MARYLAND REGISTER

Proposed Action on Regulations

Transmittal Sheet PROPOSED OR REPROPOSED Actions on Regulations	Date Filed with AELR Committee	TO BE COMPLETED BY DSD
	06/16/2017	Date Filed with Division of State Documents
		Document Number
		Date of Publication in MD Register

1. Desired date of publication in Maryland Register: 7/21/2017

2. COMAR Codification

Title	Subtitle	Chapter	Regulation
31	10	44	01-.09

3. Name of Promulgating Authority

Maryland Insurance Administration

4. Name of Regulations Coordinator Lisa M Larson

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5. Name of Person to Call About this Document Lisa Larson

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6. Check applicable items:

X- New Regulations

_ Amendments to Existing Regulations

Date when existing text was downloaded from COMAR online: .
_ Repeal of Existing Regulations
_ Recodification
_ Incorporation by Reference of Documents Requiring DSD Approval
_ Reproposal of Substantively Different Text:

: Md. R

(vol.) (issue) (page nos) (date)

Under Maryland Register docket no.: --P.

7. Is there emergency text which is identical to this proposal:
_ Yes **X-** No

8. Incorporation by Reference
_ Check if applicable: Incorporation by Reference (IBR) approval form(s) attached and 18 copies of documents proposed for incorporation submitted to DSD. (Submit 18 paper copies of IBR document to DSD and one copy to AELR.)

9. Public Body - Open Meeting
_ OPTIONAL - If promulgating authority is a public body, check to include a sentence in the Notice of Proposed Action that proposed action was considered at an open meeting held pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland.
_ OPTIONAL - If promulgating authority is a public body, check to include a paragraph that final action will be considered at an open meeting.

10. Children's Environmental Health and Protection
_ Check if the system should send a copy of the proposal to the Children's Environmental Health and Protection Advisory Council.

11. Certificate of Authorized Officer
I certify that the attached document is in compliance with the Administrative Procedure Act. I also certify that the attached text has been approved for legality by Lisa Hall, Assistant Attorney General, (telephone #410-468-2030) on 6/12/17. A written copy of the approval is on file at this agency.

Name of Authorized Officer
Alfred W. Redmer, Jr.

Title
Insurance Commissioner

Telephone No.
410-468-2090

Date
6/15/17

Title 31
MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

31.10.44 Network Adequacy

Authority: Insurance Article, §§ 2-109 and 15-112, Annotated Code of Maryland

Notice of Proposed Action

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The Insurance Commissioner proposes to adopt Regulations .01-.09 under a new chapter 44 Network Adequacy under COMAR 31.10 Health Insurance -- General.

Statement of Purpose

The purpose of this action is to adopt Regulations .01-.09 under a new Chapter 44 entitled Network Adequacy under COMAR 31.10 Health Insurance -- General. These new regulations are being adopted pursuant to updates to Insurance Article Section 15-112, Annotated Code of Maryland, that occurred as a result of changes made during the 2016 legislative session.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact.

The cost to insurance carriers may increase in order to meet these new requirements. While the definite cost can not be determined at this point, the increase is expected to be minimal.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	

	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	NONE	
(1) Administrative Expense	(+)	Minimal
(2) Expense	(+)	Minimal
E. On other industries or trade groups:	NONE	

F. Direct and indirect effects on public: NONE

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D(1). Assuming that insurance carriers are now required to submit additional forms to the Maryland Insurance Administration, their administrative expenses may go up.

D(2). Assuming that insurance carriers may have to expend some time and resources to work with additional providers to contract with them, this might increase their cost slightly.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Lisa Larson, Regulations Manager, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202, or call 410-468-2007, or email to networkadequacy.mia@maryland.gov, or fax to 410-468-2020. Comments will be accepted through August 21, 2017. A public hearing has not been scheduled.

Economic Impact Statement Part C

A. Fiscal Year in which regulations will become effective: FY 18
B. Does the budget for the fiscal year in which regulations become effective contain funds to implement the regulations?
No
C. If 'yes', state whether general, special (exact name), or federal funds will be used:

D. If 'no', identify the source(s) of funds necessary for implementation of these regulations:
No additional funds are necessary to implement these regulations.
E. If these regulations have no economic impact under Part A, indicate reason briefly:
Insurance carriers are already required to file the reports required under these regulations.
F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason and attach small business worksheet.
Most of the insurance carriers impacted by these changes in Maryland are not small businesses.
G. Small Business Worksheet:

Attached Document:

Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

Chapter 44 Network Adequacy

Authority: Insurance Article, §§ 2-109 and 15-112, Annotated Code of Maryland

.01 Scope.

