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December 6, 2022

Kathleen Birrane
Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Dear Commissioner Birrane,

RE: SB 460 Workgroup

I am writing on behalf of the Legal Action Center (Center) and the seventeen (17) undersigned members of the Maryland Parity Coalition to provide comments on the Maryland Insurance Administration's (MIA) draft proposal for a consumer assistance program. The Center convenes the Maryland Parity Coalition, which developed and advocated for the Consumer Health Access Program (SB 460). We are disappointed that the SB 460 Workgroup has not focused on the issues it was asked to consider – the resolution of which could have fine-tuned and strengthened the program that passed the Senate and received funding in Governor Hogan's FY 2023 supplemental budget. The Center submitted responses on June 14, 2022 to each of the identified issues, and we request that those comments, also attached here (Attachment A), be posted on the MIA's CHAP Workgroup page to ensure a complete record of the information we submitted for the workgroup's discussion.

We appreciate the MIA's willingness to present an alternative framework for assisting Marylanders obtain coverage of and access to mental health (MH) and substance use disorder (SUD) services through public and private insurance. While the MIA's framework would adopt several CHAP features, its structure does not – and, by virtue of its government-centric nature, cannot – achieve CHAP's fundamental vision and operation. That vision is a fully independent, consumer-centric program that implements best practices for education and outreach, individual client assistance and representation, and systemic reform. CHAP was carefully constructed by those with lived experience who know what is most helpful for individuals of diverse races, ethnicities, genders and identities, and disabilities to access insurance-based MH and SUD care as well as those with direct experience in trying to resolve health care insurance barriers via Maryland's existing government services.

The MIA's apparent goal is to retain at its core the state's existing consumer assistance services of the MIA, Maryland Health Benefit Exchange (MHBE) and HEAU. Each of these entities plays an important role in the state's health insurance education, enrollment and appeal processes and would continue to do so, under SB 460. **Yet together they do not constitute a "consumer assistance program" that is equipped to promptly address the barriers that individuals with MH and SUDs face.** The MIA's framework would sacrifice CHAP's key elements of **autonomy, transparency, seamless assistance and client representation** by placing the "program" in a state agency and relying on the state's existing assistance framework for problem identification, trouble-shooting, mediation and system-wide reform. Even with a designated Executive Director and enhanced resources, reliance on siloed, government agency-

focused model will not, in our view, do enough to help individuals and their families receive non-stigmatizing assistance and achieve their singular goal of identifying and accessing MH and SUD services **as quickly as possible** via insurance. Nor will it serve the broader goal of having an independent entity – one that has no built-in relationship to the state entities that formulate, regulate and oversee state-regulated public and private insurance activities – perform the sentinel function of identifying and resolving system-wide barriers. **For these reasons, we do not support the MIA's current proposal and would oppose a bill that puts forth this model.**

I. The MIA's Proposed Structure of a Decentralized Referral System Would Replicate Existing State Consumer Assistance Services Without Fixing Deficiencies

The MIA proposes a "hub and spoke referral" model composed of the following entities:

- The "hub" would be an independent division of the MIA led by an Executive Director (ED), who would be selected by the MIA Commissioner in consultation with other state health agencies, report to the Commissioner, and serve a designated term of office.

- The "spokes," described as "Behavioral Health Care Navigators" would be located in each of the eight connector entity regions and would, along with certified peer counselors, provide assistance to consumers in identifying MH and SUD providers, refer to other state entities for enrollment and assistance in resolving health plan coverage issues, and track information related to consumer access to care and coverage.

- "Referral entities" are existing state entities that will perform insurance related activities consistent with their current roles; i.e. enrollment (MHBE Navigators and the Connector), assistance with coverage denials (MIA and HEAU), and, additionally referral to legal resources if administrative action does not resolve the issue. (It is unclear if the hub or other agency performs this function.).

