Acle_FAV_SB484
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SB 484 - Health Insurance – Provider Panels – Coverage for Nonparticipating Providers
SUPPORT

My 14-year old daughter is diagnosed with depression and anxiety in addition to her autism diagnosis. In January of 2018, after witnessing a school fight and enduring several months of frustration for not having proper supports in place, she began refusing school and eventually refused to leave her room. She did not return to school for 9 months. School refusal triggered self-harming behavior, refusing to eating and social isolation. She required 24-hour care. I took a leave of absence from work and my husband dropped his work hours in half. My two of other children began struggle in school and at home.

After 4 months of intensive outpatient treatment with no improvement, she was admitted to John Hopkin for failure to thrive. When they were finally ready to discharge her, I was hopeful that things would start to get better. Instead, we have faced a never-ending series of battles with our insurance, CareFirst, to get my daughter the mental health care in our community that she needs.

When my daughter was discharged, the hospital recommended that she receive residential treatment. However, there was not a single residential treatment facility in CareFirst's network in Maryland that would accept a child with co-occurring diagnoses of mental health and developmental disorders. Because we had no access to the level of care my daughter needed, Maryland does not have residential placement for children with a dual diagnosis, the psychiatrist suggested a day program. But the only day program that would accept my daughter is in Baltimore, and I live in Salisbury with two other children. There was no way we could drive over 100 miles twice a day, a 4.5-hour round trip, and keep our jobs and take care of our family. Without any other options, my daughter was discharged from the hospital with only her outpatient care team in place. We had to accept a lower level of care than what our daughter's providers said she needed. I never questioned coverage as we could not find placement. **There are no residential treatment centers in MD for dual diagnoses. No one ever told me I had a right to get approval to go out of network.**

Getting an outpatient care team in place was hard enough for us, living in Salisbury. **There is only one pediatric psychiatrist within an hour of my home. He is out-of-network with CareFirst.** The closest in-network pediatric psychiatrist is three hours away. We worked with CareFirst to get a single case agreement, so that our daughter could see the provider who is only an hour away at the in-network cost. **While we managed to get this agreement in place so that CareFirst would cover the services my daughter needed, it was never implemented.** CareFirst never paid the psychiatrist. But my daughter needed the care. We have been paying out-of-pocket to see him for four years, even though CareFirst knows that they do not have an adequate network for this specialty, for children like my daughter.

Returning to outpatient treatment after the hospitalization wasn't enough though. My daughter's psychiatrist told us that she needed a higher level of care, just as the doctors at the hospital had said. With no other choice, we found a residential program in Connecticut, where our daughter has been for

the past year and a half. Of course, CareFirst denied coverage of the program because it was out-of-network, even though there were no in-network facilities available. **We are paying $150,000 a year to get our daughter the care she needs, care that should be covered under the insurance we already pay for, and care that everyone agrees is medically necessary.** It has been an incredible financial strain on my family. It is not fair that the children in our community who need the most help, the ones with multiple diagnoses and disorders, are the ones that our insurance companies and our state fails.

Additionally, my daughter needed cognitive and psychological testing while she was in her residential placement. This claim has been under appeal for 9 months as the provider was in Connecticut. We were told they had no in-network providers in Connecticut. This is a $6,500 bill we paid, **even though CareFirst should have told us we had a right to go out-of-network when there were no in-network providers within a reasonable time or distance.**

We know that this does not happen for children with medical diagnoses. Insurance companies have adequate networks of specialists for other conditions, or else they cover the cost of going out-of-network. They do not let single case agreements fall through the cracks. They would not tell the family of a child whose doctors said she needs 24-hour supervision that outpatient care is enough because they could not find a facility. Those families would not be paying $150,000 a year for the care their child has a right to receive through her insurance. We know our insurance company is in violation of parity requirements and network adequacy standards, and Maryland is letting it happen. It’s time for our state to step up and close the gaps in these laws to protect the most vulnerable residents in our community.

My hope in sharing our story is to help bring change for everyone not just myself. For these reasons, and for my daughter, I urge you to report favorably on SB 484.

MDDCSAM_FAV_SB484
Uploaded by: Adams, Joe
Position: FAV

SB 484 Health Insurance - Provider Panels - Coverage for Nonparticipating Providers
Senate Finance Committee February 26th, 2020

SUPPORT

MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

As addiction treatment providers, we are well aware that lack of access to treatment for mental health treatment, and appropriate levels of addiction treatment, is a fact of life and a tragedy.

Carriers often erect credentialing barriers to keep substance use providers out of networks in violation of state and federal parity laws. "No network need identified" may be the only unaccountable explanation.

Yet, having between zero and one in-network addiction treatment provider in some counties, or a handful of opioid treatment programs in the state, makes it impossible for most insured members to access treatment. Many people with opioid use disorder need an opioid treatment program, not just Office Based Opioid Treatment (OBOT), to achieve recovery.

This contributes to our epidemics of opioid overdoses and rising suicide rates.

We have heard the stories of patients paying out-of-pocket when forced to go out of network for behavioral health treatment. But this is the tip of the iceberg. It is more likely that people in poverty, or with serious mental illness or addictions, simply can't get treatment with inadequate networks.

Per the website of the Maryland Insurance Administration, the grand total of all penalties for parity violations since the first 2014 compliance survey was only $62,475 for all carriers. The only fines were **$25,000** for Cigna, another **$9,000** for Cigna, **$24,975** for CareFirst, **$2,000** for United, and **$1,500** for Aetna. Most of the documented parity violations resulted in no fines at all. To carriers, this is the cost of doing business.

But penalties in some other states are meaningful. California fined Kaiser $4 million, while New York sanctioned carriers a collective $2 million in fines for parity violations, and required $3 million in restitution to hundreds of consumers for out-of-pocket expenses, resulting in a 60% reduction in consumer complaints about access to mental health and addiction treatment services.

In the ten years that parity has been the law of the land, carriers remain noncompliant. It is past time to incentivize adequate networks and enforce the law to avoid the tragedy of preventable, but untreated, mental health and substance use disorders that affect whole families and communities, and lead to greater expenses in the long run for Marylanders.

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Bergan_FAV_SB484
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Senate Finance Committee Hearing, SB 484

February 26, 2020

Support

My name is Courtney Bergan. I am a graduate student at the University of Maryland School of Social Work. I also have a professional background in neuroscience research, having co-authored several publications on neuropsychiatric disorders.

I am here to voice my support for senate bill 484, which protects consumers from incurring high out of pocket costs when their insurer fails to provide access to appropriate in-network behavioral health services.

My insurance carrier does not have an adequate behavioral health provider network; therefore, I have been unable to access appropriate in-network care for my mental health condition. I have now encountered this situation with two different private health insurers in the state, just within the past year. I struggle with a complex mental health condition that requires treatment from a provider who has specialized training and experience in treating my condition, much like complicated medical conditions that require care from a specific specialist or subspecialist. Unfortunately, few providers possess this expertise, and even fewer take insurance as a result of reimbursement rates that are not commensurate with the complexity of the care required for the effective treatment of my condition.

Last year I spent four months contacting more than 60 providers of varying credentials, desperately trying to locate a provider within the CareFirst network who had the availability, willingness, and expertise necessary to assume my care. I even utilized CareFirst's Intake and Assessment service to attempt to locate a provider, however, CareFirst admitted to "exhausting their list" of in-network providers and advised me to seek care utilizing my out-of-network benefits.

Since I was unable to obtain in-network care, I began seeing a non-contracted specialist who agreed to request a single case agreement with my insurer. Within hours of initiating this request, CareFirst denied it because they then authorized me to see my psychologist at my in-network cost-sharing, making a single case agreement "unnecessary." Under this authorization, CareFirst refused to negotiate a reimbursement rate with my provider, offering my provider a rate that was less than the Medicare reimbursement for the service and wouldn't even approximate her costs for providing my care. When my provider expressed concern about the reimbursement rate, she was instructed by CareFirst that she should just balance bill me the remainder of her fee. Utilizing this authorization would ultimately have cost me more than if I were to have utilized my out-of-network benefits to obtain that same care. Under either scenario, obtaining appropriate mental health care would have been well beyond my means, despite having adequate insurance coverage. After providing testimony before this committee

on a similar bill last year, CareFirst finally approved the single case agreement that had initially been requested nearly two months earlier. Under the terms of the single case agreement, CareFirst agreed to negotiate a fair reimbursement rate with my provider, so the service was only subject to my in-network copay.

However, any relief I received following CareFirst's approval of my single case agreement was short-lived, as I was notified by my school last June that our student health insurance coverage would be changing to United Healthcare, causing me to lose the single case agreement I fought so hard to obtain. Prior to the commencement of my coverage with United Healthcare, I contacted the broker for the plan to request assistance in negotiating a single case agreement with United Healthcare and my current psychologist, as well as to request assistance in locating a psychiatrist on the plan. Since I could not access appropriate outpatient mental health care and I couldn't even locate a psychiatrist who would oversee the prescribing of my medications, I ended up spending four months in the hospital until my insurer agreed to cover appropriate outpatient care that was only available outside of their provider network.

As a result of this delay in agreeing to pay for appropriate outpatient care, I will now be graduating from my MSW program a year later than scheduled. Not only that, the delay in providing me access to appropriate outpatient care posed additional costs to Maryland taxpayers, since Maryland Medical Assistance is my secondary insurer, and Medical Assistance ended up paying the hospital costs that were not covered by my primary insurer. Neither I nor the state should be paying for my insurers' failure to comply with state law.

Insurers need to be held accountable when they fail to comply with the network adequacy regulations defined under state law. While I recognize that legislators and regulators are working with carriers to expand their networks, based on the past 2 years of network adequacy reports, no insurer has demonstrated compliance with the network adequacy regulations. Consumers can't wait for their insurers to comply with state law. Without immediate protections for consumers who are forced to utilize non-contracted behavioral health providers due to inadequate insurance networks, carriers have no incentive to expand their networks or take network adequacy exceptions seriously. Carriers can simply tell providers to balance bill their patients if they aren't happy with the reimbursement rate offered by the insurer, shifting insurance carriers' financial responsibility onto patients. Fining insurers for failing to meet network adequacy standards won't solve this problem, as it does nothing to ease consumers' urgent needs to access behavioral health services. We need to ensure consumers are provided affordable access to the behavioral health services they are paying for and are entitled to receive through their insurance coverage.

I strongly support senate bill 484, so consumers aren't paying for their insurers' failure to provide adequate behavioral health networks.

Encl: Media coverage of my story: *Bloomberg Businessweek.* "As Suicides Rise, Insurers Find Ways to Deny Mental Health Coverage."

Bloomberg Businessweek

As Suicides Rise, Insurers Find Ways to Deny Mental Health Coverage

Red tape and a lack of in-network providers frustrate those seeking treatment.

By
Cynthia Koons
and
John Tozzi

May 16, 2019, 6:00 AM EDT

The U.S. is in the midst of a mental health crisis. In 2017, 47,000 Americans died by suicide and 70,000 from drug overdoses. And 17.3 million adults suffered at least one major depressive episode. The Mental Health Parity and Addiction Equity Act, a landmark law passed more than a decade ago, requires insurers to provide comparable coverage for mental health and medical treatments. Even so, insurers are denying

claims, limiting coverage, and finding other ways to avoid complying with the law.

Americans are taking to the courts to address what they see as an intrinsic unfairness. DeeDee Tillitt joined one lawsuit in 2016, months after she lost her son Max. He'd been an inpatient for three weeks at a treatment center to recover from a heroin addiction and seemed to be making progress. His addiction specialist wanted him to stay. United Behavioral Health, a unit of UnitedHealth Group, the nation's largest insurer, declined to cover a longer stay for Max. Reluctantly, his family brought him home. Ten weeks later, Max was dead of an overdose. He was 21.

DeeDee Tillitt and her son Max, who died of a drug overdose 10 weeks after leaving a treatment center when his insurer declined to cover a longer stay.
COURTESY: DEEDEE TILLITT

Tillitt soon discovered that Max's death wasn't an isolated tragedy. Across the country, people who need mental health and addiction treatment encounter roadblocks to care that could save their lives. United Behavioral Health was already the target of a class action alleging that it improperly denied coverage for such treatment. UnitedHealth's headquarters is in the

Minneapolis suburbs, not far from where Tillitt lived. She says she spent hours on the phone getting passed from one rep to another in her quest to find Max care the insurer would cover. "I felt like, God, could I just drive down to the lobby and scream at them?' " she says.

