LEGAL ACTION CENTER

Health Insurance –Provider Panels – Coverage for Nonparticipation – HB 912
Health and Government Operations Committee Hearing
February 17, 2022
SUPPORT

Thank you for the opportunity to submit testimony **in support of HB 912** which would expand access to affordable mental health and substance use disorder services and respond to the crisis Marylanders face in obtaining this life-saving care. This testimony is submitted on behalf of the Legal Action Center, a law and policy organization that fights discrimination, builds health equity and restores opportunities for individuals with substance use disorders, arrest and conviction records, and HIV or AIDs. In Maryland, the Legal Action Center convenes the Maryland Parity Coalition and works with its partners to ensure non-discriminatory access to mental health (MH) and substance use disorder (SUD) services through enforcement of the Mental Health Parity and Addiction Equity Act, robust network adequacy standards and enforcement, and consumer protections against high out-of-pocket costs when carrier networks are not adequate.

HB 912 responds to two issues: (1) abundant evidence that Marylanders cannot access network services for MH and SUD care as they experience **the greatest need ever for care;** and (2) unfair cost barriers to treatment for members who must obtain care from a non-network provider because of the carriers' inadequate networks and are subject to balance billing. Consumers have a right to use a non-participating provider when they cannot find an in-network provider and get approval from their carrier. **That right is meaningless if the consumer must pay extra out-of-pocket costs through no fault of their own.** Maryland law allows carriers to **shift the cost of MH and SUD services to members** who have no control over their plan networks but *cannot afford* to pay for non-network services. **As state regulators and other stakeholders take steps to improve provider networks, consumers must be held harmless from costs that carriers should bear when they do not provide mandated MH and SUD services through network providers.**

HB 912 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.

- Non-participating providers can rely on the use of a fair reimbursement rate formula, established by the Maryland Health Care Commission through a non-regulatory stakeholder process, so that they do not shoulder the burden of negotiating reimbursement for each patient's care and risk non-payment.

A. Consumer Protections Against Balance Billing Based on Inadequate Networks - NAIC Model Act and Seventeen (17) Other State Standards

The standard proposed in HB 912 – 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 Commissioners (NAIC)

Health Benefit Plan Network Access and Adequacy Model Act. **Seventeen (17) states** have enacted this standard and already protect consumers who are forced into this situation.

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 plan 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. 74-5 - 74-7) (emphasis added and section number omitted).

Seventeen (17) states – Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Minnesota, Mississippi, Montana, New Hampshire, New York, South Dakota, Tennessee, Vermont, and West Virginia – 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. Attachment 1. Our neighboring state of **Delaware** explicitly requires the carrier to cover non-network providers and **prohibits those providers from balance billing**. **West Virginia** law further requires carriers to specify and inform members of the process for accessing benefits from a nonparticipating provider.

The MIA has previously offered guidance to this Committee on the carrier obligation under a "no greater cost" standard, as proposed in HB 912. Attachment 2 (October 1, 2019 Letter from Commissioner Al Redmer to Delegate Shane E. Pendergrass). To lend certainty to the reimbursement rate for non-participating providers, **HB 912 would require the Maryland Health Care Commission to develop a reimbursement formula for single case agreements and payments to the provider in PPO plans.** This will ensure that providers can spend their time treating patients, not negotiating contracts, and that they will get paid fairly for their services. **Consumers will gain better access to the timely and affordable services they already pay for and are entitled to receive.**

B. Long-standing Evidence of Inadequate Carrier Networks for Substance Use Disorder and Mental Health Services Requires Immediate Action To Ensure Affordable Care.

Maryland's policy makers have long recognized the gaps in carrier networks for providers of MH and SUD services and have taken important – yet insufficient – steps to help rectify the problem. After six (6) long years and a **one-year unprecedented loss of 2,799 lives to overdose, with a disproportionate impact on Black individuals, and 650 lives lost to suicide – Marylanders can wait no longer for carriers to meet their legal obligations**.

1. Improving Network Inclusion of MH and SUD Providers

In 2016, in response to Maryland's escalating opioid overdose deaths, the Hogan Administration offered legislation – HB 800 – to address insufficient networks of substance use disorder (and other) providers. That bill failed, and subsequent efforts to improve tracking and inclusion of network MH and SUD providers have not resolved the significant network gaps.