This chapter applies to carriers that issue or renew health benefit plans in Maryland that use a provider panel.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Access plan" means the materials that each carrier is required to file annually with the Commissioner to demonstrate that each of the carrier's provider panels is adequate to meet the needs of its enrollees.

(2) "Behavioral health care" means care for mental health or a substance use disorder.

(3) "Carrier" means:

(a) An insurer authorized to sell health insurance;

(b) A nonprofit health service plan; or

(c) A health maintenance organization.

(4) "Certified registered nurse practitioner" means an individual who is licensed as a certified nurse practitioner under Title 8, Subtitle 3 of the Health Occupations Article.

(5) "Enrollee" means a person entitled to health care benefits from a carrier.

(6) "Essential community provider" means a provider that serves predominantly low-income or medically underserved individuals including:

(a) Local health departments;

(b) Outpatient mental health and community based substance use disorder programs; and

(c) Any entity listed in § 340B(a)(4) of the Public Health Service Act.

(7) "Group model HMO" means a type of health maintenance organization that:

(a) Contracts with one multispecialty group of physicians who are employed by and shareholders of multispecialty group; and

(b) Provides or arranges for the provision of physician and other health care services to patients at medical facilities operated by the HMO or employs its own physicians and health care practitioners on a salaried basis in health maintenance organization buildings to provide care to enrollees of the health maintenance organization.

(8) "Health benefit plan" has the meaning stated in Insurance Article, § 15-112, Annotated Code of Maryland.

(9) "Health care facility" has the meaning stated in Insurance Article, § 15-112, Annotated Code of Maryland.

(10) "Health care practitioner" means a person who is licensed, certified, or otherwise authorized to provide health care services in the jurisdiction in which the health care services are provided.

(11) "Hospital" has the meaning stated in Health General Article, § 19-301, Annotated Code of Maryland.

(12) "Material change to an access plan" means a change to an access plan that affects a carrier's ability to comply with the requirements of this chapter.

(13) "Network" means:

(a) A carrier's participating providers and the health care facilities with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan; or

(b) If a carrier uses a provider panel developed by a subcontracting entity, "network" includes providers and health care facilities that contract with the subcontracting entity to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(14) "Network adequacy waiver request" means a written request from a carrier to the Commissioner wherein the carrier seeks the Commissioner's approval to be relieved of certain network adequacy requirements in this chapter for one year.

(15) "Participating provider" means a provider on a carrier's provider panel.

(16) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury or other health condition, and includes all of the services required by 42 U.S.C. § 300gg-13.

(17) "Primary care physician" means:

(a) A physician who is responsible for:

(i) Providing initial and primary care to patients;

(ii) Maintaining the continuity of patient care; or

(iii) Initiating referrals for specialist care.

(b) A primary care physician may be:

(i) A physician whose practice of medicine is limited to general practice; or

(ii) A board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.

(18) "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

(19) "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(20) "Rural area" means a region that, according to the Maryland Department of Planning, has a human population of less than 1,000 per square mile.

(21) "Specialty provider" means a health care practitioner who:

(a) Focuses on a specific area of physical, mental, or behavioral health for a group of patients;

(b) Has successfully completed required professional training; and

(c) For a physician, has obtained Board certification through the American Board of Medical Specialties.

(22) "Suburban area" means a region that, according to the Maryland Department of Planning, has a human population equal to or more than 1,000 per square mile, but less than 3,000 per square mile.

(23) "Telehealth" means:

(a) As it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located.

(b) Telehealth does not mean:

(i) An audio-only telephone conversation;

(ii) Electronic mail message; or

(iii) Facsimile transmission between a health care provider and a patient.

(24) "Tiered network" means a network of participating providers that has been divided into sub-groupings differentiated by the carrier according to:

(a) Cost-sharing levels;

(b) Provider payment;

(c) Performance ratings;

(d) Quality scores; or

(e) Any combination of these or other factors established as a means of influencing the enrollee's choice of provider.

(25) "Urban area" means a region that, according to the Maryland Department of Planning, has a human population equal to or greater than 3,000 per square mile.

(26) "Urgent care" means treatment for a condition that satisfies either of the following:

(a) A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of a carrier, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:

(i) Placing the member's life or health in serious jeopardy;

(ii) The inability of the member to regain maximum function;

(iii) Serious impairment to bodily function;

(iv) Serious dysfunction of any bodily organ or part; or

(v) The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or

(b) A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment.