Tillitt became part of the suit against the company in February 2016. In March of this year, a judge found United Behavioral Health liable for breaching fiduciary duty and denying benefits, saying the insurer considered its bottom line "as much or more" than the well-being of its members in developing coverage guidelines. United Behavioral Health says it's changed its guidelines and that "our policies have and will continue to meet all regulations." In May the company asked the court to decertify the class, which would mean only the named plaintiffs would be eligible for remedies.

Failures of the mental health system contributed to trends that have lowered U.S. life expectancy over the past three years. From 2008, when Congress passed the parity act, to 2016, the rate at which Americans died by suicide increased 16%. The rate of fatal overdoses jumped 66% in the same period. "The health insurers are not following the federal law requiring parity in the reimbursement for mental health and addiction," President Trump's commission on the opioid crisis wrote in its report in November 2017. "They must be held responsible."

● The Lawmaker

Patrick Kennedy, a former Rhode Island congressman, was the force behind the parity law. In the early hours of May 4, 2006, he crashed his car on Capitol Hill. In a press conference the next day, Kennedy disclosed lifelong trouble with depression and addiction and announced he was going to rehab. Two years later he helped push through legislation to strengthen access to mental health care.

Kennedy helped push the parity act through Congress in 2008, two years after pleading guilty to a DUI.
PHOTOGRAPHER: CHRISTOPHER LEAMAN FOR BLOOMBERG BUSINESSWEEK

The law was problematic from the start. Passed in the midst of the 2008 financial crisis, the parity act was tacked onto the emergency bill that bailed out the U.S.'s failing banks. "We didn't pass the mental health parity legislation because there was this big public outcry, because we had this great march on the mall and we had 100,000 people show up," Kennedy says. "The good news is that we got it passed. The bad news is no one

knew that we got it passed because the underlying bill was secondary to the fact that we were facing a potential Great Depression.” Kennedy now works on several initiatives to improve compliance with the law.

In 2010 the Affordable Care Act became law, mandating that commercial health insurance plans offer mental health benefits. Combined with the parity act, federal law appeared to guarantee that Americans would have access to mental health services like never before. And there are signs the laws have helped. A federal report published in February 2019 concluded that the law increased the use of outpatient addiction treatment services and, for those already getting mental health care, the frequency of their visits.

● Ghost Networks

Insurers fought the requirements from the start. The industry formed a group called the Coalition for Parity that sued to block the regulations to implement the law, saying they would be unduly burdensome. A judge dismissed the challenge.

In the years since, health insurance companies have eliminated many of the explicit policies that violate the law. Benefit plans can no longer set higher out-of-pocket limits on mental health care than on medical care, for example. But patients and their families say insurers use more subtle methods to stint on treatment. Their directories of providers are

padded with clinicians who don't take new patients or are no longer in an insurer's coverage network. They request piles of paperwork before approving treatment. They pay mental health clinicians less than other medical professionals for similar services.

"I found a great number of their providers were no longer practicing, or were dead"

Patients frequently complain of "ghost networks"—insurance directories full of clinicians listed as in-network who aren't contracted with the plan. Brian Dixon, a Fort Worth child psychiatrist, no longer accepts insurance. But Blue Cross and Blue Shield of Texas' directory indicates he's still part of the network. He says he regularly has to tell patients who call his office that he won't take their coverage. "It'll look like they have all these psychiatrists," Dixon says of the network, "but they actually don't." The insurer says it updates its directory based on information received from physicians.

Some practitioners who want to join networks are turned away. Melissa Davies, a psychologist in Defiance County, Ohio, was part of Anthem's network for years when she worked in a larger medical group. But the insurer refused to contract with her after she started a solo practice in 2012, saying the area was saturated, even though Davies is one of only three psychologists

in the county. When Davies examined Anthem's directory, "I found a great number of their providers were no longer practicing, or were dead," she says. Anthem says it works to ensure its network can meet members' needs and is dedicated to adding behavioral health providers.

It all adds up to a wall between people and the help they need, the kind of barrier that would never be tolerated if the illness were diabetes or leukemia. "You have parity coverage on paper," says Angela Kimball, acting chief executive officer of the National Alliance on Mental Illness. "But if you can't find an in-network provider in your coverage, it can become meaningless for you if you can't afford care or find it."

Out of Network, Out of Reach

Data: Milliman, National Alliance on Mental Illness, U.S. Government Accountability Office, Centers for Disease Control and Prevention

● The Advocate

People like Meiram Bendat are trying to hold insurers accountable where government authorities haven't. Bendat, an attorney who originally specialized in child welfare law, decided in the early 2000s to change tack and pursue a doctorate in psychoanalytic science and a master's in clinical psychology. He started seeing patients a few years before the parity law passed. It didn't take long for him to recognize that insurers were denying coverage for patients with persistent mental health

conditions and they might not be in compliance with the parity law.

Bendat's legal practice is dedicated to fighting claims denials for mental health care.
PHOTOGRAPHER: YE RIN MOK FOR BLOOMBERG BUSINESSWEEK

Bendat returned to the legal profession and opened his practice, Psych-Appeal, in Los Angeles. It's dedicated solely to fighting denials of mental health coverage. Because his office is "inundated" with calls, he says, he tries to build class action

suits. Bendat was one of the lead attorneys in the case against United Behavioral Health in which Tillitt participated.

Still, winning legal cases does only so much to change industry practices. The United Behavioral Health suit, for example, won't result in punitive damages for the insurer, because it was brought under a labor law, ERISA, which doesn't allow them. "Basically, there's an incentive for managed-care companies to do the wrong thing, because they know that at the end of the day they don't stand to be punished monetarily," Bendat says.

A 2017 report from Milliman Inc., a consulting firm, found that patients were going out-of-network for behavioral health care significantly more often than for medical and surgical care, which typically means they're paying more. It also found behavioral health providers got lower reimbursements than medical providers—primary care medical doctors made 20% more for a basic office visit, for example, than psychiatrists did.

"I'm so tired of staying silent about this stuff and not speaking out because of the stigma that exists around mental illness"

Higher reimbursements would lead to better access for patients, says Sam Salganik, executive director of the Rhode Island Parent Information Network, which fields parity

complaints on behalf of the state. Because patients can't find providers who take their insurance, many believe they must pay privately for mental health care. That would be unacceptable if that were the case with other health-care services, Salganik says. "Consumers on average are reluctant to go to an out-of-network cardiologist," he says, "and I think that's largely because there's a robust network of in-network cardiologists."

Kate Berry, senior vice president of clinical affairs at America's Health Insurance Plans, a trade group, says a shortage of mental health clinicians and lack of reliable ways to measure quality contribute to the problem. "Our members work very hard day in and day out to ensure there is parity between mental health care and physical health care," she says.

● Absent Enforcers

How can insurers continue to violate the letter and spirit of the law? Partly because the parity act sets ambiguous standards, advocates say, and doesn't have teeth. The federal rules don't say how to measure whether a health plan's network of mental health providers is sufficient, for example, so insurers have discretion over what they deem is an adequate network.

More important, there's no one agency or office responsible for enforcing the rules. The relevant authority may be the U.S. Department of Labor, or the U.S. Department of Health and Human Services, or a state insurance regulator, depending on

the health plan. “It’s hard to define who owns this problem when there’s so many different entities and people responsible for enforcement,” says Lindsey Vuolo, associate director of health law and policy at the nonprofit Center on Addiction.

The Labor Department oversees health plans sponsored by employers, which cover 156 million people. But it’s authorized to act only against specific plans sponsored by particular employers, not against a health insurer that may provide similar benefit plans for hundreds or thousands of companies. Secretary of Labor Alex Acosta told the opioid commission that “he needs the ability to fine violators and to individually investigate insurers, not just employers,” according to the commission’s report. When the department does punish companies for violating the parity law, it doesn’t publicly disclose which companies or insurers aren’t providing adequate coverage. The department didn’t respond to requests for comment.

At the state level, enforcement varies widely, and rarely leads to large financial penalties. In California, with relatively active regulators, the biggest fine over access to mental health care was a $4 million penalty for Kaiser Permanente in 2013. A Kaiser spokesman said the citations didn’t constitute parity violations and the plan wasn’t limiting mental health visits inappropriately.

Aetna, now a unit of CVS Health Corp., settled with the Massachusetts attorney general in December over allegations of

inaccurate network directories and agreed to improve information for consumers. An Aetna spokesman says the company had already fixed one of the issues raised by the attorney general and is moving to "give our members better access to the correct contact information" of in-network clinicians.

In 2015, New York's attorney general settled with Beacon Health Options over allegations of wrongful denials of mental health and substance abuse claims. The company neither admitted nor denied wrongdoing. A spokeswoman says Beacon relies on evidence-based criteria to determine coverage "regardless of cost."

Insurance regulators in Florida, Indiana, and Nevada haven't taken any enforcement actions against insurers over federal parity laws, according to spokespeople.

● The Determined Patient

Courtney Bergan first entered the mental health system when she was in high school after her primary care physician discovered she was cutting herself. She's been through an array of institutions, from a wilderness high school to psychiatric wards and specialist rehab in the quest to find adequate treatment for issues including complex trauma, an eating disorder, and suicidal thoughts.

Bergan struggled to find a provider who would see her at rates she could afford.
PHOTOGRAPHER: CHRISTOPHER LEAMAN FOR BLOOMBERG BUSINESSWEEK

Bergan studied neuroscience, behavior, and biostatistics in college and landed a job at Massachusetts General Hospital doing neuroimaging research for chronic pain disorders. Her insurance was sufficient to cover therapists and hospital stays as needed. She moved to Baltimore in January, in part because she learned that Maryland had better treatment options for her and in part to pursue a dual degree in social work and law at the University of Maryland.

As a student she was eligible to enroll in an insurance plan run by CareFirst. In preparation for the move, she started calling

mental health providers. She contacted more than 50, both in and out of the CareFirst network, before finding one who would agree to see her—and to apply for what's known as a "single-case agreement" to cover her out-of-network at in-network rates. CareFirst denied the single-case agreement the same day Bergan's provider requested it.

Under a Maryland network adequacy law that went into effect at the start of the year, if an insurer can't offer a patient a provider within 10 days and within 10 miles of his or her home in an urban area, it's required to cover an out-of-network provider at an in-network price—but the provider can bill the patient for the difference. In Bergan's case, that meant she was going to have to pay $92 a session out-of-pocket, and she needed to be seen twice a week.

That was still more than she could afford. She reached out to the Mental Health Association of Maryland, which asked her if she'd be willing to testify at a state senate hearing on legislation to lower the out-of-pocket burden for patients like herself. She said she was. The day after her appearance at the state capitol, she was notified that CareFirst had approved her single-case agreement, under which she'll pay $25 a session, for three months. It's just been renewed for six months. CareFirst doesn't dispute her account, but says her testimony didn't influence its decision.

"I'm so tired of staying silent about this stuff and not speaking out because of the stigma that exists around mental

illness," Bergan says. "At every point on the way, I've done what my providers have told me to do, I've followed through on treatments, I've sacrificed. When I go to file my taxes, I realize that 50% of my income is spent on medical expenses. I haven't taken a vacation in my adult life because all of my income is going to my treatment. I shouldn't be ashamed of that. I'm doing what I'm supposed to be doing. It needs to change."

If you or someone you know is having suicidal thoughts, The National Suicide Prevention Lifeline is: 1 (800) 273-8255

Brown_FAV_SB484
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SB 484
Health Insurance – Provider Panels – Coverage for Non-Participating Providers
Finance Committee
February 26, 2020
Support

Our 18 year-old son has been diagnosed with a substance use disorder as well as anxiety and depression. Last year, as a 17 year old, after overdosing on a cocktail of Benadryl and Zzzquill, he was admitted to the ER where he remained in a hallucinogenic psychotic state for over 48 hours. He then went into Sheppard Pratt. He stayed in Sheppard Pratt for two weeks. The treating clinician at Sheppard Pratt said that our son required a long-term residential treatment program to address his co-occurring mental health and substance use disorder.

Although I had reached out to our insurer for help identifying an appropriate facility, **they provided me with none**. I searched through our insurer's website and found that Maryland residential treatment centers that were in-network were for adults only. I searched literally for days to find an appropriate out-of-network facility.

We have also had tremendous difficulty locating an intensive-outpatient (IOP) substance use provider in our area. Again, there are none in-network. I finally found an IOP in Pennsylvania that is the closest to where we live in Manchester (Carroll County). This provider, however, is out-of-network.

Our family has encountered huge difficulties trying to access in-network substance use treatment for our son. Our insurer could provide us with no in-network options, and failed to provide any help identifying an out-of-network provider. We were never told that we had a right to go out-of-network when there were no in-network providers.

For these reasons I urge you to pass SB 484.

