



## MAINE MEDICAL ASSOCIATION

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### ***DELIVERED VIA EMAIL***

Sarah Hewett  
Maine Bureau of Insurance  
34 State House Station  
Augusta, ME 04333

### **RE: COMMENTS ON PROPOSED AMENDMENTS TO BUREAU OF INSURANCE RULE CHAPTER 850**

Dear Ms. Hewett:

I am writing in follow up to the Maine Medical Association's December 20<sup>th</sup> testimony regarding the Bureau of Insurance's proposed revisions to Rule Chapter 850. The Maine Medical Association (MMA) is a professional association of more than 3500 Maine physicians, residents, and medical students. Following the MMA's comments, we are also submitting comments today on behalf of the over 200 physician assistants who are members of the Downeast Association of Physician Assistants, Maine's Chapter of the American Academy of Physician Assistants.

The Maine Medical Association's mission is "to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens." As the largest and broadest physician organization in the State, the MMA represents physicians in primary care as well as all specialties, and rural and urban settings. Our members have substantial concerns that, as proposed, the changes to Section 7 of the Bureau's Rule Chapter 850 would undermine patient access to medical care, especially in rural areas of the state.

We also believe that the Bureau's proposed amendments to Rule Chapter 850 are much broader than necessary to address a vexing but narrow problem that has faced policymakers almost since the promulgation of Rule Chapter 850 in the mid-1990s – that a few hospitals and specialty physician practices, and perhaps other unique practitioners, are able because of their sole community provider status to require payment of charges from health insurance carriers rather than agreeing to a negotiated participating provider rate. We understand that carriers find this troubling, but this has been and remains a dispute between health insurers and health care providers. Patients and health insurance rate payers have been impacted only if one believes that the occasional scenarios in the state where this issue has arisen actually have a significant impact on health insurance

premium rates. The MMA long has believed that this is an isolated problem that has taken on mythical proportions.

For years, the major health insurance carriers in the state have already been able to “steer” patients to particular providers freely through their Administrative Services Only (ASO) accounts, but they do not because it is a loser in the marketplace. Patients want to receive their health care in their communities, with the support of their families and friends, unless they, not an insurance company representative, decides there is higher value in pursuing care in a more sophisticated setting. Nothing in the history of this policy debate and nothing in Public Law 2011, Chapter 90 suggest that the legislature or the public want, or that the Bureau is legally authorized, to dismantle the entire health insurance carrier network adequacy standard framework outlined in 24-A M.R.S.A. §4303(1) and Rule Chapter 850, Section 7. We urge the Bureau to reconsider its approach to these revisions and pursue a narrower course.

### **Background**

As you know, Section F-7 of the 2011 Public Laws, Chapter 90 repealed the subsection of Maine statute requiring that carriers demonstrate adequate access to providers, 24-A MRSA § 4303 (1), and replaced this with new language. The legislature adopted the following new paragraph:

*1. Demonstration of adequate access to providers. A carrier offering or renewing a managed care plan shall provide to its members reasonable access to health care services. A carrier may provide incentives to members to use designated providers based on cost or quality, but may not require members to use designated providers of health care services.*

Title 24-A MRSA § 4303 (1) has been the basis of the Bureau of Insurance’s Rule Chapter 850, Section 7, which outlines how managed care plans demonstrate and ensure member access to services. Among other things, currently Chapter 850 requires that carriers create an access plan, and contains standards for geographic accessibility in carrier networks and timely access to health care services.

It is inconsistent with the plain language of Chapter 90 as well as legislative intent to have a wholesale elimination of the standards for geographic and timely access to services and to provide no guidance to carriers regarding the incentives that they can put in place for using designated providers. The current Chapter 850 regulations are the result of careful consideration by diverse stakeholders over more than a decade. The Bureau should focus on addressing the desire by carriers, picked up by the legislature, for carriers to have the flexibility to create innovative products that contain incentives to use designated providers, rather than gutting important protections for Maine patients. Further, while the MMA has no opposition to the Bureau importing some of the National Committee for Quality Assurance (NCQA) standards into Chapter 850, the NCQA standards alone do not sufficiently address the requirement found in Chapter 90 to ensure “reasonable access to health care services” and the proposed rules have omitted some key guidance to carriers found in the NCQA standards.

Below, we provide more detailed comments in order of the proposed rule subsections.