- **In 2017**, the General Assembly enacted legislation calling for the development of **quantitative network adequacy metrics**. The MIA established strong metrics for appointment wait time, travel

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distance and provider to enrollee ratios for MH and SUD benefits and collected carrier data **that demonstrated in both 2018 and 2019** that carriers did not have sufficient SUD and MH providers to meet the needs of their members, based on appointment wait time metrics. (Attachment 3).

- **In early 2021, the MIA issued orders against 15 carriers for failure to meet network metrics in 2019 and imposed $990,000 in penalties against the carriers: a $40,000 to $100,000 penalty against each for violations of state law, including standards for mental health and substance use disorder providers.** Remarkably, the MIA suspended all penalties pending a review of the carriers' 2021 compliance reports.[1]

- **In 2021,** while more carriers reported that they had satisfied appointment wait time metrics for non-urgent MH and SUD services, **the MIA has not completed its review of the data for accuracy or completeness.** Several carriers continue to report non-compliance or incomplete data in 2021. (Attachment 3).

    - **Aetna plans** reported that their networks satisfied the 72-hour urgent care requirement for MH and SUD services for only 64% of members and satisfied the 10-day requirement for non-urgent MH and SUD services for only 72% of members.
    - **Kaiser Permanente** reported appointment wait time data for non-urgent MH and SUD services for **only 1 month** (April -May 2021). Kaiser Permanente Ins. Co. satisfied the non-urgent MH and SUD wait time metrics for only 80.4% of consumers.
    - For all other carriers, the lack of uniform reporting methodology and the lack of transparency raise significant questions about what is being measured.

- **From 2019 through mid-2021**, the MIA convened a stakeholder process to revise the network adequacy standards and, in response to the carriers' deficient networks for MH and SUD providers and continued questions related to access to care, issued a draft proposed regulation. If adopted, the new regulations would require (1) uniform reporting methodologies and templates for all metrics, (2) more frequent reporting of appointment wait time satisfaction, (3) separate reporting of appointment wait time compliance for MH services and SUD services, (4) more granular travel distance reporting for a range of MH and SUD provider types (including child psychiatrists, addiction physicians, outpatient SUD treatment facilities), and (5) mandatory disclosure of a carrier's effort to contract with providers if it failed to meet network metrics (based on the failure of most carriers to request a waiver of the metrics and explain their efforts when they did not meet the standards).

The MIA's draft proposed regulation would lend greater clarity to the underlying cause of inadequate networks for MH and SUD providers**. Yet pending the implementation of more robust standards and greater oversight, carriers – not consumers – should shoulder the cost of life-saving MH and SUD care when their networks are inadequate.**

2. Low Reimbursement Rates for MH and SUD Providers

[1] Aetna Health, Inc. (HMO), Case No. Not Listed (March 19, 2021) ($75,000 penalty); Aetna Health and Life Insurance, Case No. Not Listed (March 19, 2021) ($75,000 penalty); Aetna Life Ins. Co., Case No. Not Listed ($75,000 penalty); Kaiser Foundation Health Plan Mid-Atlantic States, Case No. Not Listed (March 23, 2021) ($50,000 penalty); Kaiser Permanente Ins. Co., Case No. Not Listed (April 15, 2021) ($100,000); Golden Rule Ins. Co., Case No. Not Listed (April 19, 2021) ($40,000 penalty); MAMSI Life and Health Ins. Co., Case No. Not Listed (April 19, 2021) ($40,000 penalty); Cigna Health and Life Ins. Co., Case No. Not Listed (April 6, 2021) ($100,000 penalty); Optimum Choice, Inc., Case No. Not Listed (April 19, 2021) ($40,000); UnitedHealthcare of Mid-Atlantic, Case No. Not Listed (April 19, 2021) ($40,000 penalty); UnitedHealthcare Ins. Co., Case No. Not Listed (April 22, 2021) ($40,000); Wellfleet Ins. Co., Case No. Not Listed (Nov. 8, 2021) ($40,000 penalty); CareFirst BlueChoice, Inc., Case No. Note Listed (May 21, 2021) ($75,000 penalty); CareFirst of Maryland, Case No. Not Listed (May 12, 2021) ($100,000); Group Hospitalization Medical Services, Case No. Not Listed (May 12, 2021) ($100,000 penalty).