NCADD_FAV_SB484
Uploaded by: Ciekot, Ann
Position: FAV

Senate Finance Committee
February 26, 2020

Senate Bill 484
Health Insurance - Provider Panels - Coverage for Nonparticipating Providers

Support

NCADD-Maryland supports Senate Bill 484. There is no longer any doubt that there are network adequacy problems among insurance carriers in Maryland. There have now been two annual reports submitted by carriers as required by Maryland Insurance Administration (MIA) regarding the standards for network adequacy. The results of the review for a second year have proved what we knew to be true, that carriers' networks are inadequate.

The analysis showed further that their networks are extremely inadequate when it specifically comes to mental health and substance use disorders services.

Insurance carriers must do their part in this state of emergency to address the opioid overdose crisis we are in. We believe this bill creates an appropriate incentive for carriers to expand their networks while ensuring that consumers have access to out of network providers when necessary without a financial penalty in the form of balance billing.

We urge a favorable report on Senate Bill 484.

The Maryland Affiliate of the National Council on Alcoholism and Drug Dependence (NCADD-Maryland) is a statewide organization that works to influence public and private policies on addiction, treatment, and recovery, reduce the stigma associated with the disease, and improve the understanding of addictions and the recovery process. We advocate for and with individuals and families who are affected by alcoholism and drug addiction.

National Council on Alcoholism & Drug Dependence – Maryland Chapter
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www.ncaddmaryland.org

LCPCM_FAV_SB 484
Uploaded by: faulkner, rachael
Position: FAV

Committee: **Senate Finance Committee**
Bill Number: **Senate Bill 484**
Title: **Health Insurance – Provider Panels – Coverage for Nonparticipating Providers**
Hearing Date: **February 26, 2020**
Position: **Support**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) strongly supports *Senate Bill 484 – Health Insurance – Provider Panels – Coverage for Nonparticipating Providers.* This bill would require insurance carriers to cover behavioral health services at the same rate as an in-network provider if its provider panel has an insufficient number or type of participating specialists. The bill also requires notification of an individual's right to request a referral from an out-of-network specialist.

LCPCM has a long history of supporting efforts to increase network adequacy for behavioral health providers. This included supporting legislation in 2016 to establish network adequacy standards under the Maryland Insurance Administration. In addition, LCPCM supported legislation in 2018 and 2019 to ensure that licensed graduate professional counselors could be credentialed by insurance carriers.

Unfortunately, even with these developments, we still hear concerns from our members about the various barriers to becoming an in-network provider. We believe this bill will ensure that regardless of whether a provider is in-network or out-of-network, that individuals with behavioral health conditions get properly diagnosed and treated.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Rachael faulkner at rfaulkner@policypartners.net or 410-693-4000.

MOTA_FAV_SB 484
Uploaded by: faulkner, rachael
Position: FAV

Maryland Occupational Therapy Association

PO Box 131 ♦ Stevenson, Maryland 21153 ♦ mota.memberlodge.org

Committee: **Senate Finance Committee**
Bill Number: **Senate Bill 484**
Title: **Health Insurance – Provider Panels – Coverage for Nonparticipating Providers**
Hearing Date: **February 26, 2020**
Position: **Support**

The Maryland Occupational Therapy Association (MOTA) supports *Senate Bill 484 – Health Insurance – Provider Panels – Coverage for Nonparticipating Providers.* This bill would require insurance carriers to inform members of their right to request a referral for a specialist who is not a part of the carrier's provider panel and require insurers to cover out-of-network behavioral health providers under certain circumstances.

Occupational therapists address barriers that individuals with mental health conditions experience in the community by providing interventions that focus on enhancing existing skills; remediating or restoring skills; modifying or adapting the environment or activity; and preventing relapse. As such, both the National Board for Certification in Occupational Therapy (NBCOT) and the American Occupational Therapy Association (AOTA) include mental health services within the scope of practice for occupational therapists. [1]

Unfortunately, carriers do not all consistently recognize occupational therapy practitioners as mental health providers. This bill would allow individuals with an opportunity to access occupational therapy services when there are not sufficient in-network occupational therapy practitioners. In addition, it is critical for consumers to be aware of their right to request a referral for appropriate mental health services as individuals may not be aware of what services are available for the treatment of a mental health condition.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

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[1] National Board for Certification in Occupational Therapy – Certificate Renewal.
https://www.nbcot.org/Certificants/Certification

American Occupational Therapy Association – Occupational Therapy's Role in Community Mental Health.
https://www.aota.org/~/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/MH/Facts/Community-mental-health.pdf

MCF_FAV_SB484
Uploaded by: Geddes, Ann
Position: FAV

SB 484 – Health Insurance – Provider Panels – Coverage for Non-Participating Providers

Committee: Finance
February 26, 2020
POSITION: Support

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for someone with behavioral health needs. Using personal experience as parents, caregivers and other loved ones, we provide one-to-one peer support and navigation services to parents and caregivers of young people with mental health issues and to any loved one who cares for someone with a substance use or gambling issue.

A persistent problem in Maryland is that many insurers have a shortage of in-network behavioral health providers. This leads to consumers having to seek services with out-of-network providers. It is burdensome for consumers to have to:

1. identify an in-network behavioral health provider, only to learn that there are no appropriate providers within a reasonable distance who can schedule an appointment within a reasonable period of time

2. then seek approval from their insurer to see an out-of-network provider

3. then identify an appropriate out-of-network provider who is within a reasonable distance and can schedule an appointment within a reasonable period of time

And this scenario assumes that a family knows of their right to get approval for non-network services; **many do not.**

After going through all of these hoops, it is then the responsibility of the patient to pay the difference between what the insurer is willing to pay an out-of-network provider and what the provider actually charges.

Given these circumstances, insurers don't need to ensure that they have adequate in-network coverage – they have little to lose – it is the consumer who bears the burden.

We recently interviewed some of the families that we have worked with, asking about their insurance coverage. Here are some of the things that we heard:

- "I tried calling six providers on my insurer's list. They all weren't taking new patients, so we went out-of-network."

- We tried three in-network providers, but none were any good, so we went out-of-network."
- "I live on the Eastern shore and there are no nearby in-network providers, so we went out-of-network."
- "My son was finally ready to accept substance use treatment, but the in-network residential facilities had no open beds, so we went out-of-network."

All of these families just gave up. None of them knew that they had a right to seek approval to go out-of-network. **SB 484 addresses this problem by putting notification requirements in place.**

SB 484 will further ensure that if families must go out-of-network, **they pay no greater costs** for covered mental health and substance use services.

We urge a favorable report on SB 484.

Contact: Ann Geddes
Director of Public Policy
The Maryland Coalition of Families
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Phone: 443-741-8668
ageddes@mdcoalition.org

MdCSWC_Pam Kasemeyer_FAV_SB0484

Uploaded by: Kasemeyer, Pam

Position: FAV

MdCSWC The Maryland Clinical Social Work Coalition

The MdCSWC, sponsored by the Greater Washington Society for Clinical Social Work,
represents the interests of more than 9,500 licensed clinical social workers in Maryland.

TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Katherine Klausmeier

FROM: Judith Gallant, LCSW-C, Chair, Maryland Clinical Social Work Coalition

DATE: February 26, 2020

RE: **SUPPORT** – Senate Bill 484 – *Health Insurance – Provider Panels – Coverage for Nonparticipating Providers*

The Maryland Clinical Social Work Coalition (MdCSWC), sponsored by the Greater Washington Society for Clinical Social Work, represents the interests of more than 9,500 licensed clinical social workers in Maryland. On behalf of MdCSWC, we **support** Senate Bill 484.

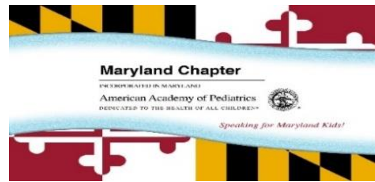
Ensuring that individuals have access to critical mental health and substance use disorder treatment services continues to be an area of concern to the clinical social work community. Recent reports from the Maryland Insurance Administration have confirmed the inadequacy of some carrier's networks. Senate Bill 484 addresses this issue in a manner that will assist in fostering adequate networks and/or adequate payment to these specialists. It also ensures that the insured has coverage for mental health or substance use disorder services at no greater cost to the member than if the services were provided in-network by allowing an insured to go out of network if the carrier's provider panel has an insufficient number or type of participating specialist or nonphysician specialist for the required services. MdCSWC strongly urges a favorable report.

For more information call:
Pamela Metz Kasemeyer
Danna L. Kauffman
Richard A. Tabuteau
410-244-7000

Greater Washington Society for Clinical Social Work: www.gwscsw.org
Contacts: Coalition Chair: Judy Gallant, LCSW-C; email: jg708@columbia.edu; mobile (301) 717-1004
Legislative Consultant: Pamela Metz Kasemeyer, Schwartz, Metz & Wise PA, 20 West Street, Annapolis, MD 21401
Email: pmetz@smwpa.com; mobile (410) 746-9003

MedChi, MDAAP, MACHC_Danna Kauffman_FAV_SB0484
Uploaded by: Kauffman, Danna
Position: FAV

MedChi



MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS
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TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Katherine Klausmeier

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
Richard A. Tabuteau

DATE: February 26, 2020

RE: **SUPPORT** – Senate Bill 484 – *Health Insurance – Provider Panels – Coverage for Nonparticipating Providers*

On behalf of the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, and the Mid-Atlantic Association of Community Health Centers, we submit this letter of **support** for Senate Bill 484. Senate Bill 484, among other provisions, allows an insured to go out of network if the carrier's provider panel has an insufficient number or type of participating specialists or nonphysician specialists with the expertise to provide the covered mental health or substance use disorder services at no greater cost to the member than if the services were provided in-network.

Ensuring that individuals have access to critical mental health and substance use disorder treatment services continues to be an area of concern. Recent reports from the Maryland Insurance Administration have confirmed the inadequacy of some carrier's networks. Senate Bill 484 addresses this issue and will assist in fostering adequate networks and/or adequate payment to these specialists. As such, the above-reference organizations support Senate Bill 484 and urge a favorable report.

For more information call:
Danna L. Kauffman
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MHAMD_FAV_SB484
Uploaded by: Martin, Dan
Position: FAV

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

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Senate Bill 484 Health Insurance - Provider Panels - Coverage for Nonparticipating Providers
Finance Committee
February 26, 2020
Position: SUPPORT

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health, mental illness and substance use. We appreciate this opportunity to present this testimony in support of Senate Bill 484.

SB 484 will improve access to care by preventing commercially insured Marylanders from being billed extra when they are forced to go out-of-network for behavioral health treatment.

The Maryland General Assembly and the Maryland Insurance Administration have taken important steps in recent years to address network adequacy concerns and improve access to treatment for individuals with mental health and substance use disorders. Unfortunately, these efforts have yet to ensure that Marylanders with commercial insurance can access in-network behavioral health care when needed.

An independent national report[1] published in late 2019 cast a harsh light on the situation. According to the data, Maryland is among the worst states for access to affordable in-network behavioral health services. It demonstrates that insurers in Maryland are much more likely to provide in-network care for physical health services compared to mental health and substance use treatment services. This limits access to care and results in higher out-of-pocket costs that can make treatment unaffordable, even for those with insurance.

Key findings are as follows (see attached infographic for more details):

- Marylanders were 10 times more likely to go out-of-network for behavioral health visits compared to primary care. This rate is twice the national average and **fourth worst in the nation**.

- Out-of-network inpatient behavioral health use rose from 5.5 times to 9.3 times more likely than for medical/surgical services between 2013 and 2017. This rate is also nearly **twice the national average**.

- Reimbursement rate for Maryland psychiatrists in 2017 was **18% less** than other physicians for the same billing codes.

[1] Melek, Stephen P.; Gray, Travis J. (T.J.); Davenport, Stoddard. Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. Milliman, Inc. November 2019. https://www.milliman.com/insight/Addiction-and-mental-health-vs-physical-health-Widening-disparities-in-network-use-and-p

Legislation was enacted in 2016 requiring the Maryland Insurance Administration to develop quantitative network adequacy regulations. The subsequent regulatory process resulted in the adoption of strong behavioral health appointment wait time and distance standards that took effect in early 2017. However, the first two rounds of carrier filings under the regulations do little to inspire confidence that insurers are doing enough to meet their new obligations. Carrier network adequacy reports filed in July 2019 indicated that only 2 of 16 carriers provided urgent mental health and substance use disorder care within the required 72 hours and only 1 of 6 carrier networks provided non-urgent care within the required 10 days.

These findings highlight the challenges that commercially insured Marylanders face when attempting to access community mental health and substance use treatment. Progress has been made, but there is much work to be done. Until we address these outstanding network adequacy failures, we must ensure that Marylanders forced to go out-of-network for behavioral health care are not penalized for doing so.

