BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION **200 ST. PAUL PLACE, SUITE 2700** **BALTIMORE, MARYLAND 21202** **vs.** **CAREFIRST OF MARYLAND, INC.** **10455 MILL RUN CIRCLE** **OWINGS MILLS, MD 21117** **NAIC# 47058** **GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.** **840 FIRST ST., NE** **WASHINGTON, DC 20065** **NAIC# 53007** **CAREFIRST BLUECHOICE, INC.** **840 FIRST ST., NE** **WASHINGTON, DC 20065** **NAIC# 96202**	*	**CASE NO: MIA-2023-10-023**

****

CONSENT ORDER

This Consent Order is issued by the Maryland Insurance Administration ("Administration") against CAREFIRST OF MARYLAND, INC. ("CFMI"), GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. ("GHMSI"), and CAREFIRST BLUECHOICE, INC. ("BlueChoice") (collectively "CareFirst" or "Respondents"), with their consent, pursuant to the authority granted in §§ 2-108 and 2-204 of the of the Insurance Article, Md. Code Ann. (2017 Repl. Vol. & Supp.)[1] ("Insurance Article"). The Insurance Commissioner for the State of Maryland ("the Commissioner") has determined that Respondents have not complied with certain network sufficiency standards as provided

[1] All statutory references herein are to the Insurance Article, Maryland Annotated Code, unless otherwise indicated.

in § 15-112 of the Insurance Article and Code of Maryland Regulations ("COMAR") 31.10.44.[2] CareFirst has requested a hearing regarding the above violation under § 2-210 of the Insurance Article.

I. RELEVANT REGULATORY FRAMEWORK

1. Each nonprofit health service plan ("NPHSP")and health maintenance organization ("HMO") that uses provider panels for health benefit plans offered in the State must assure that its provider panels meet certain adequacy standards. On July 1 of each year, each NPHSP and HMO is required to file a report with the Administration demonstrating compliance with those standards.

2. Section 15-112 of the Insurance Article provides, in pertinent part:

> (a)(1) In this section the following words have the meanings indicated.
>
> * * *
>
> (5) (i) "Carrier" means:
>
> 2. a nonprofit health service plan;
>
> * * *
>
> 3. a health maintenance organization
>
> * * *
>
> (b) (1) Subject to paragraph (3) of this subsection, a carrier that uses a provider panel shall:
>
> (i) if the carrier is an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization, maintain standards in accordance with regulations adopted by the Commissioner for availability of health care providers to meet the health care needs of enrollees;
>
> * * *

[2] Note that the text of COMAR 31.10.44 was revised, effective May 15, 2023. The 2022 network adequacy access plans were filed and reviewed for compliance under the version of COMAR 31.10.44 that was effective prior to May 15, 2023. Unless otherwise specifically noted, all references to COMAR 31.10.44 are to the regulations that were effective prior to May 15, 2023, as the revisions are not retroactive and were not in effect at the time the 2022 network adequacy access plans were filed.

(c) (1) This subsection applies to a carrier that:

(i) is an insurer, a nonprofit health service plan, or a health maintenance organization; and

(ii) uses a provider panel for a health benefit plan offered by the carrier.

(2) (i) On or before July 1, 2018, and annually thereafter, a carrier shall file with the Commissioner for review by the Commissioner an access plan that meets the requirements of subsection (b) of this section and any regulations adopted by the Commissioner under subsections (b) and (d) of this section.

3. The regulations referenced in § 15-112(c)(2)(i) of the Insurance Article are set forth in COMAR 31.10.44.

4. The network adequacy standards are set forth in COMAR 31.10.44.04 -.06 and consist of travel distance standards (COMAR 31.10.44.04), appointment waiting time standards (COMAR 31.10.44.05), and provider-to-enrollee ratio standards (COMAR 31.10.44.06) (collectively, the "Standards").

5. The access plan content and filing requirements are set forth in COMAR 31.10.44.03, which provides, in pertinent part:

.03 Filing of Access Plan.

