The
League
of
Life and
Health
Insurers
of
Maryland

200 Duke of Gloucester Street
Annapolis, Maryland 21401
410-269-1554

February 2, 2017

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

Re: Network Adequacy

Dear Deputy Commissioner Grodin:

The Maryland Insurance Administration (MIA), in consultation with stakeholders, has undertaken a process to revamp Maryland's network adequacy requirements for commercial plans sold both on and off of the Maryland Health Benefit Exchange as required by House Bill 1318 of 2016. The League of Life and Health Insurers of Maryland, Inc. (League) appreciates the opportunity to participate in the process and provide the MIA with feedback for its consideration. The League hopes it has provided information and perspective from the insurance industry that will benefit the Administration in its drafting of regulations.

Throughout this process, the League has emphasized the importance of three key themes: Flexibility, Choice, and Shared Responsibility.

> **Flexibility** - to allow health plans to innovate and create network designs that meet the needs of consumers and employers. High value provider networks, for example, give consumers access to high quality and effective care, and can maximize consumers' health care dollars. Innovative delivery models, such as patient centered medical homes, are designed to achieve better health outcomes by promoting quality and safety while reducing costs and improving efficiency;
> **Choice** - to provide consumers and employers with an array of choices, including more affordable, tailored network products; and
> **Shared Responsibility** - taking a holistic approach and looking at health plan and provider requirements in tandem, with the goal of enabling transparency, access, and affordability.

Network adequacy is certainly a topic for discussion across the country. Both the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human

Services were moving towards quantifiable standards for Medicaid managed care plans and qualified health plans on the Federally Facilitated Marketplace. To date, specific standards have not been adopted. However, in Maryland, Managed Care Organizations currently have time and distance standards on the books.

Nationally, the National Association of Insurance Commissioners has adopted its latest Model Act addressing network adequacy. That model is, in large part, the basis for the language in House Bill 1318. While states are just beginning to adopt the updated model, several have existing provisions regarding network adequacy.

Network adequacy laws are intended to establish standards for the creation and maintenance of networks by health carriers, with provisions aimed at assuring the adequacy, accessibility, and quality of health care services offered under a plan. Maryland was one of the first states to have any requirements related to network adequacy and has for many years had requirements applicable to HMOs and to PPOs. HMOs and PPOs have been governed under separate provisions of the law, rooted in their differing regulatory schemes and different limitations to access to out of network services. Under the provisions of HB 1318, the overarching requirement of a network is to "ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable travel or delay." Many state network adequacy laws establish requirements for written agreements between health carriers and participating providers, and ensure there are sufficient numbers and types of providers to assure that all covered benefits are accessible. State laws typically address access to providers, access to non-participating providers, certification or filing of access plans, and geographic access.

As the Administration moves forward with drafting regulations, the League would urge that flexibility, choice, and shared responsibility serve as principles. Standards that are too strict or narrow may be unrealistic or impossible for carriers to meet. Providers are free to decide whether or not they are willing to participate in carrier networks. In some areas, there are documented provider shortages. In other instances, there are shortages within certain specialties. Each of these issues can impact the previewed adequacy of a network and the actual ability of a carrier to meet a quantitative standard.

Based on experience nationally, the League believes that as the most widely used quantitative standard, a geography based time and distance standard would be the most appropriate quantitative standard for Maryland. Such a standard should take into consideration: 1) population and provider density by geography and 2) geography-specific distance standards that vary according to population density and the number of providers in that geography. To the extent such a standard is inappropriate for a particular delivery model, the MIA should make appropriate accommodations.

The League believes that wait times are not an appropriate quantitative standard for Maryland. 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 understanding 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 group 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 decisions. 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 patient's needs should warrant.

The League also believes that access plans should not be overly burdensome in their content and requirements on carriers and should be considered confidential, commercial information. The access plans filed with the MIA will include substantial proprietary information. Carriers will be reporting their market standards, standards that are designed to provide comprehensive access to consumers and to give the carrier a competitive advantage in the marketplace. The factors used to build the network include and reflect the carrier's internal deliberations and analysis of their enrollee's needs. In addition, these plans will reflect how carriers identify network needs and impact recruitment and provider compensation strategies. Allowing access to this information will place carriers at a competitive disadvantage and could have the effect of driving up costs for plans.

No measure is a panacea or a silver bullet addressing the issue of network adequacy. The need to ensure that standards are flexible, promote choice, and recognize the need for shared responsibility is paramount. We urge the MIA to keep these principles in mind during its deliberations. Thank you for the opportunity to provide comments.

Very truly yours,

Kimberly Y. Robinson, Esq.
Executive Director