For these reasons, MHAMD supports SB 484 and urges a favorable report.

MARYLAND PROFILE
NOVEMBER 2019

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

NEW NATIONAL REPORT DOCUMENTS INCREASED BEHAVIORAL HEALTH DISPARITIES IN EMPLOYER SPONSORED HEALTH PLANS

A new study conducted by Milliman, Inc. covering 37 million employees and their families, commissioned by The Bowman Family Foundation, reflects dramatically worsened access to behavioral health care since a similar study was published two years ago.

- Despite the National Opioid and Suicide Crises, mental health and substance use treatment* together accounted for less than 3.5% of total health care spend, with substance use treatment ranging from 0.7 to 1% of that total over the 5 year period.
- Behavioral health access disparities escalated from 2013 to 2017 in all three categories of care examined: outpatient visits, inpatient facilities and outpatient facilities. Disparities nearly doubled for inpatient and outpatient facilities, rising from almost 3 to nearly 6 times more likely, when compared to medical/surgical facility use.
- Children were 10 times more likely to receive outpatient mental health care out of network compared to primary care visits, twice the disparity faced by adults.

OFFICE VISIT ACCESS

Higher out of network for behavioral health office visits compared to primary care.

	2013	2015	2017
NATIONAL	5.04 x	5.09 x	5.41 x
MARYLAND	7.95 x	9.02 x	10.00 x

Maryland outpatient access is **4th WORST** in the nation—10 times more likely and nearly twice the national average.

INPATIENT FACILITY ACCESS

Higher out of network for behavioral health inpatient compared to medical/surgical.

	2013	2015	2017
NATIONAL	2.83 x	3.85x	5.24 x
MARYLAND	5.50 x	5.60 x	9.35 x

Maryland out of network inpatient use rose from **5.5. to 9.3 times more likely** —nearly twice the national average.

OUTPATIENT FACILITY ACCESS

Higher out of network for behavioral health outpatient facility compared to medical/surgical.

	2013	2015	2017
NATIONAL	2.97 x	5.09 x	5.72 x
MARYLAND	1.96 x	3.55 x	3.66 x

Maryland out of network outpatient facility use rose from **2 to 3.6 times more likely**.

OFFICE VISIT REIMBURSEMENT

Higher office visit reimbursement for primary care compared to behavioral health.

	2013	2015	2017
NATIONAL	20.70%	20.80%	23.80%
MARYLAND	23.20%	27.20%	18.20%

Maryland behavioral health providers **received 18% less than other doctors** for similar billing codes.

* Excludes behavioral health prescription drugs, which were 2% of total healthcare spending in 2017.

HEAU_FAV_SB0484
Uploaded by: O'Connor, Patricia
Position: FAV

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OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

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Chief
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February 26, 2020

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

From: Patricia F. O'Connor, Health Education and Advocacy Unit (HEAU)

Re: Senate Bill 484 (Health Insurance - Provider Panels - Coverage for Nonparticipating Providers): Support

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports Senate Bill 484 because carriers would no longer be able to shift the costs of inadequate provider networks for mental health and substance use disorder (MH/SUD) benefits to their insureds.

Currently, if an insured must go out of network because a carrier's network has an insufficient number or type of participating providers with the expertise to provide covered MH/SUD services to the insured within the appointment waiting time or travel distance standards established in regulations, the carrier does not accept responsibility for the balance bill. The balance bill is sent to the insured, who never bargained for that risk. The insured's deductible, copayment amount, or coinsurance is calculated as if the provider was in-network.

This bill would expressly require the carrier to cover the services provided by an out of network provider at no greater cost to the insured than if the services had been provided by an in network provider.[1] In other words, consumers would get the benefit of the bargain they assume they are making when they purchase health insurance or receive it as an employment benefit, i.e., carriers are paid premiums in exchange for paying out MH/SUD claims when services are needed. An insured expects to pay only what he would have paid in an adequate network, and this bill would fulfill that expectation.

[1] The 2000 and 2006 legislative history of Section 15-830 reflects intent for carriers whose plans in fact prove inadequate, to "bring" specialists into network for mandated referred care, at the carrier's expense, with the consumer in the same place he bargained to be – paying only what he would have paid in an adequate network.

200 Saint Paul Place ♦ Baltimore, Maryland, 21202-2021
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Consumer Complaints and Inquiries (410) 528-8662 ♦ Health Advocacy Unit/Billing Complaints (410) 528-1840
Health Advocacy Unit Toll Free (877) 261-8807 ♦ Home Builders Division Toll Free (877) 259-4525 ♦ Telephone for Deaf (410) 576-6372
www.marylandattorneygeneral.gov

While HEAU believes that all consumers should be protected from balance billing in these situations, we support this incremental step to address Maryland's current behavioral health crisis.

For these reasons, we ask that this Committee return a favorable report, assuming, as reported by the proponent, that changing the provision on page 2, in line 4, stating that HMOs "shall not" hold consumers liable for covered services to "may not" hold consumers liable, is a technical amendment with no loss in protections for consumers.

cc: Senator Klausmeier, Sponsor
Members of the Finance Committee

HEAU_FAV_SB0484
Uploaded by: O'Connor, Patricia
Position: FAV

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February 26, 2020

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

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While HEAU believes that all consumers should be protected from balance billing in these situations, we support this incremental step to address Maryland's current behavioral health crisis.

For these reasons, we ask that this Committee return a favorable report, assuming, as reported by the proponent, that changing the provision on page 2, in line 4, stating that HMOs "shall not" hold consumers liable for covered services to "may not" hold consumers liable, is a technical amendment with no loss in protections for consumers.

cc: Senator Klausmeier, Sponsor
Members of the Finance Committee

MHA_FAV_SB 484
Uploaded by: Raswant, Maansi
Position: FAV

Maryland
Hospital Association

February 26, 2020

To: The Honorable Delores Kelley, Chairman
Senate Finance Committee

From: Maansi Raswant, Vice President, Policy
Maryland Hospital Association

Re: Letter of Support - Senate Bill 484 – Health Insurance – Provider Panels – Coverage for Nonparticipating Physicians

Dear Chairman Kelley:

On behalf of the Maryland Hospital Association's (MHA) 61 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 484. Maryland's 61 nonprofit hospitals and health systems care for millions of people each year, treating 2.3 million in emergency departments. Central to this mission is ensuring the estimated one in five Marylanders suffering from mental health and substance use disorders have access to appropriate behavioral health care. However, efforts to place these patients at appropriate levels of care, particularly for post-discharge care, are often hindered by inadequate commercial insurer provider networks.

Nationwide studies rank Maryland 4th in the country for highest proportion of behavioral out-of-network use for office visits and 16th for inpatient facilities. Data show Marylanders with commercial, preferred provider organization plans are 10 times more likely to use an out-of-network provider for behavioral health office visits, than for medical/surgical office visits. Similarly, Marylanders are 9.35 times more likely to use an out-of-network inpatient facility for behavioral health needs than medical/surgical needs.[1]

SB 484 would expand access to more mental health and substance use treatment providers by allowing patients to seek care outside of carrier networks and requiring carriers to fully honor their promise to the patient for coverage of medically necessary care. In this way, the bill has the potential to incentivize insurance carriers to begin appropriately including these providers in their networks and setting adequate reimbursement rates.

For more information, please contact:
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Mraswant@mhaonline.org

[1] Milliman Research Report (Nov. 19, 2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement.

Spiegel_FAV_SB484
Uploaded by: Spiegel, Jessica
Position: FAV

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February 26, 2020
Senate Finance Committee Hearing
SB 484 – Health Insurance – Provider Panels – Coverage for Nonparticipating Providers
SUPPORT

As a provider of behavioral health services, I am writing in support of SB 484, a bill that would protect consumers from unnecessary costs and place the burden on insurers for failing to maintain adequate networks, as parity for mental health treatment is still in the dark ages. My experience as a provider of services has shown me how difficult it is to participate in insurance networks, despite my best efforts. I started the credentialing process in September of 2019 and am still awaiting a final contract with CareFirst. Unfortunately, CareFirst is the only carrier with which I am getting credentialed because it is the only insurer that offers decent reimbursement rates. Cigna, United, and Aetna's rates are currently below the Medicaid rates in the state of Maryland. I have been a licensed social worker for 10 years, have specialty training in EMDR, and cannot afford to cut my rates to comply with these insurers while giving my patients the time and effort they need and deserve. These rates do not represent parity for mental health treatment, and they will not lead to networks that will be adequate to serve the need in the state of Maryland. I have several patients that would benefit from weekly therapy but are unable to afford to come in as often as they would like due to cost. My hope is that when I am credentialed with CareFirst, this burden will be lifted off of some of my patients, however I am also aware that there will likely be delays in payment and other difficulties with reimbursement. Ask any provider of services about their experience with insurance companies and you will hear horror stories. We want to reduce the need for psychiatric hospitalizations, yet we do not have adequate provider networks. Networks are inadequate not because there aren't enough mental health providers, but because the insurance companies have gotten away with discriminating against behavioral health consumers for decades. It is unacceptable that if you need mental health treatment you could spend hours trying to find an in-network provider, only to find out they are not accepting new patients or are no longer actually in network. People who are fortunate to have the means to pay out-of-pocket often give up trying to go through their insurance because it is so burdensome, and those who cannot afford to pay go untreated. We are seeing the outcome of this with increase suicide rates, mass shootings, overdoses, etc. It is time to acknowledge the prevalence of mental health disorders among all Americans and hold insurance companies accountable to the Parity Act. All Marylanders deserve quality mental health treatment that they can afford, and providers deserve to be fairly compensated for their training and expertise. SB 484 would ensure that consumers who are forced to go out-of-network for mental health care because their network is inadequate do not bear the burden of their carrier's failure to comply with state standards. For this reason, I urge you to report favorably on SB 484. Thank you.

Batters-Thompson_FAV_SB484
Uploaded by: Thompson-Batters, Vanessa
Position: FAV

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SB484 – Health Insurance – Provider Panels – Coverage for Nonparticipating Providers
Senate Finance Committee

February 26, 2020
Position: SUPPORT

My name is Vanessa Batters-Thompson. Thank you for allowing me the opportunity to testify today. I am a Maryland resident, having lived in Montgomery County for the past seven years. I am also one of the approximately 40 million adults in the U.S. living and thriving with an anxiety disorder.
Last year, my fully-insured health plan failed to maintain an adequate network of mental health providers leaving my family unable to access quality behavioral healthcare at an affordable cost. I am testifying about my family's own struggle to highlight the importance of SB 484 and other pending bills enforcing behavioral health parity.

I married my husband ten years ago in April. When we first met, I fell in love with my husband's bright, joyful, energetic personality. A committed public servant, he served two tours in Iraq as an officer in the United States Marine Corps before receiving an honorable discharge. Like me, my husband believes serving others is our highest purpose. When Snowmaggedon closed down the District of Columbia for a week in 2010, he spent his snow days ferrying stranded patients to their dialysis treatments in his four wheel drive vehicle.

Approximately three or four years ago, my husband began feeling unwell. He lacked energy. His self-esteem plummeted, and he started verbalizing concerns about not contributing enough at work or home. After roughly a year of treatment by his primary care physician, my husband's symptoms persisted. At that time, we began looking for more specialized care. CareFirst's online provider directory lists many mental health providers in my area, but the entries were remarkably inaccurate and outdated. Over several years, I left countless messages for individual practitioners who never called back.

My family collectively saw several in-network providers at two different practices, but the services failed to meet my husband's medical needs. He became increasingly irritable and withdrawn. We began looking for an in-network therapist who would work with us as a family but failed. Out of desperation, we started seeing a therapist who did not accept any insurance. After meeting with us both together and individually, she tentatively diagnosed my husband with several conditions that his previous in-network providers overlooked.

Because my husband acknowledged experiencing suicidal thoughts, she strongly recommended he immediately seek the care of a specific psychiatrist, Dr. M. (Note: Dr. M's name is changed due to privacy concerns.) Upon being referred to Dr. M, I immediately checked CareFirst's online directory to see if he accepted our plan. While CareFirst's directory listed Dr. M as a participating provider, we quickly found the situation more complex. Dr. M's practice required our family to pay in full at the time of each appointment. After we paid in full, the practice then submitted claims directly to CareFirst. Due to an error, CareFirst initially remitted payments on our claims to MedStar Health instead of my family.

We later learned that Dr. M treated patients through a MedStar hospital in addition to the private practice where my husband received services. CareFirst considered Dr. M to be a participating provider when seeing patients at MedStar Health, but our claims would be treated as out-of-network. While MedStar Health received payments totaling $225 per visit, our family received just $130 in reimbursement for the same interactions.

