SB902 - Health Insurance - Access to Nonparticipat

Uploaded by: Abigail Snyder

Position: FAV

BALTIMORE JEWISH COUNCIL

Written Testimony
Senate Bill 902 - Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage
Finance Committee – February 26, 2025
Support

Background: Senate Bill 902 would repeal the June 30, 2025 termination date for certain provisions of law related to referrals to and reimbursement of specialists and nonphysician specialists who are not part of a carrier's provider panel; and require that a certain referral procedure required to be established and implemented by certain carriers require the carrier to provide certain assistance to a member in identifying and arranging coverage for a specialist or nonphysician specialist for treatment of mental health or substance use disorder services.

Written Comments: The Baltimore Jewish Council represents The Associated: Jewish Federation of Baltimore and all of its agencies. This includes Jewish Community Services (JCS), which offers programs and services for people of all ages and backgrounds, helping them achieve their goals, enhance their wellbeing, and maximize their independence. JCS currently provides therapy and medication management to a large population of clients with both commercial and public insurance.

It is imperative to repeal the sunset on the termination date for referrals to and reimbursement of specialists and nonphysician specialists who are not part of a carrier's in-network provider system for certain medically necessary behavioral health services. For some, receiving this care can be a matter of life and death. As we endeavor to treat mental and behavioral health with the same seriousness as physical health within our society, this is an important step in that direction.

For these reasons, the Baltimore Jewish Councils asks for a favorable report on SB902.

The Baltimore Jewish Council, a coalition of central Maryland Jewish organizations and congregations, advocates at all levels of government, on a variety of social welfare, economic and religious concerns, to protect and promote the interests of The Associated Jewish Community Federation of Baltimore, its agencies and the Greater Baltimore Jewish community.

BALTIMORE JEWISH COUNCIL
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Member of the Jewish Council for Public Affairs

SB 902.pdf
Uploaded by: Ashley Clark
Position: FAV

MARYLAND PSYCHIATRIC SOCIETY

February 11, 2025

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

RE: Support – SB 902: Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage

Dear Chairwoman Beidle and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1100 psychiatrists and physicians currently in psychiatric training.

In 2022, the Maryland General Assembly passed a law to protect Marylanders with private health insurance from having to pay higher costs when their insurance network is inadequate to meet their needs for mental health (MH) and substance use disorder (SUD) care and they are forced to go out-of-network. However, these balance billing protections are set to expire in July 2025. Our state is still facing an overdose epidemic and MH crisis, and we need to prevent health insurers from going back to shifting costs to Marylanders when they have inadequate networks, and close existing gaps in the law.

We are also in full support of the Maryland State Medical Society's (MedChi) proposed amendment to remove Maryland Health Care Administration's authority to set rates, as we agree that rate-setting may result in lower reimbursement for medical subspecialties. The unmet need for MH and SUD care in Maryland is high and continues to rise. In 2023, more than 27% of Maryland adults reported symptoms of anxiety and/or depression, and over 30% of adults had an unmet need for counseling or therapy for these conditions. Of the 252,000 Maryland adults who did not receive MH care, 1 in 3 did not because of cost. Requiring insurers to pay for approved out-of-network services at "no greater cost" to members than the in-network rate will protect Marylanders. At least 17 states have laws that comparable balance billing protections for when insurance networks are inadequate. The federal No Surprises Act protects Marylanders from higher costs when they unknowingly receive emergency services from out-of-network providers. Marylanders who get permission to go out-of-network because their insurer's network is inadequate deserve no less.

Marylanders should not pay more for mandated MH and SUD services when insurers do not have adequate networks. Maryland ranks among the worst in the country for how much more frequently Marylanders go out-of-network for MH and SUD care compared to medical care. Maryland insurers' 2024 Access Plans revealed inadequate networks for many SUD services in one or more geographic areas, despite maintaining adequate networks for virtually all medical/surgical services.

The Balance Billing Reauthorization bill (SB 902) would:
- Remove the sunset to permanently authorize balance billing protections;
- Enable people seeking MH and SUD care to get a referral to go out-of-network, not just those who already have a diagnosis;
- Align the balance billing protections with Maryland's regulatory time and distance standards, to help consumers better understand and take advantage of their rights;
- Require health insurers to provide assistance when individuals cannot find an out-of-network provider on their own;
- Prohibit the use of prior authorization as an additional barrier to getting out-of-network care;
- Ensure balance billing protections for the full duration of the treatment plan requested; and

In summary, SB 902 will reauthorize and strengthen Maryland's balance billing protections, ensuring individuals with mental health and substance use disorders pay no greater cost when their private insurance networks are inadequate. As such, MPS and WPS ask the committee for a favorable report on SB 902. If you have any questions regarding this testimony, please contact Lisa Harris Jones at lisa.jones@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society Legislative Action Committee

MCF_FAV_SB 902.pdf
Uploaded by: Ashley Tauler
Position: FAV

Senate Finance Committee

SB 902 – ACCESS TO NONPARTICIPATING PROVIDERS-REFERRALS, ADDITIONAL ASSISTANCE, AND COVERAGE

Date: February 26, 2025

Position: FAV

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) is a statewide nonprofit organization that provides family peer support services at no cost to families who have a loved one with a mental health, substance use, or problem gambling disorder. Using their personal experience as parents, caregivers and other loved ones, our staff provide emotional support, resource connection and systems navigation as well as support groups and educational trainings and workshops.

Last year, we served nearly 5,000 families, and 73% were families with children.

Insurance barriers continue to be an issue for families. Many have spent countless hours making phone calls to providers to access behavioral health treatment for their loved ones, only to be met with long waitlists and obstacles with their insurance carriers. We have seen a gap in services and unmet needs in the behavioral health space due partly to the barriers these families face regarding insurance.

This bill will require health insurers to provide much-needed assistance for families when they cannot find an out-of-network provider independently. It will also ensure balance billing protections for when families receive out-of-network care. SB 902 will dismantle additional steps to getting out-of-network care by prohibiting the use of prior authorization, which delays treatment. Delays in treatment can increase the likelihood of a patient going into a crisis state.

Accessing mental health and substance use services adequately and with fewer barriers will lead to better outcomes for families and children when their needs are met sooner rather than later.

Ashley Tauler
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Children's National Testimony - SB 902 - Laura Wil
Uploaded by: Austin Morris
Position: FAV

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Testimony of Laura Willing, MD, MEd, DFAACAP
Co-Director, Child and Adolescent Anxiety Program
Associate Program Director, Child and Adolescent Psychiatry Fellowship
Medical Director for Mental Health Policy and Advocacy, Community Mental Health CORE
Assistant Professor, Department of Psychiatry & Behavioral Sciences
Children's National Hospital

SB 902: Health Insurance – Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage
Position: FAVORABLE
February 26, 2025
Senate Finance Committee

Chair Beidle, Vice Chair Hayes and members of the committee, thank you for the opportunity to provide testimony in favor of Senate Bill 902. My name is Dr. Laura Willing, and I am a psychiatrist at Children's National Hospital. I am also the Medical Director for Mental Health Policy and Advocacy in our Community Mental Health CORE. The Community Mental Health CORE aims to improve access to and utilization of high-quality behavioral health services for children and families, advance racial and health equity, and promote sustainability and system-level change through research, policy, advocacy, and community engagement.[1] Children's National has been serving the nation's children since 1870. Nearly 60% of our patients are residents of Maryland, and we maintain a network of community-based pediatric practices, surgery centers and regional outpatient centers in Maryland.

Children's National strongly supports SB 902 which will remove the sunset to permanently authorize balance billing protections, allow people seeking care for mental health and substance use disorder to go out of their network, and align the balance billing protections with Maryland's regulatory time and distance standards, to help patients better access necessary healthcare.

Children's National cares for many children and adolescents from Maryland who have great difficulty finding appropriate mental health providers within their insurance network in a timely manner. I have seen children in the emergency room who haven't been able to connect with an in-network therapist and are on multiple waitlists. I have cared for teenagers admitted to the hospital whose families have struggled to find outpatient mental health care covered by

[1] For more information on the Community Mental health CORE, see https://childrensnational.org/advocacy-and-outreach/child-health-advocacy-institute/community-mental-health.

their insurance plan. I see many youth in my outpatient clinic who work for months to connect with a therapist in network. These are just a few of the many examples of why it is so important for patients to be able to access mental health care in a timely manner. This bill will help families and patients access care and reduce unnecessary suffering.

In addition, SB 902 will prohibit the use of prior authorization as an additional barrier to getting out-of-network care and authorize the Maryland Health Care Commission to establish a reimbursement rate formula for out-of-network mental health and substance use providers. If a patient's family does finally find an appropriate mental health provider with availability, it is important that the child and family be able to access care quickly, without additional barriers to care for the family and without additional administrative burdens for the provider. We know that in Maryland, many insurance plans do not have adequate mental health networks and that often, these networks are even worse for children and adolescents.[2] Several studies have been done that show that Marylanders go out of network far more often for mental health and substance use care than for medical/surgical care.[3],[4] We need to decrease barriers to accessing this care for patients and families and decrease disincentives for providers to participate in networks.

We commend the Senate Finance Committee for its attention to access to quality mental health care and focus on network adequacy. As the youth mental health crisis continues to affect children and their families across Maryland, it is crucial that children and adolescents are able to access quality mental healthcare close to home and in a timely manner.[5]

I applaud Senator Augustine for introducing this important legislation, which will have life-long benefits for our state's youngest residents and their families and respectfully request a favorable report on SB 902. Thank you for the opportunity to submit testimony. I am happy to respond to any questions you may have.

