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For information, contact:
Matthew Celentano, Executive Director

August 8, 2022

Lisa Larson
Regulations Manager
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Re: Network Adequacy Revisions

Dear Ms. Larson:

On behalf of the League of Life and Health Insurers of Maryland, Inc. (League), thank you for the opportunity to provide comments on the evolving network adequacy standard revisions. The League is the state trade association representing life and health insurance companies in Maryland.

The League appreciates the work the Maryland Insurance Administration (MIA) has done on this issue over the past few years to date and the collaborative process throughout. The League would like to thank the MIA for its consideration of the comments made throughout the network adequacy regulatory process, comments during the 2021 Session, the comment period last summer, and corresponding workgroups including the industry. While the process has addressed some of the questions and concerns we raised, the discussion still leaves a number of topics of interest for League members.

League members support the goals of network adequacy and all strive to provide access to care in a convenient and timely manner for all enrollees. We support a regulatory structure that meaningfully holds carriers accountable for providing access but is not overly burdensome or impossible for carriers to comply. There are areas throughout the proposed revisions that seem to set up the carriers to fail through no fault of their own.

We also wanted to reiterate our appreciation for the MIA's openness to our concerns, the balanced approach, and the commitment to continuing to keep proprietary information protected.

The League's specific concerns with and questions of regulations are as follows:

.03 Network Adequacy Standards

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A(5) requires a carrier to monitor the availability of services for continuity of care. We agree that it is important for beneficiaries to have access to the care they need. However, we're not clear on what "continuity of care" specifically means in this context or how it differs from the responsibility to meet the travel distance and waiting times standards for all appointments, whether they be a patient's first or a follow-up appointment with a provider. To the extent this requirement is vague or duplicative, we suggest removing it.

A(7) – Carrier are curious about the need for provider counts by zip by specialty. It is a large amount of data, and we are not sure what it provides when the regulations require (currently and as proposed) distance standards by specialty & urban/rural/suburban designation. There is also nothing in the proposed revisions that states we need to have a certain number and type of provider in each zip code.

.04 Filing and Content of Access Plans

We are uncomfortable with this entire section in C(3). Members have benefit plans with out of network benefits. Members have a choice if they want to access out of network providers and that shouldn't be something that should be looked at negatively due to no availability of in network providers. Additionally the requests in this section are overly burdensome. For example, in section C(3), in (a) and (b), we can't differentiate between member choice and out of network claims, and there is no way to identify a claim received from an *on-call* provider in (c). Carriers believe that the request (d) is overly burdensome, and that (e), billed and paid amounts have nothing to do with network adequacy and shouldn't be part of this requirement.

League members also feel that (f) referral requests for OON is not a measure of adequacy as members/physicians may request due to personal preference, COC, etc. Also, not all requested referral and single case agreement data can be produced. If this part section takes effect we would need additional guidance on how to handle referrals that have been partially granted. We are also concerned that the revised regulation doesn't account for tiered benefits that allow access to OON providers.

We also oppose section C(4). Multiple members commented that complaints aren't tracked to the specificity that is being requesting. Additionally, some of the categories listed do not relate to access and availability. We are once again concerned about the burdensome nature of this request. Carriers are also uncomfortable with (d), non-par reimbursement information and believe that it shouldn't be part of network adequacy requirements. Physician compensation is contractual and therefore not appropriate for this section.

Other specific concerns about the following sections that are opposed in general by carriers include:

€ – NSA is a federal regulation and isn't relevant to these regulations.

C(7) – It's overly burdensome. What regulations do these items point to? We're worried we cannot require these, and it begs the question as to providers would ever agree to this as well. We are also unsure how carriers would ever be able to monitor, and because of this ambiguity, shouldn't be part of Network Adequacy regulations

C(8) –There is no mechanism to gather and monitor this level of information.

C(9) –We don't believe this should be part of the regulations. The carrier isn't responsible for providing a patient portal that allows members' access to providers EMRs. We expect that many providers would not want carriers to play this role. Additionally, the technology isn't available to support this request.

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D - How does this work along with previously opposed Section 3(A)(7) above which requires, “A carrier shall identify, by zip code, the number of participating providers for each provider type code and specialty code listed on the uniform credentialing form described in Insurance Article, § 15-112.1, Annotated Code of Maryland.” This provision could be read to now make that standard optional. Also, would the Commissioner notify all carriers of this requirement prior to each year’s filing requirement, or would the notification be in response to a carrier’s individual filing?