By my best calculations, my family spent roughly $7,000 on my husband's office visits with behavioral health providers in 2019. To date, CareFirst issued payments to my family for just $2,088 for those expenses. This leaves my family with nearly $5,000 of out-of-pocket medical expenses, despite my plan advertising an out-of-pocket medical spending cap of $1,300 per individual or $2,600 for a family. As of today, CareFirst's website indicates my husband spent just $629.89 towards his $1,300 limit for 2019. Since October 2019, my company's insurance broker appealed my claim to CareFirst executives, but the status of my family's claims remains uncertain. **However, these additional costs and appeals would not be an issue if CareFirst's network of behavioral health providers adequately met my husband's needs.**

I doubt my family will ever be fairly reimbursed for these services. This outcome is neither just nor ideal, but we are lucky. My family possessed the financial ability to cover the cost of behavioral health services ourselves. Not all consumers can make a similar choice to prioritize care over cost.

Mental health and substance use disorders still carry a lot of stigma in our society. I recently started engaging in occasionally uncomfortable but important conversations about behavioral healthcare with my friends, family, and neighbors. I found many people struggle to access timely, quality care within insurance networks. In 2017, Marylanders filed ten times as many out-of-network claims for behavioral health office visits versus medical or surgical office visits. This rate is four times the national average. **While insurance carriers and providers blame each other for inadequate behavioral health networks, it is undisputable that consumers are assuming costs as a result.**

Today, my husband is doing far better. However, the time we lost trying to access quality services through CareFirst's network deeply frustrates me. My husband struggled with invasive and suicidal thoughts far longer than necessary due to the inadequate network of mental health providers. During this extended period, I worried daily about the real possibility he might harm himself. Concerns about cost and numerous administrative burdens compounded those fears and triggered my own anxiety. My daughter lost a great deal of quality time with her father as a result of the delay. In my family's case, insurance coverage presented a barrier versus a solution to accessing care. That should not occur. **The proposed bill, SB 484, simply requires insurance carriers to provide adequate behavioral health services to subscribers at a predictable cost if they fail to maintain a sufficient network of providers. This, in combination with other pending bills, is a crucial step towards making the promise of behavioral health parity a reality for all Marylanders. I urge you to report favorably on SB 484.**

IBR_FAV_SB484
Uploaded by: Walters, Vickie
Position: FAV

INSTITUTES FOR BEHAVIOR RESOURCES
shaping a better world

REACH HEALTH SERVICES

Health Insurance – Provider Panels – Coverage for Nonparticipating Providers – SB 484
Health and Government Operations Committee Hearing
February 26, 2020
SUPPORT

Thank you for the opportunity to submit testimony in support of SB 484 which would help individuals with substance use disorders and mental health conditions gain access to affordable treatment when they cannot get network services within a reasonable time and distance. This testimony is submitted on behalf of the Institutes for Behavior Resources, Inc. We are a full service behavioral health program offering substance use disorders treatment, including outpatient and intensive outpatient counseling, medication assisted treatment, health home case management services and mental health counseling. We accept most private insurances, Medicaid, Medicare and we offer a sliding fee scale to our uninsured and underinsured patients.

IBR participates in most state-regulated commercial insurance plans in Maryland. We do so because many of our patients have insurance through the Exchange or their employer, and we want them to be able to use their insurance to pay for treatment. Substance use disorders are chronic medical conditions, and many patients participate in treatment at IBR for an indefinite time.

In the late winter of 2018, IBR sought credentialing with Cigna because we have many patients with that coverage. IBR submitted all the required documentation. In the spring of 2018, we were notified by mail that Cigna rejected our credentialing application stating that they did not need additional substance use disorder providers in their network. We called and spoke to someone, explaining that we have patients who have Cigna who wish to remain in our treatment program, and we were told that it did not matter, they could be referred somewhere else.

We subsequently learned that the Maryland Insurance Administration had issued an order against Cigna for denying credentialing to 5 substance use disorder programs based on "no network need identified." The MIA found that Cigna exercised its discretion in a discriminatory way to exclude substance use disorder facilities from its network. IBR was one of those 5 programs that was excluded from Cigna's network.

After we learned about the decision, we resubmitted our application to Cigna for credentialing, expecting that Cigna would now evaluate IBR's application fairly like other medical facilities and admit us to their network. We were disappointed to learn in the spring of 2019 that Cigna again denied IBR's credentialing application citing there was "no network need identified."

Cigna's refusal to credential substance use disorder programs has serious consequences for Marylanders who need opioid treatment services and cannot afford to pay more for a non-participating provider. We know from carrier network adequacy reporting that most carriers, including Cigna, cannot provide non-urgent substance use treatment within 10 days, as required by law. Yet, they unfairly deny credentialing to programs like IBR.

When carriers cannot satisfy Maryland's network adequacy standards for mandated substance use disorder services, consumers should not be forced to pay more for non-network services. They purchase health plans expecting to cover their treatment needs and should be protected when carriers do not meet their legal obligations.

We urge you to issue a favorable report on SB 484 so that Marylanders can get carrier approval to get non-network providers at no additional cost to them.

Thank you for considering our views. We urge you to issue a favorable report on SB 484.

Vickie Walters, LCSW-C
Executive Director
vwalters@ibrinc.org

Legal Action Center_FAV_SB484
Uploaded by: Weber, Ellen
Position: FAV

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Health Insurance – Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists – SB 484
Health and Government Operations Committee Hearing
February 26, 2020
SUPPORT

Thank you for the opportunity to submit testimony **in support of SB 484** which would expand access to affordable mental health and substance use disorder services for Marylanders. This testimony is submitted on behalf of the Legal Action Center, a law and policy organization that fights discrimination against individuals with histories of substance use disorders, HIV/AIDs and criminal history records. In Maryland, the Legal Action Center works with its partners to ensure that the Maryland Insurance Administration (MIA) strengthens enforcement of the State's network adequacy standards for mental health (MH) and substance use disorder (SUD) services and that consumers are protected from high out-of-pocket costs when carriers do not meet network adequacy requirements.

SB 484 responds to two issues: (1) abundant evidence that carrier networks are not sufficient to meet their members' need for mental health and substance use treatment services; and (2) unfair cost barriers to treatment for members who must obtain care from a non-network provider because of the carriers' inadequate networks. **Maryland law allows carriers to shift the cost of services to members who have no control over the adequacy of their plan networks and lack the financial resources to pay. As stakeholders take steps to improve provider networks, consumers must be held harmless from costs that carriers should bear for failing to comply with network adequacy standards.**

SB 484 would ensure that:

- Consumers are **informed of their right** to request approval to obtain non-network services when they cannot access in-network mental health and substance use treatment without "unreasonable delay or travel."
- Consumers with a PPO plan get the full benefit of a network service by paying **"no greater cost"** than the cost of in-network services when they get approval to go to a non-participating provider.

A. NAIC Model Act and Other State Standards

The standard proposed in SB 484 – requiring a carrier to cover an approved non-network services at no greater cost to the member than if that service were provided by a network provider – is modeled on the National Association of Insurance Commissioner's (NAIC) Health Benefit Plan Network Access and Adequacy Model Act and the standard enacted in ten (10) states.

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The NAIC Model Act requires carriers to:

> (C)(1)…*assure that a covered person obtains a covered benefit at an in-network level of benefits*, *including an in-network level of cost-sharing*, from a non-participating provider…when the health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable delay or travel….
>
> (C)(3) The health carrier shall treat the health plans services the covered person receives from a non-participating provider [when the network is insufficient] *as if the services were provided by a participating provider, including counting the covered person's cost sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan*.

NAIC Model Act, Sec. 5(C)(1)-(3), pp. 74-8 and 74-9) https://www.naic.org/store/free/MDL-74.pdf (emphasis added and section number omitted).

Ten (10) states – Arkansas, Colorado, Illinois, Maine, Mississippi, Missouri, Nebraska, New Hampshire, South Dakota and Washington – have adopted standards that protect consumers from paying a greater cost for a non-participating provider's services when a carrier's network is inadequate. **These states had all adopted their standards as of 2014, and 8 states enacted their laws from 1997 to 2011.**

When the Health and Government Operations Committee asked the Maryland Insurance Administration (MIA) to comment on the reimbursement strategies implemented by seven (7) of these states, (Attachment 1, June 5, 2019 Letter from Chairman Shane E. Pendergrass to Commissioner Al Redmer), the MIA stated that "[e]nacting similar laws as the seven states referenced could require an HMO or other carrier to pay the non-participating provider's full billed charge in order to ensure that the cost of the services are no greater to the member/insured than if those services were rendered by a participating provider." (Attachment 2, October 1, 2019 Letter from Commissioner Al Redmer to Delegate Shane E. Pendergrass). Maryland law, Health-Gen. § 19-710.1, establishes a reimbursement standard for HMOs when making a service available through a non-participating provider, and that standard would not be altered by SB 484, under a proposed amendment.

SB 484 is necessary to similarly ensure that Marylanders enrolled in PPOs have access to the timely and affordable services they already pay for and are entitled to receive.

B. Evidence of Inadequate Carrier Networks for Substance Use Disorder and Mental Health Services.

The MIA has gathered overwhelming evidence from the carriers' 2018 and 2019 network adequacy reports and its three market conduct investigations that demonstrates that Maryland's carriers do not have sufficient mental network health and substance use disorder providers to meet the needs of their members.

- In 2019, the second year in which carriers were required to report on their compliance with Maryland's network adequacy regulations, **only 2 of 16 carriers** (CareFirst BlueChoice and Kaiser Foundation) provided urgent MH and SUD Care within the required 72 hours. **Only 1 of 6 carrier networks** (United Healthcare) reported providing non-urgent MH and SUD care within 10 days, as required by law. (Attachment 3, Appointment Wait Time – Mental Health and Substance Use Disorder Services).

- In 2019, CareFirst reported far worse performance in providing timely non-urgent MH and SUD services than in 2018, meeting the wait time metric for only 57.5% of its members in 2019 compared to 95% of its members in 2018). (Attachment 4, Appointment Wait Time for Non-Urgent MH/SUD Services 2018-2019 Comparison.)

Carriers that failed to meet the wait time requirements could have requested a waiver of the standard by disclosing their efforts to contract with MH and SUD providers, as set out in COMAR § 31.10.44.07(C). **Yet, as in 2018, no carrier did so, and policymakers have again been deprived of critical data to assess the cause(s) of network gaps.**

The MIA's market conduct investigations of carrier compliance with the Mental Health Parity and Addiction Equity Act (Parity Act) also confirm network gaps for MH and SUD providers and demonstrate that some inadequacies result from discriminatory carrier practices in network admission. The MIA's July 2019 third survey report again identified disparities and violations:

- Cigna used its discretion to discriminatorily exclude 5 of 13 SUD treatment programs from its network in 2017, while admitting 122 medical facilities from 2015-2017, even though it concluding its network had no need for medical facilities. (Consent Order # MIA-2019-06-012).
- Aetna required inpatient and outpatient MH and SUD facilities to complete detailed Personnel Review assessments that were not required of medical facilities. (Consent Order # MIA-2018-10-037).
- All carriers reported that members received MH and SUD services from out-of-network providers more frequently than for medical/surgical services.

The MIA has issued a total of 9 orders since late 2015 related to Parity Act violations, most of which relate to network admission practices. (*See* Attachment 5, Summary of the MIA's Market Conduct Orders and Findings). **Consumers should not be required to pay more for MH and SUD treatment in the face of clear discrimination.**

Finally, carrier reimbursement data also demonstrate that MH and SUD providers are reimbursed at a lower rate than comparable medical services, which is a clear contributor to the inadequate MH and SUD provider networks.

- The Maryland Health Care Commission's analysis of 2017 data from the Maryland All-Payer Claims Database revealed that psychiatrists were paid less than three other medical specialties (primary care physicians, medical specialists, and surgeons) for the same four Evaluation and Management (E&M) Codes. Some physicians received as much as 30%

more than psychiatrists for the same billing codes and, in most cases, psychiatrists were paid below the Medicare benchmark while the other three physician specialists were paid at or above the Medicare rate. (*See* Attachment 6, Comparison of Reimbursement Rates for Four Medical Specialists Billing Four Evaluation and Management Codes).

- Milliman, Inc. found that, in 2017, PPO plans reimbursed behavioral health providers 18% less than medical providers, relative to the Medicare rate, for comparable outpatient office visits. S. Melek, S. Davenport, T.J. Gray, "Addiction and Mental Health v. Physical Health: Widening Disparities in Network Use and Provider Reimbursement, App. B-20 at p. 53, available at https://www.milliman.com/insight/Addiction-and-mental-health-vs-physical-health-Widening-disparities-in-network-use-and-p.

