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H.B. 11: Health Insurance – Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage
Health and Government Operations Committee Hearing
January 30, 2025
Favorable

Thank you for the opportunity to submit testimony in support of House Bill 11, 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.

H.B. 11 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 H.B. 11 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, H.B. 11 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, H.B. 11 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, H.B. 11 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. H.B. 11 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. H.B. 11 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. H.B. 11 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. H.B. 11 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 H.B. 11 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.