2024 MCA SB 487 Support.pdf
Uploaded by: Ashlie Bagwell
Position: FAV

MARYLAND
CHIROPRACTIC
ASSOCIATION

Testimony on behalf of the Maryland Chiropractic Association
Senate Bill 487--Health Maintenance Organizations - Payments to Nonparticipating Providers - Reimbursement Rate
Support
February 7, 2024
Senate Finance Committee

The Maryland Chiropractic Association (MCA) is a professional organization founded in 1928 and is the leading voice for chiropractors in Maryland. Comprised of individual members, our mission is to elevate the chiropractic profession by educating the public and advancing chiropractic care for the citizens of Maryland. We have weighed in on many issues concerning patient care, insurance and other issues of importance to our members as well as our patients and the general public.

The Maryland Chiropractic Association supports SB 487. Doctors of Chiropractic are proud to serve the citizens of Maryland as participating as well as non-participating providers of Health Maintenance Organizations (HMO). Indexing the non-participating reimbursement rate to inflation is sound fiscal policy and will have a positive effect on access to care for those in need of chiropractic services.

We appreciate the opportunity to provide written comments on this bill and appreciate Senator Lam's leadership on this issue.

2024 Testimony - Favorable - Senate Bill 487.pdf
Uploaded by: Barbara Brocato
Position: FAV

BROCATO & SHATTUCK

Date: Wednesday, February 7, 2024
Committee: Senate Finance Committee
The Honorable Pam Beidle, Chair
Bill: Senate Bill 487 - Health Maintenance Organizations - Payments to Nonparticipating Providers - Reimbursement Rate
Position: **Favorable**

On behalf of our clients: The Maryland Society of Anesthesiologists (MSA) and US Acute Care Solutions (USACS)we support this important legislation.

Senate Bill 487 "alters the reimbursement rate that a health maintenance organization (HMO) must pay a nonparticipating provider. Specifically, if an HMO pays a nonparticipating provider 125% of the average rate the HMO paid, reimbursement must be based on the rate paid as of January 31, 2019, indexed for inflation as specified."

Background:
Maryland has an extensive history and track record of success in addressing nonparticipating physician payment in both the HMO and PPO markets. The methodologies in statute strive to ensure fair and transparent payment for providers and balance billing protection for consumers/insured individuals.

Maryland most recently resolved its PPO surprise billing problem in 2010 by requiring insurers to reimburse hospital-based physicians who accept assignment of benefits (i.e., agree not to balance bill their patients) in accordance with a statutory formula. Hospital-based physicians accepting assignment of benefits would be reimbursed the greater of 140% of the average rate the insurer paid to contracting hospital-based physicians or the final amount the insurer paid to that hospital-based physician as of January 1, 2010 adjusted for inflation. **Maryland's benchmark includes a floor in order to be sure insurers enter contract negotiations with hospital-based physicians in good faith and not simply to lower the benchmark rate year over year.**

Positive Impact:
Maryland's AOB law has provided patient protection for almost 10 years, has been impartially reviewed[1] and determined to be widely successful. It has eliminated patient complaints of surprise billing, doubled network participation by physicians overall and tripled participation in rural areas. The law is a time tested, evidence based, sound method to protect patients without disrupting existing safety nets and long-standing balances between safety and access to care.

The success of the Maryland law has been due to the balanced incentives for physicians and insurers to come together to negotiate and be in-network. This success has been supported by data reviewed by the Maryland Health Care Commission (MHCC), showing a consistent decreased volume of out of network payments since the law's implementation in 2010. In fact, the MHCC's review of data in Maryland's All Payer Claims Database (APCD) shows that the overall proportion of health care users with out-of-network services has steeply declined: From 20.9% in 2010 to 9.4% in 2013 to 3.6% in 2017.

[1] FINAL REPORT - Impact of the Assignment of Benefits Legislation - January 15, 2015; Prepared for: The Maryland Health Care Commission; Prepared by: Social & Scientific Systems, Inc.