SB 484 would address the impact of network gaps in the most limited way possible. It would apply to a small portion of consumers who request approval to go to a non-participating provider based on the carrier's failure to offer services within a reasonable time and distance.

C. Impact of Proposed Reimbursement Standard on Carrier Networks

Questions may arise as to whether requiring carriers to cover approved non-network services at no greater cost to the member would have the unintended consequence of "destabilizing" existing networks; spurring some providers to leave the network to receive a higher reimbursement rate. **There is no evidence that providers would leave or not join networks.** Network disruptions seem unlikely, as many MH and SUD providers **want to join carrier networks**, but are either told that networks have sufficient providers or are offered reimbursement rates that are not adequate to provide quality services. Moreover, there is no incentive for network participants to leave the network, as they would be required to separately negotiate a reimbursement rate and contract for each patient – a burdensome and uncertain process.

This same concern was raised in 2010 when the General Assembly adopted consumer payment protections for services delivered by on-call physicians and hospital-based physicians (Chapter 537, 2010 Laws of Maryland). **The Maryland Health Care Commission (MHCC) reviewed the impact of establishing a statutory reimbursement rate for physicians who accepted an assignment of benefits and put this concern to rest.** It found that the law:

- Eased the financial burden on patients by discouraging non-participating physicians from balance billing patients.
- Protected payment levels for non-participating physicians who also benefitted from "increased predictability in payments."
- Did not lead to a "systematic deterioration in networks….Some up and down fluctuations in network participation did occur by specialty [and were] more significant for smaller carriers….

Letter from Ben Steffen, Executive Director, Maryland Health Care Commission, to Governor O'Malley and Chairs Middleton and Hammen (Jan. 15, 2015) at 1-2.

Carriers must play their role in addressing Maryland's opioid and suicide epidemics. Meeting state and federal obligations to provide network coverage for mental health and substance use disorder benefits is an essential starting point. SB 484 will protect consumers as stakeholders work to build more robust networks.

Thank you for considering our views, and we urge a favorable report on SB 484.

Ellen M. Weber, JD
Vice President for Health Initiatives
Legal Action Center
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202-544-5478 Ext. 307

ATTACHMENT 1

SHANE PENDERGRASS
CHAIR

JOSELINE PEÑA-MELNYK
VICE CHAIR

THE MARYLAND HOUSE OF DELEGATES
HEALTH AND GOVERNMENT OPERATIONS COMMITTEE

June 5, 2019

Al Redmer, Jr.
Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Dear Commissioner Redmer,

I am writing on behalf of the Health and Government Operations Committee to request the assistance of the Maryland Insurance Administration (MIA) in providing HGO with information to ensure the General Assembly can begin to identify solutions that will address perceived gaps in provider networks for mental health and substance use disorder services.

As you know, HGO considered House Bill 837, Health Insurance – Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists, that would have established a reimbursement rate for mental health and substance use disorder services that a carrier must pay for delivery by a noncontracting specialist or a nonphysician specialist because a network provider is not available. Although HGO considers the issue to be extremely important, it was not ready to approve House Bill 837 during the last legislative session because the committee understands that MIA has approached the network adequacy regulations as a work in progress that will require some incremental monitoring and changes. Further, it is the committee's understanding that the second set of network adequacy reports are due July 1, 2019 and will be the first opportunity for MIA to compare the year to year carrier submissions.

However, during the 2019 interim HGO requests that MIA provide the following information and recommendations by October 1, 2019:

(1) Steps taken since July 2018 to improve carrier compliance with the network adequacy reporting requirements, under COMAR 31.10.44.09, including any new reporting tools that the MIA has developed to facilitate the submission of carrier reports;

(2) Enforcement orders issued in the past two years for violations of referrals to specialists under § 15-830 of the Health Insurance Article;

(3) Remedial action taken or waiver requests made, including related information as required under COMAR 31.10.44.07.C;

(4) Comments on reimbursement strategies implemented in Arkansas, Maine, Mississippi, Nebraska, New Hampshire, South Dakota, and Washington under the following statutory and regulatory citations including recommendations on whether similar strategies could be implemented in Maryland:

- Arkansas, 54 Ark. Code R. § 106-5(C);
- Maine, 2-031 Ch. 850 Me. Code R. § 7(b)(5);
- Mississippi, 19 Miss. Code. R. § Pt. 3 R. 14.05;
- Nebraska, Neb. Rev. Stat. § 44-7105;
- New Hampshire, N.H. Code Admin. R. Ann. Ins §§ 2701.04,
- South Dakota, 2701.10; S.D. Codified Laws § 58-17F-6; and
- Washington; Wash. Admin. Code § 284-170-200;

(5) Please provide the following information, as applicable: (i) the reimbursement rate that each carrier pays for in–network services; (ii) if the carrier reimburses at a set percentage of the Medicare rate, the reimbursement percentage and the Medicare benchmark year; and (iii) if the carrier reimburses medical practitioners and mental health/substance use disorder practitioners at different rates, the different rates:

For psychiatrists and psychiatric nurse practitioners:

Code	Services	Reimbursement Rate	Reimbursement Percentage and Medicare Benchmark Year	Different rates for practitioners
99203	E&M new patient office visit – mid-level			
99205	E&M new patient office visit – high complexity			
99213	E&M established patient office visit – mid-level			
99215	E&M established patient office visit – high complexity			

For psychiatrists, psychiatric nurse practitioners, psychologists (LPC, LCSW, Psych D):

Code	Services	Reimbursement Rate	Reimbursement Percentage and Medicare Benchmark Year	Different rates for practitioners
90791	Psychiatric diagnostic evaluation w/o medical services			
90792	Psychiatric diagnostic evaluation w/medical services			
90834	Psychotherapy 45 minutes			
90837	Psychotherapy 60 minutes			

(6) Recommendations on what penalty structure may be used for a carrier that does not meet the State network adequacy standards or obtain a waiver of the standards.

The committee understands that some of the information requested may be considered confidential. However, HGO would greatly appreciate MIA providing as much information as possible to ensure that Marylanders do not face cost-barriers to treatment and that carriers expand their networks to address gaps that have been documented under the State's network adequacy regulations. If you have any questions, please contact Lisa Simpson, counsel for the HGO, at (410) 946-5350.

Sincerely,

Shane E. Pendergrass,
Chairman, Health and Government Operations Committee

cc: The Honorable Sheree Sample–Hughes
The Honorable Bonnie Cullison

ATTACHMENT 2

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

MARYLAND INSURANCE ADMINISTRATION

AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

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Email: Michael.paddy@maryland.gov
410-468-2000 1-800-492-6116
TTY: 1-800-735-2258
www.insurance.maryland.gov

October 1, 2019

Delegate Shane E. Pendergrass
Chairman, Health & Government Operations Committee
House Office Building, Room 241
6 Bladen Street
Annapolis, MD 21401

Re: June 5, 2019 HGO Letter - House Bill 837 - Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists

Dear Shane,

This letter is in response to your June 5, 2019 letter to the Maryland Insurance Administration (MIA) in regards to providing the Health and Government Operations Committee ("HGO") with information to "ensure the General Assembly can begin to identify solutions that will address perceived gaps in provider networks for mental health and substance use disorder services."

Please find below answers to the questions in the order in which they were raised in the June 5th letter.

Question 1 - Steps taken since July 2018 to improve carrier compliance with the network adequacy reporting requirements, under COMAR 31.10.44.09, including any new reporting tools that the MIA has developed to facilitate the submission of carrier reports.

> Response -- Initially, the MIA used the 2018 network adequacy filings to establish a baseline for each carrier. The MIA then contacted carriers prior to the July 1, 2019 filing deadline if the MIA uncovered any errors in the executive summary filing format from the 2018 filings. In 2019 there was overall improvement among carriers with limited exception. The MIA has developed a 9 step internal review process for 2019 that will be amended as needed in preparation for the 2020 filings and review process. The MIA has been proactive in posting executive summaries on its website at the following hyperlink:
> https://insurance.maryland.gov/Consumer/Pages/Network-Adequacy-Regulations-Information.aspx.

Please note that the executive summaries posted on the MIA's website are posted with the following disclaimer:

> "Please note: the information contained in the executive summary forms provided below has not yet been reviewed by MIA staff for accuracy or completeness. The preliminary information reported below may be subject to change after the MIA completes its review of the 2019 access plans."

In addition, the MIA is preparing a procurement for software to assist in its review of the network adequacy information. Also, attached as **Exhibits 1, 2, & 3,** are three Market Conduct Orders identifying a network adequacy issue and ordering each carrier to provide documentation.

Question 2 – Enforcement orders issued in the past two years for violations of referrals to specialists under § 15-830 of the Health Insurance Article.

Response – In the past two years the MIA has issued two Orders for the violation of

§ 15-830(d) of the Insurance Article, referrals to specialists. The carriers failed to process referrals to specialists within the time frame required by law. The Orders are attached to this letter as **Exhibits 4 and 5.**

Question 3 – Remedial action taken or waivers request made, including related information as required under COMAR 31.10.44.17.C.

Response - The MIA received 13 reports on time and 1 report after the July 1, 2019 due date. During its preliminary review, the MIA has determined that none of the filings are 100% compliant with the network adequacy regulations. The MIA continues its review of each filing and is corresponding with each carrier regarding the information contained in the filings.

Only one carrier submitted a waiver request which is also under review. The MIA is currently communicating with carriers regarding their failure to submit requests for waivers in an effort to determine why waiver requests were not filed.

Question 4 – Comments on reimbursement strategies implemented in Arkansas, Maine, Mississippi, Nebraska, New Hampshire, South Dakota, and Washington under the following statutory and regulatory citations including recommendations on whether similar strategies could be implemented in Maryland:

- Arkansas, 54 Ark. Code R. § 106-5(C);
- Maine, 2-031 Ch. 850 Me. Code R. § 7(b)(5);
- Mississippi, 19 Miss. Code. R. § Pt. 3 R. 14.05;
- Nebraska, Neb. Rev. Stat. § 44-7105;
- New Hampshire, N.H. Code Admin. R. Ann. Ins§§ 2701.04,
- South Dakota, 2701.1O; S.D. Codified Laws§ 58-17F-6; and
- Washington, Wash. Admin. Code§ 284-170-200;

Response – Each of the above-listed states have enacted laws providing that, in the event of an inadequate network of providers, a carrier must provide that covered persons receive services from non-participating providers at a cost no more than the covered person would have had to pay if he or she had received the benefit from a participating provider.

While the basic language is similar across the state laws, there are variations. The full descriptions are included below, but the variations include:

- Maine, Mississippi, and South Dakota allow carriers to make alternative coverage arrangements, provided the alternative meets with the approval of that state's Insurance Commissioner/ Superintendent/ Director.
- Nebraska requires the carrier to pay its usual and customary rate, or "an agreed upon rate."
- New Hampshire does not require reimbursement to a non-participating provider who has been excluded from the carrier's network for failing to meet credentialing standards.

Some states provide waivers, and others limit the requirement to managed care plans. In each instance, however, the burden is on the carrier to assure that the insured is not responsible for some or all of the additional cost incurred from receiving services from a non-participating provider.

The following are the specific state requirements in each of the seven states.

Arkansas -Ark. Admin. Code 054.00.106-5 (C)

> In the event that a Health Carrier has an insufficient number or type of participating providers to provide a Covered Benefit, the Health Carrier shall ensure that the Covered Person obtains the Covered Benefit at no greater cost to the Covered Person than if the benefit were obtained from a participating provider.

Maine
02-031 CMR Ch. 850, § 7 (b)(5)

> In any case where the carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the Superintendent.

Mississippi
19 Miss. Admin. Code Pt. 3 R. 14.05

A health carrier providing a managed care plan[1] shall maintain a network that is sufficient in numbers and types of participating providers to assure that all services to covered persons will be accessible without unreasonable delay.

* * *

In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the commissioner.

Nebraska
Neb.Rev.St. § 44-7105 (l)(a)

A health carrier providing a managed care plan[2] shall maintain a network that is sufficient in numbers and types of providers to assure that all health care services to covered persons will be accessible without unreasonable delay.

* * *

In any case in which the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit and the health carrier shall reimburse the nonparticipating provider at the health carrier's usual and customary rate or at an agreed upon rate.

New Hampshire
N.H. Code Admin. R. Ins. 2701.04 (d)

In any county in which compliance with Ins 1701.04(a) is required and in which a health carrier's[3] network is insufficient to meet one of the access standards in Ins 2701.06 and in which the carrier has not been

---

[1] A managed care plan includes a plan operated by a licensed insurance company, hospital or medical service plan, health maintenance organization, or an employer or employee organization. The term does not include a plan operated by a licensed insurance company unless it contracts with other entities to provide a network of participating providers. *See* Miss. Code Ann. § 83- 41-403 (b) and (c).