For more information, please contact:
Austin Morris, Government Affairs Manager
almorris@childrensnational.org

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[2] Melek, S.; Davenport, S.; and Gray T.J. *Milliman Research Report Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement.* November 2019.
[3] Melek, S.P. FSA, MAAA; Perlman, D. FSA, MAAA, and Davenport, S. *Milliman Research Report Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates.* December 2017.
[4] Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International.
[5] AAP, AACAP, CHA declare national emergency in children's mental health | AAP News | American Academy of Pediatrics

SB0902_FAV_GWSCSW_HI - Access Nonparticipating Pro

Uploaded by: Christine Krone
Position: FAV

Greater Washington Society for Clinical Social Work

Senate Finance Committee
February 26, 2025
Senate Bill 902 – *Health Insurance – Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage*
POSITION: SUPPORT

The Greater Washington Society for Clinical Social Work (GWSCSW) was established in 1975 to promote and advance the specialization of clinical practice within the social work profession. Through our lobbying, education, community building, and social justice activities, we affirm our commitment to the needs of those in our profession, their clients, and the community at large. On behalf of GWSCSW, we support Senate Bill 902.

Appropriate and adequate access to mental health and substance use disorder services is essential if the State is to address the increasing demand for these services. In 2022, legislation was passed to protect Maryland residents with private health insurance from having to pay higher costs when their insurance network did not have the practitioners necessary to meet their need for mental health and substance use disorder care and they were forced to go out-of-network. The protections provided by the 2022 legislation sunset in July 2025. Passage of Senate Bill 902 will extend the current protections and will also close existing gaps in the law that have been identified since the implementation of the original legislation.

Senate Bill 902 provides several provisions that will strengthen Maryland's current law. These include but are not limited to enabling insured who are seeking mental health and substance use disorder care to get a referral to go out-of-network without the requirement of having a diagnosis; aligning the balance billing protections with Maryland's current time and distance standards regulations, to help consumers better understand and take advantage of their rights to access out of network providers; requiring health insurers to provide assistance when individuals cannot find an out-of-network provider on their own; prohibiting the use of prior authorization as an additional barrier to getting out-of-network care; and ensuring that balance billing protections apply for the full duration of the treatment plan requested. Senate Bill 902 also authorizes the Maryland Health Care Commission (MHCC) to establish a reimbursement rate formula for out-of-network mental health and substance use disorder providers.

Passage of Senate Bill 902 is essential to ensuring Marylanders with private insurance are able to access services for mental health and substance use disorders in a timely manner without incurring additional expenses because the insurance carriers' network is insufficient, and insureds are forced to go out-of-network for necessary services. For these reasons we strongly request a favorable report.

For more information call:
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Danna L. Kauffman
410-244-7000

DRM_SB0902_Support.pdf
Uploaded by: Courtney Bergan
Position: FAV

Empowering People to Lead Systemic Change

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DisabilityRightsMD.org

Senate Finance Committee
Senate Bill 902: Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage
Wednesday, February 26, 2025, 1:00 PM
Position: Support

Disability Rights Maryland (DRM) is the protection and advocacy organization for the state of Maryland; the mission of the organization, part of a national network of similar agencies, is to advocate for the legal rights of people with disabilities throughout the state. In the context of mental health disabilities, DRM advocates for access to person-centered, culturally responsive, trauma-informed care in the least restrictive environment. DRM appreciates the opportunity to provide testimony on SB 902, which will require insurance companies to provide access to appropriate mental health care from an out-of-network provider, when appropriate care is either not available from a provider within an insurance carrier's network, or not available within the time or distance standards set forth under Maryland's network adequacy regulations.

No one should be forced to go without life-saving mental health or substance use care simply because an insurance company fails to provide this care within their network, but unfortunately, this happens far too often. Narrow insurance networks mean that appropriate mental health and substance use care is unavailable to far too many Marylanders, especially Marylanders with disabilities who are often deemed "complex" or "high risk" by in-network mental health providers due to histories of hospitalizations, suicide attempts, self-injurious behaviors, co-occurring medical conditions, and/or multiple disabilities. Nonetheless, appropriate care usually exists in our communities; it is often just not available within many commercial insurance carriers' provider networks because reimbursement rates are not commensurate with the time and expertise required to provide adequate mental health care to patients with more complex needs.[1] When Marylanders with significant mental health and substance use related disabilities cannot obtain timely access to care from a provider who is trained in treating their condition or meeting their unique needs, too many end up being unnecessarily hospitalized. SB 902 helps to remedy this harm by ensuring that Marylanders can access timely coverage for mental health and substance use related care from providers who have appropriate training and expertise in treating their conditions, even if they are forced to go outside of their insurance carrier's network to access this care

While the law currently requires health insurance carriers to cover out-of-network mental health and substance use disorder services when such care is not available within an insurance carrier's provider network[2]; the sunset on patient protections that allow patients to enforce these rights will soon lapse.[3] Prior to the 2022 bill that initially wrote these processes into Maryland law, insurers were simply fined for failing to guarantee timely access to essential mental health and substance

[1] A 2020 Milliman report indicated disparities in reimbursement for behavioral health services, finding only 4.4% of healthcare spending goes towards behavioral health care. Stoddard Davenport, et al., *How do individuals with behavioral health conditions contribute to physical and total healthcare spending?* 6–11 (2020), https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx.

[2] *See* Md. Code Ann., Ins. § 15-830 (authorizing patients to seek a referral to see a non-network specialist when an appropriately trained specialist is not available within an insurance carrier's provider network).

[3] *See* Md. Code Ann., Ins. § 15-830 (d)-(e).

use care within their provider networks, while patients were forced to pay more for these failures. These fines were generally less expensive than covering appropriate treatment, so carriers often strategically chose to be fined, rather than comply with the law and cover the care their members were legally entitled to and paying for via their monthly premiums. SB 902 will maintain the remedy initially created back in 2022 by making it so that when a carrier refuses to provide a member with access to appropriate in-network mental health and substance use care; the carrier is required pay for the member to access mental health and substance use services from a non-network provider at no greater cost to the member than if those services were provided by an in-network provider. In addition to maintaining these vital balance billing protections, SB 902 also fixes language from the 2022 law that was erroneously interpreted to deprive Marylanders of these crucial legal protections by imposing an arbitrary preauthorization requirement. SB 902 is essential to ensuring that state law provides a just remedy, which both makes Marylanders whole and incentivizes carriers' compliance.

DRM urges the committee to issue a favorable report on SB 902 and help guarantee Marylanders' access to mental health and substance use related care that will support them in both surviving and thriving in our communities. The General Assembly must refuse to put insurance company profits before Marylanders' lives.

Please contact Courtney Bergan, Disability Rights Maryland's Equal Justice Works Fellow, for more information at CourtneyB@DisabilityRightsMd.org or 443- 692-2477.

SB0902_MHAMD_FAV.pdf
Uploaded by: Dan Martin
Position: FAV

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

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Senate Bill 902 Health Insurance - Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage
Finance Committee
February 26, 2025
Position: SUPPORT

Mental Health Association of Maryland (MHAMD) is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). We appreciate the opportunity to provide this testimony in support of Senate Bill 902.

SB 902 will reauthorize important consumer protections preventing commercially insured Marylanders from being billed extra when they are forced to go out-of-network for behavioral health care. The bill also prohibits prior authorization requirements for out-of-network appointments, reimbursement or treatment plans, and requires the Maryland Health Care Commission to determine a reimbursement formula for out-of-network providers.

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

An independent national report[1] published in April 2024 cast a harsh light on the situation. According to the data, Maryland continues to be among the lowest states in the nation with respect to several indicators used to determine overall access to mental health and substance use care. These access challenges result in higher out-of-pocket costs that can make treatment unaffordable, even for those with insurance.

Similar to findings from a 2019 report by Milliman, Inc., the 2024 report demonstrates that:

- Marylanders are nearly nine times more likely to go out-of-network for behavioral health care versus primary care, a rate that is twice the national average and **fourth worst in the nation**.

[1] Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International.

- Marylanders are nearly 21 times more likely to go out of network for inpatient behavioral health treatment versus inpatient medical/surgical treatment, a rate that is **more than three times the national average**.

- Maryland in-network **behavioral health clinicians are reimbursed 23% less** than other doctors performing similar services.

Commercially insured Marylanders face enormous challenges when attempting to access community mental health and substance use care. Progress has been made, but there is much work to be done. Until we address these continuing network adequacy failures, we must ensure that Marylanders forced to go out-of-network for behavioral health care are not penalized for doing so. For these reasons, MHAMD supports SB 902 and urges a favorable report.

2025 Legislation MHCC (SB 902- HI– Access to Nonpa

Uploaded by: David Sharp

Position: FAV

MARYLAND Health Care Commission

Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

2025 SESSION
POSITION PAPER

BILL NO: **SB 902**

COMMITTEE: **Senate Finance Committee**

POSITION: **Support**

TITLE: **Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage**

BILL ANALYSIS

SB 902 - Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage repeals the termination date for certain provisions of law related to referrals and reimbursement of specialists and nonphysician specialists who are not part of an insurer's provider panel. The bill also requires that a certain referral procedure be established and implemented by health insurers, nonprofit health service plans, and health maintenance organizations and requires the carrier to help a member in identifying and arranging coverage for a specialist or nonphysician specialist for treatment of mental health or substance use disorder services. SB 902 prohibits carriers from imposing prior authorization requirements for scheduling, reimbursing, or continuing an established treatment plan by certain nonparticipating providers. The bill requires the Maryland Health Care Commission to establish certain reimbursement rates for nonparticipating providers; and generally, relates to access to nonparticipating providers.

POSITION AND RATIONALE

The Maryland Health Care Commission (MHCC) supports SB 902. The bill requires MHCC to establish a reimbursement rate formula no later than January 1, 2026, for nonparticipating providers who deliver mental or substance use disorder treatment.

The bill also requires MHCC to hold public meetings with carriers, mental health and substance use disorder providers, consumers of mental health and substance use disorder services, and other interested parties to determine the reimbursement formula.