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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 2019 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.** Attachment 4.
- Milliman, Inc. found that, in 2017, PPO plans reimbursed behavioral health providers in Maryland **18% less than medical providers**, relative to the Medicare rate, for comparable outpatient office visits. **Maryland was the 4th worst state in utilization of non-network services for outpatient MH and SUD 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 912 would address the impact of network gaps in the most limited way possible. It would apply to 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. Federal and State Law Protects Consumers Against Balance Billing for Emergency Department Services and Maryland Reimbursement Rate Standards Have Not Disrupted Carrier Networks

1. No Surprises Act Prohibits Balance Billing Even Without Carrier Approval on Non-Network Services

Enactment of the federal No Surprises Act by Congress and Maryland's twelve-year history of protections against surprise billing by emergency departments and on-call hospital practitioners should inform deliberation on HB 912.

First, federal law now protects consumers from balance billing – **without carrier permission** – when they receive services from a non-network provider of emergency services and non-emergency services from nonparticipating providers at specific facilities. **Consumers deserve that same protection when they do all they can to find a network provider and receive carrier permission to use a non-participating provider.** That right is meaningless if the consumer must pay extra out-of-pocket costs through no fault of their own.

The cost burden harm should not fall on consumers when, nationally, carriers spend a miniscule amount on MH and SUD services relative to their total healthcare spending. Milliman found that between 2013 and 2017:

- "Carrier spending for MH treatment (excluding prescription drugs), as a percentage of total healthcare spending, has been consistent, between **2.2% and 2.4%**."
- "Spending for SUD treatment (excluding prescription drugs), as a percentage of total healthcare spending, has increased from **0.7% in 2013 to 0.9%** in 2017."

Milliman, https://www.milliman.com/insight/Addiction-and-mental-health-vs-physical-health-Widening-disparities-in-network-use-and-p at 7.

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2. Maryland's Assignment of Benefits Standards Have Not Destabilized Networks

Second, 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.

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 overdose and suicide epidemics and the long-term heightened need for MH and SUD services resulting from the COVID-19 pandemic. These dual epidemics – COVID and drug overdose and mental health crises – have had a particularly harsh and disproportionate impact on communities of color. Meeting state and federal obligations to provide network coverage for MH and SUD benefits is essential as state policymakers pursue multiple strategies to ensure access to care and more robust networks.

Thank you for considering our views, and we urge a favorable report on HB 912.

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ATTACHMENT 1

Balance Billing Protections
Fifty State Survey

As of January 2022, seventeen (17) states protect plan members from balance billing for non-network services if a health plan does not have an adequate provider network. These provisions apply to non-health maintenance organization (HMO) plans.

State	Citation	Language
Arkansas	Ark. Admin. Code 054.00.106-5 (C) (2014)	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**.
California	Cal Health & Saf. Code § 1374.72(d) (2021).	If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. **The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.**
Colorado	Colo. Rev. Stat. Ann. 10-16-704(2)(a) (2020).	In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and **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.**
Connecticut	Conn. Agencies Regs. § 38a-472f-3(a) (2018).	Each health carrier that delivers, issues for delivery, renews, amends or continues any individual or group health insurance policy or certificate in this state that uses a provider network shall: (6) Have an adequate process in place **to provide in-network levels of coverage from nonparticipating providers, without unreasonable travel or delay or unreasonable wait time for an appointment, when a participating provider is not available.**
Delaware	Del. Code Ann. tit. 18, § 3348(b) (2001).	All individual and group health insurance policies shall provide that if medically necessary covered services are not available through network providers, or the network providers are not available within

	18 DE ADC 1403-11.3.1.2	a reasonable period of time, the insurer, **on the request of a network provider, within a reasonable period, shall allow referral to a non-network physician or provider and shall reimburse the non-network physician or provider at a previously agreed-upon or negotiated rate. In such circumstances, the non-network physician or provider may not balance bill the insured.** Such a referral shall not be refused by the insurer absent a decision by a physician in the same or a similar specialty as the physician to whom a referral is sought that the referral is not reasonably related to the provision of medically necessary services. If a plan has an insufficient number of providers that are geographically accessible and available within a reasonable period of time to provide covered health services to enrollees, **the MCO shall cover non-network providers, and shall prohibit balance billing.**
Hawaii	Haw. Rev. Stat. § 431:26-103(c)(1) (2019). Note: Health carriers also have an obligation to specify and inform covered persons of the process by which they may request access to obtain a covered benefit from a nonparticipating provider under subsection (1). Haw. Rev. Stat. § 431:26-103(c)(2).	A health carrier shall have a process to ensure 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 nonparticipating provider,** or shall make other arrangements acceptable to the commissioner when: (A) The health carrier has a sufficient network but does not have a type of participating provider available to provide the covered benefit to the covered person or does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or (B) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.
Illinois	215 Ill. Comp. Stat. § 124/10(b)(6) (2017).	A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, or unreasonable travel distance or delay, the insurer shall ensure, directly or indirectly, by terms contained in the payer contract, **that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider.**
Maine	02-031-850 Me. Code R. § 7(B)(5) (2012).	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.