[2] "Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier." Neb.Rev.St.§ 44-7103 (14).

[3] A "health carrier" includes "an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services." N.H. Code Admin. R. Ins. 2701.03 (e).

granted an exception pursuant to Ins. 2701.08[4] or Ins. 2701.14[5], the health carrier shall cover services provided by a non-participating provider located within the applicable geographic area at no greater cost to the covered person than if the services were obtained from a participating provider. Coverage under this paragraph shall be subject to all other terms and conditions of the covered person's health benefit plan, including, but not limited to, referral and authorization requirements. Nothing in this paragraph shall be construed to require a health carrier to provide, coverage for services provided by a non-participating provider who has been excluded from the health carrier's network for failing to meet any applicable credentialing standards.

South Dakota
SDCL § 58-17F-6

> In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the director[6].

Washington
WAC 284-170-200 (5)

> In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities.

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[4] A health carrier can request an exception to network adequacy standards for a variety of enumerated reasons, including that an insufficient number of qualified providers or facilities are available in the county to meet the standards, or that it is due to the refusal of a local provider to accept a commercially reasonable rate, fee, tenn, or condition, or that the service can be obtained through telemedicine or telehealth from a participating provider. *See* N.H. Code Admin. R. Ins. 2701.08 (a).

[5] Written requests to the New Hampshire Insurance Commissioner for waiver shall be granted if the waiver does not contradict the objective and intent of the network adequacy law. *See* N.H. Code Admin. R. Ins. 2701.014 (a).

[6] This law applies to a health carrier providing a "managed care plan." A managed care plan includes a plan operated by a licensed insurance company, hospital or medical service plan, health maintenance organization, or an employer or employee organization. The term does not include a plan operated by a licensed insurance company unless it contracts with other entities to provide a network of participating providers. *See* SD St. § 58-1 7F-l.

Question 4 continued - Recommendations on whether similar strategies could be implemented in Maryland.

Response - Notwithstanding that it is within the purview of the legislature to determine whether similar strategies should be enacted in Maryland, there are certain Maryland HMO and insurance laws that should be carefully considered.

For example, Insurance Article, Sections 19-710 and 19-710.1 prohibit a non-participating Maryland-licensed provider from balance billing an HMO member and require an HMO to reimburse a non-participating Maryland licensed provider a certain amount. Similarly, Insurance Article, Sections 14-205.2 and 14-205 prohibit certain non-preferred providers such as Maryland-licensed hospital-based physicians and on-call physicians who are not hospital based and may be licensed outside of Maryland, from balance billing certain insureds under certain circumstances and also require an insurer or nonprofit health service plan to reimburse a non-preferred hospital-based physician and on-call physician who is not hospital based the correct rate provided for by law under certain circumstances. Enacting similar laws as the seven states referenced could require an HMO or other carrier to pay the non-participating provider's full billed charge in order to ensure that the cost of the services are no greater to the member / insured than if those services were rendered by a participating provider.

Question 5 – Please provide the following information as applicable: (i) the reimbursement rate that each carrier pays for in-network services; (ii) if the carrier reimburses at a set percentage of the Medicare rate, the reimbursement percentage and the Medicare benchmark year; and (iii) if the carrier reimburses medical practitioners and mental health/substance use disorder practitioners at different rates, the different rates:

Response - The requested information is attached as **Exhibit 6**. This information was provided by Mr. Kenneth Yeates-Trotman, Maryland Healthcare Commission. Further reimbursement rate inquiries may be directed to Mr. Yeates-Trotman at (410)764-3557 or kenneth.yeates-trotman@maryland.gov.

Question 6 – Recommendations on what penalty structure may be used for a carrier that does not meet the State network adequacy standards or obtain a waiver of the standards.

Response – All penalties assessed by the MIA must be calculated according to Code of Maryland Regulations (COMAR) 31.02.04.02, a copy of which is attached for your convenience as **Exhibit 7.** The MIA recommends that the same regulation and penalty structure be used for a carrier that does not meet the State network adequacy standards or obtain a waiver of the standards.

If we can be of any further assistance, please do not hesitate to call or email Michael Paddy, Director of Government Relations at 410-468-2408 or michael.paddy@maryland.gov.

Sincerely,

Al Redmer, Jr.
Insurance Commissioner

Cc: Delegate Bonnie Cullison
Delegate Sheree Sample-Hughes
Lisa Simpson, Committee Staff

ATTACHMENT 3

Appointment Wait Time – Mental Health and Substance Use Disorder Services *

Carrier	Urgent Care[1]	Non-Urgent BH/SUD Services
Aetna Health Ins.[2]	• Urgent BH/SUD (HMO): Not Satisfied: 80% within 48 hours (no data on 72 hours) • Urgent BH/SUD (PPO): Not Satisfied: 80% within 48 hours (no data on 72 hours) Exchange Plans • Urgent BH/SUD (HMO): Not Satisfied NA • Urgent BH/SUD (PPO): NA • Urgent BH/SUD (EPO): NA	• HMO: Not Satisfied (89%) • PPO: Not Satisfied (89%) Exchange Plans • HMO: NA • PPO: NA • EPO: NA
Aetna Life Ins. Co.	Same as Aetna Health Ins.	Same as Aetna Health Ins.
CareFirst	PPO: Not Satisfied (93.00%)	PPO: Not Satisfied (57.53%)
CareFirst BlueChoice	HMO: Satisfied (95.30%)	HMO: Not Satisfied (57.53%)
CareFirst GHMS	PPO: Not Satisfied (93.00%)	PPO: Not Satisfied (57.53%)
Cigna Life and Health Ins. Co.[3]	Not Satisfied (48 hours; no data 72 hours) (53%)	Not Satisfied (76%)
Connecticut Gen. Life Ins. Co.	Not Satisfied (48 hours; no data 72 hours) (53%)	Not Satisfied (76%)
Golden Rule Ins. Co.	Not Satisfied (92%)	Satisfied (96%)
Kaiser Found. HP of M.A. States	Satisfied (100%)	Not Satisfied (84.3%)
Kaiser Perm. Ins. Co.	Not Satisfied (42%)	Not Satisfied (28%)
MAMSI Life and Health Ins. Co.	Not Satisfied (92%)	Satisfied (96%)
Optimum Choice Inc.	Not Satisfied (92%)	Satisfied (96%)
United Healthcare Ins. Co. Choice Plus	Not Satisfied (92%)	Satisfied (96%)
United Healthcare Ins. Co. (CORE)	Not Satisfied (92%)	Satisfied (96%)
United Healthcare of the M.A. Inc. (CORE)	Not Satisfied (92%)	Satisfied (96%)
United Healthcare of the M.A. Inc. (Choice)	Not Satisfied (92%)	Satisfied (96%)

* Shaded area designates metric not satisfied.

1. Includes medical, MH and SUD services.
2. Aetna urgent care data differs for medical, MH and SUD services.
3. National data rather than Maryland data.

ATTACHMENT 4

Appointment Wait Time for Non-Urgent MH/SUD Services 2018-2019 Comparison and Member Enrollment

Carrier	2018 Report[1]	2019 Report	Enrollment Individual Market[2] (7.31.19)	Enrollment Small Group Market[2] (7.31.19)
Aetna Health Ins.	82% (in 14 days)	89%	NA	166
Aetna Life Ins. Co.	82% (in 14 days)	89%	NA	629
CareFirst	95%	57.5%	11,493 (combined with GHMS)	22,158 (combined with GHMS)
CareFirst BlueChoice	95%	57.5%	108,301	168,248
CareFirst GHMS	95%	57.5%	11,493 (combined with CareFirst)	22,158 (combined with CareFirst)
Cigna Life and Health Ins. Co.	Missing data	76%	NA	NA
Connecticut Gen. Life Ins. Co.	Missing data	76%	NA	NA
Golden Rule Ins. Co.	72%	96%	NA	NA
Kaiser Found. Health Plan of Mid-Atlantic States	89.3%	84.3%	70,686	10,344
Kaiser Permanente Ins. Co.	Missing data	28%	NA	NA
MAMSI Life and Health Ins. Co.	72%	96%	NA	21,092
Optimum Choice Inc.	72%	96%	NA	17,205
United Healthcare Ins. Co. Choice Plus	72%	96%	NA	23,895[3]
United Healthcare Ins. Co. (CORE)	NA	96%	NA	
United Healthcare of the Mid-Atlantic Inc. (CORE)	72%	96%	NA	5,079[4]
United Healthcare of the Mid-Atlantic Inc. (Choice)	72%	96%	NA	

1. Reports are available at https://insurance.maryland.gov/Consumer/Pages/Network-Adequacy-Regulations-Information.aspx and the Legal Action Center submitted an analysis of compliance to the MIA in September 2018. See Letter from Ellen Weber, Legal Action Center, to Robert Morrow, Assoc. Comm. Life & Health Maryland Insurance Administration, Sept. 18, 2018 (on file with the Legal Action Center).
2. Hogan Administration Announces Second Consecutive Decrease in Health Insurance Premiums, Sept. 19, 2019, available at https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2019236.
3. The enrollment data does not distinguish between United Healthcare Ins. Co's CORE and Choice plans.
4. The enrollment data does not distinguish between United Healthcare of the Mid-Atlantic CORE and Choice plans.

ATTACHMENT 5

MIA Orders and Market Conduct Survey Findings: Parity Act Compliance

Carrier	Order/ Date	Violations	Penalty
Aetna/Coventry[i]	MIA-2015-12-035	• No in-network psychologists in all of Western Maryland • 2 counties with no in-network psychiatrists and 1 county had 1 • 1 county no in-network licensed professional counselors or licensed social workers • Statewide - 1 or no in-network methadone treatment programs	No Financial Penalty
CareFirst Blue Choice	MIA-2015-10-036	• Statewide - no in-network methadone treatment programs • Different reimbursement rates for MH/SUD network because used a separate vendor to manage MH/SUD benefits • Geofactors applied to somatic illnesses not applied to MH/SUD providers	Initial Financial Penalty of $30,000; Retracted Based on Consent Order
CareFirst GHMSI	MIA-2015-10-034	• Failure to meet network adequacy goals for neuropsychological doctors and geriatric psychiatrists	No Financial Penalty
Cigna[ii]	MIA-2015-10-007	• Additional screening requirement for MH/SUD credentialing • Requirement that MH/SUD applicants who had received treatment for SUD must be sober for 2 years • Imposed shorter response time for MH/SUD providers to submit requested credentialing information	$9,000 Financial Penalty

Evergreen	MIA- 2015-10-033	• Used 2 different vendors for MH/SUD services and somatic services and no coordination to ensure no more stringent credentialing requirements • Used different factors to set reimbursement rates for MH/SUD • 1 county - no in-network psychiatrists, psychologists, licensed social workers or professional counselors	No Financial Penalty
United Healthcare[iii]	MIA-2017-08-009	• Reviewed 5-year malpractice history for all MH/SUD facilities applying for credentialing but no malpractice review for med/surg facilities	$2,000 Financial Penalty
CareFirst BlueChoice, Inc. GHMSI (CareFirst BlueCrossBlueShield)	MIA-2018-01-023	• BlueChoice – on-line behavioral health directory failed to list 25 of 27 in-network MH hospitals and 5 of 7 MH non-hospital facilities • BC/BS Blue Preferred – online behavioral health directory failed to list any in-network inpatient MH facilities	$20,250 Financial Penalty against BlueChoice $4,725 Financial Penalty Against CareFirst BC/BS
Second Market Conduct Survey Other Findings	June 2017 MIA indicated carriers corrected issues during investigations. Carriers not identified	• Carrier limited disclosure of med/surg medical necessity criteria to 3 guidelines at a time to member/provider • Large group plan – financial testing did not account for all OP benefits • Carrier – on-line directory indicated no in-network inpatient MH facilities • Carrier's credentialing documents for MH/SUD	

		providers required site visit but not for med/surg providers • Carrier reported different authorization practices in notices for inpatient MH/SUD treatment and med/surg treatment.	
Second Market Conduct Survey Other Findings	June 2017 Carriers with inadequate networks not identified	• 6 counties – no in-network non-hospital facilities for opioid use disorders[iv] • 11 counties – no in-network non-hospital facilities for treatment of bi-polar disorders[v] • 4 counties – no in-network opioid providers[vi] • 7 counties – no in-network providers of bi-polar disorders[vii]	No Financial Penalties or Other Actions Taken
Aetna	MIA-2018-10-037	• Required MH/SUD outpatient and inpatient facilities to complete detailed Personnel Review for credentialing; medical facilities not required to complete Personnel Review	$1,500 Financial Penalty
Cigna	MIA-2019-06-012	• Denied credentialing for 5 of 13 SUD treatment facilities based on "no network need identified." Admitted all 122 medical facilities even though "no network need identified."	$25,000 Financial Penalty
Third Market Conduct Survey Other Findings	Sept. 18, 2019 MIA indicated that carriers corrected issues during investigations but investigation was not complete.	• 1 carrier imposed prior authorization requirements on all MH/SUD services but not all medical services • 1 carrier's standards for submitting malpractice history during credentialing differs for	No Financial Penalties or Other Actions Taken

	Carriers not identified	MH/SUD facilities and med/surg facilities • 1 carrier imposed 7-day cap on the number of days for inpatient MH/SUD authorization, but no cap on inpatient medical services	
Third Market Conduct Survey Other Findings	Sept. 18, 2019 Carriers not identified.	• All carriers reported that non-network MH/SUD services are accessed more frequently than non-network med/surg services • Some carriers took longer to credential MH/SUD facilities than med/surg facilities • Carriers have not assessed "in operation" compliance; some carriers have no team to conduct compliance audits • Some carriers have no policies for conducting review of plan compliance and some have no documentation of reviews • Contracts with entities that manage MH/SUD benefits do not address Parity requirements.	