C. Each annual access plan filed with the Commissioner shall include:

(1) An executive summary in the form set forth in Regulation .09 of this chapter;

(2) The information and process required by Insurance Article, §15-112(c)(4), Annotated Code of Maryland, and the methods used by the carrier to comply with the monitoring requirement under §15-112(c)(5);

(3) Documentation justifying to the Commissioner how the access plan meets each network sufficiency standard set forth in Regulations .04—.06 of this chapter; and

(4) A list of all changes made to the access plan filed the previous year.

6. COMAR 31.10.44.07 allows a carrier to apply for a temporary waiver from compliance with one or more of the Standards provided that certain criteria are met.

7. The criteria that must be met in order to qualify for a waiver of a Standard are set forth in COMAR 31.10.44.07, which states, in pertinent part:

.07 Waiver Request Standards

A. A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement listed in this chapter.

B. The Commissioner may find good cause to grant the network adequacy waiver request if the carrier demonstrates that the physicians, other providers, or health care facilities necessary for an adequate network:

(1) Are not available to contract with the carrier;

(2) Are not available in sufficient numbers;

(3) Have refused to contract with the carrier; or

(4) Are unable to reach agreement with the carrier.

C. A carrier seeking a network adequacy waiver shall submit a written request to the Commissioner that includes the following information:

* * *

(2) A list of physicians, other providers, or health care facilities within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(3) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(4) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(5) Steps the carrier will take to attempt to improve its network to avoid future network adequacy waiver requests.

II. FINDINGS

8. CFMI and GHMSI each currently hold a Certificate of Authority from the State of Maryland to act as a NPHSP. BlueChoice currently holds a Certificate of Authority from the State of Maryland to act as a HMO. CFMI, GHMSI, and BlueChoice use provider panels for health benefit plans offered in the State. As such, each is subject to § 15-112 of the Insurance Article and the network adequacy standards set forth in COMAR 31.10.44.04 - .06. In addition, each is required to file a network adequacy plan in accordance with COMAR 31.10.44.03.

9. On May 12, 2022, the Commissioner issued Bulletin 22-05, reminding carriers of the due date and specifying the submission method for the 2022 access plan filings required by § 15-112 of the Insurance Article.

10. On the submission deadline of July 1, 2022, CareFirst submitted network adequacy plans (the "CareFirst 2022 Access Plans") to the Administration via email, explaining that they did not obtain a SERFF account with the necessary permissions for the individual responsible for the access plan filings in time for the filing deadline.

11. On July 11, 2022, CareFirst submitted the CareFirst 2022 Access Plans to the Administration through SERFF, supplemented with additional information and documentation from March through August 2023.

12. On March 10, 2023, CareFirst requested a temporary waiver from compliance with certain unmet travel distance standards (the "Travel Distance Waiver Request").

13. From April through August 4, 2023, CareFirst submitted additional information to the Administration supplementing the Travel Distance Waiver Request.

A. <u>Travel Distance Standards</u>

14. The data submitted by CareFirst in connection with the CareFirst 2022 Access Plans failed to demonstrate compliance with the Travel Distance Standards.

15. COMAR 31.10.44.04 provides, in pertinent part:

> .04 Travel Distance Standards
>
> A. Sufficiency Standards.
>
> (1) Except as stated in §B of this regulation, each provider panel of a carrier shall have within the geographic area served by the carrier's network or networks, sufficient primary care physicians, specialty providers, behavioral health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §A(5) of this regulation for each type of geographic area. The distances listed in §A(5) of this regulation shall be measured from the enrollee's place of residence.
>
> (2) When an enrollee elects to utilize a gynecologist, pediatrician, or certified registered nurse practitioner for primary care, a carrier may consider that utilization as a part of its meeting the primary care provider standards listed in §A(5) of this regulation.
>
> * * *
>
> (5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			

Allergy and Immunology	15	30	75

* * *

Gynecology, OB/GYN	5	10	30
Gynecology Only	15	30	75

* * *

Oncology-Medical and Surgical	10	20	60

* * *

Pediatrics-Routine/Primary Care	5	10	30
Pulmonology	10	30	60

* * *

Urology	10	30	60

Facility Type:			
Acute Inpatient Hospitals	10	30	60
Critical Care Services-Intensive Care Units	10	30	100