The proposed program would also offer a telephone hotline to respond to requests for assistance using existing call center operations, such as 211 or MHBE for intake and emergency triage, and it would provide a website with information about available MH/SUD services, plan coverage, and forms to request assistance, which would be linked to the intake system.

We have several questions and concerns about the proposed framework. As baseline observations, we note that:

- The proposal offers no indication of the ED's qualifications, including lived experience with MH and SUDs, expertise in MH and SUD care delivery, consumer assistance and policy development, or demonstrated commitment to the expansion of MH and SUD services, elimination of discriminatory insurance practices, and health equity. **The MIA expressed that the ED would have significant discretion to establish the culture, direction and operations of the program, and the above qualifications are essential for an effective program and, therefore, must be included in the framework.**

- The functions of the hub are administrative in nature – standing up and managing the various components of the program and reporting to the General Assembly – rather than on-the-ground substantive work. This model is quite different from the NY CHAMP model, other effective programs in Vermont, California, and Connecticut and that proposed in SB 460, in which the hub team manages the call center, conducts intake for individuals who do not go directly to the spoke entities, and represents clients in informal and formal resolution of complaints in addition to carrying out all administrative tasks (hiring spoke organizations, conducting training, and activity reporting). **The proposed MIA administrative hub would appear to add additional costs to the program without generating direct consumer or provider assistance**. To the extent the hub is also responsible for improving the coordination the MH and SUD services performed by various state agencies, that work should be done by the existing agencies with existing resources and not a central function of the

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consumer assistance program.

- The proposal does not articulate the meaning of an "independent division" of the MIA, offer examples of existing independent offices within the MIA, if any, or identify whether the program would be represented by a state Attorney General who is separate from the MIA, HEAU or any other state agency. **These are critical features that are needed to assess whether (1) this model creates the appearance of or an actual conflict of interest that will fundamentally influence the willingness of consumers to seek the program's assistance and (2) system-wide reform, which inherently requires external stakeholders tracking and possessing unfiltered data, would be possible (or any different from existing practices).**

  We are familiar with the People's Insurance Counsel Division (PICD), established by statute (State Gov. § 6-301 et seq.), placed in the Maryland Attorney General's office, and directed by the People's Insurance Counsel (§6-303). The People's Counsel is explicitly authorized and required to represent consumer interests in matters before the MIA on medical professional liability and homeowner's insurance matters, including "appear[ing] before the Commissioner and courts on behalf of insurance consumers in each matter or proceeding over which the Commissioner has original jurisdiction." § 6-603(a)(2). This statutory framework establishes independent, legal representation on behalf of consumers in insurance matters that the MIA regulates. **Nothing less should be available to Maryland's consumers who will be involved in disputes with health plans and issuers that the MIA regulates and implicates laws that the MIA enforces.** (*See* below for additional concerns regarding client representation.)

- The Behavioral Health Navigators would have a limited role in the **initial engagement** of consumers and would apparently act solely upon referrals from the call center. Unlike the significant and pro-active role of the "spoke" entities in SB 460, the proposed model **would not utilize** the on-the-ground expertise of these entities to conduct outreach, education and engagement activities with community members to **affirmatively identify** needs and system-wide problems and **deliver assistance to those who would not otherwise contact the call center**. The proposed "passive" role does not capture what true engagement means and requires for individuals and family members who face significant stigma related to their MH and SUD and may never get to the call center or website. **It also misses a significant opportunity to identify, through on-going public interaction, the most critical on-the-ground insurance barriers that the program should be addressing.**

  The community-based spoke organizations should be an on-the-ground resource through which individuals and families learn about rights and services they may not be aware of and have the opportunity to develop a personal, trusting relationship with one person who has lived experience in accessing MH or SUD care and is their "first-responder" ally for problem-solving. As we learned from the NY CHAMP presentation, community-based organizations are key to their program's outreach, education and engagement because they are in the community and a trusted, non-stigmatizing entity. **The MIA's model offers no assurance that the program will adequately reach many Marylanders who would benefit most from the services, including those with current drug use conditions who may be engaging in illegal activities, those who have had negative experiences with a range of government agencies, persons leaving carceral settings, and others with few family supports or an inability to navigate call centers and websites in a crisis.**