[i] Includes Aetna Health Inc., Aetna Life Insurance Co., Coventry Health Care of Delaware, Inc. and Coventry Health and Life, Insurance Co.

[ii] Includes Cigna Health and Life, Insurance Co. and Connecticut General Life Insurance Company.

[iii] Includes MAMSI Life and Health Insurance Company, Optimum Choice, Inc,. UnitedHealthcare Insurance Company, All Savers Insurance Company and UnitedHealthcare of the Mid-Atlantic, Inc.

[iv] Calvert, Charles, St. Mary's, Allegany, Garrett and Washington Counties had no in-network opioid treatment facilities.

[v] Calvert, Caroline, Charles, Kent, Dorchester, Queen Anne's, Somerset, St. Mary's, Wicomico, Worchester and Talbot Counties had no in-network non-hospital facilities for bi-polar disorder treatment.

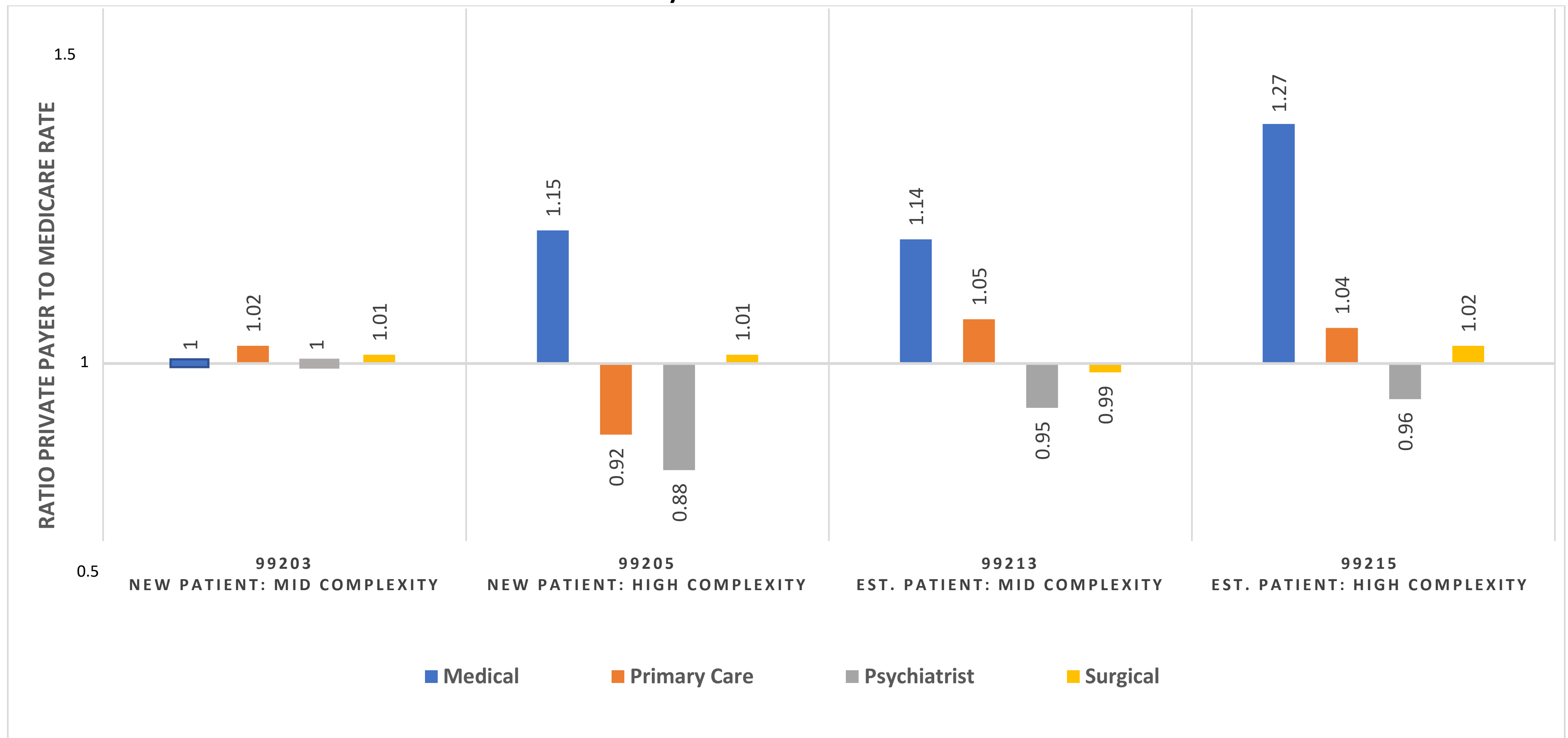
[vi] Garrett, Queen Anne's and Worchester Counties had no in-network opioid treatment providers.

[vii] Charles, Garrett, Kent, Queen Anne's, Somerset, Talbot and Worchester Counties had no in-network providers for bipolar-disorders.

ATTACHMENT 6

Evaluation & Management Services: 2017 All Maryland Reimbursement Rates Relative to Medicare Benchmarks by Private Payer and Four Physician Specialties[1]

The reimbursement rate for psychiatrists was ***less than or equal*** to the Medicare allowed amount for four outpatient Evaluation & Management Codes (E&M) that are billed by medical, primary care, surgical and psychiatry specialties. In contrast, the reimbursement rate for the three other physician specialties exceeded the Medicare benchmark for most E&M codes. The reimbursement rate for psychiatry was less than the 3 other medical specialties listed for all E&M codes.



[1] Kenneth Yeates-Trotman, Maryland Healthcare Commission, Maryland All-Payer Claims Database. Prepared in response to June 5, 2019 HGO Letter – House Bill 837 – Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists (Oct. 1, 2019). All Private Payers includes CareFirst, United Healthcare, Aetna, and Cigna.

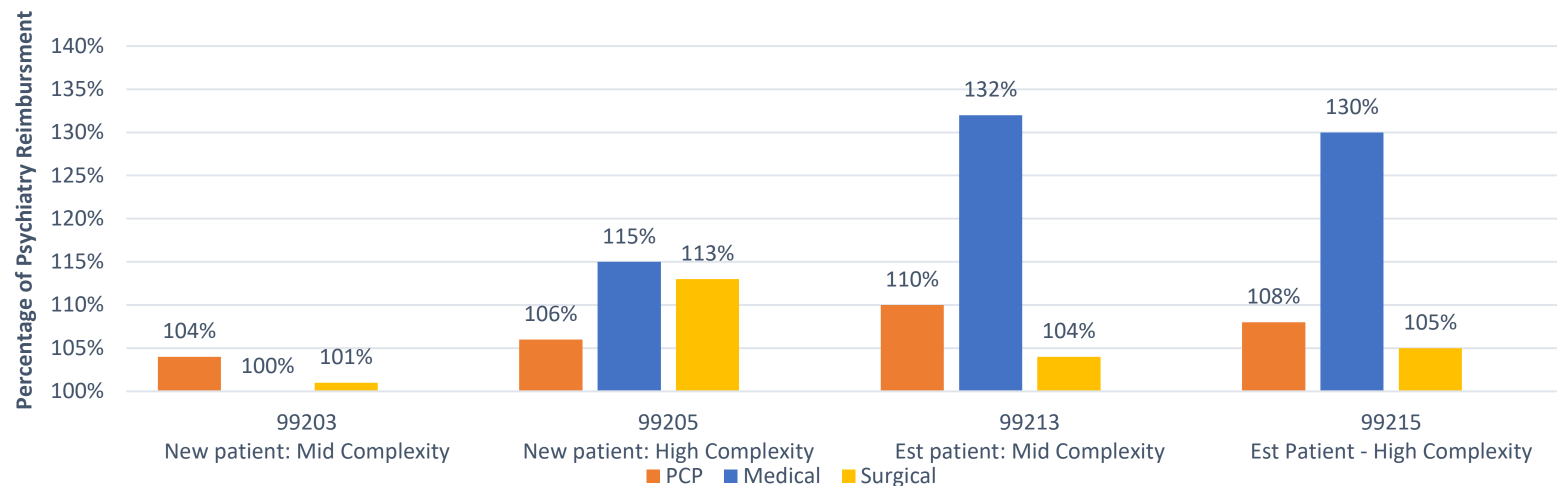
2017 All Maryland-All Private Payer Reimbursement Data for Common E&M Services

Comparing Private Payer Reimbursement for Four Physician Specialties

Psychiatrists were paid less, on average, than three other physician specialties (primary care, medical, and surgical) for the same Evaluation and Management Codes by Maryland's private carriers - CareFirst, United Healthcare, Aetna and Cigna - in 2017.

ALL OF MARYLAND - ALL PRIVATE PAYERS
(Reimbursement by Physician Specialty/As Percentage Relative to Psychiatry Reimbursement)

E&M Code	99203 New Patient: Mid Complexity		99205 New patient: High Complexity		99213 Est patient: Mid Complexity		99215 Est Patient: High Complexity	
PCP	$120.57	104%	$207.55	106%	$83.02	110%	$164.46	108%
Medical	$115.87	100%	$254.01	115%	$99.21	132%	$197.47	130%
Surgical	$117.46	101%	$223.11	113%	$78.22	104%	$159.45	105%
Psychiatrist	$115.78		$196.06		$75.19		$151.90	



MRHA_FAV_SB 484
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Position: FAV

Statement of Maryland Rural Health Association
To the Finance Committee
February 26, 2020
Senate Bill 484: Health Insurance – Provider Panels – Coverage for Nonparticipating Providers

POSITION: SUPPORT

Senator Klausmeier, Chair Kelley, Vice Chair Feldman, and members of the Finance Committee, the Maryland Rural Health Association (MRHA) is in SUPPORT of Senate Bill 484 – Health Insurance – Provider Panels – Coverage for Nonparticipating Providers.

This legislation would require each carrier to inform members and beneficiaries in a certain manner of the right to request a referral to a specialist or non-physician specialist who is not part of the carrier's provider panel; requiring, under certain circumstances, certain insurers, nonprofit health service plans, and health maintenance organizations to cover certain mental health or substance use disorder services provided to a member by a nonparticipating provider at a certain cost; etc.

MRHA's mission is to educate and advocate for the optimal health and wellness of rural communities and their residents. Membership is comprised of health departments, hospitals, community health centers, health professionals, and community members in rural Maryland.

Rural Maryland represents almost 80 percent of Maryland's land area and 25% of its population. Of Maryland's 24 counties, 18 are considered rural by the state, and with a population of over 1.6 million they differ greatly from the urban areas in the state.

Maryland law states that "many rural communities in the State face a host of difficult challenges relating to persistent unemployment, poverty, changing technological and economic conditions, an aging population and an out-migration of youth, inadequate access to quality housing, health care and other services, and deteriorating or inadequate transportation, communications, sanitations, and economic development infrastructure." (West's Annotated Code of Maryland, State Finance and Procurement § 2-207.8b)

The 2018 Maryland Rural Health Plan (www.MDRuralHealthPlan.org), an extensive assessment of Maryland's rural health needs, identified access to specialists and access to behavioral health services as a prevalent concerns in most rural counties. MRHA believes this legislation will give residents greater access to these important services needed by rural Marylanders.

MHRA believes this legislation is important to support our rural communities and we thank you for your consideration.

Lara Wilson, Executive Director, larawilson@mdruralhealth.org, 410-693-6988

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