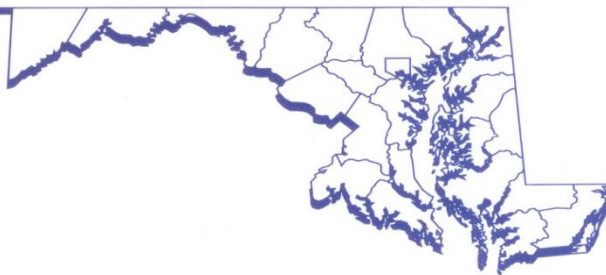


Maryland Association of  
COUNTY HEALTH OFFICERS

an affiliate of Maryland Association of Counties, Inc.



Maryland Insurance Administration  
200 St. Paul Place Suite 2700  
Baltimore, MD 21202

August 21, 2017

Maryland Insurance Administration Staff,

In response to Title 31 Maryland Insurance Administration Subtitle 10 Health Insurance – General 31.10.44 Network Adequacy, and in light of new feedback that the MIA does not have the authority to compel private insurers to contract with local health departments (LHDs):

The Maryland Association of County Health Officers, the Maryland Association of Counties, and the Maryland Rural Health Association strongly recommend amending the following sections of the current draft:

1. Section .04 C should be changed to the following: ***Each provider panel of a carrier shall include at least 60 percent of the available essential community providers delivering behavioral health services in each jurisdiction served by the plan.***
2. The current Section .04C should be renumbered as .04D and changed to the following: ***Each provider panel of a carrier shall include at least 30 percent of the remaining essential community providers in each of the urban, rural, and suburban areas.***
3. The current Section .04 D should be renumbered .04E.

The threshold of 30% of available ECPs is a minimum target established by the federal government. States have the ability modify the definition of Essential Community Provider (including the establishment of ECP subcategories) and to raise the percentage of ECPs included in provider panels as needed to assure adequate treatment networks for their residents.

The current draft of Title 31 Maryland Insurance Administration Subtitle 10 Health Insurance – General 31.10.44 Network Adequacy only requires that, ***“Each plan shall have 30 percent of the available essential community providers as part of its provider panel in each of the defined rating areas.”*** This does not take into account that many ECPs do not provide behavioral health services. As such, the

federal standards are inadequate to meet network adequacy needs in Mental Health Provider Shortage Areas. Allowing carriers to meet their 30% threshold by contracting with an ECP that provides no behavioral health care, and thereby excluding an ECP with significant behavioral health resources, fails to address critical health shortage needs of many Marylanders.

Data from the U.S. Department of Health and Human Services (HHS) clearly shows that behavioral health services are insufficient across the majority of Maryland. Nineteen of Maryland's 24 jurisdictions contain HHS-designated mental health provider shortage areas (MHPSA). As a result, raising the requirement to include at least 60% of ECPs providing behavioral health treatment in each carrier panel is justified as a necessary means to assure enrollees access to desperately needed care.

The qualifier *in each jurisdiction* is also needed in Maryland due to both the limitations of public transportation systems and the special needs of people suffering from behavioral health disorders. Most public transportation is limited to intra-county routes. Requiring people to travel 60 miles, as allowed by federal regulations, will leave some Marylanders 2-3 counties away from the closest behavioral health provider. Sixty miles may be a reasonable distance standard in Montana, but it makes treatment inaccessible for Marylanders. In addition, people requiring a common form of outpatient substance use therapy known as Intensive Outpatient Treatment attend appointments three times each week. Restricted provider panels that result in multi-hour roundtrips to access care is equivalent to barring enrollees from treatment for opioid addiction and other substance use care. Requiring lengthy trips also force parents into the dilemma of pulling their children out of school for a half of a day every time they have a behavioral health appointment. These children are already more likely to be struggling in school due to their underlying disorders. When coupled with therapy that is often weekly or biweekly, insurance carriers that refuse to contract with available providers in each local jurisdiction leave parents with a Hobson's choice that guarantees harm to their children.

The Maryland Association of County Health Officers, the Maryland Association of Counties, and the Maryland Rural Health Association understand that no regulatory requirements should be taken lightly. However, the impact of inadequate access to behavioral health services in Maryland is undeniable. The National Alliance on Mental Illness (NAMI) and U.S. census surveys report that >2/3 of adults and >1/2 of children with mental health problems do not receive care for their conditions. This directly correlates with the number of federally designated MHPSAs in a state. Inadequate provider networks for behavioral health care take their toll in the form of individual suffering, increased overdoses and suicides, and incalculable damage to families.

Although economic impact of expanded coverage is often focused on the short-term effects on insurance carriers, data from the World Health Organization show that neuropsychiatric disorders (primarily depression and PTSD/anxiety) are the leading causes of workplace disability in the U.S., leading to >400 million disability days/yr. After adding costs due to substance use disorders, SAMHSA calculates that U.S. businesses lose \$500 billion in production each year. This translates into a \$10,000,000,000 drain on the Maryland economy each year. These costs are primarily due to absenteeism, poor work-place performance (faulty or poor-quality production, workplace injuries, etc.), and higher staff turnover (recruitment and training costs, etc.). Improved access to behavioral health care through more robust provider panels should positively impact the entire Maryland economy.

The AHRQ reported that nationally there are 7.6 million emergency department visits for mental health conditions each year. This does not take into account the likely tens of millions of additional ER encounters for somatic conditions that manifest or are exacerbated by inadequately controlled chronic, mental health problems. Statistics from a pilot study at Calvert Memorial Hospital (CMH) show that 67%

of all high utilizers of ER services have a primary or secondary behavioral health diagnosis. Even with the contracting limitations imposed by most private carriers, a joint case management program developed by the health department and CMH was able to decrease hospital utilization costs by over \$2 million/year as a result of more effective links to outpatient behavioral health care. These savings to the All-Payer Model would further increase if the LHD (a proposed ECP) had contracts with all area carriers. And given that Calvert County accounts for only 1.5% of Maryland's population, the potential for statewide health care savings as a result of greater access to outpatient behavioral health services is substantial.

The amendments proposed above will greatly improve access to critically needed behavioral health care to millions of Marylanders living in MHPSAs and move us substantially closer to true network adequacy. As a result, parents will be able to obtain care for their children without sacrificing their education, families will suffer less trauma and disruption, and Maryland businesses will have more stable and productive workforces. Although this may result in a temporary increase in carrier payments, long-term savings to the All-Payer model will ultimately lead to lower insurance rates for Maryland's employers and tax payers. MACHO, MACo, and the MRHA urge the adoption of the above listed regulatory changes to meaningfully address current behavioral health network inadequacies.

Thank you very much for your consideration,



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