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February 1, 2017

Nancy Grodin
Deputy Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Re: Comments on HB 1318 Regulations

Dear Deputy Commissioner Grodin:

I write on behalf of CareFirst BlueCross BlueShield ("CareFirst") and in response to the December 20, 2016 letter from the University of Maryland Carey School of Law ("UM") regarding the confidentiality of access plans that are to be submitted under Maryland Insurance Article § 15-112(c). CareFirst appreciates the opportunity to provide feedback to the Maryland Insurance Administration ("MIA") on some of the concerns CareFirst has with the potential disclosure of information contained in carriers' access plans.

As detailed below, CareFirst considers the network access plan it submits to the MIA confidential and proprietary and therefore not subject to public disclosure under the Maryland Public Information Act ("PIA"). To the extent that the MIA believes that at least some portions of access plans must be made available to the public, the MIA regulations should provide that the access plan portions that a carrier identify that, if disclosed, would cause competitors to obtain valuable business information, are confidential and proprietary and therefore not subject to public disclosure.

Confidential and Proprietary Information

CareFirst wishes to make clear why carriers aggressively and consistently advocate that the access plans they file with the MIA are proprietary and trade secret information. The access plan includes a carrier's proprietary market standards for network adequacy, which make a given carrier competitive in the market. Additionally, the underlying factors a carrier uses to establish its network (that must be included in an access plan) includes a carrier's internal analysis of how it fares in the competitive landscape. Release of this information would enable competitors to modify their benefit designs and marketing strategies putting other carriers at a clear disadvantage.

Moreover, carriers use their network access plans to identify the types of providers that a carrier needs to contract with and what an appropriate rate proposal might be. If the MIA releases a carrier's attainment of market penetration standards, this will likely negatively affect a carrier's ability to negotiate the best available provider rates for its members, thereby again making the carrier less competitive in the market and driving up health care costs for businesses and consumers. Disclosure of this information will therefore directly impact a carrier's ability to maintain and negotiate competitive

provider rates, which in turn will directly cause the carrier's cost of care to rise and premium rates to increase in response.

Finally, disclosing a carrier's adherence to the network adequacy standards does not meet the consumer needs the UM's letter describes as important to consumer. The letter provides that consumers should have access to information that will allow them to evaluate if a plan (1) meets their needs for healthcare services, (2) provides coverage for in a linguistically and culturally appropriate manner and (3) ensures that the carrier has an effective plan to monitory and address deficiencies. However, Md. Insurance Article § 15-112(n)(3) already requires a carrier's provider directory to provide sufficient information to consumer specifically to ensure that they can evaluate if there are available providers to meet their healthcare needs. This includes the name and specialty areas of the provider, if the provider is accepting new patients, the provider's office locations, the provider's gender, and the languages that the provider speak (to the extent known). This is the information that allows consumers to make educated decisions about where to obtain health insurance coverage. The extent to which a carrier has a plan to address network adequacy deficiencies is not information that a consumer reasonably would consider in purchasing insurance.

The MIA should therefore consider a carrier's access plan confidential and proprietary trade secret information under the PIA to ensure a thriving, competitive market in Maryland with commercially reasonable provider and member rates.

To the extent the MIA believes that at least a portion of carriers' access plans should nevertheless be made available to the public, CareFirst notes the following concerns with the UM's letter's analysis.

The State Law Access Plan Disclosure Standard the UM Letter Cites Disregards the Consistent Standard Used by Other States

The UM letter concludes that the only applicable standard for a carrier to seek protection from disclosure of portions of an access plan is if there is "substantial harm" from the information's disclosure. This, however, fails to reflect the consistent standard for the custodian of records to determine if portions of the access plan contain proprietary and confidential information adopted or proposed in 6 out of the 8 states that have addressed network adequacy and access plans:

State	Citation	Standard
CT	Conn. Gen. Stat. Ann. § 38a-472f(h)(3)	A health carrier shall post each access plan on its Internet web site and make such access plan available at the health carrier's business premises in this state and to any person upon request, except that such health carrier may exclude from such posting or publicly available access plan any information such health carrier deems to be proprietary information that, if disclosed, would cause the health carrier's competitors to obtain valuable business information. A health carrier may request the commissioner not to disclose such information under section 1-210.

State	Citation	Standard
MS	Miss. Code R. § 19-3:14.05(B)	Beginning August 1, 2014, a health carrier shall file with the commissioner an access plan meeting the requirements of this Regulation for each of the managed care plans that the carrier offers in this state. The health carrier may request the commissioner to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any material change to an existing managed care plan.
MI	MO. Ann. Stat. § 354.603(2)	A health carrier shall file with the director, in a manner and form defined by rule of the department of insurance, financial institutions and professional registration, an access plan meeting the requirements of sections 354.600 to 354.636 for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information will cause the health carrier's competitors to obtain valuable business information. The health carrier shall provide such plans, absent any information deemed by the director to be proprietary, to any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any change as defined by the director to an existing managed care plan. The director shall approve or disapprove the access plan, or any subsequent alterations to the access plan, within sixty days of filing.
MT	Mont. Code Ann. § 33-36-201(5)	A health carrier may request the department to designate parts of its access plan as proprietary or competitive information, and when designated, that part may not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. A health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide a copy of the plan upon request.