**Consequences for failure to file or follow an access plan, Section 7(A).** Proposed changes to this subsection eliminate the consequences for the failure by a carrier to file or implement an access plan. The statutory language still requires that a carrier “demonstrate. . . adequate access to providers” and “provide to its members reasonable access” to services. The proposed rule still requires an access plan. Yet, without the ability by the Bureau to impose penalties for the failure of a carrier to comply with these requirements, such as the suspension or revocation of a managed care plan approval, this language loses any enforceability. The MMA recommends that this language remain.

**Reporting ratio of specialty care providers to enrollees, Section 7(A)(2).** The proposed rule strikes the requirement that carriers report the projected ratio of specialty care providers to enrollees by county yet retains the requirement that carriers report the projected ratio of primary care providers to enrollee by county. Under proposed Section 7(B)(2), carriers will already have to establish quantifiable and measurable standards for the number of each type of high-volume specialty care practitioner and analyze performance against the standard. It appears inconsistent with this requirement and the requirement that carriers report the ratio of primary care providers to enrollee to no longer require carriers report the ratio of specialty care providers. Therefore, we suggest that the Bureau retain the following language in Section 7(A):

- 2) The projected ratio of high-volume specialty care ~~specialty care~~ and primary care providers to enrollees by county

**Written standards for network, Section 7(A)(3).** The proposed rule adds language that carriers must create “written standards for providing a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay.” As mentioned above, the language of Chapter 90 requires that “reasonable access” to services be maintained. Nothing in the plain language of the statute suggests that this means only *timely* access to care and not also *local* access to care.

In fact, the legislative record reflects that the Senators who adopted this final language intend that enrollees must continue to have access to local provider networks. In the debate over language allowing carriers to provide incentives to travel to designated providers, Senator Phil Bartlett, a Democrat with concerns about the language, stated that

the problem with the bill is by repealing 850 it appears that an insurance company could simply not cover certain providers. They could say they were only going to cover their preferred providers, which means you could end up having to travel a distance if there is nobody covering your area.

Senate President Kevin Raye, a proponent of the law, responded:

[L]et the record reflect and let all those who shall interpret this record as well as interpret this law in the future very clearly

understand that the intent of this legislature is, as the bill is written, that there is nothing to suggest that any carrier can make a denial such as was suggested by [Senator Bartlett]. . . [Y]ou can go to your local hospital or any hospital you want to. . . and it will be covered under the terms of this law.

Senators McKane, Katz, Schneider and Whittemore all echoed that enrollees will continue to be able to receive care from local providers and travel would not be required.

In addition, the NCQA Health Plan Accreditation Requirements state that NCQA assesses whether practitioners are located throughout the plans' service area (QI 4). See 2011 NCQA Health Plan Accreditation Requirements, available at: <http://www.ncqa.org/tabid/689/Default.aspx>.

Consistent with the language of Chapter 90, the legislative intent and NCQA standards, we suggest that Chapter 850 be amended to state:

3) Written standards for. . . providing a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay and within a reasonable distance of a covered person's residence.

**Description of plan for providing services for rural populations, Section 7(A)(4).**

The Bureau suggests striking Section 7(A)(4), which currently requires that a carrier submit a "description of the carrier's plan for providing services for rural and underserved populations and for developing relationships with essential community providers." As just described, the amended statute, legislative intent, and NCQA standards all require that enrollees have local access to care. This includes access in rural areas of the state. The Senate debate reflects a particular concern with those in rural Maine being able to continue to obtain care from local providers. See, for example, comments by Senator Alford (worried that "we now are telling people in rural Maine that they can't go to the more convenient place") and Senator Katz's response ("I've heard that someone in Ft. Kent is now going to be forced to go to the hospital in Portland. Will all due respect, it's my understanding that this just isn't so."). The MMA recommends that this language be retained, reflecting the critical need for Mainers to be able to access local services, as well as the legislative intent behind Chapter 90.

**Addressing language and literacy barriers, Section 7(A)(5).** The proposed rule strikes the requirement that carriers provide "a description of the carrier's strategy to identify and address language and literacy barriers to accessing needed services." Nothing in the language of Chapter 90, nor the legislative debate, reflects an intent to remove protections for those with language or literacy barriers in accessing needed services. In addition, NCQA looks for whether carriers have objectives for serving "culturally and linguistically diverse memberships" (QI 1) and whether a "plan consider[ed] the cultural needs of its members when it created its practitioner network." (QI 4). See 2011 NCQA Health Plan Accreditation Requirements, available at:

<http://www.ncqa.org/tabid/689/Default.aspx>. Thus, the MMA recommends this requirement be maintained.