- The proposal diminishes the value of peers and suggests that individuals with lived experience are not, in fact, the same as individuals who would perform navigator and other services in the program. In contrast, SB 460 **lifts up** those with lived experience both through the qualification requirements for *both* the hub and spoke entities (SB 460 Sec. 13-4404) and requirement that CHAP promote equity in access to MH and SUD services by, among other things, "employing individuals with lived experience in mental health and substance use disorder treatment, including individuals engaged in peer service delivery." (SB 460 Sec. 13-4406 (3)).

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Additionally, the certification requirement seems unnecessary, as many individuals who do peer service delivery in Maryland are not required to obtain certification. According to the Maryland Addiction and Behavioral Health Professional Certification Board (MABPCB), 524 Marylanders currently have peer certification, as of December 2022,[1] and, according to the Maryland Peer Advisory Council, a far greater number of individuals who deliver peer services are not certified, and the credential is generally based on grant requirements.[2] For those who seek or need certification, Maryland's existing certification program would provide the required education and testing and fully satisfies the MIA's proposal.

- The reliance on 211 and MHBE for the call center function would require far greater training, oversight and resources than a centrally-located center that is part of a **single point-of-contact entity,** which would directly connect individuals with MH and SUD treatment and insurance-related needs (and providers of such services) with the source of help. This is neither the mission nor experience of 211 or MHBE staff; the former having the role of identifying and directing callers to resources and the latter being responsible primarily for insurance enrollment. Additionally, the implementation of 988 means that 211 will have a much more limited role with MH/SUD crisis services and will invariably turn its attention to other activities that would compete with the proposed consumer assistance call center role. **Splitting intake and referral responsibilities between 211 and MHBE not only further diffuses assistance but would also require MHBE to conduct time-sensitive and highly emotional tasks in the midst of many other responsibilities, including open enrollment.** One questions the capacity of MHBE to respond in a sufficiently timely and detailed manner at the height of open enrollment season without the addition of dedicated staff (adding additional costs to the consumer assistance program).

  In contrast, SB 460 would place the call center in the hub so that it is incorporated seamlessly with the entity having responsibility for all program activities – both operational and substantive. A new mission-driven entity would be in a better position than 211 or MBHE in "getting this function done right," which will require a team with compassion and commitment to helping individuals in crisis as much as technical functionality.

- The identified "coordinating agencies" do not include the Opioid Operation Command Center (OOCC), a state agency that focuses on Maryland's opioid use and SUD epidemics, or provide any role in the program, including being a member of the proposed Advisory Council or consulted on the selection of the ED. This omission reflects a lack of coordination and engagement across existing state entities and could signal a lack of awareness of the systemic problems a consumer assistance program should address or the many Maryland organizations with which OOCC has worked to address Maryland's SUD epidemic.

From an operational perspective, the proposed model is the antithesis of a centralized single point of contact for consumers and providers of MH and SUD care. **A consumer would have to deal with no less than 4 to 6 different entities when seeking assistance**: a call center, MHBE for triage, a Behavioral Health Navigator, a certified peer, the MHBE for enrollment, HEAU and/or MIA and/or an external entity, such as SHIP for problem assistance. **With multiple players from different organizations, we expect that many individuals who contact the call center will fail to connect with a Behavioral Health Navigator or the MIA and/or HEAU.** Connector entities, such as AHEC West, presently deal with this same disconnected set of resources, and have observed that, even with their dedicated support and encouragement, consumers are not able to or fail to follow through on the multiple recommended contacts. Many are not able to follow through on even one recommended contact, especially when they are in crisis or struggling with a MH or SUD. The SB 460 model was designed specifically to address the existing fragmented assistance model and the individual's fundamental need to work with a trusted ally who is viewed as ***their*** advocate, owing no allegiance to a government entity.

