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**TESTIMONY OF**
**THE**
**MARYLAND INSURANCE ADMINISTRATION**
**BEFORE THE**
**SENATE FINANCE COMMITTEE**

**MARCH 9, 2022**

**SENATE BILL 834 – HEALTH INSURANCE - TWO-SIDED INCENTIVE ARRANGEMENTS AND CAPITATED PAYMENTS - AUTHORIZATION**

**POSITION: LETTER OF INFORMATION**

Thank you for the opportunity to provide written comments on SB 834.

SB 834, if enacted, would amend certain statutes in the Health-Occupations and Insurance Article to allow plans in Maryland's commercial market to utilize voluntary "two-sided incentive arrangements" between carriers and health care providers, and to authorize all carriers to compensate health care providers on a capitated basis without triggering a requirement for the health care provider to be licensed as an insurer. **The bill intends to align provider compensation models in the commercial insured market in Maryland more closely with the commercial markets nationally, and with the public markets (Medicare and Medicaid) within Maryland.** The bill is consistent with the national shift toward value-based care models in health care delivery and financing, which has been gaining momentum as data seems to increasingly suggest that such models reduce health care costs while also improving patient care, particularly with the emphasis on wellness and prevention. The statutory changes proposed in the bill are necessary to fully implement value-based care programs in Maryland because the Maryland Insurance Administration (MIA) and other regulators have historically interpreted existing Maryland statutes as prohibiting two-sided incentive arrangements in the commercial market, and only permitting incentive-based compensation programs that provide upward adjustments to compensation. Additionally, under existing Maryland statutes, only health maintenance organizations and dental plan organizations are expressly authorized to capitate providers.

The MIA examined the bill closely to ensure that the bill had been drafted to fit within the current statutory framework and included necessary guardrails and protections for consumers and providers. To that end, SB 834 makes several changes to the provisions of § 15-113 of the Insurance Article that describe the types of bonuses or other incentive-based compensation programs between carriers and providers that are permitted in the commercial market. These changes include authorizing carriers to enter into two-sided incentive arrangements where the eligible provider may earn an incentive for meeting performance standards, and the carrier may recoup funds from the provider if certain contractual benchmarks are not reached. The bill also revises § 4-205 of the Insurance Article to clarify that a health care practitioner or set of health care practitioners that accepts capitated payments under certain circumstances is not engaging in insurance business. Correspondingly, the bill adds a new Subtitle 21 under Title 15, which authorizes health care practitioners and sets of health care practitioners to receive capitated payments under insured or self-funded plans without being considered as engaging in insurance business.

Generally, the two-sided incentive arrangements authorized under this bill must comply with the same standards for other incentive-based compensation programs currently allowed under § 15-113, but will also establish a target budget for the cost of care for a population of patients attributed to the provider or group of providers who have agreed to the arrangement. Providers that meet the agreed upon performance measures will share in the savings achieved by the carrier if the health care spending of the population comes in under the target budget. However, the same providers will also share in the losses incurred by the carrier if the target budget is exceeded.

SB 834 includes specific guardrails for these two-sided incentive arrangements to ensure that: 1) the arrangements are voluntary on the part of the provider; 2) the specific terms of the arrangements are clearly disclosed to the provider and are mutually agreed upon by both parties; 3) limits are placed on the magnitude of the annual and total recoupments that may be collected from the provider; 4) providers have an opportunity for an independent audit and dispute resolution process; 5) good faith adjustments to the target budget must be negotiated when unforeseen circumstances occur during the term of the agreement; and, 6) recoupments will not be collected during the first 12 months of an arrangement, unless mutually agreed by both parties. It is also very important to note that these new two-sided incentive arrangements are made subject to the existing requirement in § 15-113 that incentive-based compensation may not create a disincentive to the provision of medical appropriate or medically necessary health care services.

The guardrails included in the proposed bill address some of the specific concerns that have been raised in the past about implementing value-based care programs in Maryland. These guardrails are important to ensure that the programs do not financially incentivize providers to reduce the number and types of services the providers deem medically necessary, and do not align provider interests too closely with carrier interests at the expense of patient care. Value-based care programs have been implemented across the country for years, and these types of arrangements are already in semi-existence now in Maryland in the Medicaid and Medicare markets, as well as in the self-funded market (to an extent). The concerns referenced above have

not materialized in those other markets. This is likely because providers have a strong financial incentive under these programs to meet quality benchmarks to help avoid preventable future health care expenses, which includes the provision of all medically necessary services for each policyholder, regardless of health status. However, due to the fact that some aspects of these programs are currently prohibited in the commercial market in Maryland, discussions about expanding value-based care have often included a focus on potential drawbacks of the programs. As a result of these discussions, SB 834 includes significantly more express language addressing checks and balances under the programs than has customarily been included in applicable regulatory standards for Medicare, Medicaid, and other states.

**If enacted, SB 834 will provide industry with more options for provider reimbursement arrangements in the commercial market and will allow carriers to be able to develop arrangements that incentivize contracted health care providers to consider the total cost of care provided to patients. Operationally, the bill allows carriers to streamline and coordinate contracting agreements with providers across markets and across the nation by aligning the Maryland commercial market with Medicare, Medicaid, and the national commercial markets. Greater uniformity may lead to increased efficiencies and an improved ability to influence total health care costs by promoting better health outcomes for patients and avoiding potentially preventable future health problems. If the new programs are implemented effectively, consumers should ultimately benefit from receiving more efficient and coordinated high quality care from providers, as reimbursement shifts away from straight fee-for-service arrangements to total cost of care models where providers have a stronger financial incentive to meet quality benchmarks and remain engaged in all aspects of a patient's treatment.**

The MIA did note one technical issue with the bill that may need to be addressed. Section 15-2102 on page 13 appears intended to apply to all insured plans in addition to self-funded group health insurance plans. However, lines 13 and 14 on page 13 include the phrase "an insured or a self-funded group health insurance plan." This language implies that the insured plan must be a "group" health insurance plan, which does not appear to be the intent based on the other provisions of § 15-2102. It appears the phrase should be reworded in a manner such as the following to accomplish the perceived intent: "a health benefit plan offered by a carrier or a self-funded group health insurance plan." In this case, § 15-2101 should likely also be revised to include a definition of "health benefit plan," and it seems that a broad definition, such as that currently used in § 2-112.2 of the Insurance Article, would be appropriate.

The MIA thanks the committee for its attention to this information concerning SB 834.