LEGAL ACTION CENTER
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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.

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[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.