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[1] E-mail Conversation, Deborah Steinberg, Legal Action Center Health Policy Attorney, with Monica White, Vice President and Peer Committee Chair of MABPCB (Dec. 1, 2022).

[2] Telephone Conversation, Deborah Steinberg, Legal Action Center Health Policy Attorney, with Tiffinee Scott, Director, Maryland Peer Advisory Council (Dec. 2, 2022).

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The benefit of the MIA's proposal, as described by Commissioner Birrane, – "government talking to government about how we're going to take care of our consumers" – misses the key ethos of a consumer assistance program. The focus must be on providing resources and support to individuals with MH and SUDs to help them identify and achieve their health goals rather than presuming that government agencies know what the consumer needs and arriving at a solution that may not meet their needs. It also eliminates the possibility that consumers will be able to learn from their experience to self-advocate in the future, which will give them more autonomy and control over these very difficult situations. While government should do all it can to assist consumers, removing them from the center of the problem-resolution process only silences those who know the most about their health condition and undermines self-efficacy and self-advocacy.

II. Limitations of State Government Entities to Deliver Client Assistance and Pursue Systemic Reform

A. Individuals with MH and SUD Are Not Receiving Appropriate Assistance to Challenge Care Denials Under Maryland's Current Health Insurance Appeal Model

The imperative to establish an effective independent consumer assistance program – as opposed to building on the existing system – is clear from the HEAU's 2022 Annual Report on the Health Insurance Carrier Appeals and Grievance Process. As in previous years, few consumers filed grievances with carriers to challenge an adverse MH or SUD decision. Of the 88,539 adverse decisions, 620 (.7%) involved a MH or SUD matter and 75 grievances (.78%) were filed. The portion of MH/SUD grievances was lower than all other care services, except for emergency room, home health, and skilled nursing/nursing home services. (*Id*. at 26). Thirty-five (35%) of the MH/SUD grievances were overturned; a much lower rate than the overall rate of 54% for all grievance. (*Id*. at 5 and 27).

Even fewer individuals challenged their carrier's MH/SUD denial administratively. The MIA investigated 323 complaints challenging a carrier's grievance decision, only 4 of which were MH/SUD matters. (*Id*. at 7 and 35). The carrier overturned all 4 matters during the MIA's investigation. (*Id*. at 35). **One can only guess the number of MH/SUD grievance decisions that could have been overturned had the plan member had support to challenge the carrier's decision before the MIA.**

These plan members are clearly not seeking that assistance from the HEAU. As in previous years**, only 3% of the HEAU's matters involved mental health claims** – 13 cases out of the 436 mediated matters in 2022. (*Id*. at 9 and 51). The MIA's proposal does not address one of the most critical issues underlying the SB 460 proposal: **individuals with MH and SUD problems do not seek HEAU assistance for care denials.** SB 460 would solve the problem of limited MH/SUD appeals by creating an independent entity to represent individuals in their insurance disputes from start to finish. Indeed, the MIA's proposal to supplement the HEAU's work through contract legal assistance for complex MH and SUD matters amounts to having the legal resources proposed for the SB 460 hub assist clients, (albeit without the right to actually **represent** the individual). *See* Section III. The SB 460 hub would carry out this client assistance function more effectively.

One element that certainly plays a role in whether individuals with MH and SUD problems seek assistance **is their expectation around and experience with stigma**. Stigma "occurs at three levels in society – structural (laws, regulations, policies), public (attitudes, beliefs, and behaviors of individuals and groups), and self-stigma (internalized negative stereotypes)."[3] Structural and public stigma influence self-stigma, and, at the individual level, self-stigma "reduces self-efficacy and can discourage people from disclosing their condition for fear of being labeled and subjected to discrimination." (*Id*.) This, in turn, discourages individuals from seeking treatment and help. (*Id*.) The Director of the National Institute on Drug Abuse (NIDA) has identified stigma as "one of the biggest obstacles in confronting America's current drug crisis," emphasizing the connection between

[3] National Academies of Sciences, Engineering and Medicine 2016, ENDING DISCRIMINATION AGAINST PEOPLE WITH MENTAL AND SUBSTANCE USE DISORDERS: THE EVIDENCE FOR STIGMA CHANGE, Washington, D.C.: The National Academies Press, at 5.