**Access to primary care services, Section 7(B)(1).** We support the Bureau's maintenance of a target of one full-time equivalent primary care provider to 2000 enrollees. However, to maintain consistency with NCQA Standards and proposed Section 7(B)(2) requirements for access to specialty care, Section 7(B)(1) should include the requirement that carriers set standards for the number and distribution of primary care providers and annually analyze performance against the standards. In addition, this section lacks the guidance that NCQA provides as to acceptable methods carriers can use to express the number and geographic distribution of practitioners and the requirement that carriers provide an analysis of any deficiencies in meeting the standard. See 2012 HP Standards and Guidance pages 76-77. If the Bureau is going to rely on NCQA standards, it should retain at least the level of detail in Rule 850 that NCQA provides.

We recommend the following language (proposed additions in italics):

- 1) Primary Care. To the extent reasonably possible, carriers that offer managed care plans utilizing primary care providers shall maintain a minimum ratio of one full-time equivalent primary care provider to 2000 enrollees. Carriers shall ensure the availability of practitioners who provide primary care services, including general and internal medicine, family practices and pediatrics. *The carrier shall:*
  - a. *Establish quantifiable and measurable standards for both the number and geographic distribution of each type of practitioner providing primary care.*
  - b. *The carrier shall express the number of practitioners as one of the following:*
    - i. *The ratio of member-to-practitioner availability in each area;*
    - ii. *The ratio of the number of sites accepting new members for primary care to the number of members in each geographic area;*  
*or*
    - iii. *The ratio of the number of open practices to the number of members within each geographic area.*
  - c. *The carrier shall express the geographic distribution of practitioners as one of the following:*
    - i. *The percentage of members with a practitioner of each type available within a certain number of miles; or*
    - ii. *Acceptable driving times to primary care sites that are accepting new members.*

- d. Analyze performance against the standards at least annually. The assessment methodology selected must allow direct measurement against standards. Analysis of findings must include an analysis of causes of any deficiencies (if appropriate) that must go beyond data display or simple reporting of results.

Finally, to ensure transparency and employer and enrollee choice in coverage options the MMA recommends that the standards and analysis be made publicly accessible.

**Access to specialty care, Section 7(B)(2).** As with primary care providers, this section should contain target ratios of the high volume specialty care practitioners to enrollees. Access to these practitioners, such as obstetricians and cardiologists, is as critical as primary care access, and the Bureau should provide guidance to plans on what “reasonable access” means. In addition, the standards on access to specialty care should provide the guidance to carriers found in the NCQA Standards regarding how to express the number and geographic distribution of specialists and requiring an analysis of deficiencies in meeting the access standard set. Again, these standards and the analysis should be publically available.

We recommend inserting the following language after Section 7(B)(2)(b):

- c. The carrier shall express the number of specialty care practitioners as one of the following:
  - i. The ratio of member-to-specialty care provider availability in each area;
  - ii. The ratio of the number of sites accepting new members for specialty care to the number of members in each geographic area;  
or
  - iii. The ratio of the number of open practices to the number of members within each geographic area.
- d. The carrier shall express the geographic distribution of practitioners as one of the following:
  - i. The percentage of members with a specialty care provider of each type available within a certain number of miles; or
  - ii. Acceptable driving times to specialty care sites that are accepting new members.

We further recommend amending the current Section 7(B)(2)(c) to read:

- e. Analyze performance against the standards at least annually. The assessment methodology selected must allow direct measurement of performance against standards. Analysis of findings must include an

*analysis of causes of any deficiencies (if appropriate) that must go beyond data display or simple reporting of results.*

**Access to behavioral healthcare, Section 7(B)(3).** As with primary and specialty care access, described above, the standards on access to behavioral health care should provide the guidance to carriers found in the NCQA Standards regarding how to express the number and geographic distribution of behavioral healthcare practitioners (see 2012 HP Standards and Guidance page 82), and an analysis of deficiencies in meeting the access standard (see 2012 HP Standards and Guidance page 81). The full language is not repeated here as it mirrors that provided above. In addition, the standards and analysis should be made publically available.