The MHCC has worked with stakeholders to develop the current out of network formula, which largely rely on carriers' in-network rates and the Medicare Fee Schedule to derive out-of-network (OON) rates. More recently, the MHCC compared the out-of-network payment formula for PPOs and HMOs. Our study concluded that the PPO OON rates were more favorable than the HMO OON rates that applied to nonparticipating providers. The study notes that even if the payment formula were aligned, PPO OON rates would be higher because PPO in-network rates are usually higher than HMO in-network rates.

Earlier this fall, the MHCC released a report on payment for behavioral health services delivered in-person and via telehealth. We understand that legislation implementing those recommendations will be introduced this session.

The Behavioral Health Work Force Assessment study, Investing in Maryland's Behavioral Health Talent, was required by Senate Bill 283 (2024) that established the Behavioral Health Workforce Investment Fund (the Fund). Strategy 1 in that report recommended elevating reimbursement for behavioral health professionals.

> STRATEGY 1 – PROVIDE COMPETITIVE COMPENSATION: Paying a living wage and keeping pace with other settings (e.g., hospitals, schools, telehealth providers, private practice) is foundational to addressing the shortage. Other strategies will have limited impact if professionals and students perceive current and expected future wages for careers in BH as inadequate.

The MHCC does not have a specific solution on a new OON formula for behavioral health services. The MHCC is committed to working with providers and payers to develop a formula that would be acceptable and workable for all stakeholders.

For the stated reasons above, we ask for a favorable report on SB 902.

SB902 MH Referrals LOS Final.pdf
Uploaded by: Irnise Williams
Position: FAV

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STATE OF MARYLAND
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February 24, 2025

TO: The Honorable Pamela Beidle, Chair
Senate Finance Committee

FROM: Irnise F. Williams, Deputy Director, Health Education Advocacy Unit

RE: Senate Bill 0902 Health Insurance - Access to Nonparticipating Providers Referrals, Additional Assistance, and Coverage- **SUPPORT**

The Health Education Advocacy Unit supports Senate Bill 902, which, among other things, makes permanent balance billing protections for consumers of mental health or substance use disorder (MH/SUD) services who are compelled to obtain their care from out-of-network providers. The HEAU sees no reason to eliminate this protection which we supported in 2022, because consumers who pay premiums in reliance on a contract that entitles them to adequate networks should not have to assume the risk of having to pay excess costs when they are forced to receive out-of-network care. Current law expressly requires the carrier to cover the services provided by an out-of-network provider *at no greater cost to the insured than if the services had been provided by an in-network provider.* In other words, consumers get the benefit of the bargain they assume they are making when they purchase health insurance or receive it as an employment benefit, i.e., carriers are paid premiums in exchange for paying out MH/SUD claims when services are needed. An insured expects to pay only what he would have paid in an adequate network. This bill maintains the balance billing protection by removing the sunset date. This bill also enables consumers seeking mental health or substance use disorder care to get an out-of-network referral even if they have not yet been diagnosed.

The bill also requires the Maryland Healthcare Commission, with input from stakeholders, to establish a reimbursement formula to determine the payment rate for nonparticipating MH/SUD providers. From a consumer perspective, the HEAU often sees carriers providing the required out-of-network referrals for MH/SUD care, but the carrier and provider won't agree on the reimbursement amount, leaving the consumer in the middle of that debate and ultimately unable to receive needed care or the balance billing protections this law affords. Setting a reimbursement rate will take consumers out of the middle of the reimbursement dispute.

Our office also generally supports the elimination of other unnecessary barriers to care. We should not roll back the important protections that do exist, doing so will leave even more Marylanders without access to care. As it is, Maryland ranks among the worst in the country for how frequently care must be provided out-of-network.

We urge a favorable report for SB902.

cc: The Honorable Malcolm Augustine

2025 MCHS SB 902 Senate Side.pdf
Uploaded by: Jennifer Navabi
Position: FAV

Maryland Community Health System

Bill Number:	**Senate Bill 902 – Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage**
Committee:	**Senate Finance Operations**
Hearing Date:	**February 26, 2024**
Position:	**Support**

The Maryland Community Health System (MCHS) supports *Senate Bill 902 – Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage*. The bill would remove the sunset to permanently authorize balance billing protections; aligns the balance billing protections with Maryland's regulatory time and distance standards, helps consumers better understand and take advantage of their rights; requires health insurers to provide assistance when individuals cannot find an out-of-network provider on their own; prohibits the use of prior authorization as an additional barrier to getting out-of-network care; and requires balance billing protections for the full duration of the treatment plan requested.

The Maryland Community Health System is a network of federally qualified health centers (FQHC) located across Maryland. FQHCs are vital for communities lacking access to healthcare. They offer primary care, dental services, and behavioral health services. These centers focus on low-income and marginalized populations, ensuring equitable access to health services. Allowing patients the ability to seek out-of-network service, when there are not in network equivalents can lead to numerous benefits, such increased access to specialists, potentially greater treatment options, and improved overall health because better access to tailored services can lead to enhanced patient health outcomes.

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

2025 MdAPA SB 902 Senate Side.pdf
Uploaded by: Jennifer Navabi
Position: FAV

The Maryland Academy of Physician Assistants

mdapa

To: **Senate Finance Committee**

Bill: **Senate Bill 902 – Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage**

Date: **February 26, 2025**

Position: **Favorable**

The Maryland Academy of Physician Assistants (MdAPA) strongly supports *Senate Bill 902 – Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage*. The bill would remove the sunset to permanently authorize balance billing protections; align the balance billing protections with Maryland's regulatory time and distance standards to help consumers better understand and take advantage of their rights; require health insurers to provide assistance when individuals cannot find an out-of-network provider on their own; prohibit the use of prior authorization as an additional barrier to getting out-of-network care; and require balance billing protections for the full duration of the treatment plan requested.

This bill requires health insurers to assist individuals in situations where finding an out-of-network provider proves challenging. This assistance is vital, as navigating the healthcare system can become overwhelming for patients. Physician Assistants (PA), frequently serve as advocates for their patients' needs, support measures that facilitate access to care and ensure patients are not stranded without options. Additionally, prohibiting the use of prior authorization as a barrier to obtaining out-of-network care reinforces the message that patient care should come first. Prior authorization often creates delays that can hinder timely treatment. PAs emphasize the need for prompt access to care, as delays can worsen health outcomes. This bill's aim is to streamline the process and prioritize the patient's need for effective and timely treatment.

We ask for a favorable report. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net.

2025 MOTA SB 902 Senate Side.pdf
Uploaded by: Jennifer Navabi
Position: FAV

Maryland Occupational Therapy Association

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

Committee: **Senate Finance**

Bill Number: **Senate Bill 902 – Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage**

Hearing Date: **February 26, 2025**

Position: **Support**

The Maryland Occupational Therapy Association (MOTA) supports *Senate Bill 902 – Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage*. The bill would remove the sunset to permanently authorize balance billing protections; align the balance billing protections with Maryland's regulatory time and distance standards to help consumers better understand and take advantage of their rights; require health insurers to provide assistance when individuals cannot find an out-of-network provider on their own; prohibit the use of prior authorization as an additional barrier to getting out-of-network care; and require balance billing protections for the full duration of the treatment plan requested.

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

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

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

LCPCM-SB 902-Balance Billing - Support.pdf
Uploaded by: John Favazza
Position: FAV

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee:	Senate Finance Committee
Bill: SB 902 –	Health Insurance – Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage
Hearing Date:	February 26, 2025
Position:	Support

The Licensed Clinical Professional Counselors of Maryland (LCPCM) supports Senate Bill 902 - Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage. The bill removes the sunset from the law preventing commercially insured Marylanders from being billed extra when they are forced to go out-of-network for behavioral health treatment. Removal of the sunset permanently will ensure Marylanders continue to receive necessary treatment and not allow health insurers to shift costs back to patients.

In addition to the sunset repeal, Senate Bill 902 makes several changes that should improve patient access to care and patient outcomes. Under the bill, individuals seeking care can obtain a referral to go out-of-network, prior to having a specific diagnosis. Senate Bill 902 also seeks to ensure balance billing protections for the full duration of the treatment plan requested and requires health insurers to provide additional assistance when individuals cannot find an out-of-network provider on their own.

Much progress has been made, and Senate Bill 902 will help better address the unmet need for mental health and substance abuse treatment.

LCPCM urges the Committee to give Senate Bill 902 a FAVORABLE Report. Please contact Andrea Mansfield at amansfield@maniscanning.com or (410)562-1617 if we can provide additional information.

Nonpar providers SB 902 FAV.pdf
Uploaded by: Joseph Adams, MD
Position: FAV

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

Hearing: February 26, 2025
SB 902
Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage
Senate Finance Committee.

FAVORABLE

Greetings Chair Beidle, Vice Chair Hayes, and members of the committee.

in 2022, the **Consumer Payment Protection Bill**, which sunsets this year.

HB 11 will extend these protections permanently, and address some existing gaps. Otherwise, many Marylanders will be unable to access mental health and substance use services, even though they are covered for these (on paper), and pay premiums for them.

But when people suddenly learn, in the midst of a health crisis, that there are no in-network providers, the barriers are too great.

Also, many people cannot afford surprise out-of-network medical fees, and don't even know what these fees will be.

Many people need clear guidance to navigate these opaque systems. The stakes of not receiving covered services can be enormous. **Inadequate provider networks are commonplace far behavioral health** services, vs. for medical conditions.

Inability to access services for which you're already paying premiums - is unfair.

It can also be personally devastating. And is costly to Maryland in the long-run.

Respectfully,

Joseph A. Adams, MD, FASAM

MD Addiction Directors Council - SB 902 FAV.pdf
Uploaded by: Kim Wireman
Position: FAV

Maryland Addiction Directors Council

Senate Finance Committee

February 24, 2025

Written Testimony in Support of SB 902

SB 902(2025)

Health Insurance – Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage

Maryland Addictions Directors Council (MADC) represents outpatient and residential SUD and dual recovery treatment across the State of Maryland. Our members provide over 1,200 treatment beds across Maryland and provide treatment on the front lines of the Opioid Epidemic.

