS, THE SUFFICIENCY OF THE NETWORK TO MEET THE HEALTH CARE NEEDS OF ENROLLEES;
(III) THE FACTORS USED BY THE CARRIER TO BUILD ITS PROVIDER NETWORK,…
(VI) THE CARRIER'S METHODS FOR ASSESSING THE HEALTH CARE NEEDS OF ENROLLEES AND ENROLLEE SATISFACTION WITH HEALTH CARE SERVICES PROVIDED TO THEM.

In addition, the League believes that the regulations should provide for the protection of the documentation of compliance with the standards that is to be submitted under 31.10.44.03C(3) and waiver requests under 31.10.44.07. Additionally, the Commissioner should retain some ability to deem other parts of the filing confidential if he finds a compelling need without having to change the regulation.

A simpler approach may be to make the Executive Summary required under 31.10.44.03 a document that can be provided to public with sufficient information to be informative while excluding information that carriers would consider proprietary or anticompetitive if released and protecting the balance of the access plan filing.

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

Very truly yours,

*Kimberly Robinson*

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Executive Director