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stigma and the reluctance of insurers to cover addiction treatment or to offer only limited coverage.[4] She observed that "addressing stigma must be a central prong of our public health efforts[i]f we're going to end the current addiction and overdose crisis…." (*Id.)*

Unfortunately, the implicit biases that stigmatize individuals with MH and SUDs, and particularly those with SUDs, can be seen in the MIA and HEAU's work. A recent MIA and HEAU education module on the State's new balance billing protections for consumers with SUD and MH problems (Ins. § 15-830(d)) displayed as its cover image **an utterly stigmatizing image of individuals with a SUD. The image displays a hand with a syringe surrounded by powder and pills.** Such an image speaks volumes to individuals in need of SUD care and their families. It objectifies an individual's health condition, does not convey compassion, empathy or an offer of help, and undermines the individual's perceived efficacy to address their health and other problems. For advocates who work on behalf of this community, the image hardly builds confidence in the ability of these entities to deliver services effectively and with respect for the dignity of individuals with SUDs.

SB 460 was carefully crafted to establish a non-stigmatizing operation by including staff in the hub and spokes with individuals with lived experience. The Substance Abuse and Mental Health Services Administration (SAMHSA) identified the critical role of individuals with lived experience in developing communication messages that reduce stigma and has developed materials to help government agencies, the media and health providers promote a "realistic presentation of [individuals with SUD or in recovery], free from biased and discriminatory undertones." **For a consumer assistance program to be effective in assisting individuals and reducing stigma, it must be centered in an independent entity that has knowledge of and experience in non-stigmatizing communications.**

B. Government Agency Control of Program Data Will Undermine Stakeholder Ability to Identify System-Wide Trends and Recommend Solutions

The MIA's proposal recognizes that data gathering, analysis of access problems and public reporting is needed to systematically improve access to affordable MH and SUD care. It has also identified some of the key data points and metrics that should be reported, including information about Parity Act, network adequacy and provider directory issues and violations. Visibly absent from the list is carrier reimbursement issues, a key metric to understanding and addressing access, network adequacy and affordability of care. **Consumers and providers will likely raise reimbursement issues in disputes, and limited reimbursement is a significant element that underlies access problems. The MIA's failure to identify this metric is troubling.**

While a broad-based scope of data-gathering and analysis are important, an even more significant factor in resolving systemic problems promptly is **the entity that holds and controls the data**. The proposed government-centric framework means that all data will be collected and held by the very agencies whose regulatory practices may contribute to access gaps and who may not have the on-the-ground presence to learn about barriers not yet reflected in the data. Additionally, these agencies will share data among themselves and make their **aggregate data** analysis and recommendations available **only on an annual** basis to the General Assembly. **The MIA's approach will only allow for the sharing of filtered information and will prevent consumers, providers and other stakeholders from identifying problematic trends quickly, which can help agencies improve access to care.**

In contrast, SB 460, was based on best practices that recognize the nonprofit community-based consumer assistance programs are the most appropriate entities to both deliver consumer assistance and conduct the important "sentinel" function.[5] The SB 460 model would allow for greater transparency rather than creating the impression that the consumer assistance program is appearing to serve the interests of state agencies and the

[4] Nora Volkow, MD, Nora's Blog "To End the Drug Crisis, Bring Addiction out of the Shadows" (Nov. 8, 2021), https://nida.nih.gov/about-nida/noras-blog/2021/11/to-end-drug-crisis-bring-addiction-out-shadows.