State	Citation	Standard
NE	Neb. Rev. Stat. § 44-7105(2)	A health carrier shall maintain an access plan meeting the requirements of the Managed Care Plan Network Adequacy Act for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to the director or any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan and shall update an existing access plan whenever it makes any material change to an existing managed care plan.
RI	HB H5597 (2015) (not passed)	Beginning January 1, 2016, a health carrier shall file with the commissioner, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this chapter for each of the network plans the carrier offers in this state. The health carrier may request the commissioner to deem sections of the access plan as proprietary or confidential, and such sections shall not be made public. The health carrier shall make the access plans, absent any proprietary or confidential information, available on its business premises and shall provide them to any person upon request. For the purposes of this subsection, information is proprietary or confidential if revealing the information would cause the health carrier's competitors to obtain valuable business information.

It is clear from those states that have addressed or attempted to address the disclosure of carrier access plans that the standard most consistently used by other insurance regulators to determine if information is proprietary and confidential is "if revealing the information would cause the health carrier's competitors to obtain valuable business information." To the extent the MIA determines it must establish a standard for the disclosure of portions of access plan, CareFirst urges the MIA to follow this standard.

Federal Law Does Not Require Carriers to Disclose All Network Adequacy Information to the Public

The UM letter implies that federal law requires that carriers must disclose network adequacy information to the public. We disagree for two reasons.

First, the Centers for Medicare and Medicaid Services ("CMS") has never required Medicare Advantage ("MA") organizations to make publicly available the MA organization's network access plans or network adequacy information provided to CMS despite CMS' robust oversight of a MA organization's

network adequacy.[1] In fact, the provisions of the regulations that address network adequacy make no such requirement. It is therefore not the case that there is consistent federal law that network adequacy standards and adherence is information to which the public is entitled.

Second, the UM letter argues that the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") regulations require carriers to disclose access plans to group plan members as a non-quantitative treatment limitation ("NQTL"). To the contrary, there is nothing in MHPAEA's regulations or accompanying FAQs that provides that carriers' disclosure obligations pertain to or have any bearing on a carrier's network adequacy standards.

45 CFR § 146.136(c)(4)(i) provides that NQTLs only apply to health insurance ***benefits***, not network access plans or network adequacy. Specifically, it provides:

> (i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation ***with respect to mental health or substance use disorder benefits*** in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used ***in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits*** in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation ***with respect to medical/surgical benefits*** in the classification.

MHPAEA's regulation's illustrative list of NQTLs supports this conclusion as it only includes items that could affect plan benefits such as medical management standards and formulary design for prescription drugs. *Id.* at (c)(4)(ii). The enumerated list of NQTLs specified in MHPAEA's regulations does not, however, identify, reference, or even mention network adequacy standards or access plans as the UM letter contends.

This reading of MHPAEA's regulations is also wholly consistent with the explanation in MHPAEA's regulations' requirement that carrier required disclosures are necessary to understand plan benefits, the criteria for plan medical necessity determinations and the reason for any plan denial. *See* 78 *Federal Register* 68240, 68247. In fact, the FAQ the UM cites confirms that a carrier or plan administrator must disclose only the following[2]:

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[1] See, for example, 42 CFR § 422.112 and CMS' Contract Year 2017 Medicare Advantage Health Service Delivery (HSD) Provider and Facility Specialties and Network Adequacy Criteria Guidance and Methodology, available at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2017_MA_HSD_Network_Criteria_Guidance.PDF.

[2] The FAQ provides:

> **Q9: I am a provider acting as an authorized representative for an ERISA group health plan participant. The health plan has requested that I complete a pre-authorization form after the patient's 9th visit for the treatment of depression. I understand that there are a number of documents that plans must provide upon request. Which of those documents would generally be most helpful for me to request regarding the plan's compliance with MHPAEA?**
>
> You may request the following documents and plan information, which could be helpful in evaluating the plan's compliance with MHPAEA. While it may not be necessary to review all of the following documents

1. A Summary Plan Description or similar summary information;
2. The specific NQTL plan language (such as a preauthorization requirement);
3. The specific underlying processes, strategies, evidentiary standards, and other factors that determine that NQTL will apply to a ***particular MH/SUD benefit***;
4. Information regarding the application of NQTL ***to any medical/surgical benefits*** within the benefit classification at issue;
5. The specific underlying processes, strategies, evidentiary standards, and other factors considered by the plan to determine the extent to which NQTL will apply to any ***medical/surgical benefits*** within the benefit classification at issue; and

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and plan information, the plan must provide any of these documents and plan information to you if requested, when you as a provider are acting as an individual's authorized representative:

1. A Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;
2. The specific plan language regarding the imposition of the NQTL (such as a preauthorization requirement);
3. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit;
4. Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;
5. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and
6. Any analyses performed by the plan as to how the NQTL complies with MHPAEA.