MADC strongly supports SB 902, the Access to Nonparticipating Providers Bill. MADC providers see first-hand the limited health plan networks that result in more costly treatment or no treatment for those in need. When people are in crisis and open to SUD treatment, time is of the essence. Treatment delivered as rapidly as possible provides the best chance to engage those in need. The barriers to coverage including negotiating long wait times for limited in-network benefits or administrative jostling and delays to obtain more expensive out of network providers are obstacles to life saving treatment.

In areas with reduced coverage, even if an out of network provider is secured, these non-network providers can bill clients for the cost of the treatment "not covered" by the client's carrier. Effectively Marylanders most in need pay twice: once for insurance premiums and twice to access care that should be covered under the carrier's network.

In Maryland approximately 80% of adults who were classified as needing SUD treatment did not receive treatment in 2022. Tragically, Maryland has experienced a 300% increase in overdose-related deaths in the last decade. In Baltimore City alone there have been approximately 900 deaths due to overdose a year for the last six years. A recent study entitled *Improving Access to Evidence-Based Medical Treatment for Opioid Use Disorder: Strategies to Address key Barriers within the Treatment System* (Madras, Ahamad, Wen & Sharfstein, April 2020, p. 17) details the enormous gap in SUD need versus treatment access. The study cites a national survey from 2018. In this survey 30% of those with SUD who did not seek treatment indicated they did not seek treatment because they did not have health insurance coverage or could not afford care. The article goes on to cite the failure of payers to meet the Mental Health Parity and Addiction Equity Act (2008) in several ways including payors failing to provide timely access to in-network mental health and addiction treatment providers.

(over)

MADC strongly supports SB 902, the Access to Nonparticipating Providers Bill, which will:

- Require health insurers to provide help when individuals cannot find an out-of-network provider on their own
- Enable people seeking mental health and SUD care to get a referral to go out-of-network, not just those who already have a diagnosis
- Authorize the Maryland Health Care Commission (MHCC) to establish a reimbursement rate formula for out-of-network mental health and SUD providers
- Prohibit the use of prior authorization as an additional barrier to getting out-of-network care

In closing, thank you for the opportunity to offer written testimony. Maryland Addictions Directors Council strongly supports SB 902.

Sincerely,

Kim Wireman

Kim Wireman
Board Member, MADC

Mitchell L - TESTIMONY IN SUPPORT OF Health Insura

Uploaded by: Laura Mitchell

Position: FAV

Laura Mitchell, MBA
25508 Woodfield Rd, Damascus, MD 20872
E-mail: Laura@LauraMitchell.org
Telephone 410 422 2694

TESTIMONY IN **SUPPORT** OF **Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage (SB0902)**

Submitted by Laura Mitchell to the Maryland Senate Finance Committee

January 28, 2025

Chair, Senator Beidle, Vice Chair, Senator Hayes, and Respected Members of the Senate Finance Committee:

As a multigenerational survivor and advocate, I urge you to support SB0902, Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage.

The Personal Impact

For over two years, my family struggled to get the multi-faceted mental health treatment our granddaughter required and that struggle very nearly cost her life. Even our insurer could not find an appropriate provider to address her trauma, autism, and other conditions in their network, much less within a reasonable time and distance. Thanks to the balance billing law, we were finally able to access the lifesaving mental health treatment she needed with an appropriately credentialed therapist. She is now a high school senior, thriving at home and in school - we simply cannot go back!

We do, however, need to move forward to enhance the utility and effectiveness of the current law. Under the current balance billing law, we must go back to the insurer for approval every six months to maintain the “Inadequate Network Exception” they approved or risk losing access to the provider with whom our granddaughter has built a therapeutic relationship she trusts. The requirement to continuously renew this critically important authorization falls to the family – to me – with no reminders or prompts from the insurer, such as you might receive for much less consequential things such as when a subscription, membership, or credit card is expiring. It is a nightmare that often wakes me in the middle of the night – “Is it time to renew?”, “Did I miss making that call?”, “Will her therapy for this week be covered?”. It defeats the whole purpose of ensuring access to and continuity of care.

Additionally, I must first pay for the services and then submit to the insurer for reimbursement. The provider continues to initially process every claim as out of network, despite my putting their “Inadequate Network Exception” authorization number in big, bold, red print on every related claim document I send them to get reimbursed – per their instructions. Then I am saddled with filing appeals, spending hours on tracking the errors and on the phone explaining the issue to someone who, invariably, seems to have never heard of the “Inadequate Network Exception” and suggesting that I do exactly what I have already done – note the case number on the claim documents. Generally, they elevate the review, and I get the same response, another Explanation of Benefits with the claim processed as out of network and stating that the full benefit has been paid. We go through several iterations of the process until sometimes, not always, we get someone to process the claim correctly and we get fully reimbursed 3-12 months later for claims that are typically $1,000 per month. This creates tremendous stress on my time, emotions, and our financial ability to continue treatment.

In this time of widespread mental health needs and provider shortages, insurers must be required to continue providing access to out of network providers at no greater cost to the patient and be encouraged to build adequate networks by removing the sunset provision of the “Balance Billing” law. Further, the legislature must remove the reauthorization requirements and require correction to the erroneous payment of these claims, both of which I believe to be parity violations. My granddaughter’s life, and that of many others, depends on retaining and enhancing this law.

The Broader Impact

In 2022, the Maryland General Assembly passed a law to protect Marylanders with private health insurance from having to pay higher costs when their insurance network is inadequate, and they are forced to go out-of-network to meet their needs for mental health (MH) and substance use disorder (SUD) care. However, this law is set to expire in July 2025. Maryland is still facing an overdose epidemic and mental health crisis. We need to prevent health insurers from returning to the practice of shifting costs to vulnerable Marylanders due to inadequate networks; we also need to close existing gaps in the law.

SB0902 has many necessary provisions; it will: Enable people seeking MH and SUD care to get a referral to go out-of-network, whether or not they already have a diagnosis; Align the balance billing protections with Maryland's regulatory time and distance standards, to help consumers better understand and exercise their rights; Require health insurers to provide assistance when individuals cannot find an out-of-network provider on their own; Prohibit the use of prior authorization as an additional barrier to getting out-of-network care; Ensure balance billing protections for the full duration of the treatment plan requested; and Authorize the Maryland Health Care Commission (MHCC) to establish a reimbursement rate formula for out-of-network MH and SUD providers.

The unmet need for MH and SUD treatment in Maryland is immense and increasing.

- In 2022-23, 28% of Maryland high school students and 22% of middle school students reported that their MH was not good most of the time or always, and 18% of high school students and 24% of middle school students reported they had seriously considered suicide.
- In 2023, more than 27% of Maryland adults reported symptoms of anxiety and/or depression, and over 30% of adults had an unmet need for counseling or therapy for these conditions.
- Of the 252,000 Maryland adults who did not receive MH care, 1 in 3 did not get it because of the cost.
- Approximately 80% of adults who were classified as needing SUD treatment in Maryland did not receive treatment in 2022.
- Maryland has experienced a 300% increase in overdose-related deaths in the last decade, with over 2,000 overdose-related deaths each year since 2016.

Marylanders deserve the coverage we are paying for, including access to the MH & SUD care we need, when and where we need it, at no greater cost than the in-network rate when the insurer's network is inadequate to meet the needs of their subscribers.

Maryland currently ranks among the worst in the country for the frequency they must rely on out-of-network providers for MH and SUD treatment compared to somatic medical care. Compared to medical specialists, residents go out of network 21 times more frequently for psychiatrists – the 4th worst in the nation - and 36 times more frequently for psychologists – the 2nd worst in the nation. Maryland's insurers maintain adequate networks for nearly all medical and surgical services; however, time and distance metrics are not met for addiction medicine providers of at least 5 plans nor for opioid treatment services providers of at least 8 plans. Similarly, 11 plans do not meet the required adequacy metrics for SUD residential treatment facilities in Maryland. (Source: Maryland insurers' 2024 Access Plans.)

Overall, I support SB0902 because Maryland can and must do better at ensuring equitable and affordable access to mental health and substance use treatment for every Marylander who needs the services without additional costs to those seeking treatment outside of their insurer's admittedly inadequate network.

For all the reasons cited above, I urge you to support SB0902.

Respectfully submitted, for Morgan,

Laura Mitchell

Laura Mitchell, MBA

Co-Founder of Montgomery Goes Purple Community Coalition, Appointed Member, Montgomery County Alcohol and Other Drug Addiction Advisory Council (AODAAC); Liaison to the Montgomery County Mental Health Advisory Committee; Member, Montgomery County Overdose Fatality Review Team (OFRT); Vice President of

Administration & Chair & Substance Use Prevention Committee, Montgomery County Council of PTAs (MCCPTA), Multiple Award Winning Volunteer Advocate for Mental Health and Substance Use Prevention, Intervention & Treatment.

Here are some resources that CASA shared at our Know Your Rights event:

https://wearecasa.org/know-your-rights-learn-how-to.../

https://nipnlg.org/.../2024-12/2024_Trump-what-to-expect.pdf

https://nipnlg.org/.../2024_Trump-what-to-expect-ESP.pdf

https://wearecasa.org/wp-content/uploads/2024/11/SPANISH.pdf

SB902 FAV - NAMI.pdf
Uploaded by: Michael Gray
Position: FAV

February 26, 2025

Chair Beidle, Vice Chair Hayes, and distinguished members of the Finance Committee,

The National Alliance on Mental Illness (NAMI)-Maryland respectfully requests a favorable report on SB902.

NAMI Maryland and our 11 local affiliates across the state represent a network of more than 58,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a 501(c)(3) non-profit dedicated to providing education, support, and advocacy for people living with mental illnesses, their families, and the wider community.

The General Assembly passed legislation in 2022 to prevent people living with serious mental illness (SMI) and substance use disorder (SUD) from paying higher costs when they are forced to seek treatment out of their insurer's network. That legislation made it possible for more Marylanders to access the healthcare services and medications they need. However, those important protections are set to expire in 2025. NAMI Maryland supports SB902 to permanently extend the balance billings provisions currently in place.

