2 February 2017

Chief Deputy Robert Morrow
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Dear Chief Deputy Morrow,

Aetna appreciates the opportunity the Maryland Insurance Administration (MIA) has provided to all interested parties as you develop health insurer network adequacy and provider directory regulations required by House Bill 1318. The hearing process has allowed all parties the chance to speak and has provided equal time for all.

Aetna supports the testimony made by representatives of the League of Life and Health Insurers of Maryland, Inc. (the League). We agree that access and adequacy standards will not solve patient access concerns in underserved areas of the state or when there are shortages of specific types of health care providers. We agree that any standards must be flexible enough to consider physician extenders, centers of excellence, telemedicine/telehealth, and other innovative ways to delivery appropriate health care services. Finally, we also agree that the data in the provider directories are only as good as the information supplied by the providers themselves so there must be some motivation for the providers to respond to the carriers' inquiries for information.

Network Adequacy

Many advocates have recommended the MIA adopt standards that are the same or similar to those network adequacy standards in California and/or Colorado. Since Aetna does business across the United States, including both California and Colorado, we have experience with both states' requirements. In each of these states, the requirements were just finalized earlier in 2016 and there has not been sufficient time to determine if they have any positive impact on provider access or network adequacy. Reporting requirements are very labor-intensive and demand many employee resources. These costs will ultimately be passed on to the consumer without evidence that the citizens of these states will receive sufficient benefit.

In contrast, Aetna participated in a Summer Network Adequacy Work Group (NAWG) the North Carolina Department of Insurance (NC DOI) hosted. The NAWG meetings allowed the NC DOI to have interested parties meet to develop recommendations for network adequacy standards. Aetna supports the Industry Representative Recommendations to the NC DOI and supports applying these same recommendations in Maryland.

The recommendations include:

1. Establishing standards that consider population and provider density by geography.
2. Establishing geography-specific distance standards that vary according to population density and the number of providers in that geography.
3. Identifying which providers count toward measuring adequacy and accessibility (including physician extenders, telemedicine, and other innovations for delivery of health care services).
4. Having different standards based on provider type and type of service.

The group also recommended:

1. Not establishing appointment wait time standards as they are difficult for insurers to measure and for the regulators to monitor and audit as many of these standards rely on self-reporting by providers.
2. Not establishing standards at the county level as medical care referral and access patterns cross county lines and some counties may not have certain types of providers within their borders.
3. Not establishing any willing provider standards.

In order to measure network adequacy effectively, the carriers must know the complete universe of Maryland health care providers by location and specialty. The MIA should make this available to all carriers. In addition, the network standards must consider the outreach attempts to those providers that are unwilling to participate in the carrier's network and must have flexibility for carriers to demonstrate compliance with standards through innovations or alternative means of health care delivery such as centers of excellence, telemedicine/telehealth, and the use of physician extenders.

Provider Directories

Aetna supports having language in the provider directory portion of the regulation that allows carriers to delay payment to providers if they fail to respond to an inquiry to verify the provider directory; this would be similar to the language in the 2015 California SB 137 information (see attached). We also recommend clear audit standards be developed so that all carriers are clear on how to document compliance but flexible enough to ensure carriers may have some options.

We hope the MIA finds Aetna's comments informative and helpful. Please contact Laura Lee Viergever at 804.873.1116 or viergeverl@aetna.com with any questions you may have or if you need further information.

Sincerely,

Michael Bucci

Executive Director, Capitol Market

cc: Kim Robinson
The League of Life and Health Insurers of Maryland, Inc.

California Code:
1367.27
(3) The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider or provider group is accepting new patients for each plan product.
(4) If the plan does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within 30 business days, the plan shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The plan shall document the receipt and outcome of each attempt to verify the information. If the plan is unable to verify whether the provider's information is correct or requires updates, the plan shall notify the provider 10 business days in advance of removal that the provider will be removed from the provider directory or directories. The provider shall be removed from the provider directory or directories at the next required update of the provider directory or directories after the 10-business day notice period. A provider shall not be removed from the provider directory or directories if he or she responds before the end of the 10-business day notice period.