February 27, 2017

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

Dear Ms. Grodin:

Consumer Health First (CHF), the University of Maryland Carey School of Law Drug Policy Clinic, and the Mental Health Association of Maryland have been pleased to participate in the collaborative process that you have led for the Maryland Insurance Administration (MIA) to develop regulations specifying quantitative standards for carrier networks as required by HB 1318. We particularly appreciate the invitation to present our research and recommendations at the January 5th hearing. Our mission is to promote health equity through access to high quality, comprehensive, affordable health care for all Marylanders, and ensuring adequate provider networks is key to achieving that equity.

As you know, Consumer Health First and our partner organizations submitted recommendations well in advance of the final deadline, with the goal of stimulating a productive discussion among all stakeholders. To our great disappointment, many of the carriers waited until the very last day of the comment period to submit their key recommendations. From our perspective, this made it impossible to engage in a truly productive discussion among all stakeholders that would lead us to a consensus as to how best to balance the importance of timely access to covered health care services for consumers and the business operations of carriers. Absent the opportunity for a face-to-face meaningful discussion, we offer the following responses for your consideration.

Appointment Wait Times

For consumers, the most important metric for ascertaining network adequacy is appointment wait time standards. We agree with Kaiser Permanente regarding the importance of appointment wait time standards to assess a carrier's network adequacy. NCQA also recognizes appointment wait times as an important metric for demonstrating network adequacy and requires carriers to monitor wait time standards (see page 2 of the appendix of our November 16, 2016, letter, hereinafter referred to as November letter). The carrier recommendation that the MIA flatly reject a metric that has been adopted by 12 other states and recognized by a leading national carrier as well as one of the nation's leading accreditation organizations and all consumer groups is misguided and inadequate to allow consumers to assert their right to timely care.

While we recognize the value of surveying consumers about their experience with their health plan, the CAPHS is wholly inadequate for monitoring appointment wait times. To our knowledge, the CAPHS survey does not ask a representative sample of respondents who have sought the care of specific medical specialties to recall the length of time they had to wait to get an appointment.

Assessing appointment wait times is best done by: (1) surveying a representative sample of designated providers or analyzing administrative data for the designated providers using the protocol developed by California; or (2) effective and on-going monitoring of consumer complaints.

Time/Distance Standards

It is wholly inadequate to rely on distance standards alone. As we noted in our November letter, travel time is especially important for individuals who must use public transportation or live in rural communities. Indeed, 13 states have recognized the importance of both time and distance standards to assess network adequacy.

We would be remiss if we did not take this opportunity to note that the geographic areas specified in Colorado's time/distance standards were not developed for that state but for the Medicare Advantage Program. They remain relevant and applicable to Maryland, too.

Additionally, the set of practitioners for which the carriers propose they be required to demonstrate compliance is far too limited to ensure that many commonly needed medical services will be available through a carrier's network. We note that Colorado imposes geographical standards for a very comprehensive set of providers. Although the carrier's recommendation falls short in many critical areas, including dental, endocrinology, gastroenterology, pulmonology, and physical therapy services, it is particularly inadequate for behavioral health services. Indeed, based on the proposed standard of one psychiatrist and one other behavioral health practitioner in each geographical area, there is no guarantee that a network would have any practitioner specializing in substance use disorder treatment.

Confidentiality

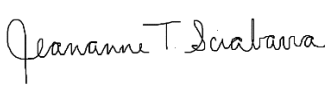
We note the provisions of HB 1318 differentiate between a carrier's access plan and the quantitative and non-quantitative criteria that will be used to evaluate the network sufficiency of the health benefit plans subject to state regulation. *See* Insurance Article §§15-112 (c)(2) and (d)(1). We understand the access plans described in Insurance Article §15-112 (c)(2) may contain some confidential and proprietary information, and, thus, it may not be appropriate to allow public inspection of parts of an access plan.

However, the quantitative and non-quantitative criteria adopted in regulation to evaluate network sufficiency are separate from the access plan and should be reported in a robust and consumer-friendly manner by the MIA. Absent public disclosure, consumers will be unable to consider the carrier's network when selecting a health plan. Other than price, the network is the most important feature of a health benefit plan. Additionally, the factors and processes used by carriers in the development of

networks for medical and mental health and substance used disorder providers are subject to disclosure under federal law.

In closing, we ask you to move forward with our recommendations for quantitative standards to evaluate network sufficiency outlined in our November letter. We are grateful to the MIA for the opportunity to provide input to this important process. Thank you for taking the time to consider our recommendations, and please do not hesitate to contact us if you have any questions.

Sincerely,



Jeananne T. Sciabarra
Executive Director
Consumer Health First

Ellen Weber
Professor of Law
Drug Policy Clinic

Dan Martin
Public Policy Director
Mental Health Association of MD