* * *

Outpatient Infusion/ Chemotherapy	10	30	60

* * *

Other Behavioral Health/Substance Abuse Facilities	10	25	60

* * *

All other licensed or certified facilities under contract with a carrier not listed	15	40	90

16. The data self-reported by CareFirst disclosed the following deficiencies based on distance of a provider to an enrollee's address:

Provider/Facility	CFMI	GHMSI	BlueChoice	Total Enrollees Impacted
Allergy & Immunology Compliance % Deficiency Area Zip Code(s) **Enrollees outside of standard**	99.5% Suburban 21842 **649**	99.9% Suburban 21842 **14**	99.4% Suburban 21842 **935**	**1,598**
Gynecology, OB/GYN Compliance % Deficiency Area Zip Code(s)	99.9% Urban 21133 99.4% Suburban 20625 21716 21842 21913	 99.9% Suburban 20625 21716 21842	99.8% Urban 21403 21767[3] 21133 98.9% Suburban 20732 21716 20714 21842 20625 21702 21913 21703	

[3] As explained in MIA Bulletin 22-05, some of the zip code classifications carriers are required to use to determine rural, suburban, and urban zip codes for the purposes of calculating the travel distance standards were revised in 2022 based on updated information provided by the Maryland State Department of Planning and the U.S. Census Bureau. Zip code 21767 was reclassified from "urban" to "suburban," resulting in a less stringent travel distance standard. Although BlueChoice self-reported that 83 enrollees in zip code 21767 resided outside the urban standard,

Provider/Facility	CFMI	GHMSI	BlueChoice	Total Enrollees Impacted
Enrollees outside of standard	**835**	**58**	**1,908**	**2,801**
Gynecology Only Compliance % Deficiency Area Zip Codes(s) **Enrollees outside of standard**	99.6% Suburban 21842 99.2% Rural 21550 21536 21561 21520 21531 21541 21523 21538 21562 21540 21522 21539 **2,189**	99.9% Suburban 21842 99.9%[4] Rural 21550 21541 21561 21536 21562 21520 21531 **34**	99.5% Suburban: 20686 21842 99.1% Rural: 21550 21536 21520 21541 21531 21561 21538 21523 21562 21522 21540 21539 **2,158**	**4,381**
Neurology Compliance % Deficiency Area Zip Code(s) **Enrollees outside of standard**	N/A **0**	N/A **0**	99.9% Urban 21040 **40**	**40**
Pulmonology Compliance % Deficiency Area Zio Code(s) **Enrollees outside of standard**	N/A **0**	N/A **0**	99.9% Urban 21040 **40**	**40**

the supporting documentation provided by BlueChoice demonstrated that these 83 enrollees resided within the suburban standard that was actually applicable

[4] There is a discrepancy between the summary percentages in the Executive Summary and the detailed zip code and enrollee information included in the supporting documentation. The supporting documentation identifies specific rural enrollees outside of the standard and shows no urban enrollees outside the standard. The Executive Summary erroneously displays 100% for rural enrollees and 99.9% for urban enrollees.

Provider/Facility	CFMI	GHMSI	BlueChoice	Total Enrollees Impacted
Acute Inpatient Hospitals Compliance % Deficiency Area Zip Code(s) **Enrollees outside of standard**	N/A **0**	N/A **0**	99.9% Urban 21040 **64**	**64**
Critical Care Services / Intensive Care Units Compliance % Deficiency Area Zip Code(s) **Enrollees outside of standard**	N/A **0**	N/A **0**	99.9% Urban 21040 **27**	**27**
Outpatient Infusion / Chemotherapy Compliance % Deficiency Area Zip Code(s) **Enrollees outside of standard**	99.3% Urban 20904 21114 **921**	98.4% Urban 20904 21114 **1,400**	98.2% Urban 21040 20904 21114 **2,470**	**4,791**
Other Behavioral Health/Substance Abuse Facilities Compliance % Deficiency Area Zip Code(s) **Enrollees outside of standard**	N/A **0**	N/A **0**	99.9% Urban 21040 **64**	**64**
All other licensed or certified facilities under contract with a carrier not listed Compliance % Deficiency Area Zip Code(s) **Enrollees outside of standard**	N/A **0**	N/A **0**	99.5%[5] Rural 21550 21531 21541 21520 **807**	**807**