(27) "Waiting time" means 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.

.03 Filing of Access Plan.

A. Each carrier that issues or renews a health benefit plan in Maryland that uses participating providers shall file an annual access plan with the Commissioner through the System for Electronic Rate and Form Filing (SERFF) on or

before July 1 of each year for each provider panel used by the carrier, with the first access plan filing due on or before July 1, 2018.

B. If a carrier makes a material change to an access plan, the carrier shall:

(1) Notify the Commissioner of the change in writing within 15 business days after the material change to the access plan occurs; and

(2) Include in the notice required under § B(1) of this regulation a reasonable timeframe within which the carrier will file with the Commissioner an update to the existing access plan for review by the Commissioner.

C. Each annual access plan filed with the Commissioner shall include:

(1) An executive summary on the form set forth in Regulation .09 of this chapter;

(2) The information and process required by Insurance Article, § 15-112(c)(4), Annotated Code of Maryland, and the methods used for monitoring pursuant to § 15-112(c)(5);

(3) Documentation justifying to the Commissioner how the access plan meets each network sufficiency requirement set forth in Regulations .04-.06 of this chapter; and

(4) A list of all changes made to the access plan filed the previous year.

.04 Geographic Accessibility of Providers.

A. Sufficiency Standards.

(1) Except as stated in § B of this regulation, each provider panel shall have within the geographic area served by the carrier's network or networks, sufficient primary care physicians, specialty providers, mental health and substance use disorder providers, hospitals, and health care facilities to accept each enrollee within the maximum travel distance standards listed in the chart in § A(4) of this regulation for each type of specialty and geographic area. The distances stated in § A(4) of this regulation shall be measured from the enrollee's home.

(2) When an enrollee elects to utilize a gynecologist, pediatrician, or certified registered nurse practitioner for primary care, a carrier may consider that utilization as a part of its meeting the requirements of Regulation .04 of this chapter.

(3) Other Facilities as listed in § A(4) of this regulation, does not include the following facility or program types:

(a) Home health care;

(b) Durable medical equipment;

(c) Heart transplant programs;

(d) Heart or lung transplant programs;

(e) Kidney transplant programs;

(f) Liver transplant programs;

(g) Lung transplant programs; or

(h) Pancreas transplant programs.

(4) Chart of Specialty and Geographic Area Distance Requirements.

	Urban Area Maximum Distance (miles)	*Suburban Area Maximum Distance (miles)*	*Rural Area Maximum Distance (miles)*
Provider Type:			
Primary Care Physician	*5*	*10*	*30*
Gynecology, OB/GYN	*5*	*10*	*30*
Pediatrics—Routine/Primary Care	*5*	*10*	*30*
Allergy and Immunology	*15*	*30*	*75*
Cardiovascular Disease	*10*	*20*	*60*
Chiropractic	*15*	*30*	*75*
Dermatology	*10*	*30*	*60*
Endocrinology	*15*	*40*	*90*
ENT/Otolaryngology	*15*	*30*	*75*

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Gastroenterology	10	30	60
General Surgery	10	20	60
Gynecology Only	15	30	75
Licensed Clinical Social Worker	10	25	60
Nephrology	15	25	75
Neurology	10	30	60
Oncology—Medical and Surgical	10	20	60
Oncology—Radiation/Radiation Oncology	15	40	90
Ophthalmology	10	20	60
Physiatry, Rehabilitative Medicine	15	30	75
Plastic Surgery	15	40	90
Podiatry	10	30	60
Psychiatry	10	25	60
Psychology	10	25	60
Pulmonology	10	30	60
Rheumatology	15	40	90
Urology	10	30	60
Other Medical Provider Not Listed	15	40	90
Facility Type:			
Pharmacy	5	10	30
Acute Inpatient Hospitals	10	30	60
Applied Behavioral Analysis	15	30	60
Critical Care Services—Intensive Care Units	10	30	100
Diagnostic Radiology	10	30	60
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	10	30	50
Outpatient Infusion/Chemotherapy	10	30	60

	Urban Area Maximum Distance (miles)	*Suburban Area Maximum Distance (miles)*	*Rural Area Maximum Distance (miles)*
Skilled Nursing Facilities	*10*	*30*	*60*
Surgical Services (Outpatient or Ambulatory Surgical Center)	*10*	*30*	*60*
Other Facilities	*15*	*40*	*90*

B. Group Model HMO Plans Sufficiency Standards.

(1) Each group model HMO plan's provider panel shall have sufficient primary care physicians, specialty providers, mental health and substance use disorder providers, hospitals, and health care facilities to accept each enrollee within the maximum travel distance standards listed in the chart in § B(2) of this regulation for each type of specialty and geographic area. The distances stated in § B(2) shall be measured from the enrollee's location, home or place of employment, from which the enrollee gains eligibility for participation in the group model HMO's plan.