.05 Travel Distance Standards

In respect to ECP providers, carriers need clarification on whether it is going to be 30% or 35%. 35% is the new federal standard and links from the Maryland Health Benefit Exchange (MHBE) website reference that 35% is required, even though other documents on the MHBE page reference 30%.

B(5) adds the category “physician certified in addiction medicine.” We recommend changing this term to “addiction medicine.” This change would make the language more consistent with the other provider types listed and is more reflective of the holistic approach to substance use treatment.

.06 Appointment Waiting Time Standards

Specifically the additional requirement to survey providers twice a year instead of the current once a year, along with the addition of twice yearly member surveys is overly burdensome and costly. Carriers have a plethora of concerns surrounding the validity and reliability of a member survey. The proposed regulations mention the requirement to have the survey show that the enrollees have the willingness and ability to use telehealth services. These requirements are confusing and we aren’t sure they are practical. If the member wasn’t willing then they wouldn’t have utilized telehealth services.

League members recommend the MIA explore the new policy concepts for provider outreach concerning wait times. Whether one provider survey outsourced by the MIA for all carriers at a specified frequency would be more effective than a quarterly, carrier initiated survey. This would also ensure consistency and limit the burden on providers of responding to multiple carrier calls per quarter. We also believe we should require providers to list approximate wait times for an appointment either on their website and/or on their phone line. Only providers can speak to their true average scheduling availability. Surveys are far less reliable and variable based upon a variety of factors outside the scope of the questions (cancellations, new providers joining a practice, etc.). These concepts may require authorizing legislation but would make results more accurate and meaningful in evaluating carrier compliance.

The League believes that wait times are not appropriately defined in the regulation as quantitative standard for the entire Maryland market. Nationwide, less than a quarter of states use wait times as a network adequacy metric and we are struggling to find states in which their standards are not being reevaluated. 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. We were starting to make progress on this front during the 2020 Maryland General Assembly but had to be shelved due to the

COVID-19 outbreak as the state shortened the General Assembly Session for the first time since the Civil War.

The ability of a carrier to effectively manage wait times is also impacted by the delivery model. The relationship between a carrier operating a staff 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 provider decisions, beyond contractual requirements included in provider contracts. 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 patients needs should warrant.

It is also unclear how this measure is to be assessed. Wait times may be sufficient over a broad category of services, yet still fall short for a particular patient at a particular moment in time. How will the MIA continue to determine compliance across all providers for compliance reviews? The difficulty carriers experience with enforcement of wait times will also continue to be a review challenge for the department.

The standard for wait times is “the time from the initial request for health care services by an enrollee or by the enrollee’s treating provider to the earliest date offered for the appointment for services.” However, the wait time experienced by a patient is often dictated by their acceptance of an appointment rather than an offer of an appointment. It’s also a challenge for carriers to track these differences. Carriers are often able to meet wait time standards established in regulation by offering an appointment to a patient; however, ultimately, the patient must accept an appointment. If a patient declines the appointment, a carrier should not be penalized. These instances of a patient declining the offer of an appointment occurs when a patient requests a specific provider due to a myriad of factors including a preferred provider type as well as other considerations such as the provider’s race/ethnicity and/or gender. Sometimes specific providers are not readily available due to scheduling or lack of supply.

It seems apparent to the League that even after years of working on this important part of the network adequacy puzzle that we have yet to see the desired progress. The current regulation places an undue burden on provider, consumer, and carriers alike. We have inquired with our colleagues in other states for their approaches to try to zero in on a best practice, and we do not believe that we have yet to find an approach that would satisfy the intention of the wait time standards.

.07 Waiver Request Standards

We believe the modification in (7) would be very unreliable – a reason for not contracting may not even be provided by the provider, reasons provided may not be accurate, or there may be several various reasons that cannot be adequately categorized for analysis purposes.

.08 Telehealth

Carriers appreciate the new telehealth language and the 10% credit to plans. We could use some guidance on specific language, but the proposed revised regulations are streamlined for ease of use. We also feel that consumers are happy with telehealth expansions, will continue to use the modality far after we have past the pandemic, and provides options for consumers where other factors might present challenges for in-person appointments.

Thank you, again, for the opportunity to provide this feedback on the network adequacy regulations and proposed revisions. Should you have any questions, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew Celentano", with a long horizontal line extending to the right.

Matthew Celentano
Executive Director
The League of Life and Health Insurers of Maryland, Inc.