[5] Community Service Society, MAKING HEALTH REFORM WORK: STATE CONSUMER ASSISTANCE PROGRAMS (Sept. 2010), at 4.

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carriers, health plans, and Medicaid Administrative Services Organization that they regulate. It would "serve as the eyes and ears of policy makers, yet remain independent of changes in political administrations." (*Id*.) The goal would be to "work closely with government officials to alert them to emerging trends, issues, and challenges faced by their shared constituencies." It would do so by "providing real-time, data-driven feedback and recommendations" based on individual cases that reveal both problematic and positive practices. (*Id*.) As experts have noted, the benefit of this model is that independent entities can "detect patterns relating to specific policies – often much faster than can be done at the state level." (*Id*. at 7).

The SB 460 approach to data gathering and analysis is designed, in part, to address long-standing Parity Act enforcement problems in Maryland. Prior to enactment of parity compliance reporting requirements (Ins. § 15-144), the MIA conducted market conduct surveys to identify carrier practices that constituted a Parity Act violation. The MIA's public reports did not identify the specific carrier engaged in a violation unless a formal order was issued – a process that could take more than a year. In other circumstances, the MIA would provide information that suggested a violation, but the analysis was not sufficiently detailed to determine whether the MIA had conducted a correct analysis or took appropriate action. Public stakeholders had no information to pursue those matters independently. Even with the new parity compliance reporting requirement in place, the MIA's lengthy review process has not resulted in any formal findings on the merits – nine months after the carriers submitted their reports – and the public will be left in the dark pending any orders and report to the General Assembly. In the meantime, discriminatory insurance coverage continues to harm consumers.

A more **transparent and timely** process, as proposed in SB 460, is needed to address system-wide problems so that Marylanders gain access to MH and SUD care promptly. System-wide reform need not be adversarial, and it benefits the state and all Marylanders who pay the cost of untreated MH and SUDs in lives lost to overdose and suicide and economic burden on the health, social services and criminal legal systems.

III. Individuals with MH and SUDs Require Direct Client Representation to Resolve Insurance Barriers to Care

The Workgroup has recognized that individuals with MH and SUDs have particularly complex insurance issues and require intensive hands-on assistance in the midst of a crisis. As the Supervising Attorney for CHAMP described in her SB 460 testimony, compared with the Community Service Society's other consumer assistance programs, "CHAMP clients are more likely to need help appealing insurer denials, and CHAMP's insurance appeals are typically two to three times longer than appeals related to medical/surgical care." (Attachment B). CHAMP and other state consumer assistance programs (*see, e.g*. Connecticut Health Advocate) deliver this assistance through direct, client representation. Under the SB 460 model, this means that when a problem cannot be resolved through informal discussions with a carrier and an internal grievance or administrative agency appeal is required, an attorney would enter an attorney-client relationship with the individual and is obligated to represent them under the rules of professional responsibility. (Other individual client assistance would also be governed by an agreement that clearly identifies the scope of work and other individual protections, including health privacy.) This role stands in sharp contrast to the HEAU's limited authority to provide assistance with drafting internal grievances, external reviews, and complaints and mediating disputes and its lack of authority to bring a civil action seeking review of a State agency determination. (Comm. Law § 13-4A-02). While the HEAU's current assistance model may work for many consumers, as noted above, it clearly has not been sufficient for individuals with MH and SUDs, who invariably need an advocate to organize medical evidence, frame legal arguments and present the merits of their case in written materials and hearing procedures.