(2) Chart of Specialty and Geographic Area Distance Requirements.

	Urban Area Maximum Distance (miles)	*Suburban Maximum Distance (miles)*	*Rural Maximum Distance (miles)*
Provider Type:			
Primary Care Physician	*15*	*20*	*45*
Gynecology, OB/GYN	*15*	*20*	*45*
Pediatrics—Routine/Primary Care	*15*	*20*	*45*
Allergy and Immunology	*20*	*30*	*75*
Cardiovascular Disease	*15*	*25*	*60*
Chiropractic	*20*	*30*	*75*
Dermatology	*20*	*30*	*60*
Endocrinology	*20*	*40*	*90*
ENT/Otolaryngology	*20*	*30*	*75*
Gastroenterology	*20*	*30*	*60*
General Surgery	*20*	*30*	*60*
Gynecology Only	*15*	*30*	*60*
Licensed Clinical Social Worker	*15*	*30*	*75*
Nephrology	*15*	*30*	*75*
Neurology	*15*	*30*	*60*
Oncology—Medical, Surgical	*15*	*30*	*60*

	Urban Area Maximum Distance (miles)	*Suburban Maximum Distance (miles)*	*Rural Maximum Distance (miles)*
Oncology—Radiation/Radiation Oncology	*15*	*40*	*90*
Ophthalmology	*15*	*20*	*60*
Physiatry, Rehabilitative Medicine	*15*	*30*	*75*
Plastic Surgery	*15*	*40*	*90*
Podiatry	*15*	*30*	*90*
Psychiatry	*15*	*30*	*60*
Psychology	*15*	*30*	*60*
Pulmonology	*15*	*30*	*60*
Rheumatology	*15*	*40*	*90*
Urology	*15*	*30*	*60*
Other Medical Provider	*20*	*40*	*90*
Facility Type:			
Pharmacy	*5*	*10*	*30*
Acute Inpatient Hospitals	*15*	*30*	*60*
Applied Behavioral Health	*15*	*30*	*60*
Critical Care Services—Intensive Care Units	*15*	*30*	*120*
Diagnostic Radiology	*15*	*30*	*60*
Inpatient Psychiatric Facility	*15*	*45*	*75*
Outpatient Dialysis	*15*	*30*	*60*
Outpatient Infusion/Chemotherapy	*15*	*30*	*60*
Skilled Nursing Facilities	*15*	*30*	*60*
Surgical Services (Outpatient or Ambulatory Surgical Center)	*10*	*30*	*60*
Other Facilities	*15*	*40*	*120*

(3) When an enrollee elects to utilize a gynecologist, pediatrician, or certified registered nurse practitioner for primary care, a carrier may consider that utilization as a part of its meeting the standards stated in Regulation .04 of this chapter.

(4) Other facilities, as stated in § B(2) of this regulation, does not include the following facility or program types:

(a) Home health care;

(b) Durable medical equipment;
(c) Heart transplant programs;
(d) Heart or lung transplant programs;
(e) Kidney transplant programs;
(f) Liver transplant programs;
(g) Lung transplant programs; or
(h) Pancreas transplant programs.

C. Each provider panel shall include 30 percent of the available essential community providers in each of the defined rating areas.

D. If a carrier uses a tiered network, the carrier's provider panel shall meet the standards of this regulation for the lowest cost-sharing tier.

.05 Waiting Times for Appointments with Providers.

A. Sufficiency Standards.

(1) Except as provided in § B of this regulation and Regulation .07 of this chapter, each carrier's provider panel shall meet the waiting time standards set forth in § C of this regulation for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel.

(2) When it is clinically appropriate and an enrollee elects to utilize a telehealth appointment, a carrier may consider that utilization as a part of its meeting the standards stated in § C of this regulation.

B. Preventive care services and periodic follow-up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating health care practitioner acting within the scope of the health care practitioner's license.

C. Appointment Wait Time Standards.

Wait Time Standards	
Urgent care (including medical, mental health, and substance use disorder)	72 hours
Routine primary care	15 calendar days
Preventive visit/well visit	30 calendar days
Non-urgent specialty care	30 calendar days
Non-urgent ancillary services	30 calendar days
Non-urgent mental health/substance use disorder provider	10 calendar days

.06 Provider-to-Enrollee Ratios.