What Senate Bill 487 does:
Maryland's PPO law has the date certain of January 1, 2010 in order to be sure insurers enter contract negotiations with hospital-based physicians in good faith and not simply to lower the benchmark rate year over year. **However, Maryland HMO law does not provide a date certain in the calculation methodology for out of network rates.**

This legislation aligns the HMO law with the PPO law by adding a date certain in the HMO law from which the insurer must base calculations for out of network payment to providers. Current law references 125% of the average contractual rate the health maintenance organization paid as of **"***January 1 of the previous calendar year***". House Bill 570** changes this to … "125% of the average contractual rate the health maintenance organization paid as of **JANUARY 31, 2019… INFLATED BY THE CHANGE IN THE MEDICARE ECONOMIC INDEX FROM 2019 TO THE CURRENT YEAR."**

This date reflects what is established in the Federal No Suprises Act to serve as a date certain from which insurers must utilize in determining out of network rates. The date certain provides an important baseline from which insurers must base their non-par reimbursement calculations. Aligning the HMO and AOB laws through the utilization of a date certain that coincides with the Federal No Surprises Act is an important step to take.

For these reasons we ask for a **Favorable report on Senate Bill 487**.

For more information:
Barbara Brocato – barbara@bmbassoc.com
Dan Shattuck – dans@bmbassoc.com

Legal Action Center Testimony SB487 _FAV_HMO_Payme
Uploaded by: Ellen Weber
Position: FAV

LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

Health Maintenance Organizations – Payments to Nonparticipating Providers Reimbursement Rate (SB 487)
Finance Committee
February 7, 2024
FAVORABLE

Thank you for the opportunity to submit testimony in favor of SB 487, which would adjust the reimbursement rate benchmark that health maintenance organizations (HMOs) use in reimbursing nonparticipating providers. This testimony is submitted by the Legal Action Center, a law and policy organization that has worked for 50 years to fight discrimination, build health equity and restore opportunities for individuals with substance use disorders, arrest and conviction records, and HIV or AIDs. In Maryland, we convene the Maryland Parity Coalition and work with our partners to ensure non-discriminatory access to mental health and substance use disorder services through enforcement of the federal Mental Health Parity and Addiction Equity Act (Parity Act) in both public and private insurance. We have worked to improve Maryland's network adequacy standards so that individuals with mental health and substance use disorders have access to network providers and do not pay high out-of-pocket costs for out-of-network services because of inadequate carrier networks.

We support SB 487 to ensure that Marylanders with mental health (MH) and substance use disorders (SUD) have equal access to treatment through their HMO plans. Reimbursement rates determine whether providers participate in an HMO's network. Under Maryland's existing standards, HMOs can limit reimbursement rates for in-network providers as well as nonparticipating providers because the benchmark for reimbursement of a nonparticipating provider is the average rate paid by the HMO as of January 1 of the previous calendar. Under this payment structure, HMOs are effectively incentivized to keep the participating provider rates low or reduce rates from year to year, which forces providers to leave the network while allowing the HMOs to still control their costs for nonparticipating providers. **Most important, HMOs have no incentive to create a sufficient provider network because their cost for nonparticipating providers is also capped at a low rate.**

The existing reimbursement standard harms Marylanders who cannot find an in-network provider with the skill to treat their condition in a timely manner and within a reasonable distance. **This inequity harms Marylanders with MH and SUDs to a far greater degree than individuals with other medical conditions because they access treatment through out-of-network (OON) providers at a disproportionately higher rate.** A Milliman study found that, as of 2017, Marylanders with PPO plans utilized OON providers for MH and SUD outpatient office visits at 10 times the rate that they accessed OON primary or specialty care providers for medical/surgical services. There is nothing to suggest that HMOs are any different. More recently, a national survey conducted by NORC found that:

- Nationwide, 43% of patients with individual private insurance reported using at least one OON MH or SUD provider compared to 19% for physical health providers.
- Of those patients, 47% reported that they went to an OON MH or SUD provider "all of the time" compared to 9% for physical health care.
- In Maryland, for all insurance types combined, 33% of patients reported seeing at least one

OON MH or SUD provider compared to 12% for physical health providers and, of those, 70% reported seeing an OON MH or SUD provider "all of the time" compared to 5% for physical health care.[1]

The ability to get a carrier's approval to obtain services from an OON provider is labor intensive and stressful, particularly when seeking care for a MH or SUD. It first requires the individual or family member to contact multiple practitioners that the carrier claims to be in network and appropriate to treat the patient's condition. Frequently, the patient finds no one who has the skill required to treat the patient's condition, is in network and/or taking new patients within the wait time established in state law. After exhausting the carrier's list, the patient must then find an OON provider who will accept the HMOs reimbursement rate, as established by state law. While the HMO is obligated to deliver covered benefits through a nonparticipating provider, plan members have difficulty identifying ***any provider*** who is willing and able to deliver services at the HMO's low, non-negotiable reimbursement rate. As a result, Marylanders with HMOs may be forced to forego MH or SUD treatment or pay for their care entirely out-of-pocket.