[5] There is a discrepancy between the summary percentages in the Executive Summary and the detailed zip code and enrollee information included in the supporting documentation. The supporting documentation lists specific rural

17. On February 2, 2023, the Administration notified CareFirst that the Administration could not determine whether CareFirst used the correct population density standards updated for 2022 to calculate travel distance because the access plans did not include sufficient zip code level reports. The Administration also notified BlueChoice that the detailed enrollee and zip code information BlueChoice submitted for certain zip codes was based on the outdated population density standards that were in effect prior to the updates the Administration required for 2022. Specifically, BlueChoice classified zip codes 21052 and 21767 as urban, even though these zip codes were reclassified as suburban in the updated 2022 population density standards. BlueChoice also classified zip code 21664 as suburban, when it should have been rural The Administration advised CareFirst that the Administration was therefore unable to determine if the travel distance standards were met for the misclassified zip codes. The Administration directed CareFirst to provide additional information, including the numbers of enrollees within and outside each required standard in every Maryland zip code where CareFirst had enrollees, so that a determination could be made that was consistent with the updated 2022 zip code classifications.

18. On March 10, 2023, CareFirst submitted additional supporting documentation that was based upon the misclassified zip codes. Additionally, the documentation lacked the enrollee data the Administration requested on February 2, 2023 for every zip code where CareFirst reported that all enrollees resided within the applicable travel distance standard at the time of the July 2022 filing.

19. On June 28, 2023, for a third time, CareFirst submitted detailed enrollee and zip code information, but the submission contained deficiencies. The BlueChoice

enrollees outside of the standard and shows no urban enrollees outside the standard. The Executive Summary erroneously displays 100% for rural enrollees and 99.5% for urban enrollees.

access plan continued to misclassify zip code 21767 as urban, leading to deficiencies incorrectly reported in that zip code for the provider type Gynecology, OB/GYN. Additionally, CareFirst did not provide any documentation to demonstrate that the correct population density categories were used for the reclassified zip codes in which a travel distance deficiency was not previously reported.

20. On August 4, 2023, CareFirst provided updated Executive Summaries, but did not submit updated detailed enrollee and zip code information. There are discrepancies between the summary percentages in Executive Summaries for BlueChoice and GHMSI and the detailed zip code and enrollee information submitted on June 28, 2023. For example, the BlueChoice supporting documentation submitted on June 28 indicates that there were no enrollees outside the standard in urban areas for the Pediatrics-Routine/Primary Care and Urology provider types, while the Executive Summary submitted on August 4 displays that the standards were met for 99.9% of enrollees.

B. The Travel Distance Waiver Request

21. The Administration has not found good cause to grant the Travel Distance Waiver Requests for Gynecology Only; Gynecology, OB/GYN; Dermatology; Oncology; Urology; Acute Inpatient Hospitals; Critical Care Services/Intensive Care Units; Outpatient Infusion/Chemotherapy; and Other Behavioral Health/Substance Abuse Facilities because the requests failed to demonstrate that the providers necessary for an adequate network were not available to contract with CareFirst, were not available in sufficient numbers, refused to contract with CareFirst, or were unable to reach an agreement with CareFirst.

(a) The Travel Distance Waiver Request failed to demonstrate that an exhaustive good faith search was performed for available providers for the specific provider and facility types in the zip codes where deficiencies existed, including the dates and frequency of search efforts. The Travel Distance Waiver Request offered only generalized statements without sufficient details or documentation to substantiate the statements. For example, the Waiver Requests submitted for BlueChoice, CFMI, and GHMSI all included the statement: "CareFirst has every acute inpatient hospital and critical care facility in Maryland in network." However, CareFirst failed to identify the source used to determine the total number of facilities in Maryland, and the supporting documentation provided for the "Description of Network" requirement reported a different number of acute care hospitals in the BlueChoice network than the CFMI and GHMSI networks.