**Standards for geographic accessibility, Section 7(C)(1)&(2)** As mentioned above, but bears repeating, it was not the legislature's intent within Chapter 90 to undermine local access to medical care. Indeed, the language of Chapter 90 continues to require "reasonable access to health care providers." The legislature intended only to allow insurance carriers additional flexibility in designing products that include incentives to travel to designated providers. See, for example, Senator McKane's comments: Chapter 90 "does not allow insurers to impose unreasonable travel restrictions, but it will let insurers offer incentives that can save consumers thousands.... We have disallowed that incentive for years and consumers want that option. It's only an option. It's their choice. You can also keep your own doctor. . . or go to the same hospital."

The legislature was crafting a narrow solution to a specific problem. 24-A MRSA §4303(1) did include a framework for allowing exceptions to geographic access requirements (see §§ 4303(B) and (C)) however they were fairly detailed and as far as we know, no fully-insured plan has qualified. The legislature intended to make it easier to qualify for exceptions, not eliminate the actual underlying geographic access requirement. To carry out this intent, Sections 7(C)(1) and (2) should remain – specifying primary care access within 30 minutes travel time and specialty care or hospital service within 60 minutes. This fulfills both legislative intent and the plain language of Chapter 90 requiring "reasonable access" to providers. While the NCQA standards provide a useful framework for measuring quality, and we have suggested additional language that should be imported into Rule 850 if the Bureau is going to rely, in part, on NCQA Standards, these are not sufficient to implement Chapter 90. Allowing carriers free reign to determine their own standard for geographic access and measure if they are meeting the goal that they, themselves, have set in no way ensures "reasonable access" to care. Once sufficient geographic access standards are in place, as the legislature intended, carriers can then have added flexibility to design incentives to travel beyond these distances, if enrollees so choose.

**Standards for incentives to use designated providers, Section 7(C)(3).** Where sections 7(1) and (2) of existing Chapter 850 specify maximum travel distances to primary, specialty and hospital care, section 7(C)(3) has contained a framework for the Bureau to grant exceptions to the travel times. The Bureau proposes eliminating from this Section not only the travel time requirements but also any framework for designating providers or providing travel incentives.

However, the legislature envisioned more guidance being provided to plans in creating incentives for enrollees to travel to providers. As quoted previously, the statute reads: “*A carrier may provide incentives to members to use designated providers based on cost or quality, but may not require members to use designated providers of health care services.*” The Senate debated this provision at length and members stated that they envision a structure “that is not punitive to anyone” (Senator Raye), that provides positive incentives such as “having your co-pay covered or something of that nature” (Senator Raye), “offers a waiver of the co-pay, for instance, or some other economic incentive to [travel]” (Senator Katz), “pay[s] their deductible or, in some cases, pay[s] transportation to the hospital, etcetera. It’s not going to hurt anybody” (Senator Whittemore). However, the proposed rules provide no guidance to carriers on how to structure such an incentive program in a way that fulfills the legislative intent.

The MMA recommends that the Bureau look to some of the current language within Rule 850, Section 7(c)(3) to create an incentive program. This language was the result of a 2007 consensus-based rule development process, including participation by health plans, health care providers, businesses and the Bureau of Insurance. While some of the language is no longer relevant, other sections can continue to provide critical guidance to carriers.

The MMA recommends that the final rules address, at a minimum:

1. A description of what an “incentive” can be. The MMA recommends that the Bureau retain the language currently found in Section 7(c)(3) clarifying that “Any financial incentive to encourage a member to utilize a service of a designated . . . provider must be an additional benefit for using the designated . . . provider. A carrier may not reduce the benefits otherwise applicable on the ground that services were provided by a provider who is not a designated . . . provider.”
2. Limitations on providing incentives for emergency care. The MMA recommends that the Bureau limit the ability of carriers to designate, or provide incentives for members to travel to obtain, emergency or urgent care. Language could be modeled after that currently found in Section 7(c)(3)(c).
3. Guidance to carriers regarding “designating” providers that ensures transparency and consistency for providers. For example, the rule should parallel the statute in stating that only cost and/or quality can be used to designate providers. Further, the rule should require that carriers disclose to providers if cost or quality or both are being used to designate providers and to disclose the data and methodologies that are being used as the basis for the designation. The rule should state that providers have the ability to request an explanation of why they did not qualify as a designated provider and what they must do in order to qualify. Designations should be updated on a regular basis, at least every six months. The MMA suggests that some of this language can be drawn from the current language in Section 7(c)(3)(f)(ii) and (iii) of the rule.

