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For information, contact:  
Matthew Celentano, Executive Director

December 4, 2020

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

*Re: Draft Proposed Regulations 31.10.44.02 Network Adequacy*

Dear Ms. Larson:

Thank you for the opportunity to provide comments on the Draft Proposed Regulations 31.10.44 regarding Network Adequacy on behalf of the League of Life and Health Insurers of Maryland, Inc. (League). 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 from 2016 to date and also appreciates the collaborative process throughout.

This letter will highlight specific concerns and questions with the draft proposed regulations. As a general suggestion, when the MIA begins to develop the standardized forms, the League suggests working with carriers on the development of the form. A user-friendly form that works well across the industry will minimize the expense of compliance, make completion more efficient for carriers who are filing multiple forms for various plans and ensure that there are no concerns that will make meeting a July 1 deadline difficult.

Cost of compliance to these proposed changes also create concerns for League members. To remain actuarially sound, this will have a direct impact to premium rates which are likely to increase as a direct result of this regulation.

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League members are supportive of the intentions of the draft proposed regulations, but are troubled that these steps will set up carriers to fail. Without significant stakeholder involvement and accountability, especially from the provider community, we are concerned that the aspirations of the regulations are not attainable.

In general, networks remain stable and when provider or provider groups leave a network, a health plan's provider relations department will review why it occurred and evaluate the impact that loss has on its system and react accordingly to meet the expectations of our enrollees, employers and the state's regulations. Forcing continuous reviews provides no benefit to the consumer with a very hefty price tag.

The regulation does not seem to consider shortages of provider specialists – health plans cannot recruit and add to networks when there are no providers physically located in the area. As of September 30, 2020, the U.S. Health Resources and Services Administration's *Designated Health Professional Shortage Statistics Report* stated Maryland has only met 34% of the need for mental health professionals and 55% for primary care providers. While health insurance providers progress innovative methods for attracting providers to specific regions, all stakeholders need to work towards addressing provider shortages by geographic region and specialty.

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

### **31.10.44.02 Definitions**

#### **31.10.44.02B(29) "Telehealth"**

The League supports the change to the definition of "telehealth" to align with section 15-139 of the Insurance Article so that it includes delivery of mental health care services to a patient in the patient's home setting. League members would also like to see the definition account for the telehealth flexibilities that have been afforded through the COVID-19 pandemic, such as an audio-only telephone conversation between a health care provider and a patient. The League requests that the MIA consider adding this to the definition or otherwise issuing guidance that permits League members to count those encounters during the ongoing crisis.

### **31.10.44.03 Network Adequacy Standards**

**31.10.44.03A(1)** provides that "a carrier shall develop and maintain a complete network of adult and pediatric primary car[e], mental and behavioral health, substance use disorder, specialty care, ancillary service, vision, pharmacy, home health, and any other providers adequate to deliver the full scope of covered benefits." This requirement does not take into consideration that all health benefit plans covered by the regulations such as large group plans do not necessarily provide certain services such as vision or dental and, therefore, need not maintain a complete network of all listed providers. The League recommends revising this provision to require a carrier to develop and maintain a network of providers adequate to deliver the full scope of covered

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services, including, as appropriate, the listed providers. Alternatively, the regulation could require carriers to maintain a network that is sufficient in numbers and types of providers to assure that, to the extent feasible based on the number and type of providers in the service area, all covered services will be accessible to enrollees in a timely manner appropriate for the enrollees' condition.

**31.10.44.03A(3)** requires a carrier to ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities. The extent to which members have physical access to providers is dependent upon the providers' policies and may not always be necessary depending on the circumstances or achievable in times like the current pandemic. The League recommends that this provision be revised to require carriers to take reasonable steps to ensure physical access to providers.

**31.10.44.03B(1)** requires a carrier to monitor its provider network for compliance with the network adequacy regulations on at least a monthly basis. League members continually monitor their provider networks for compliance but it may take longer than one month to ensure requirements are met. The League requests that the monthly requirement be deleted.

**31.10.44.03B(2)** requires a carrier to monitor out of network costs to members when network providers are not available and report this information on a form provided by the Administration on a quarterly basis. League members do not have the ability to differentiate between members who voluntarily choose to see an out-of-network provider and those who see an out-of-network provider because a network provider is not available. The League requests that this provision be removed from the draft proposed regulation.

#### **31.10.44.04 Filing of Access Plan**

**31.10.44.04C(5)(b)** requires carriers to report, for each hospital, the percentage of the following types of providers practicing in the hospital who are participating providers in the carrier's network: on-call physicians, hospital-based physicians, anesthesiologists, and radiologists. It also requires carriers to report whether any non-physician providers, who routinely provide services to patients, are not participating providers. League members do not have information regarding the percentage of these types of providers practicing in the hospital who participate in the carrier's network. Carriers would need to request the information from participating hospitals and a carrier's ability to comply with this requirement would be dependent on hospitals providing timely and accurate information. The League requests that this provision be removed from the draft proposed regulation.