(b) The Travel Distance Waiver Requests submitted for BlueChoice, CFMI, and GHMSI were identical, even though the travel distance deficiencies were not the same across access plans. The deficiencies noted in the waiver requests were inconsistent with the deficiencies shown in the Executive Summaries and supporting documentation. Additionally, the waiver requests were not revised to account for deficiencies related to the previously identified issue of misclassified zip codes.

22. The Administration has found good cause to grant the Travel Distance Waiver Request for Allergy and Immunology. The waiver for the travel distance standard is granted for one year. The request included a description of unsuccessful efforts to

locate any additional providers within the required distance standards in the specific zip codes where deficiencies existed using both internal data, such as reviews of single case agreements and provider networks for other types of CareFirst insurance products, and external resources, including network analytic services. However, CareFirst did not include the dates and frequency of search efforts. In order to consider waiver requests for future access plan filings, the Administration expects CareFirst to include this additional information.

C. Appointment Waiting Time Standards

23. The data submitted by CareFirst in connection with the CareFirst 2022 Access Plans failed to demonstrate compliance with the Appointment Waiting Time Standards.

24. COMAR 31.10.44.05 states, in pertinent part:

.05 Appointment Waiting Time Standards

A. Sufficiency Standards.

(1) Subject to the exceptions in §B of this regulation, each carrier's provider panel shall meet the waiting time standards listed in §C of this regulation for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel.

(2) When it is clinically appropriate and an enrollee elects to utilize a telehealth appointment, a carrier may consider that utilization as a part of its meeting the standards listed in §C of this regulation.

* * *

C. Chart of Waiting Time Standards

Waiting Time Standards	
Urgent care (including medical, behavioral health, and substance use disorder services)	72 hours
Routine Primary Care	15 Calendar Days
Preventive Visit/Well Visit	30 Calendar Days
Non-Urgent Specialty Care	30 Calendar Days
Non-urgent behavioral health/substance use disorder services	10 Calendar Days

25. The data self-reported by CareFirst in the Executive Summary submitted on July 11, 2023 indicated that that the waiting time standards were met for 95% of enrollees for each appointment type.

a. CareFirst did not provide supporting documentation to substantiate the reported 95% metric for urgent care wait time.

b. CareFirst provided supporting documentation, including provider survey results, for the routine primary care, preventive visit / well visit, non-urgent specialty care, and non-urgent behavioral health / substance use disorder services categories. However, the 95% compliance metric reported on the Executive Summary was not consistent with the percentages calculated from the survey results provided in the supporting documentation, as indicated in the chart below. Additionally, the supporting documentation showed that in calculating waiting time for non-urgent behavioral health / substance use disorder services, CareFirst used a standard of 30 calendar days, rather than the 10 calendar day standard required by COMAR 31.10.44.05C.

Appointment Type	Routine Primary Care 15 Days	Preventive Visit/Well Visit 30 Days	Non-Urgent BH/SUD 30 Days	Non-Urgent Specialty Care 30 Days

Responding Yes	1,487	1,403	944	1,637
Responding No	84	54	196	74
Compliance %	94.65%	96.29%	82.81%	95.68%

26. In response to the Administration's request, on March 10, 2023, CareFirst provided a revised Executive Summary and new waiting time documentation. In the revised Executive Summary, CareFirst listed its non-urgent behavioral health/substance use disorder services waiting time compliance as 82.8%, and increased its self-reported compliance for the urgent care waiting time standard from 95% to 100%. In the supporting documentation:

(a) CareFirst did not address the Administration's objections to using a 30-day standard for compliance measurement rather than the 10-calendar day regulatory standard for non-urgent behavioral health/substance use disorder services, but indicated a waiver request would be submitted with respect to the 82.8% metric once additional data was collected.