A. Except for a Group Model HMO plan, the provider panel for each carrier shall meet the provider-to-enrollee ratios listed in § B of this regulation.

B. The provider-to-enrollee ratios shall be the equivalent to at least 1 full-time physician, or as appropriate, a full-time health care practitioner for:

(1) 1,200 enrollees for primary care;
(2) 2,000 enrollees for pediatric care;
(3) 2,000 enrollees for obstetrical/gynecological care;
(4) 2,000 enrollees for mental health care or services; and
(5) 2,000 enrollees for substance use disorder care or services.

.07 Waiver Request Requirements.

A. A carrier may apply for a network adequacy waiver, for up to one year, of a network adequacy requirement listed in this chapter.

B. The Commissioner may find good cause to grant the network adequacy waiver request if the carrier demonstrates that providers or physicians necessary for an adequate local market network:

(1) Are not available to contract;
(2) Are not available in sufficient numbers;
(3) Have refused to contract with the carrier; or
(4) Are unable to reach agreement with the carrier.

C. A carrier seeking a network adequacy waiver shall submit its request to the Commissioner and include the following information:

(1) A description of any waiver previously granted by the Commissioner;
(2) A list of providers or physicians within the relevant service area that the carrier attempted to contract with, identified by name and specialty or facility type;
(3) A description of how and when the carrier last contacted the providers or physicians;
(4) A description of any reason each provider or physician gave for refusing to contract with the carrier;
(5) Steps the carrier will take to attempt to improve its network to avoid future requests to seek further waivers;
(6) If applicable, a statement that there are no providers or physicians available within the relevant service area for a covered service or services for which the carrier requests the waiver; and
(7) An attestation to the accuracy of the information contained in the waiver request.

.08 Confidential Information in Access Plans.
A. The following information that is included in a carrier's access plan shall be considered confidential by the Commissioner:
(1) Methodology used to annually assess the carrier's performance;
(2) Methodology used to annually measure timely access to health care services; and
(3) Factors used by the carrier to build its provider network.
B. A carrier submitting a network access plan or waiver request may submit a written request that specific information not be disclosed under the Public Information Act and shall:
(1) Identify the particular information that the carrier requests not be disclosed; and
(2) Cite the statutory authority that permits denial of access to the information.
C. The Commissioner may review a request made under § B of this regulation upon receipt of a request for access pursuant to the Public Information Act.
D. The Commissioner may notify the carrier who made a request under § B of this regulation before granting access to information that was the subject of the request.

.09 Network Adequacy Access Plan Executive Summary Form.
A. For each provider panel, the carrier shall provide the network sufficiency results for the plan service area as follows:
(1) Geographic Accessibility of Providers.
(a) List the percent of the network providers within the stated parameters of Regulation .04 of this chapter that the carrier met in the following format:

	Urban	*Suburban*	*Rural*
Primary Care			
Specialty Provider			

(b) List the total number of certified registered nurse practitioners counted as a primary care provider.
(c) List the total percentage of primary care providers that are certified registered nurse practitioners.
(d) List the total number of essential community providers in the network.
(e) List the total percentage of the essential community providers available in the plan service area that are network providers.
(2) Appointment Wait Time Standards.
(a) List the percent of the network providers within the stated parameters of Regulation .05 of this chapter that the carrier met in the following format:

Appointment Wait Time Standard Results	
Urgent care- within 72 hours	
Routine primary care- within 15 calendar days	
Preventative Visit/Well Visit – within 30 calendar days	
Non-urgent specialty care – within 30 calendar days	
Non-urgent ancillary services – within 30 calendar days	
Non-urgent mental health/substance use disorder provider – within 10 calendar days	

(b) List the total percentage of telehealth appointments counted as part of the appointment wait time standard results.
(3) Provider to Enrollee ratios.
(a) This section does not apply to Group Model HMO plans.
(b) For all other carriers, list the percent for provider to enrollee ratios that the carrier met within the stated parameters of Regulation .06B of this chapter.
(i) 1,200 enrollees for primary care;
(ii) 2,000 enrollees for pediatric care;

(iii) 2,000 enrollees for obstetrical/gynecological care;

(iv) 2,000 enrollees for mental health care or service; and

(v) 2,000 enrollees for substance use disorder care and services.

B. The network adequacy access plan executive summary form filed by a carrier pursuant to § A of this regulation is not confidential information.