People living with mental health conditions face numerous obstacles to accessing healthcare, community services, housing, and other basic needs that many people take for granted. The General Assembly removed a major barrier to accessing mental health treatment in 2022 and allowing your earlier efforts to sunset would have the effect of returning an obstacle to mental healthcare services.

For these reasons, we urge a favorable report on SB902.

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

NCADD-MD - 2025 SB 902 FAV - Access to Nonparticip
Uploaded by: Nancy Rosen-Cohen
Position: FAV

Senate Finance Committee
February 26, 2025

Senate Bill 902 - Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage

NCADD-Maryland supports Senate Bill 902, a bill that first and foremost removes the sunset on a law that has proven to be effective. In 2022, the Maryland General Assembly made the policy decision to allow people to access mental health and substance use disorder services when their carriers have inadequate networks, without financial penalty. This policy has allowed more people to find services for the mental health and substance use needs, without the concern about being billed the difference between what the provider charges and the insurance company is willing to pay.

Network adequacy problems among insurance carriers in Maryland persist despite attempts by the General Assembly and the Maryland Insurance Administration to fix them. National data shows Maryland among the worst states in terms of access to in-network providers. The April 2024 report from RTI International (*Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue*), found that Maryland patients had out-of-network behavioral health clinician office visits more than 7 times more frequently than for office visits to medical/surgical clinicians.

We urge the General Assembly to make this law permanent by removing the sunset, and adding some clarifications. Nothing in the law should be interpreted to put a utilization review requirement on a service that does not otherwise require one. There should be no additional barriers to accessing care or continuing that care once a member identifies an appropriate provider.

With the amendments being offered by the sponsor, we urge a favorable report on Seante Bill 902.

CBH-FAV-SB902.pdf
Uploaded by: Nicole Graner
Position: FAV

COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

Testimony on SB902
Health Insurance – Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage
Senate Finance Committee
February 26, 2025
POSITION: SUPPORT

The Community Behavioral Health Association of Maryland (CBH) is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 87 members serve the majority of individuals who access care through the public behavioral health system. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

In 2022, the Maryland General Assembly passed a law to protect Marylanders with private health insurance from having to pay higher costs when their insurance network is inadequate to meet their needs for mental health and substance use disorder care and they are required to go out-of-network for care. These protections are set to expire in July 2025. Maryland is still facing an overdose epidemic and mental health crisis, and we must prevent health insurers from reverting to shifting costs to Marylanders when their networks are inadequate to meet the need.

There continue to be significant barriers to behavioral health provider participation in commercial carrier networks. Most of these revolve around low reimbursement rates and challenges with the carrier credentialling process. The unmet need in Maryland is high and continues to rise. For example:

- In 2023, **more than 27%** of Maryland Adults reported symptoms of anxiety and/or depression and over 30% of adults had an unmet need for counseling or therapy for these conditions
- Of the 252,000 Maryland Adults who did not receive care, **1 in 3** reported this was due to cost
- Approximately **80% of adults** who were identified as needing SUD treatment in Maryland in 2022 did not receive treatment
- Maryland has experienced a **300% increase** in overdose-related deaths in the last decade, with **over 2,000 over-dose related deaths each year since 2016**.

SB902 is critical in ensuring Marylanders have access to mental health and substance use related care where and when needed. SB902 would:

7310 Esquire Court, Mailbox 12, Elkridge, MD 21075 410.788.1865

- Remove the sunset to permanently authorize balance billing protections
- Enable *anyone* seeking mental health or substance use care to get a referral to go out of network – *not just those who already have a diagnosis*
- Align the balance billing protections with Maryland's regulatory time and distance standards
- Require health insurers to provide assistance when individuals cannot find an out-of-network provider on their own
- Prohibit the use of prior authorization as an additional barrier to getting out-of-network care
- Ensure balance billing protections for the full duration of the treatment plan requested
- Authorize the Maryland Health Care Commission (MHCC) to establish a reimbursement rate formula for out-of-network mental health and substance use disorder providers.

It has been more than 15 years since the federal Mental Health Parity and Addiction Act passed in 2008, yet there continue to be significant barriers to Marylanders seeking in-network care. It is time we make permanent the protections that hold consumers financially harmless for the limitations of their carrier's network. We urge a favorable report on SB902.

For more information contact Nicole Graner, Director of Government Affairs and Public Policy, at 240-994-8113 or Nicole@MDCBH.org

SB 902 - MHCC - FIN - LOS.pdf
Uploaded by: State of Maryland (MD)
Position: FAV

MARYLAND Health Care Commission

Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

2025 SESSION
POSITION PAPER

BILL NO: **SB 902**

COMMITTEE: **Senate Finance Committee**

POSITION: **Support**

TITLE: **Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage**

BILL ANALYSIS

SB 902 - Health Insurance - Access to Nonparticipating Providers - Referrals, Additional Assistance, and Coverage repeals the termination date for certain provisions of law related to referrals and reimbursement of specialists and nonphysician specialists who are not part of an insurer's provider panel. The bill also requires that a certain referral procedure be established and implemented by health insurers, nonprofit health service plans, and health maintenance organizations and requires the carrier to help a member in identifying and arranging coverage for a specialist or nonphysician specialist for treatment of mental health or substance use disorder services. SB 902 prohibits carriers from imposing prior authorization requirements for scheduling, reimbursing, or continuing an established treatment plan by certain nonparticipating providers. The bill requires the Maryland Health Care Commission to establish certain reimbursement rates for nonparticipating providers; and generally, relates to access to nonparticipating providers.

POSITION AND RATIONALE

The Maryland Health Care Commission (MHCC) supports SB 902. The bill requires MHCC to establish a reimbursement rate formula no later than January 1, 2026, for nonparticipating providers who deliver mental or substance use disorder treatment.

The bill also requires MHCC to hold public meetings with carriers, mental health and substance use disorder providers, consumers of mental health and substance use disorder services, and other interested parties to determine the reimbursement formula.

The MHCC has worked with stakeholders to develop the current out of network formula, which largely rely on carriers' in-network rates and the Medicare Fee Schedule to derive out-of-network (OON) rates. More recently, the MHCC compared the out-of-network payment formula for PPOs and HMOs. Our study concluded that the PPO OON rates were more favorable than the HMO OON rates that applied to nonparticipating providers. The study notes that even if the payment formula were aligned, PPO OON rates would be higher because PPO in-network rates are usually higher than HMO in-network rates.

Earlier this fall, the MHCC released a report on payment for behavioral health services delivered in-person and via telehealth. We understand that legislation implementing those recommendations will be introduced this session.

The Behavioral Health Work Force Assessment study, Investing in Maryland's Behavioral Health Talent, was required by Senate Bill 283 (2024) that established the Behavioral Health Workforce Investment Fund (the Fund). Strategy 1 in that report recommended elevating reimbursement for behavioral health professionals.

> STRATEGY 1 – PROVIDE COMPETITIVE COMPENSATION: Paying a living wage and keeping pace with other settings (e.g., hospitals, schools, telehealth providers, private practice) is foundational to addressing the shortage. Other strategies will have limited impact if professionals and students perceive current and expected future wages for careers in BH as inadequate.

The MHCC does not have a specific solution on a new OON formula for behavioral health services. The MHCC is committed to working with providers and payers to develop a formula that would be acceptable and workable for all stakeholders.

For the stated reasons above, we ask for a favorable report on SB 902.

SB 902.pdf
Uploaded by: Taylor Dickerson
Position: FAV

MARYLAND
PSYCHOLOGICAL ASSOCIATION

PO Box 368 Laurel, MD 20725 410-992-4258 www.marylandpsychology.org

February 24, 2025

Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice Chair
Finance Committee
Miller Senate Office Building, 3 East
Annapolis, MD 21401

RE: SB 902 – Health Insurance – Access to Nonparticipating Providers
Position: SUPPORT

Dear Chair, Vice-Chair, and Members of the Committee:

The Maryland Psychological Association, (MPA), which represents over 1,000 doctoral level psychologists throughout the state, asks the Health and Government Operations Committee to **SUPPORT SB 902.**

Access to mental health care is critical for fostering healthy communities, reducing societal costs, and enhancing individual well-being. Research demonstrates that untreated mental health conditions contribute to higher rates of unemployment, homelessness, substance abuse, and chronic medical conditions, which strain public resources. Furthermore, mental health care reduces crime rates and enhances workplace productivity, yielding economic benefits that far outweigh the cost of care.

Maryland's citizens have a significant problem accessing these critical and needed services, especially in-network treatment. *Inadequate provider panels are the direct result of the carriers' low reimbursement to behavioral health practitioners - rates have decreased more than 50% in the last twenty-five years.* In response to inadequate provider networks, Maryland law allows consumers with health insurance to go out of the network when the network panel cannot meet the subscriber's specific treatment needs. The Maryland General Assembly also passed a law in 2022 which assisted consumers by limiting their co-payment when they were forced to go out-of-the-network.

Unfortunately, the carriers added other barriers which impedes access to care. Insurance companies now require pre-authorization - which is not required for in-network services - when the consumer must go out-of-network because of inadequate provider panels. In addition, insurance companies negotiate below-market rates with out-of-network therapists so that many therapists are unwilling to provide services under these circumstances.

SB 902 works to provide consumers with needed protections so they can reasonably access mental health services when in-network care is not available based on standards which have been established in regulation. SB 902 prohibits insurance carriers from using pre-authorization for services as a barrier to treatment and also ensures that these protections remain in place for the duration of the treatment. In addition, SB 902 authorizes the Maryland Health Care Commission to establish a reimbursement rate formula for out-of-network providers in these circumstances – when consumers cannot access needed care because of the carriers' inadequate insurance networks.