(b) With respect to the absence of survey data to support the reported waiting time metric for urgent care, CareFirst maintained that compliance with COMAR 31.10.44.05 was achieved on the grounds that all in-network Urgent Care Centers are required by contract to provide same-day care. CareFirst also stated: "We acknowledge that on the Consent Order[6] the MIA requested that we include survey data from Urgent Care providers. We received this request after the 2022 Adequacy Filing date and therefore

[6] The Administration and CareFirst entered into two Consent Orders related to the 2021 access plan filings. Both Consent Orders instructed CareFirst to provide additional data in future access plan filings to support the urgent care waiting time metric, such as surveys from a representative sample of in-network providers offering urgent care. The Consent Orders were not executed until March 13, 2023.

were unable to include in the 2022 filing. We will include this in the 2023 filing."

(c) CareFirst provided the following rationale to explain why the urgent care metric was increased from 95% to 100%: "We believe that at least 95% of our membership has access to urgent care services within 72 hours but based on GeoAccess reports (previously provided to the MIA on June 2, 2022) confirm that 100% of our membership has access to urgent care centers all of which offer same-day appointments thereby meeting the 72-hour standard. We can update the Executive Summary to reflect 100% access."

27. On May 26, 2023, CareFirst acknowledged the Administration's subsequent request for survey data related to urgent care, but repeated that because the guidance from the Administration was received after CareFirst had already conducted its surveys for the 2022 access plan filings, it was not able to provide the data for 2022.

28. On August 4, 2023, CareFirst submitted a revised Executive Summary that adjusted the self-reported waiting time compliance metrics from 100% to 95% for urgent care, and from 82.8% to 95% for non-urgent behavioral health/substance use disorder services without any additional supporting documentation to justify how the 95% metrics were calculated. CareFirst repeated, for a third time, that the Administration's guidance on the need for additional documentation were received after the provider survey was completed for 2022, even though more than six months passed since the Administration provided guidance on the need for additional documentation on February 2, 2023.

29. On August 4, 2023, CareFirst also submitted, for the first time, a waiver request for the non-urgent behavioral health/substance use disorder services waiting time

category, even though CareFirst was no longer reporting a deficiency for this category. While the waiver request was not formally considered since a deficiency was not reported, note that the request failed to address any of the information required by COMAR 31.10.44.07, did not include any supporting documentation, and simply provided a web link to a CareFirst policy statement and a brochure style description of a third-party partnership.

30. The Administration acknowledges it is reasonable to conclude that urgent care centers can provide medical services within the required 72-hour waiting time standard for most enrollees. However, carriers reporting urgent care appointment waiting time compliance are expected to demonstrate that each service type that would satisfy the definition of "urgent care" in COMAR 31.10.44.02B(26) is appropriately represented in the appointment waiting time calculation. Specifically, the measurement methodology must include in-network behavioral health/substance use disorder service providers and specialty medical providers who perform services that are not customarily available at urgent care centers, which must then be supported with documentation such as claims data. Furthermore, if urgent care centers are used to satisfy the medical waiting time measurement calculation, the centers must be within the required travel distance standard applicable to All Other Licensed or Certified Facilities Under Contract for all enrollees, and this must be substantiated by zip code level mileage reports and maps.

31. CareFirst provided zip code mileage reports on June 28, 2023 that demonstrated urgent care centers are within the required travel distance standard applicable to All Other Licensed or Certified Facilities Under Contract for all enrollees, except for 807 BlueChoice enrollees in zip codes 21550, 21531, 21541, and 21520. However, the Administration finds that CareFirst has not provided sufficient justification

and documentation to demonstrate that the urgent care appointment waiting time standard was met, particularly for those enrollees seeking specialty or behavioral health/substance use disorder services.

32. The Administration finds that CareFirst has failed to provide documentation justifying how the 2022 access plans meet the 72-hour waiting time standard for urgent care (including medical, behavioral health, and substance use disorder services), and the 10-calendar day waiting time standard for non-urgent behavioral health/substance use disorder services, as required by COMAR 31.10.44.03C(3).