Establishing a benchmark that is tied to the HMO's reimbursement rate as of January 31, 2019 and inflated by the change in the Medicare Economic Index will provide greater certainty to the OON rate and establish a fairer rate. Conforming Maryland's HMO nonparticipating provider reimbursement rate to the benchmark date set out in the federal No Suprises Act will also ensure greater consistency across state and federal standards.

Thank you for considering our views. We urge the Committee to issue a favorable report on SB 487.

Ellen M. Weber, J.D.
Sr. Vice President for Health Initiatives
Legal Action Center
eweber@lac.org

[1] Equitable Access to Mental Health and Substance Use Care: An Urgent Need, Maryland Data (Aug. 2023). Maryland data on file with Legal Action Center.

2024 MCHS SB 487 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill: **Senate Bill 487 – Health Maintenance Organizations - Payments to Nonparticipating Providers - Reimbursement Rate**

Hearing Date: **February 7, 2024**

Position: **Support**

The Maryland Community Health System (MCHS) supports Senate Bill 487 – Health Maintenance Organizations - Payments to Nonparticipating Providers - Reimbursement Rate. Maryland Community Health System is a network of federally qualified health centers (FQHC) across the state whose mission is to provide care to underserved communities. MCHS supports legislative initiatives that remove barriers to access to care.

The bill requires health maintenance organizations to reimburse nonparticipating providers a reimbursement rate that takes into consideration the Medicare Economic Index from 2019 to the current year. FQHCs are committed to providing accessible and affordable healthcare services to underserved populations. By ensuring that nonparticipating providers are reimbursed at a fair rate, FQHCs can promote greater access to care for patients who are unable to access participating providers. Taking into account the Medicare Economic Index ensures that reimbursement rates are updated to reflect changes in the cost of providing healthcare services over time. A change like this helps FQHCs cover their costs and maintain sustainability, ultimately allowing them to continue serving their communities effectively.

We ask for a favorable report on Senate Bill 487. If we can provide any further information, please contact Michael Paddy mpaddy@policypartners.net.

2024 MOTA SB 487 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

Maryland Occupational Therapy Association

PO Box 36401, Towson, Maryland 21286 ♦ mota-members.com

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 487**

Title: **Health Maintenance Organizations - Payments to Nonparticipating Providers - Reimbursement Rate**

Hearing Date: **February 7, 2024**

Position: **Support**

The Maryland Occupational Therapy Association (MOTA) supports Senate Bill 487 – *Health Maintenance Organizations - Payments to Nonparticipating Providers - Reimbursement Rate*. The bill requires health maintenance organizations (HMOs) to reimburse nonparticipating providers a reimbursement rate that takes into consideration the Medicare Economic Index from 2019 to the current year.

Occupational therapists understand the importance of accessible and comprehensive care for patients. When HMOs fail to adequately reimburse out-of-network providers, it limits the options available to patients and can hinder their ability to receive the necessary treatment. By increasing the reimbursement rate, occupational therapists believe that more providers will be willing to work with HMOs, leading to better access to care and improved outcomes for patients. Additionally, a fairer reimbursement rate would also incentivize providers to join HMO networks, strengthening the overall healthcare system. Overall, occupational therapists support the change in reimbursement policies to ensure that patients receive the best possible care.

We ask for a favorable report. If we can provide any further information, please contact Michael Paddy at mpaddy@policypartners.net.

SB 487_Nonpar Reimbursement_Oppose.pdf
Uploaded by: Allison Taylor
Position: UNF

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

February 7, 2023

The Honorable Pamela Beidle
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 487 – Oppose

Dear Chair Beidle and Members of the Committee:

Kaiser Permanente respectfully opposes SB 487, "Health Maintenance Organizations - Payments to Nonparticipating Providers - Reimbursement Rate."

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for over 825,000 members. In Maryland, we deliver care to approximately 475,000 members.

