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

Dear Ms. Larson:

Cigna appreciates the opportunity to provide comments on the draft network adequacy regulations. We respectfully offer these comments for consideration.

In general, the draft requires non-Staff Model HMO plans to adhere to sufficiency standards, provider to enrollee ratios, and waiting time measures. Currently, a carrier may promote an adequate network by meeting one or two of these standards but potentially miss the threshold on the third. Cigna respectfully requests the MIA consider a more consistent approach to other states and not require carriers to meet all three thresholds. A potential solution for consideration is permitting a carrier to meet two of the three adequacy measures.

Section .04 of the proposed regulation establishes standards related to the geographic accessibility of providers. Presumably, the intent of this section is to ensure that consumers have access to health care providers within a reasonable travel distance; a concept we support. However, it is not clear to us why the MIA would proposes to hold Staff Model HMOs to different, less stringent standards than for other plans. From a consumer perspective, the adequacy of a health plan's network should not depend of which type of health plan a consumer decides to purchase and, consequently, we do not support different standards for Staff Model HMO plans.

The MIA may wish to reconsider the standard for licensed clinical social workers. These valuable providers are extremely challenging to recruit into the network. A "Masters' level licensed therapist" may provide additional options to carriers to meet this provider need.

In addition, speech therapists or ABA providers are omitted from the list of specified providers contained in the Geographic Accessibility of Providers – Sufficiency Standards for Staff Model HMOs in Section 4(B). Our understanding is the autism mandate applies to Staff Model HMOs

as well as other carriers and the key providers of these services should be included in the Staff Model HMOs requirements. We are concerned for our autistic customers transitioning to a Staff Model HMO product may not have the appropriate providers to address their specific needs if these standards are adopted as drafted. These providers are no less important in a Staff Model HMO than any other type of plan.

Section .04(C) requires carriers to include 30 percent of the available essential community providers in its network. In Section 156.235 of the recently adopted market stabilization rules, the U.S. Department of Health and Human Services acknowledged the 30 percent threshold for essential community providers as too stringent a standard and reduced it to 20 percent of available essential community providers in the final rule. Cigna supports the federal standard and respectfully recommends that Maryland follow the federal rules.

In addition, Section .05 of the proposed regulation requires health insurers to meet very specific provider waiting time standards. Health insurers are committed to maintaining adequate networks. We do not derive any benefit from promoting a network of providers that are inaccessible to our customers. The terms of our specific expectations with our provider networks are captured in our provider contracts, and we enforce our contracts with our providers to ensure that our customers have the access to providers that they rightfully expect. However, health insurers are not equipped to manage the day-to-day operations of our providers' practices. For example, a health insurer will not know whether the waiting time for a routine primary care visit has slipped from 15 days to 30 days without the provider taking responsibility for their information and proactively alerting the carrier. As a result, the inclusion of this section requires health insurers to accept additional compliance risks for the operational failures of its participating providers.

Assuming for a moment that a health plan could manage the operations of its providers' practices, there are additional implementation challenges with Section .05. Specifically, the MIA proposes waiting times for different categories of treatment. These categories range from "urgent care" to "preventive/well visit" to "non-urgent ancillary services," etc. However, with the exception of "urgent care" and "preventive," none of these terms are defined in the regulation, making it impossible for the health plans to understand their specific obligations related to the identified categories of treatment.

Consistent with our comments in Section .04, Cigna requests clarification on the varying provider-to-enrollee ratios for Staff Model HMOs and other plans contained in Section .06. Cigna does not oppose the ratios included in the proposal. However, these provider-to-enrollee ratios are no less important to a Staff Model HMO insured than they are to a member of a PPO or HMO. Further, exempting them from any provider-to-enrollee standard potentially puts the member at risk for their necessary care. Cigna respectfully requests reconsideration of the differing standards between Staff Model HMOs and other plan types throughout the

proposal since it minimizes the importance of network adequacy for Staff Model HMOs and creates an unlevel playing field.

In Section .07(C)(2), the proposal requires carriers to submit a copy of the network adequacy waiver request to any provider or physician named in the waiver request. Requiring this additional submission to providers injects additional IT processes and costs with minimal benefit. Cigna respectfully asks what benefit is achieved by this provision other than potentially inciting a group of providers and slowing the waiver processes? Any questions from the MIA will be directed to the company and answered by the company. Adding another party to an issue between the carrier and MIA creates unnecessary tension between the carrier and provider community. We recommend removing Section .07(C)(2).

Lastly, Cigna appreciates the MIA recognition that several provisions of the access plan will be considered confidential. However, Cigna respectfully requests the MIA consider permitting the carriers to assert confidentiality and privilege to the entire access plan. We consider our networks proprietary and a differentiator among our peers and, as such, contend the entire access plan should be treated as confidential.

Thank you for your time and consideration of these comments to the draft proposal. Please contact me with any questions at 860.226.3160 or jeffrey.tindall@cigna.com.

Sincerely,

Jeffrey E. Tindall
Director, Regulatory and State Government Affairs