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To: The Honorable Delores G. Kelley
Chair, Finance Committee

From: The Office of the Attorney General's Health Education and Advocacy Unit

Re: Senate Bill 1148 (Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization): Concern

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) asks that the committee consider the following information about potential improvements to the bill that would better serve consumers because of the HEAU's concerns about the impact that risk-shifting may have on consumers without independent review of patient outcomes. We understand that fee-for-service models invite unneeded services, upcoding, or adding extra diagnosis codes to patient charts to increase profits, but are concerned that incentivizing cost savings will drive provider profits, not patient care. We are especially concerned about such models with investor owned and controlled entities, including private equity firms.

1) **Consumers must be informed if their healthcare providers are participating in these models.** Consumers would be better served by more clarity and transparency than the bill provides about Capitated Payments and Two-Sided Arrangements to compensate physicians in Preferred Provider Organization (PPO) plans as well as Health Maintenance Organization (HMO) plans. While carriers are already required to provide material information about the costs and coverage terms of the plans they market and sell, we believe it is important that specific information be provided a) before plans are purchased about the differences in cost and coverage terms of PPO plans versus HMO plans that would use these arrangements and b) after plans are purchased about the providers who are eligible for these payments by identifying them in directories and on the website. Information about the incentives that physicians receive that may

decrease access to care is material information that would need to be disclosed under the Consumer Protection Act and this bill should require providers engaged in these arrangements to alert consumers, in advance, to these incentives.

2) **The performance measures upon which the payment arrangements are based must include improved health care quality and must be based on objective, nationally based clinical or quality improvement standards that are clearly defined, objectively measured, and well-documented.**

3) **The performance measures must be independently evaluated by a state agency.** The Maryland Health Care Commission, in consultation with the Maryland Insurance Administration should, within three years, evaluate these payment arrangements and performance measures to verify that patients are not simply being short-changed without any improvement in health outcomes or reduction in costs and premiums, and to screen for potential misuse by carriers of the payment arrangements to avoid premium reimbursements to consumers pursuant to the Medical Loss Ratio and other provisions of the Affordable Care Act. https://chirblog.org/questionable-quality-improvement-expenses-drive-proposed-changes-medical-loss-ratio-reporting/ ("Under the Affordable Care Act (ACA), insurers must provide rebates to enrollees when their spending on clinical services and quality improvement, as a proportion of premium dollars, falls below a minimum threshold known as the "medical loss ratio" (MLR). Federal regulators have discovered some insurers are gaming the system by misallocating expenses or inflating their spending on providers, while minimizing their reported administrative expenses and profits. When this happens, consumers don't receive the rebates they deserve. New proposed rules aim to crack down on these practices.")

Providers and consumers would be better served by requiring communications about the performance measures and the shared medical decision making between carriers and providers that is built into these payment arrangements because including consumers as equal partners in meeting the metrics should result in premium reimbursements under the Affordable Care Act.

Such communications, combined with meaningful oversight, would be needed for the appeals and grievances processes under current law to remain effective for consumers.

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