As a group-model health maintenance organization (HMO), KP closely coordinates primary, secondary, and hospital care; places a strong emphasis on prevention; and extensively uses care pathways and electronic medical records. Compared with more than 1,000 health plans nationwide, Kaiser Permanente's Mid-Atlantic region is one of only two commercial health plans to receive 5 out of 5 stars from the 2023 National Committee for Quality Assurance's (NCQA) Health Plan Ratings annual report. Kaiser Permanente is renowned for the tight integration of its clinical services, meaning that it is selective about which health providers it contracts with in order to provide the highest quality affordable health coverage for its members.

Current law requires that an HMO pay a nonparticipating provider the greater of two rates for an evaluation and management service: 1) either 140% of the rate paid by Medicare, or 2) 125% of the average rate from January 1 of the previous year. SB 487 proposes to amend the latter alternative, to tie the reimbursement rate to 125% of the average rate paid as of January 31, 2019, inflated by the change in the Medicare Economic Index from 2019 to the current year.

This law would substantially increase the rates nonparticipating emergency service providers could charge HMOs, with no corresponding benefit to consumers. The No Surprises Act, which

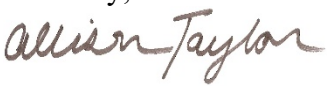
[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

took effect in 2022, prohibits a provider from billing a patient more than their in-network cost-sharing for emergency services, even if the provider is out-of-network. Consequently, average provider rates are lower now because they no longer include amounts that patients received as balance/surprise bills.

By tying the reimbursement rate to 2019, i.e., before the No Surprises Act, this bill would allow nonparticipating providers to bill HMOs for the amount they would have previously billed patients. Consequently, it provides a disincentive for provider groups to join HMO networks, and patients will experience these increased costs in the form of higher premiums. As a result, this legislation is at odds with the objective of the No Suprises Act to protect patients from the high costs of out-of-network emergency care. It is also at odds with the objective of Kaiser Permanente to provide the highest quality care at the lowest cost.

Kaiser Permanente respectfully requests an unfavorable report for SB 487. Thank you for the opportunity to comment. Please feel free to contact me at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,



Allison Taylor
Director of Government Relations
Kaiser Permanente

SB 487_MDCC_Health Maintenance Organizations - Pay
Uploaded by: Andrew Griffin
Position: UNF

MARYLAND
Chamber of Commerce

LEGISLATIVE POSITION:
Unfavorable
Health Maintenance Organizations - Payments to Nonparticipating Providers - Reimbursement Rate
Senate Bill 487
Finance Committee
Wednesday, February 7, 2024

Dear Chairwoman Beidle and Members of the Committee:

Founded in 1968, the Maryland Chamber of Commerce (Maryland Chamber) is the leading voice for business in Maryland. We are a statewide coalition of more than 6,800 members and federated partners working to develop and promote strong public policy that ensures sustained economic recovery and growth for Maryland businesses, employees, and families.

Senate Bill 487 would amend the reimbursement rate at which health maintenance organizations are required to pay nonparticipating health care providers for services.

Under current statute, HMOs must compensate nonparticipating providers for evaluation and management services at either 140% of the Medicare rate or 125% of the previous year's average rate. SB 487 would tie the reimbursement rate 125% of the average rate paid as of January 31, 2019, adjusted by the Medicare Economic Index change from 2019 to the current year.

There is already a formula for what an HMO must pay out of network, and patients are protected under federal law from unexpected costs of emergency services. The federal No Surprises Act of 2022 prevents providers from charging patients more than their in-network cost-sharing for emergency services, even if the provider is out-of-network. This means that a provider cannot 'balance bill' out of network members who receive emergency services, protecting patients from receiving a large or surprise bill. This reduces the rate at which providers can charge for their services. SB 487 would substantially raise the rates nonparticipating emergency service providers could bill HMOs, without offering any corresponding benefits to consumers.

SB 487 would lead to increased health care costs to employers and their employees without any increase in the quality of health care services. Employers could also see impacts in employee satisfaction and retention if healthcare costs rise significantly.

We urge the committee to consider that implications this legislation could have on consumers. Additionally, there is concern that this is a workaround to the existing federal law.

For these reasons, the Maryland Chamber of Commerce respectfully requests an **unfavorable report** on SB 487.