LEGAL ACTION CENTER

Health Insurance – Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists – HB 1165
Health and Government Operations Committee Hearing
February 20, 2020
SUPPORT

Thank you for the opportunity to submit testimony **in support of HB 1165** 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.

HB 1165 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.**

HB 1165 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 HB 1165 – 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. 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 HB 1165, under a proposed amendment.

HB 1165 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.

HB 1165 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. HB 1165 will protect consumers as stakeholders work to build more robust networks.

Thank you for considering our views, and we urge a favorable report on HB 1165.

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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;

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(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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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

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[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-l 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

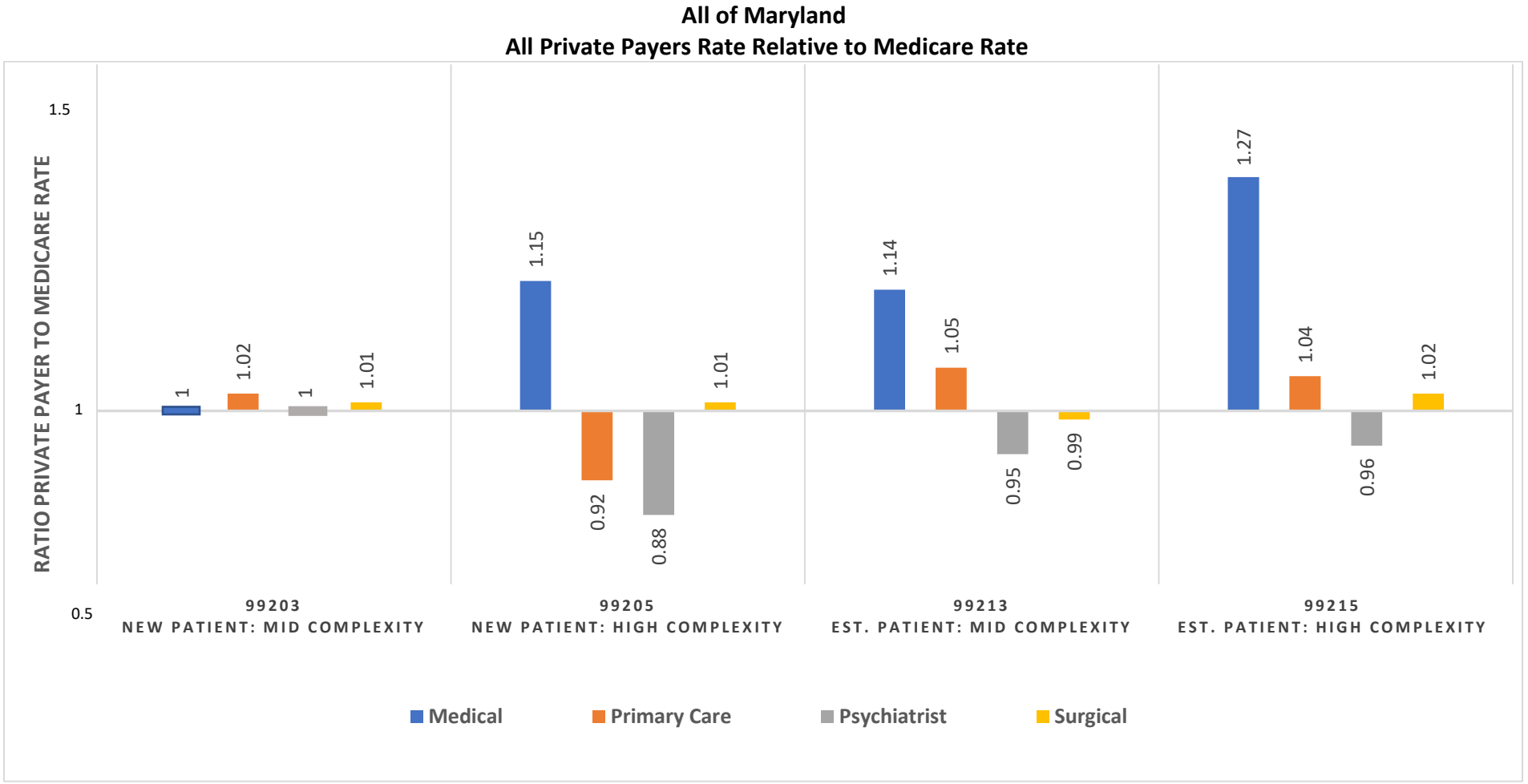
	Carriers not identified	MH/SUD facilities and med/surg facilities • 1 carrier imposed 7-day cap on the number of days for inpatient MH/SUD authorization, but no cap on inpatient medical services	
Third Market Conduct Survey Other Findings	Sept. 18, 2019 Carriers not identified.	• All carriers reported 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