#### **31.10.44.05 Travel Distance Standards**

**31.10.44.05A(5)** and **31.10.44.05B(5)** add to the travel distance standards charts several new provider and facility types raising the total specific provider and facility types to 46. Despite their best efforts, League members are often unable to contract with certain provider types such as child psychiatrists, which will be added to the travel distance standard regulation. It will be difficult for League members to achieve compliance with the expanded travel distances

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standards. League members also believe that a threshold of 95% compliance with the travel distance standards should be used, consistent with the standards for waiting time.

We are unaware of other state insurance regulations that require travel distance standards to be met for such a large number of specific provider types including specialties and subspecialties. Some state regulations also require carriers to demonstrate that a certain percentage of members have access to different provider types to achieve compliance with the regulations. For example, Washington State regulations require carriers to demonstrate that 80% of the enrollees in the service area have access within 30 miles in an urban area and 60 miles in a rural area from either their residence or workplace to specific provider types such as primary care, mental health and substance use disorder, pediatric services, specialty services, and therapy services. See WAC 284-170-280(3)(e).

CMS provides telehealth credits toward compliance with Medicare Advantage plan network adequacy requirements. Specifically, Medicare Advantage organizations receive a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when they contract with telehealth providers in the certain specialties.

The League requests the Administration to work with League members to develop travel distance standards that are achievable by League members, including consideration of providing telehealth credits similar to those provided by CMS, by requiring compliance to be achieved by if the travel distances standards are met for a specific percentage of enrollees, and/or by eliminating new subspecialties that make compliance difficult to attain.

One provider type added to the chart is Ambulatory Infusion Therapy Centers. League members believe that this should not be listed as a separate provider type as infusion services can be performed in a hospital outpatient setting, physician office or home setting. Creating a separate category for Ambulatory Infusion Therapy Centers does not accurately reflect carriers' ability to provide infusion services to members within the travel distance standards.

#### **31.10.44.06 Appointment Waiting Time Standards**

**31.10.44.06A(2)** requires, on a quarterly basis, each carrier shall make available to its members the median wait times to obtain the following appointments with a participating provider within the applicable maximum travel distance standards described in Regulation .05 of this chapter as measured from the date of the initial request to the date of the earliest available appointment:

- (a) Urgent care for medical services;
- (b) Inpatient urgent care for mental health services;
- (c) Inpatient urgent care for substance use disorder services;
- (d) Outpatient urgent care for mental health services;
- (e) Outpatient urgent care for substance use disorder services;
- (f) Routine primary care;
- (g) Preventive care/well visits;
- (h) Non-urgent specialty care;
- (i) Non-urgent mental health care; and

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(j) Non-urgent substance use disorder care.

It would be administratively difficult if not impossible for League members to comply with this requirement. The maximum travel distance standards are determined on a member-by-member basis. The regulation will require carriers to determine for each member for each of the ten classes of providers which providers in the classes are within the travel distance standards. Carriers separately need to use member surveys meeting the requirements of the regulation and provider inquiries to obtain median wait time data. The difficulty arises from attempting to take median wait time data from a random sampling of members and from provider inquiries and attempting to determine median wait times for classes of providers within travel distance standards which are member specific. This would be virtually impossible to do and would likely result in unreliable data. To attempt to make this information available to members on a quarterly basis would also be virtually impossible to do. We are unaware of any similar requirement imposed by other state insurance regulators. California regulations require a quarterly review and evaluation of wait time information by carriers but does not require carriers to determine median wait times quarterly or require median wait times based on travel distance standards. However, the requirement imposed by this regulation appears to be unprecedented.

The new appointment waiting time standards also require carriers to use member surveys tools and provider inquiries to obtain information to satisfy the regulatory requirements. League members are concerned with the ability to obtain accurate or useful information from provider surveys. League members also estimate that it will take a significant amount of time, money, man hours and resources to attempt to comply with the proposed new waiting time requirements.

**31.10.44.06A(3)** requires carriers to “Ensure the accuracy of its provider directory.” The accuracy of League members’ provider directories depends on receiving timely and accurate information from providers. League members can make every effort to obtain information from providers to ensure an accurate provider directory, but ultimately the accuracy depends on provider cooperation. Therefore, the League recommends that this provision be revised to require carriers have procedures in place to maintain an accurate provider directory.

**31.10.44.09 Confidential Information in Access Plans**

**31.10.44.09A** is revised to replace references to “Methodology” with “Proprietary Methodology” regarding information in an access plan that is considered confidential. The League opposes this change. We understand that certain constituents do not believe that methodologies that are standard among carriers should be confidential. However, creating a standard that treats only “proprietary” methodologies as confidential creates ambiguity as to what methodologies are considered confidential and may result in carriers’ methodologies being made public even if they are not what may considered a standardized methodology. The carriers’ methodologies used to annually assess their performance in meeting the regulatory standards and used to annually measure timely access to health care services should be treated as confidential.

Thank you, again, for the opportunity to provide this feedback on the draft proposed regulations. 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.