As a result of all of the above, we ask that the Committee vote favorably and pass SB 902. If we can be of any further assistance to the Committee, please do not hesitate to contact MPA's Legislative Chair, Dr. Stephanie Wolf, JD, Ph.D. at mpalegislativecommittee@gmail.com.

Respectfully submitted,

David Goode-Cross, Ph.D.
David Goode-Cross, Ph.D.
President

Stephanie Wolf, JD, Ph.D.
Stephanie Wolf, JD, Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

SB902 - LAC - FAV.pdf
Uploaded by: Teresa Miller
Position: FAV

LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

S.B. 902: Health Insurance – Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage
Senate Finance Committee Hearing
February 26, 2025
Favorable

Thank you for the opportunity to submit testimony in support of Senate Bill 902, which would remove the sunset and strengthen Maryland's balance billing protections to continue to ensure Marylanders can access affordable mental health and substance use disorder care. The Legal Action Center (LAC) is a non-profit law and policy organization that fights discrimination, builds health equity, and restores opportunities for people with substance use disorders, arrest and conviction records, and HIV/AIDS. LAC 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 insurance networks are inadequate.

The unmet need for MH and SUD care in Maryland is high and continues to rise. In 2023, more than 27% of Maryland adults reported symptoms of anxiety and/or depression, and over 30% of adults reporting such symptoms had an unmet need for counseling or therapy. Of the 252,000 Maryland adults who did not receive needed care for a MH condition, 1 in 3 did not because of cost. In 2022-23, 28% of Maryland high school students and 22% of middle school students reported their MH was not good most of the time or always, and 18% of high school students and 24% of middle school students reported they had seriously considered suicide. Approximately 80% of adults who were classified as needing SUD treatment in Maryland did not receive treatment in 2022. Maryland has experienced a 300% increase in overdose-related deaths in the last decade, with over 2,000 overdose-related deaths each year since 2016.

S.B. 902 would help ensure Marylanders get the affordable and accessible MH and SUD care they need without rolling back critical consumer protections, and we urge you to issue a favorable report on this bill.

1. **Maryland must remove the sunset on the balance billing protections to preserve affordable access to MH and SUD care.**

We thank the Committee and the Maryland General Assembly for unanimously passing H.B. 912 in 2022, which established the balance billing protections we currently have today. This law ensures that Marylanders who cannot access a MH or SUD provider in their insurance network within a reasonable time and distance can see an out-of-network provider without paying more for this care. In short, it prevents insurers from shifting costs to Marylanders by failing to maintain an adequate provider network and forcing them to pay more out-of-pocket than they would have to pay if they were able to see an in-network MH or SUD provider. However, the balance billing protection is set to sunset on July 1, 2025, and we urge the Committee to pass S.B. 902 to ensure that, in the midst of the ongoing overdose epidemic and MH crisis,

Marylanders do not lose access to this critical right that ensures they can receive affordable treatment without unreasonable travel or delay.

2. **The National Association of Insurance Commissioners' Model Act, and at least 26 other states, have balance billing protections.**

Maryland's balance billing protection is modeled on the National Association of Insurance Commissioners' (NAIC) Health Benefit Plan Network Access and Adequacy Model Act (Section 5(C)). In addition to Maryland, we have identified 26 states that have adopted this or similar language: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New York, Ohio, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, and West Virginia. (See attached). Marylanders deserve no less, especially during the ongoing overdose epidemic and MH crisis.

3. **Maryland insurers' networks are still insufficient to meet the need for MH and SUD services.**

While there is undoubtedly a MH and SUD provider shortage in the state, research over the past decade shows that this is not the sole reason Marylanders cannot access the treatment they need. Many Marylanders are able to access MH and SUD care – they are just forced to go outside of their insurance networks to do so. Maryland ranks 4th worst in the country for how often individuals have to go out-of-network for all MH and SUD (behavioral health) office visits compared to how often they have to go out-of-network for medical or surgical office visits. Marylanders go out-of-network 21.1 times more frequently for psychiatrists than for medical/surgical specialist physicians (4th worst in the country). Even more notably, Marylanders go out-of-network 36.4 times more frequently for psychologists than for medical/surgical specialist physicians (2nd worst in the country).

The private insurance reimbursement rate disparities paint a much clearer picture for why Marylanders are seeking out-of-network MH and SUD care. RTI International's data reveals Maryland's in-network behavioral health clinicians are reimbursed 23.4% lower on average than comparable medical/surgical clinicians. These average reimbursement rates are only a piece of the puzzle, because insurers often reimburse some providers at higher levels when they want to incentivize them to join their networks to meet the demand for care. However, the data shows that Maryland's insurers are not taking the necessary steps to meet this heightened demand for MH and SUD care in the same way they do so for medical/surgical care. Maryland in-network behavioral health clinicians are reimbursed 44.5% lower than medical/surgical clinicians at the 75th percentile, and 58.3% lower than medical/surgical clinicians at the 95th percentile.

While Maryland insurers have taken some steps to improve their networks of MH and SUD providers, critical gaps still remain. According to the insurers' 2024 Access Plans submitted to the Maryland Insurance Administration (MIA), a number of plans failed to meet the required time and distance standards for MH and SUD providers and facilities, while consistently meeting these standards for medical/surgical providers and facilities. Specifically, five plans did not meet the time and distance standards for at least one geographic region for addiction medicine

providers, eight plans did not meet the time and distance standards for at least one geographic region for opioid treatment services providers, and eleven plans did not meet the time and distance standards for at least one geographic region for SUD residential treatment facilities. Many other plans met the 90% threshold to fulfill their obligations under the network adequacy standards, but still failed to provide adequate access to MH and SUD providers for all of their enrollees, meaning that some still cannot access a provider within the required time and distance.

While a longer term solution is necessary to resolve these ongoing disparities and network inadequacies, S.B. 902 offers the immediate solution to the problem that is facing Marylanders – the unaffordability and inaccessibility of the MH and SUD care they need.

4. **Maryland's balance billing law must be strengthened to remove additional barriers to MH and SUD care when insurance networks are inadequate.**

We have gained valuable insight over the last few years while Maryland's balance billing protections have been in place into how the law can be strengthened to more effectively meet its goal, beyond just removing the sunset. Therefore, S.B. 902 would remove additional barriers that Marylanders have identified as preventing them from getting the care they need when their insurance networks are inadequate.

- **Extending balance billing protections to those seeking MH or SUD care but who do not have a MH or SUD diagnosis**: Under the current law, Marylanders are only afforded balance billing protections if they are diagnosed with a condition or disease that requires specialized health care services or medical care. However, given the network inadequacies and disparities described above, many individuals may not be able to access a provider in their network who can appropriately diagnose them with a MH or SUD condition. Thus, S.B. 902 would ensure that individuals who are seeking MH or SUD care are also entitled to access out-of-network care at no greater cost when their networks are inadequate.
- **Aligning the balance billing protections with Maryland's regulatory time and distance standards**: Under current law, Marylanders are permitted to seek out-of-network care when they cannot access a network provider without unreasonable delay or travel. S.B. 902 would clarify this standard by aligning it with the MIA's network adequacy requirements, so that Marylanders have specific metrics by which they can assess what constitutes an unreasonable delay or travel such that they can more easily take advantage of this right to access an out-of-network provider at no greater cost.
- **Requiring additional consumer assistance when Marylanders cannot locate an out-of-network provider**: Under current law, the onus is on Marylanders to find their own out-of-network provider when they are unable to locate an in-network provider who can meet their needs. While some Marylanders are in a position to do this, many are not, especially in the midst of a MH or SUD crisis. Often, the window in which an individual is willing to seek MH or SUD care is very short, and not being able to find a provider can deter someone from getting the care they need, leading to devastating if not fatal outcomes. Maryland families in particular have expressed a need for additional assistance, especially for helping find providers that can deliver MH and SUD care for their children. S.B. 902 would ensure that Maryland insurers are providing that additional assistance that carriers purport to already be providing.

- **Prohibiting additional utilization management for out-of-network care when it would not be required for in-network care**: Some Maryland insurers have interpreted the current law to enable them to impose prior authorizations and concurrent review on services when they are delivered by an out-of-network provider, even when they do not impose these types of utilization management on the services when they are delivered by an in-network provider. For example, most insurers do not require prior authorization for outpatient therapy, but then require this additional review when the patient needs to see an out-of-network provider when there is no in-network provider available. S.B. 902 would ensure that insurers cannot require additional utilization management for out-of-network MH and SUD care when their network is inadequate beyond what would be required for in-network care.
- **Ensuring balance billing protections for the full duration of treatment**: Some insurers have also added additional re-authorization requirements for people who are forced to go out-of-network for MH and SUD care when their networks are inadequate. This additional requirement is not only time-consuming and burdensome, but it is also scary and stressful for Marylanders who fear they may lose access to the treating provider with whom they have developed a therapeutic relationship after going through the already frustrating process of exhausting their insurance network directory. S.B. 902 would ensure that the balance billing protections extend for the full duration of treatment that has been authorized by the plan.

Thank you for considering our testimony. We urge the Committee to issue a favorable report on S.B. 902 so Marylanders do not lose these vital balance billing protections for MH and SUD care.

Thank you,

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Balance Billing Protections
State Survey

As of January 2025, there are **26** states that have protections against balance billing.