4. Transparency for enrollees. The Bureau should maintain Section 7(c)(3)(i) of the Rule, currently proposed for deletion, which requires that carriers “create a directory of designated. . . providers under the plan, and the directory must be made available to any prospective applicant or covered member under the plan.” In addition, the basis for designating providers (cost and/or quality) and data and mechanisms used to designate providers should be made available not only to providers, but to all prospective applicants and covered members. Consumers should also be informed of any implications of traveling for care, including who will bear travel expenses, lodging and meal expenses, and should have the opportunity to switch providers should their provider lose designated status.

**Standards for timely access to health care services, Section 7(D).** The proposed rule eliminates fixed time requirements for accessing health care services, other than behavioral health. Instead, it imports NCQA requirements which allow carriers to set standards and measure performance against those standards for access to regular and routine care appointments, urgent care, after-hours care, and telephone services. In contrast, for behavioral health services, the proposed rule does specify fixed standards for access to care (e.g. 6 hours for care for non-life-threatening emergencies).

The MMA applauds the Bureau for recognizing the importance of behavioral health and including fixed standards for accessing such services. The MMA also recognizes the goal of consistency with NCQA standards. However, there is nothing in the language of Chapter 90 that changes, nor was there any discussion in the legislature suggesting an intent to change, the standards for timely access to care found in Rule 850. Further, Maine has a longstanding commitment to integrating behavioral and physical health care and not treating them as distinct types of medical care. The State has sought to reflect this in insurance regulation as well as in health care delivery. In light of that goal and the language and history of Chapter 90, this Section should not have separate standards for “health care” and “behavior healthcare.” Instead, both should be measured against the same standards of access within 6 hours for care for non-life-threatening emergencies, 48 hours for urgent care and 10 business days for routine office visits. In addition, the analysis of performance against such a standard should be made publicly available.

### **Conclusion**

The Maine Medical Association appreciates the need to improve health care efficiency and eliminate unduly burdensome regulations. We agree that it is time to allow carriers some additional flexibility in designing health plans. However, any change in regulation must be consistent with statute and legislative intent. Based on the language of Chapter 90 and comments made in the Senate, we expect final revisions to Chapter 850 to ensure both timely and local access to care and to provide carriers guidance on designating providers and providing incentives to use designated providers.

### **Comments of the Downeast Association of Physician Assistants (DEAPA)**

DEAPA asks that you consider the following comments in finalizing this rule:

1. **Definition of Primary Care Provider in Section 5(FF)**: Section 5 as currently written defines Primary Care Provider as “a physician, or a nurse practitioner or physician’s assistant...” To reflect the accurate title of the profession and current references to the profession in state statute and rule, we request that the language read: “a physician, or a nurse practitioner or physician’s assistant...,” with no apostrophe or ‘s.’ This is consistent with Maine’s physician assistant licensing statute, 32 MRSA § 3270-B (referring to “physician assistants”), and the Board of Licensure in Medicine (BOLIM) regulations for physician assistants. See BOLIM Rule Chapter 2 §1(G) (defining “physician assistant”). See also the American Academy of Physician Assistant description of the profession, available at [http://www.aapa.org/the\\_pa\\_profession.aspx](http://www.aapa.org/the_pa_profession.aspx).
2. **Direct Supervision Requirement in Section 5(FF)**: The current definition of a primary care provider includes a “physician’s assistant under the *direct* supervision of a physician. . . .” (Emphasis added). We request that the language be amended to read: a “physician’s assistant under the ~~direct~~ supervision of a physician. . . .”

It is inconsistent with current state regulation of the physician assistant profession to require direct physician supervision. For example, see the BOLIM Rule Chapter 2 §7 stating that “Supervision [of physician assistants] shall be continuous but shall *not* be construed as necessarily requiring the physical presence of the supervising physician at the time and place that the services are rendered.” (Emphasis added). See also BOLIM Rule Chapter 2 §1(I) (defining a “Primary Supervising Physician” as a “physician who has been approved by the Board to provide supervision of physician assistants,” without specifying direct supervision) and BOLIM Rule Chapter 2 §1(L) (defining “Supervision” as “overseeing, and accepting responsibility and liability for, the medical activities delegated by a physician to a physician assistant,” without any reference to direct supervision).

Thank you for considering these additional comments of DEAPA and the Maine Medical Association on the proposed revision of Rule Chapter 850.

Sincerely,



Jessa E. Barnard, Esq.