We believe this limited assistance model, incorporated into the MIA's proposal, will continue to prove ineffective for individuals with MH and SUDs and may be even more ill-suited to assist Marylanders who are Medicaid enrollees and who may experience more social determinants of health. The HEAU has identified the need for additional support to respond to an increase in callers in mental health crisis, including individuals with social work expertise to support consumers, and those with expertise in Medicaid. Yet, it makes little sense to tie the hands of attorneys – hired for the explicit purpose of helping those with more complex insurance problems – **by preventing them from providing direct client representation in grievances before**

carriers, external reviews before the MIA or ERISA plans, Medicaid fair hearings and Medicare disputes or by barring them from suing health plans or filing actions to challenge an unfavorable state agency decision. Indeed, HEAU acknowledged that its efforts to resolve ERISA plan problems are not as successful as state-regulated plan disputes; one can imagine that HEAU's limited role invites health plan obstruction.

The SB 460 model would address these client representation limitations by establishing an independent consumer assistance program that takes advantage of all legal options to resolve a person's problem. **This does not mean that program resources would be used to engage in frequent and costly judicial proceedings. As in any dispute, all parties seek and benefit from a prompt and informal resolution of the dispute, particularly to expedite the delivery of MH and SUD care – the primary goal of individuals seeking access to care.** Yet, without the right to legal representation in both administrative and judicial forums, a consumer left to *pro se* representation would be less likely to succeed in an administrative forum and would be forced to undertake one additional referral to find no or low-cost legal counsel to pursue their rights. Those legal resources are limited in Maryland and would require additional capacity building and funding to establish.

We are also concerned that the MIA's proposal would not create internal capacity to address disputes that involve Medicare beneficiaries and, particularly beneficiaries who are Medicare-eligible based on disability or have multiple insurance coverage. The HEAU's proposed approach to refer individuals to the State Health Insurance Assistance Program (SHIP) is insufficient, as SHIP does not represent clients in disputes and provides limited assistance to Medicare beneficiaries under 65 years of age with disabilities. With increasing numbers of Medicare beneficiaries having MH and SUDs, resources will need to be devoted to building Medicare expertise within the hub and/or contracting with a spoke entity that has this expertise.

IV. The Scope of the Proposed Consumer Assistance Program Cannot Be Fully Evaluated Without a Cost Estimate

The MIA has not determined the cost of its proposal, which prevents an assessment of the level of services and relative priority of various activities. It also prevents an assessment of whether the distribution of activities across many state agencies increases the cost of the program. As a state-agency centric program, funding will always be contingent on the Administration's priorities, and support for the program could vary over time with various components of the program taking priority over others. Under SB 460, an independent entity would not be constrained by political or other interests that may seek to limit its activities. By meeting the needs of consumers and providers, it will gain consistent support from the public to ensure on-going State appropriations and will be incentivized to seek external funding to enhance operations.

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Thank you for considering our views.

Sincerely,

Ellen M. Weber
Sr. Vice President for Health Initiatives
Legal Action Center

Addiction Resources Connection
AHEC-West
DC-MD Society of Addiction Medicine
Health Care for the Homeless
Institutes of Behavior Resources, Inc.
James' Place, Inc.
Maryland Addiction Directors' Council (MADC)
Maryland Association for the Treatment of Opioid Dependence (MATOD)
Maryland Coalition of Families
Maryland Heroin Awareness Advocates
Maryland Psychiatric Society
Maryland Psychological Association
NCADD-Maryland
NAMI-Maryland
Voices of Hope, Inc.
Courtney Bergan, Univ. of Maryland Carey School of Law, JD Candidate, Class of 2023
Laura Mitchell, Member, Montgomery County Alcohol and Other Drug Advisory Council, MCCPTA

Attachment A

LEGAL ACTION CENTER

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Director of Operations

June 14, 2022

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

RE: SB 460 Workgroup

Dear Commissioner Birrane:

Thank you for convening a workgroup to address the establishment of the Consumer Health Access Program (CHAP) for mental health and addiction care. The Legal Action Center (LAC) is a non-profit organization that uses legal and policy strategies to fight discrimination against individuals with substance use disorders, arrest and conviction records, and HIV or AIDS and to build health equity and restore opportunities for these individuals. LAC chairs the Maryland Parity Coalition, which developed the proposed CHAP framework, set out in SB 460 and HB 517, and worked closely with the bill sponsors, Senator Augustine and Delegate Lewis, to educate members of the General Assembly about CHAP and secure passage. The Senate passed SB 460 unanimously, and Governor Hogan provided funding for CHAP for FY 2023 in his supplemental budget, contingent on passage by the General Assembly.