State	Citation	Language
National Association of Insurance Commissioners (NAIC)	Health Benefit Plan Network Access and Adequacy Model Act § 5(C)	(1) 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 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 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 provider available to provide the covered benefit to the covered person without unreasonable travel or delay. … (3) The health carrier shall treat the health care services the covered person receives from a nonparticipating provider pursuant to Paragraph (2) 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.
Alaska	3 AAC 26.110(f)	If a health insurance policy provides in-network and out-of-network benefits, the policy must provide at a minimum the in-network benefit level for the following: (2) services or supplies provided by an out-of-network health care provider or health care facility, if an in-network health care provider or health care facility is not reasonably accessible as defined in the policy;
Arizona	Ariz. Admin. Code § 20-6-1910	(A) An HCSO shall have an effective process for assisting an enrollee to obtain timely covered services when the enrollee or enrollee's referring provider cannot find a contracted provider who is timely accessible or available. (E) An HCSO shall have an effective process for handling network exceptions that ensures the HCSO reimburses an enrollee for any out-of-network cost the enrollee incurs that the enrollee would not have incurred if the enrollee had received the services in-network.
Arkansas	Ark. Admin. Code 003.22.106-5(C) (2022)	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 followup 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 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.
Hawaii	Haw. Rev. Stat. § 431:26-103(c)(1) (2019).	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). Note: this is only for preferred provider plans	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, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, 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.
Massachusetts	211 CMR § 52.12(1)	In any case where the Carrier has an inadequate number or type of Participating Provider(s) to provide services for a Covered Benefit, the Carrier shall ensure that the Insured receives the Covered Benefit at the same benefit level as if the Benefit was obtained from a Participating Provider, or shall make other arrangements acceptable to the Commissioner.
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	19 Miss. Admin. Code. R. 3-14.05(C) (Rev. 2022)	In any case where the health carrier has an insufficient number or type of participating providers/facilities to provide a covered benefit to a covered person consistent with the geographic access standards set forth in Rule 14.05(B), 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/facilities, and additionally, if the covered persons must travel more than one hundred (100) miles one way or more than the distance standard prescribed by this regulation, whichever is greater, to obtain the aforementioned covered benefit, the health carrier shall provide such persons reasonable round trip reimbursement for their food, lodging and travel.
Missouri	20 Mo. CSR 400-7.095(2)(A)(3)(E) Note: this is only for HMO plans	For all managed care plans, written policies and procedures to assure that, with regard to providers not addressed in Exhibit A of this regulation, access to providers is reasonable. For otherwise covered services, the policies and procedures must show that the HMO will provide out-of-network access at no greater cost to the enrollee than for access to in-network providers if access to in-network providers cannot be assured without unreasonable delay;

Montana	Mont. Code Ann. § 33-36-201(2) (2023).	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 commissioner.
Nevada	NAC § 687B.782(2) (2017)	Except as otherwise provided in subsection 3, during the period in which the network plan does not meet the standards required pursuant to NAC 687B.768 or any other requirement of NAC 687B.750 to 687B.784, inclusive, the carrier shall, at no greater cost to the covered person: (a) Ensure that each covered person affected by the change may obtain any covered service from a qualified provider of health care who is: (1) Within the network plan; or (2) Not within the network plan by entering into an agreement with the nonparticipating provider of health care pursuant to NRS 695G.164;
New Hampshire	N.H. Code Admin. R. Ins 2701.10(b)	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.
Ohio	Ohio Rev. Code 1751.13(A)(2)	When a health insuring corporation is unable to provide a covered health care service from a contracted provider or health care facility, the health insuring corporation must provide that health care service from a noncontracted provider or health care facility consistent with the terms of the enrollee's policy, contract, certificate, or agreement. The health insuring corporation shall either ensure that the health care service be provided at no greater cost to the enrollee than if the enrollee had obtained the health care service from a contracted provider or health care facility, or make other arrangements acceptable to the superintendent of insurance.

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)	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.
Texas	28 Tex. Admin. Code § 3.3708(a)	For an out-of-network claim for which the insured is protected from balance billing under Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, or when no preferred provider is reasonably available, an insurer must pay the claim at the preferred level of coverage, including with respect to any applicable copay, coinsurance, deductible, or maximum out-of-pocket amount.
Vermont	Vt. Admin. Code 4-5-3:5(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.
Virginia	12 VAC 5-408-260(D)	If the MCHIP licensee does not have a health care provider within its network capable of providing care to covered persons, the licensee shall cover such care out of network. The covered person shall not be responsible for any additional costs incurred by the MCHIP as a result of this referral, consistent with the evidence of coverage, other than any applicable copayment, coinsurance or deductible.
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. An issuer must satisfy this obligation even if an alternate access delivery request has been submitted and is pending commissioner approval.
West Virginia	W. Va. Code § 33-55-3(c)(1).	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.

Public Health Law Clinic_SB902_FAV WITH AMENDMENTS
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Testimony in Support of Senate Bill 902 with Amendments
Health Insurance – Access to Nonparticipating Providers –
Referrals, Additional Assistance, and Coverage
Before the Finance Committee: February 26, 2025

The Public Health Law Clinic submits this testimony in support of Senate Bill 902 and ultimately in support of making access to adequate behavioral health care permanent for insurance consumers who experience barriers to accessing in-network providers.[1] Maryland has worked hard to ensure residents have access to care, with an uninsured population of only 6%.[2] However, even those who are insured continue to face challenges in accessing the appropriate care they need, particularly when it comes to behavioral health services. Current Maryland law permits health insurance consumers to seek out-of-network care when the insurer does not provide adequate in-network services.[3] The law requires insurers to assist with referrals for when the insurer's network is inadequate and ensure the consumer pays no more than what they would have paid for an in-network provider. When originally passed in 2022, the law contained a sunset provision ending effectiveness on June 30, 2025, with the hope that insurers would use the time to enhance their networks to meet their enrollees' needs. Insurers have not done so and the long-standing inadequacies, particularly in behavioral health care, persist, necessitating this bill that repeals the sunset provision and makes permanent the provisions that ensure Marylanders maintain access to essential care.

Accessing in-network behavioral health services remains a barrier for many Marylanders. Maryland implemented network adequacy standards in order to promote equity in the behavioral health space and ensure all Marylanders have accessible health care.[4] The current network adequacy standards include appointment wait time, distance, and provider-enrollee ratio.[5] In substance use care delivery, **the insurance companies' own 2024 network adequacy reports revealed that several plans consistently failed to meet the required wait time and distance standards for most substance use services.[6]** Five plans did not meet the wait time and distance metrics for addiction medicine providers. Eight plans did not meet wait time and distance metrics for opioid treatment service providers. Eleven plans did not meet the time and distance metrics for substance use disorder residential treatment facilities. The deficiency in insurers' network adequacy for substance use services demonstrates the continued need for Senate Bill 902. Other

[1] As noted below, we concur with a corrective amendment designed to align certain procedural rules for coverage for out-of-Network care access with those for in-Network care access.
[2] *Health Insurance Coverage of the Total Population, Multiple Sources of Coverage*, KFF (2023), https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-multiple-sources-of-coverage/?dataView=0&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[3] MD. CODE, INSURANCE § 15-830(d)(4).
[4] MD. CODE. REGS 31.10.44 (2023).
[5] Compliance for the wait time standard is determined by whether insurers reported wait times median appointment wait times that are within 72 hours for inpatient and outpatient urgent care for mental health and substance use services and 10 calendar days for non-urgent mental health and substance use care; Compliance for the distance standard is determined by whether 90% of insurance plan enrollees had access to providers within a specified distance depending on a rural, suburban, or urban geographic area; Compliance for the provider-enrollee ratio standard is determined by whether insurers have at least one mental health provider and one substance use provider per 2000 plan enrollees.
[6] *2024 Access Plans*, MD. INS. ADMIN., https://insurance.maryland.gov/Consumer/Pages/2024-Access-Plans.aspx (last accessed Jan. 26, 2025).

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data further supports the findings in these reports. In 2022, 80% of adults in Maryland who needed substance use disorder treatment did not receive that treatment.[7] This is particularly concerning considering Maryland has experienced a 300% increase in overdose-related deaths since 2016, amounting to over 2,000 overdose-related deaths every year.[8] The inability of insurance companies to meet time and distance standards, coupled with the staggering treatment gap and escalating overdose crisis, underscores the necessity of SB902 in making substance use disorder care accessible to Marylanders by expanding covered care to out-of-network providers.

In mental health care delivery, **data shows that Marylanders are forced to seek out-of-network mental health care more frequently compared to medical and surgical care**. For psychiatrist care, Maryland ranks fourth worst in the country, with Marylanders going out-of-network 21.2 times more frequently than for medical specialist physicians.[9] For psychologist care, Maryland ranks second worst in the country, with Marylanders going out-of-network 36.4 times more frequently than for medical specialist physicians. Among adults in Maryland who are experiencing anxiety or depression, nearly a third did not receive any care, and one-third of adults who needed care could not access mental health services because of cost.[10] Making the provisions of SB902 permanent is a critical step toward closing this gap in access and addressing the systemic issues that force Marylanders to rely on costly out-of-network services.

Further, **providers are deterred from contracting with insurance companies and providing services due to disparities in reimbursement rates for behavioral health services.** In Maryland, behavioral health providers are "reimbursed 23% less than other doctors performing comparable services."[11] Reimbursement rate gaps discourage providers from contracting with insurers and exacerbate provider shortages. The resulting shortages can negatively impact appointment wait time, provider availability, and out-of-pocket expenses.

Importantly, **provider shortages alone do not fully account for the disparities in out-of-network utilization.** According to the U.S. Health Resources and Services Administration, there are "25% more shortage areas for primary care physicians than for mental health providers."[12] Despite this, out-of-network utilization for primary care office visits is significantly lower than for mental health office visits. However, insurers' 2024 network adequacy reports reveal a telling pattern: every plan met the adequacy standards for all other medical services, including primary care, yet consistently fell short for some mental health and several substance use treatment services. These findings make clear that provider shortages are not the primary driver behind the high rates of out-of-network utilization in behavioral health.

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[7] *Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN. (2023), https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-annual-national-web-110923/2022-nsduh-nnr.htm.

[8] *The Maryland Inter-Agency Opioid Coordination Plan: 2022-2024*, OPIOID OPERATIONAL COMMAND CTR. 2 (Jul. 2022), https://stopoverdose.maryland.gov/wp-content/uploads/sites/34/2022/07/The-Maryland-Inter-Agency-Opioid-Coordination-Plan-2022-2024.pdf.

[9] Tami L. Mark & William Parish, *Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue*, RESEARCH TRIANGLE INST. B-9 (Apr. 2024), https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf.