D. The Executive Summary

33. As noted in the findings above, the final Executive Summary form submitted by CareFirst on August 4, 2023 included multiple discrepancies and inconsistencies, despite the Administration's repeated requests for CareFirst to ensure consistency between the Executive Summary and the supporting documentation in the CareFirst 2022 Access Plans.

III. CONCLUSIONS OF LAW

34. The Commissioner finds that CareFirst, through the actions of CFMI, GHMSI, and BlueChoice violated § 15-112 of the Insurance Article and COMAR 31.10.44.03C by submitting access plans that failed to comply with the required travel distance and appointment waiting time standards.

ORDER

WHEREFORE, for the reasons set forth above, it is this 15th day of April, **ORDERED:**

a) That, pursuant to § 4-113 of the Insurance Article, Respondent will pay an administrative penalty of $50,000 for the submission of access plans that do not comply

with the required travel distance and appointment waiting time standards, which the Administration determined to not sufficiently comply with the provisions of § 15-112 and COMAR 31.10.44.03C. Respondents further acknowledge that their repeated failure to respond to requests from the Administration for information needed to complete its review of the CareFirst 2022 Access Plans and to correct information in its filings with the Administration, as outlined in the Findings of this Consent Order, directly contributed to the imposition of the administrative penalty in this paragraph. It is the expectation of the Administration that these issues will be addressed in future filing periods for network adequacy.

b) The executed Consent Order shall be sent to the attention of: David Cooney, Associate Commissioner, Life & Health, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

c) All administrative penalties should be made payable to the Maryland Insurance Administration and sent to the attention of Hearings Clerk, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202-2272. Please include the MIA Order number on all correspondence to the Administration.

d) For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondent, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about Respondent made under the Maryland Public Information Act, or properly made by governmental agencies, this Consent Order will be kept and maintained in the regular course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Consent Order.

e) The parties acknowledge that this Consent Order resolves all matters relating to the factual assertions and agreements contained herein and are to be used solely for the purposes of this proceeding brought by or on behalf of the Administration. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or civil action for violations not specifically identified in this Consent Order, including, but not limited to, specific consumer complaints received by the Administration, nor shall anything herein be deemed a waiver of the right of Respondent to contest other proceedings by the Administration. This Consent Order shall not be construed to resolve or preclude any potential or pending civil, administrative, or criminal action or prosecution by any other person, entity or governmental authority, including, but not limited to, the Insurance Fraud Division of the Administration, regarding any conduct by Respondent including the conduct that is the subject of this Consent Order.

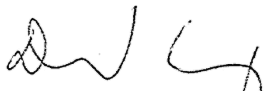
f) Respondent has had the opportunity to have this Consent Order reviewed by legal counsel of its choosing, and is aware of the benefits gained and obligations incurred by the execution of the Consent Order. Respondent waives any and all rights to any hearing or judicial review of this Consent Order to which it would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Consent Order.

g) This Consent Order contains the entire agreement between the parties relating to the administrative actions addressed herein. This Consent Order supersedes any and all earlier agreements or negotiations, whether oral or written, including the Order issued on September 28, 2023, numbered MIA-2023-09-017. All time frames set forth in this Consent Order may be amended or modified only by subsequent written agreement of the parties.

h) This Consent Order shall be effective upon signing by the Commissioner or her designee, and is a Final Consent Order of the Commissioner under § 2-204 of the Insurance Article.

i) Failure to comply with the terms of this Consent Order may subject Respondent to further legal and/or administrative action.

Kathleen A. Birrane
INSURANCE COMMISSIONER



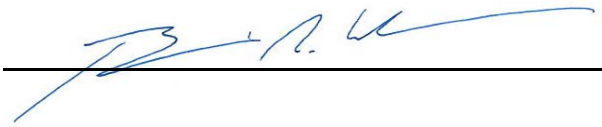
By: David Cooney
Associate Commissioner, Life & Health

Date: 4/15/24

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does, in fact, have the authority to bind Respondent to the obligations stated herein resolving MIA case number MIA-2023-10-023.

Name: Brian R. Wheeler

Signature: 

Title: Senior Vice President, Health Services

Date: April 15, 2024