Madison Harden
Public Health Law Clinic
University of Maryland Carey School of Law

500 W. Baltimore St.
Baltimore, MD 21301
publichealth@law.umaryland.edu

Testimony in Support of House Bill 11

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

Before the Health and Government Operations Committee: January 30, 2025

The Public Health Law Clinic submits this testimony in support of House Bill 11 and ultimately in support of making access to adequate behavioral health care permanent for insurance consumers who experience barriers to accessing in-network providers. Maryland has worked hard to ensure residents have access to care, with an uninsured population of only 6%.[1] 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.[2] 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.[3] The current network adequacy standards include appointment wait time, distance, and provider-enrollee ratio.[4] 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.[5]** 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 House Bill 11. Other

[1] *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¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[2] MD. CODE, INSURANCE § 15-830(d)(4).
[3] MD. CODE. REGS 31.10.44 (2023).
[4] 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.
[5] *2024 Access Plans*, MD. INS. ADMIN., https://insurance.maryland.gov/Consumer/Pages/2024-Access-Plans.aspx (last accessed Jan. 26, 2025).

Commented [KH1]: Thanks for using the Template properly!!!

Commented [CA2]: Re Kathi's comment about reworking this section, alternatively, you could say "for insurance consumers who are unable to access in-network providers because" x and y...

Commented [KH3]: This strikes me as blaming the consumer; can you rework in some way to avoid that?

Commented [KH4]: Note that for citations to Maryland Code, you must include the article—here Insurance. I am not up on the latest Bluebook version but this works.

Commented [KH5]: No need to id. in most cases in testimony—big difference from other writing you have done in law school, I am sure.

Commented [KH6]: I think it is important to explain why they did a sunset and link that to why they need to make permanent.

Commented [KH7]: Adding to the footnote?

Commented [MH8]: To what extent should I explain the network adequacy standards?

Commented [KH9R8]: I do not think you want (or need) to go into this more here—this is kind of the advantage of being in the committee that has been doing this work—they know this stuff. So this may be an example of not treating them like lay people when often we write to them as if they are lay people.

Commented [KH10]: Can you combine the three notes here into one? FNs are helpful but can be overwhelming so having one at the end is preferred.

Madison Harden
Public Health Law Clinic
University of Maryland Carey School of Law

500 W. Baltimore St.
Baltimore, MD 21301
publichealth@law.umaryland.edu

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.[6] 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.[7] 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 HB11 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.[8] 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.[9] Making the provisions of HB11 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."[10] 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."[11] 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

Commented [KH11]: I tried to make this a bit more accurate per the source; just tightened up some of the language.

Commented [KH12]: This Id is to a resource from Md Insurance Admin but you say this is from HRSA—can you cite the original source—if not, we can talk through how to use this.

Commented [MH13R12]: The data was collected by HRSA but the percentage was calculated by MD insurance admin. Who would be best to cite to? Perhaps I could do both?

Commented [KH14R12]: Can you add a parenthetical that says (referring to [insert HRSA source])?

Commented [KH15]: Including primary care? Because if so, we should be clear about that here since that is the comparator you've used above.

[6] *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.
[7] *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.
[8] 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.
[9] *Mental Health in Maryland*, NAT'L ALL. ON MENTAL ILLNESS (2021), https://www.nami.org/wp-content/uploads/2023/07/MarylandStateFactSheet.pdf.
[10] Tami L. Mark & William Parish, *supra* note 8 at C-79.
[11] 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.

Madison Harden 500 W. Baltimore St.
Public Health Law Clinic Baltimore, MD 21301
University of Maryland Carey School of Law publichealth@law.umaryland.edu

use treatment services. These findings make ~~it~~ clear that provider shortages are not the primary driver behind the high rates of out-of-network utilization in behavioral health.

HB11 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**.[12] 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 House Bill 11 presents is a critical step to addressing mental health and substance abuse crises in Maryland.

Commented [KH16]: Rework because you do not want to say "until" because that invites another sunset.

Conclusion

Because Marylanders continue to struggle to access adequate in-network behavioral health services despite efforts by insurance companies to remedy the issue, House Bill 11 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 House Bill 11.

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.

---

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