Minnesota	Minn. Stat. § 62Q.58(4)(b) (2001).	If an enrollee receives services from a nonparticipating specialist because a participating specialist is not available, **services must be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received from a participating specialist.**
Mississippi	Miss. Admin. Code 19-3:14.05(1) (2011).	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.
Montana	Mont. Code Ann. § 33-36-201(2) (2003).	Whenever 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 covered benefit were obtained from participating providers** or shall make other arrangements acceptable to the department.
New Hampshire	N.H. Code R. Ins 2701.10(b) (2018).	Each health carrier shall ensure that covered persons may obtain a referral to a health care provider outside of the health carrier's network when the health carrier does not have a health care provider with appropriate training and experience within its network who can meet the particular health care needs of the covered person. Services provided by out-of-network providers shall be subject to the utilization review procedures used by the health carrier. **The covered person shall not be responsible for any additional costs incurred by the health carrier under this paragraph other than any applicable co-payment, coinsurance, or deductible**.
New York	N.Y. Ins. Law § 4804(a).	If an insurer offering a managed care product determines that it does not have a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, the insurer shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the insurer in consultation with the primary care provider, the non-participating provider and the insured or the insured's designee, **at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network.**
South Dakota	S.D. Codified Laws § 58-17F-6 (2011).	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.

Tennessee	Tenn. Code Ann. § 56-7-2356(c) (1998).	In any case where the managed health insurance issuer has no participating providers to provide a covered benefit, the managed health insurance **issuer shall arrange for a referral to a provider with the necessary expertise and 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 network provider**.
Vermont	Vt. Code R. § H-2009-03(5.1)(K)(3) (2017).	Coverage required pursuant to this subsection shall be without any additional liability to the member whether the service is provided by a contracted or non-contracted provider. **The member shall not be responsible for any additional costs incurred by the managed care organization under the paragraph other than any copayment, coinsurance or deductible applicable to the level of coverage required by this subsection.**
West Virginia	W. Va. Code § 33-55-3(c)(1). Note: Health carriers also have an obligation to specify and inform covered persons of the process by which they may request access to obtain a covered benefit from a nonparticipating provider under subsection (1). W. Va. Code § 33-55-3(c)(2).	A health carrier shall have a process to 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 nonparticipating provider, or make other arrangements acceptable to the commissioner when**: (A) The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person, or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or (B) The health carrier has an insufficient number or type of participating providers available to provide the covered benefit to the covered person without unreasonable travel or delay.

Please contact Ellen Weber (eweber@lac.org) or Deb Steinberg (dsteinberg@lac.org) with questions.

ATTACHMENT 2

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October 1, 2019

Delegate Shane E. Pendergrass
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House Office Building, Room 241
6 Bladen Street
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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 Satisfaction for Non-Urgent MH/SUD Services 2018-2021