[10] *Mental Health in Maryland*, NAT'L ALL. ON MENTAL ILLNESS (2021), https://www.nami.org/wp-content/uploads/2023/07/MarylandStateFactSheet.pdf.

[11] Tami L. Mark & William Parish, *supra* note 8 at C-79.

[12] Tami L. Mark & William Parish, *supra* note 8 at 9 (referring to *Health Workforce Shortage Areas*, HEALTH RESOURCES & SERVICES ADMINISTRATION (Jan. 27, 2025), https://data.hrsa.gov/topics/health-workforce/shortage-areas.

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SB902 presents the most immediate solution. People seeking mental health and substance use treatment need care now. **Delays, or even worse, no care at all due to inadequate networks can result in worsening conditions, crises, or even loss of life**.[13] While there are other solutions that the insurers have proposed to address this issue, this provision creates an immediate remedy that holds insurance companies accountable and bridges gaps in care access. Because of the critical nature of this issue, the immediate remedy Senate Bill 902 presents is a critical step to addressing mental health and substance abuse crises in Maryland.

Amendment

As introduced, Senate Bill 902 unintentionally provides more rigorous protection for out-of-Network care than for in-Network care with respect to provisions prohibiting the requirement for prior authorization for out-of-Network care. A corrective amendment was introduced by the House Bill sponsor, Delegate Cullison, to eliminate that difference and align the prior authorization provisions for out-of-Network care with those for in-Network care, which had been the original intent. House Bill 11 passed the Health and Government Operations Committee unanimously with that amendment. We support adding that amendment (HB0011/273927/1) to Senate Bill 902.

Conclusion

Because Marylanders continue to struggle to access adequate in-network behavioral health services despite efforts by insurance companies to remedy the issue, Senate Bill 902 is vital to ensuring consumers get the care they need as soon as possible at reasonable expense. While there may be other factors impacting the complex issue of network adequacy, such as provider shortages, reimbursement rates, and geographic disparities, this bill addresses the immediate harm caused by inadequate networks. For these reasons, we request a favorable report on Senate Bill 902.

This testimony is submitted on behalf of the Public Health Law Clinic at the University of Maryland Carey School of Law and not by the School of Law, the University of Maryland, Baltimore, or the University of Maryland System.

[13] *See* Catherine G. McLaughlin, *Delays in Treatment for Mental Disorders and Health Insurance Coverage*, 39 HEALTH SERV. RSCH. 221, 221 (2004).

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SB0902/233528/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

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BY: Senator Augustine
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 902
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 10, after "of" insert "a"; in line 11, strike "services"; strike beginning with "prior" in line 11 down through "providers" in line 13 and substitute "utilization review requirements other than what would be required if the covered benefit was provided by a provider on the carrier's provider panel under certain circumstances"; and strike beginning with "requiring" in line 13 down through "providers;" in line 15.

AMENDMENT NO. 2

On page 3, in line 15, after "(i)" insert "**1.**"; in the same line, strike "**OR SEEKING CARE FOR**"; in lines 17 and 20, strike "(ii) 1." and "2.", respectively, and substitute "**2. A.**" and "**B.**", respectively; in line 22, strike the brackets; in line 23, before "**WITHIN**" insert "**, INCLUDING**"; and in line 24, after "**REGULATION**" insert "**FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES; OR**

(II) 1. THE MEMBER IS SEEKING MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE; AND

2. THE CARRIER CANNOT PROVIDE REASONABLE ACCESS TO A SPECIALIST OR NONPHYSICIAN SPECIALIST WITHIN THE REASONABLE APPOINTMENT WAITING TIME AND TRAVEL DISTANCE STANDARDS ESTABLISHED IN REGULATION FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES".

On page 4, strike beginning with "**THE**" in line 4 down through "**PANEL**" in line 12 and substitute "**IF A CARRIER APPROVES A MEMBER'S REQUEST FOR A REFERRAL MADE IN ACCORDANCE WITH THIS SUBSECTION, THE CARRIER MAY NOT REQUIRE UTILIZATION REVIEW OTHER THAN WHAT WOULD BE REQUIRED IF THE COVERED BENEFIT WERE PROVIDED BY A PROVIDER ON THE CARRIER'S PROVIDER PANEL**".

On pages 4 and 5, strike in their entirety the lines beginning with line 32 on page 4 through line 8 on page 5, inclusive.

SB902 Sponsor Testimony Favorable with Amendments.

Uploaded by: Malcolm Augustine

Position: FWA

MALCOLM AUGUSTINE
Legislative District 47
Prince George's County

PRESIDENT PRO TEMPORE

Executive Nominations Committee

Education, Energy and the Environment Committee

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

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February 26, 2025

The Honorable Pamela G. Beidle
Chairwoman, Senate Finance Committee
3 East Miller Senate Office Building
11 Bladen Street Annapolis, MD 21401

RE: SB902 – Health Insurance – Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage

Position: **Favorable with Amendments**

Chair Beidle and Members of the Committee,

Thank you for the opportunity to testify in support of Senate Bill 902. This bill requires that certain carriers provide assistance to members in identifying and arranging coverage for a specialist or nonphysician specialist for treatment of mental health or substance use disorder services with nonparticipating providers.

The Problem – Persistent Barriers to MH/SUD Care
In 2022, the Maryland General Assembly unanimously passed legislation to protect patients who must seek out-of-network MH/SUD treatment due to inadequate provider networks. This legislation ensured they would not pay more than in-network rates, preventing carriers from shifting costs to consumers.

However, this critical protection is set to expire on July 1, 2025, even though Maryland's MH/SUD networks remain insufficient. Recent data[1] show that Marylanders are

- 8.9 times more likely to go out-of-network for psychiatric services than for medical or surgical care.
- 10.6 times more likely to go out-of-network for psychological services than for medical or surgical care.

While there are providers available, many are not included in insurance networks, often due to administrative barriers and low reimbursement rates. These ongoing challenges disproportionately delay or deny care for individuals experiencing MH/SUD crises.

What SB902 Does – Strengthens Consumer Protections and Promotes Parity

[1] https://www.mhamd.org/news/new-study-finds-continuing-pervasive-disparities-in-access-to-in-network-mental-health-and-substance-use-care/?utm_source=chatgpt.com

SB902 and its amendments directly address these ongoing barriers by making critical consumer protections permanent and closing loopholes that have undermined their effectiveness. Specifically, SB902:

- Eliminates the 2025 sunset, making permanent the requirement that when no in-network MH/SUD provider is available within regulatory time and distance standards, insurers must cover out-of-network services with the same cost-sharing terms as in-network care.
- Ensures fairness in utilization review, prohibiting insurers from imposing stricter utilization review requirements for out-of-network MH/SUD care than they would for in-network providers.
- Mandates active carrier assistance, requiring insurers to help patients locate and arrange coverage with out-of-network providers when no in-network options are available.

Why SB902 Matters – Breaking Down Its Impact

Without this bill, we risk a return to harmful cost-shifting practices that punish patients for insurance network failures. The consequences would include:

- Continued administrative roadblocks that delay or deny critical mental health care.
- Widening disparities, as patients with limited resources are priced out of lifesaving treatment.
- Increased strain on emergency rooms and public health systems as untreated mental health crises escalate.

SB902 ensures that:

- Balance billing protections become permanent, so no Marylander pays more for out-of-network MH/SUD care due to network inadequacies.
- Red tape is eliminated, stopping unnecessary prior authorization and reauthorization requirements.
- Families in crisis receive real support, requiring insurers to actively assist in locating out-of-network care when no in-network options exist.
- Continuity of care is protected, allowing patients to complete treatment without repeated interruptions caused by reauthorization requirements.

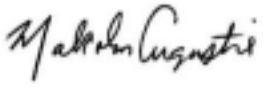
Finally, SB902 upholds Maryland's commitment to true mental health parity. This means ensuring that MH/SUD treatment is just as accessible and affordable as physical health care. SB902 brings us closer to that reality by ensuring that cost and coverage standards for mental health services match those for any other medical condition.

Amendments

House Government and Operations met and passed the SB 902 cross file, House Bill 11, with agreed upon amendments that I support and attached as conforming as follows:

- Language that makes it clear this applies only to mental health and substance use disorders
- Language from MIA that they prefer and that are limited to MH and SUD
- Deleted the development of a formula by the MHCC at the request of carriers

Chair Beidle and members of the committee, I urge you to issue a favorable report with amendments on SB902.



Sincerely, Senator Malcolm Augustine
President Pro Tempore -- District 47 – Prince George's County

SB 902 - MIA - FWA.pdf
Uploaded by: Marie Grant
Position: FWA

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Date: **February 26, 2025**

Bill # / Title: **Senate Bill 902 - Health Insurance - Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage**

Committee: **Senate Finance Committee**

Position: **Support with Amendments**

The Maryland Insurance Administration (MIA) appreciates the opportunity to share its support, with amendments, for Senate Bill 902.

Senate Bill 902 seeks to enable individuals with mental health and substance use disorders to receive services from out-of-network providers without additional costs, long travel distances, or extensive prior authorization requirements. In addition to these protections, the bill removes the sunset clause on certain already-established consumer protections and imposes additional requirements on insurance carriers to assist those seeking out-of-network treatment. These additional requirements include providing assistance to individuals who cannot find an out-of-network provider on their own, and ensuring that balance billing protections last for the full duration of the treatment plan requested. Finally, the bill changes the out-of-network referral process to enable people who are seeking mental health and substance use disorder care to get a referral prior to receiving a formal diagnosis.

The protections contained within Senate Bill 902 would represent an important step towards insurance plans providing equitable coverage for mental health and substance use disorder treatments relative to other healthcare services.

The MIA looks forward to continuing a dialogue with the sponsor and stakeholders to refine amendments for enhancing the bill's clarity and enforceability.

For these reasons, the MIA urges a favorable recommendation for Senate Bill 902.