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August 12, 2022

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Re: Draft Proposed Regulations 31.10.44 Network Adequacy

Dear Commissioner,

Thank you for the opportunity to provide the Maryland Insurance Administration (MIA) comments on Draft Proposed Regulations 31.10.44 regarding Network Adequacy on behalf of Cigna. Cigna appreciates the work the Maryland Insurance Administration (MIA) has done on this issue from 2016 to date and also appreciates the collaborative process throughout.

General concerns

Provider engagement

Providing a sufficient and comprehensive provider network for all our customers remains incredibly important to Cigna. Our provider contracting teams work diligently to recruit and contract with providers and our provider relations professionals work to keep those providers engaged and participating in our network. Cigna is supportive of the intentions of the draft proposed regulations. Throughout the development of Maryland's network adequacy statute and the regulations, carriers have emphasized that an approach to monitoring network adequacy which focuses exclusively on carriers is incomplete. The revisions within the draft proposed regulations continue to exacerbate the gaps and data access challenges that exist in the current regulation. The regulations do not examine the impact of existing provider shortages in the state and their impact on carriers' ability to meet the stated standards. The draft further increases required provider surveys and the need to place increasing administrative burden and pressure on providers through repeated inquiries from every carrier. Increasing the administrative burden of participation in provider networks will further disincentivize participation by providers who can sustain their business model without private insurance. Expecting providers who chose not to respond, or who have limited capacity to respond to a myriad of carrier surveys, to respond positively to threats to their reimbursement or network status is unrealistic and does not benefit consumers. We continue to encourage the MIA to engage the carrier and provider communities collectively to better understand where provider shortages exist, understand the capacity of existing providers, understand the concerns about overly burdensome data requests to providers, and secure provider buy in to make such requirements effective. Carriers believe the state's assistance is crucial to move this kind of provider engagement forward.

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Effective Date

Cigna requests the MIA consider making the revisions to the regulations effective for the July 2024 report. It is not feasible to begin implementing the data collection before the regulation's final language is known. The proposed language requires both an exceedingly granular collection of data and a very specific and unique analysis of the data that requires system changes and updates that are not turnkey in nature. Further, it seems inappropriate to analyze networks and potentially penalize carriers under a new set of retrospective metrics when carriers have not had the opportunity to determine where they stand and make network changes to comply.

Comments on Draft Proposed Regulations 31.10.44

31.10.44.04 Filing of Access Plan

31.10.44.04C (3) requires carriers to report, for each hospital, the percentage of out of network claims and specific data around out of network claims. The inclusion of this data in a network adequacy reporting seemingly presupposes that out of network claims indicate something about the adequacy of a network. In a PPO, members, however, have the right to choose an out of network provider and do so when seeing a specific provider is more important to the patient than staying in network, even when a provider in network is available. The specific reporting requested is both detailed and complicated as it requires several layers of analysis (out of network claims filtered for provider type then filtered for geography, for instance.) In addition, Regulation .04C(3)(c) asks for data specific to "on call physicians" and "hospital based physicians." This is a challenging request as these are not terms broadly used for purposes of insurance claims or collected in a typical data base. While they are part of Maryland's law, they require cumbersome, manual data collection from a larger claims system. We would suggest if the MIA wishes to learn more about out of network claims behavior in the State that it be done outside of these regulations before determining this type of annual reporting is appropriate for a network adequacy regulations.

31.10.44.05 Travel Distance Standards

31.10.44.05A Sufficiency Standards

As drafted, the regulations require measurement from the location of the provider to the facility. We would like to note that GeoAccessis measured from the enrollee's resident to the provider's location, not the other way around. We suggest updating the language in the regulation to reflect this. In addition, GeoAccess reporting software does not support road travel distance. It can support "estimated driving distance" methodology. This methodology does not fully mimic road travel distance. However, it is industry standard and it is critical that carriers are able to rely on popular, generally accepted industry tools to make these significant assessments.

The regulation requires carriers to "Identify any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider location." This is not possible in GeoAccess. A GeoAccess report will show zip codes that fall outside of the applicable distance standards but that is the most granular level the software can reach— it does not report on geographic areas within a zip code.

31.10.44.06 Appointment Waiting Time Standards

The wait time standards have been a subject of significant conversation throughout the review of these regulations. Cigna understands why there is a desire to quantify wait times. Quantifying this measure in a meaningful way is difficult under the current regulations and remains difficult under this draft. Because carriers do not have an active role in obtaining appointments for customers, and because carriers do not have direct oversight of provider offices, it is impossible for a carrier to truly know what the wait time is for a specific customer with a specific provider. The need to determine this information via survey remains a hurdle.

In our experience, multi-carrier curves create a poor provider experience when every commercial plan in the state is required to individually survey each provider office twice a year. Given that wait times should not vary based on the carrier, if this is truly vital information, it should be a coordinated request of all providers throughout the state performed either by the state or as a coordinated payer survey.

Further, surveys are not a good method for capturing this information. Patient memories are undependable and providers are likely only to respond if they meet the standard. This imposed standard can drive providers to meet data requirement rather than to optimize multiple treatment coordination based on local needs. Earliest date offered for an in-person appointment can depend on work and travel schedule of patients, not providers and report of 'median' can still be skewed by extreme outliers.

While the proposal creates a uniform methodology for all carriers, it does not address the fundamental reasons why this standard is difficult to assess in a meaningful way. Ultimately, the only reliable source of information regarding wait times is from providers directly. We continue to urge the state to work collaboratively with the provider community to garner further insight. Requiring costly investment by carriers and burdensome requirements that have failed to have the desired impact on network adequacy in other states is the wrong approach. We believe further focused discussion with the provider community regarding a streamlined, single survey would more likely produce useful data for the state, carriers and consumers.

31.10.44.10 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. Cigna is concerned with this change. There is no definition of "proprietary methodology" in the regulation. We continue to seek more information about how the MIA will assess what is proprietary. Allowing information that negatively impacts a carrier competitively in to the public space harms the market and remains a concern. We urge the MIA to remove this change.

Again, thank you for the opportunity comment on these proposed draft regulations. We look forward to participating in the ongoing stakeholder discussions regarding the regulation and doing our part to assist the MIA in crafting regulations that monitor and assess networks in an accurate and meaningful way.

Sincerely,

Kimberly Y. Robinson

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Director, Regulatory and State Government Affairs