For example, if the plan can demonstrate that it imposes pre-authorization requirements for both MH/SUD and medical/surgical benefits in the outpatient, in-network classification when the length of treatment for a condition exceeds the national average length of treatment by 10% or more, it has identified a factor on which the NQTL is based. Furthermore, to the extent the plan can document, via studies, schedules or similar documents that contain relevant information or data, that the national average length of outpatient treatment for depression is eight visits, it has identified an evidentiary standard used to evaluate the factor. Finally, by applying the eight visit standard to the case at hand, it demonstrates how the evidentiary standard is applied and the result.

Accordingly, to be in compliance with the MHPAEA and ERISA disclosure requirements, the plan must furnish to the provider sufficient documentation of the NQTL factor, evidentiary standard and the analysis outlined above. Additionally, it must produce documentation of how the factor, evidentiary standard and analysis is applied in the outpatient, in-network classification for medical/surgical benefits to demonstrate that the NQTL is not being applied to MH/SUD benefits more stringently than to medical/surgical benefits in the classification. As the Departments indicated in prior guidance, the fact that any information (including factors and evidentiary standards used for medical/surgical benefits) may be characterized as proprietary or commercially valuable is not legitimate grounds for not providing the information.

The information outlined in 1-6 above must also be provided by non-grandfathered health plans under PHS Act section 2719 in instances of internal claims and appeals related to the application of an NQTL to a MH/SUD benefit.

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf

6. Any plan analyses performed as to how NQTL complies with MHPAEA.

As the FAQ then concludes, "to be in compliance with the MHPAEA and ERISA disclosure requirements, the plan must furnish to the provider sufficient documentation of the NQTL factor, evidentiary standard and the analysis outlined above" (citing to the above 6 items). (emphasis added). This is understandable, as those specific items reasonably enable consumers to know if a given benefit is covered, under what circumstances, and if the mental health and substance use benefit coverage under a plan is no more stringent than a comparable medical/surgical benefits under the same plan. This is precisely the information members, prospective members and providers need to determine if a plan covers the benefits they need covered and what steps the provider must take to provide services to a member and have the service covered. Whether or not a carrier has met its network adequacy requirements will not provide members, prospective members or providers with that benefit information.

Moreover, as this limited list of items must be provided, the FAQ states that a carrier or plan may not deem the specified information proprietary or confidential. The FAQ does not, however, as the UM letter argues, provide a global precedential statement that there is no legitimate grounds for a carrier to deem or request other information confidential and proprietary and not subject to disclosure.

Technical Issues with UM Letter

Finally, we note two technical issues. Section II(A) of the UM letter provided that all of the seven state laws it cited "provides authority to the insurance department to designate, at the request of the carrier, sections of the access plan it consider to be proprietary or competitive information that may not be made public." This, however, is not accurate. Connecticut's statute clearly provides that a carrier may deem what information in an access plan is considered proprietary and confidential.[3] The MIA should consider Connecticut's standard that a carrier's assessment of what constitutes proprietary information prevails.

Moreover, the UM letter incorrectly assigns responsibility to consumer stakeholders in offering recommendations on the portions of an access plan that may not be disclosed. Md. Insurance Article §§ 15-112(c)(3) and (4) provide:

> (c)(i) In accordance with § 4–335 of the General Provisions Article, ***the Commissioner*** shall deny inspection of the parts of the access plan filed under this subsection that contain confidential commercial information or confidential financial information.
>
> (ii) The regulations ***adopted by the Commissioner*** under subsection (d) of this section shall identify the parts of the access plan that may be considered confidential by the carrier.

(emphasis added). General Provisions Article § 4-335 provides that a "***custodian*** shall deny inspection of the part of a public record that contains" trade secret, confidential commercial or confidential financial information. (emphasis added). Neither the General Provisions Article nor the Insurance Article authorizes anyone other than the custodian (here the MIA Commissioner) to determine what

[3] The statute provides that a carrier must post its access plan on the carrier's website, "except that such health carrier may exclude from such posting or publicly available access plan ***any information such health carrier deems to be proprietary information*** that, if disclosed, would cause the health carrier's competitors to obtain valuable business information." (emphasis added).

information should or should not be disclosed under the PIA. Maryland law does not provide for unrelated third parties to be part of a custodian's analysis of what information should be exempt from public disclosure under the PIA.

For the above reasons, CareFirst supports Kaiser Permanente's December 1, 2016 letter urging the MIA to specify in its upcoming network adequacy regulations that carriers' network access plans submitted under Md. Insurance Article § 15-112(c) are proprietary and trade secret information not disclosable under the PIA. In the alternative, CareFirst strongly recommends that the MIA follow the standard that other states have elected in trying to address network access plan disclosures and deem such plans confidential and proprietary if revealing the information would cause the carrier's competitors to obtain valuable business information.

Thank you again for the opportunity to comment on the upcoming regulations. If you have any questions, please feel free to contact me.

Sincerely,

Deborah Rivkin