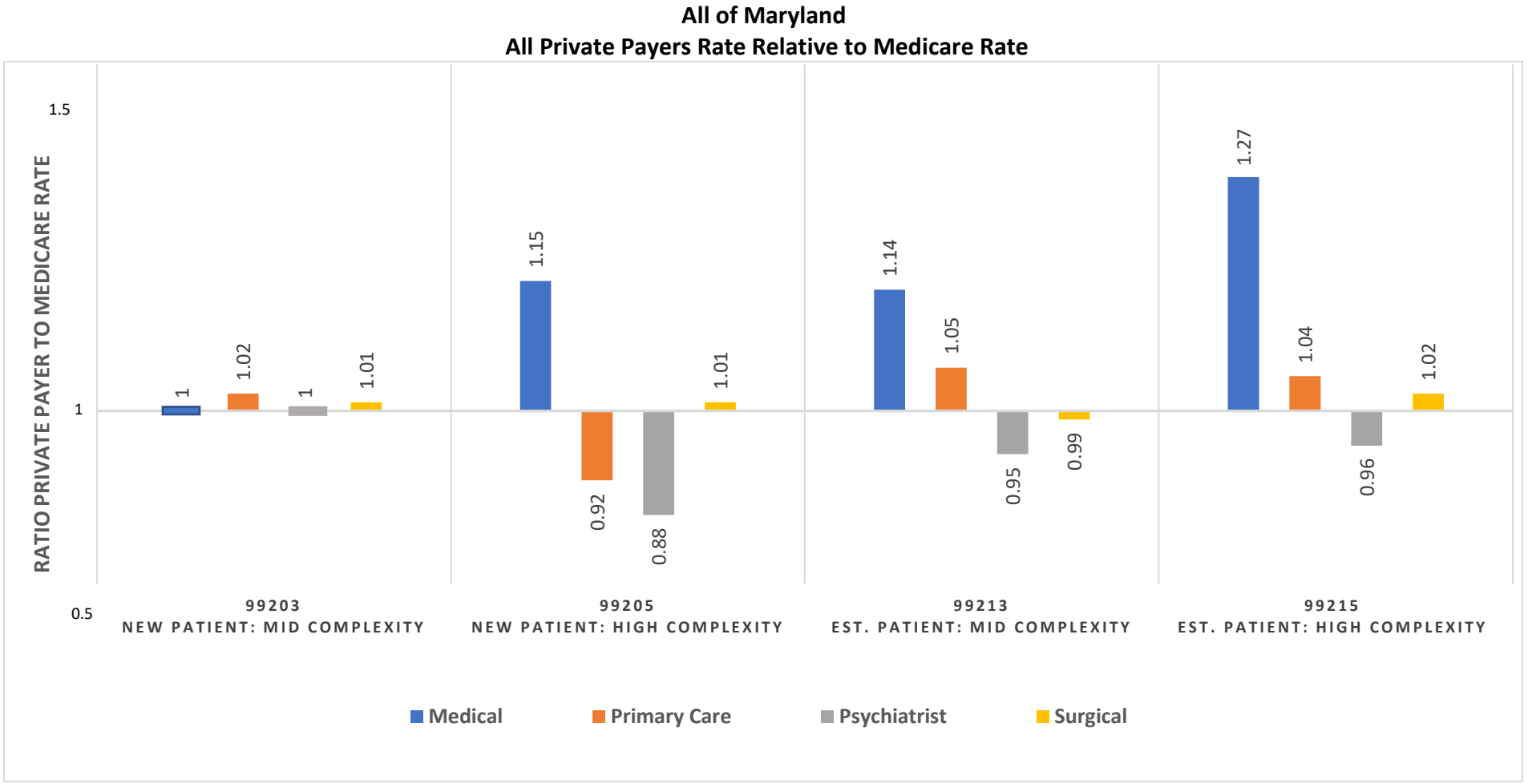
Carrier	2018 Report	2019 Report	2021 Report
Aetna Health Ins.	82% (in 14 days)	89%	72%
Aetna Life Ins. Co.	82% (in 14 days)	89%	72%
Aetna Health & Life Ins.	NA	NA	72%
CareFirst	95%	57.5%	98.1% PPO and HMO
CareFirst BlueChoice	95%	57.5%	98.1%
CareFirst GHMS	95%	57.5%	98.1% PPO and HMO
Cigna Life and Health Ins. Co.	Missing data	76%	100% (POS, OAP, PPO)
Connecticut Gen. Life Ins. Co.	Missing data	76%	NA
Golden Rule Ins. Co.	72%	96%	100%
Kaiser Found. Health Plan of Mid-Atlantic States	89.3%	84.3%	Not complete – 1 month count only
Kaiser Permanente Ins. Co.	Missing data	28%	80.48%
MAMSI Life and Health Ins. Co.	72%	96%	100%
Optimum Choice Inc.	72%	96%	100%
Optimum Choice Inc. Individual Exchange	NA	NA	100%
United Healthcare Ins. Co. Choice Plus	72%	96%	100%
United Healthcare Ins. Co. (CORE)	NA	96%	100%
United Healthcare of the MidAtlantic Inc. (CORE)	72%	96%	100%

United Healthcare of the MidAtlantic Inc. (Choice)	72%	96%	100%
United Healthcare of the MidAtlantic Inc. (Navigate)	NA	NA	100%
United Healthcare Navigate	NA	NA	100%
United Healthcare Nexus ACO	NA	NA	100%
United Healthcare Options PPO	NA	NA	100%
Wellfleet Insurance Co.	NA	NA	100% (PPO and OAP)

ATTACHMENT 4

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.