During the legislative debate on SB 460, Senator Augustine in consultation with LAC (acting on behalf of the Parity Coalition) addressed numerous questions presented by the Maryland Insurance Administration (MIA) and the Health Education and Advocacy Unit (HEAU) related to the structure, role, activities and accountability of the proposed program and privacy protections for consumer health and financial information. Numerous clarifying amendments offered by the MIA and HEAU were incorporated into SB 460 prior to Senate-passage. Many of the issues identified as workgroup discussion items have, in fact, been addressed by those amendments.

The following responses address key points with the goal of (1) identifying how SB 460 addresses many of the identified issues and (2) helping to narrow the essential items for further discussion. LAC continues to conduct research on several issues and will submit subsequent comments to address those issues and others based on the workgroup discussion

I. Scope of CHAP Activities and Potential Overlap with Other State Agency Work

CHAP's role and scope of activities, as set out in Senate-passed SB 460, is based on the federal consumer assistance program standards adopted under the Affordable Care Act (ACA) (42 U.S.C. § 300gg-93) and best-practices identified by experts engaged in such programs. **In brief, we consider the full scope of proposed CHAP activities to be appropriate to address comprehensively the health care access needs of consumers with mental health (MH) and substance use disorders (SUD). Additionally, we do not view the potential overlap with state agency activities to be significant or inefficient (where overlap exists) based on the scope of the respective entity's activities and the value of enhanced targeted resources in this context of critical need.** There is no question that existing resources are not sufficient to meet the needs of Marylanders who seek access to insurance-based MH and SUD care and need support to secure those health services. CHAP is designed to collaborate with state agencies, complement existing services and bring additional resources to fill activity gaps, engage Marylanders through intentional non-stigmatizing practices, and help identify and address barriers that state agencies may not focus on for any number of reasons.

A. CHAP – Proposed Activities

The consumer assistance structure proposed for CHAP aligns with the federal framework for such programs, thereby ensuring CHAP is consistent with nationally recognized best practices. The model established under the ACA requires the entity to be an "independent office" and conduct specific activities:

- Assist with filing complaints and appeals, including internal appeals of the group health plan or issuer, and providing information about the external appeal process;
- Collect, track and quantify problems and inquiries encountered by consumers;
- Educate consumers on their rights and responsibilities related to group health plans and health insurance coverage;
- Assist consumers with enrollment in a group health plan or health insurance coverage; and
- Resolve problems with obtaining premium tax credits.

Importantly, in considering how the independent consumer assistance program would relate to the state's insurance department and other existing consumer assistance organizations, federal law made clear that the independent entity would either "directly or in coordination with State health insurance regulators and consumer assistance organizations," receive and respond to inquiries and complaints about federal and state law insurance requirements. 42 U.S.C. § 300gg-93(b)(1). In other words, federal law expected that multiple entities **could and would deliver** assistance on consumer inquiries and complaints and would coordinate their efforts. **The existence of a state agency with overlapping activities was not a reason to restrict the functions or activities of a new consumer assistance program.** Rather, federal law recognized that independent consumer assistance entities would serve a unique and important role in getting consumers the help and support they needed, beyond what existing entities could provide**.**

CHAP would engage in this full range of functions (with the exception of resolving problems with obtaining premium tax credits) for Marylanders with MH and SUDs, recognizing that (1) MIA, HEAU, MHBE and navigators offer assistance for a some, but not all, insurance programs/payers and (2) multiple state entities conduct some, but not all, of the core functions through a patchwork of

assistance, which is difficult to navigate without support. That said, CHAP would not duplicate activities that are thoroughly addressed by the State, such as plan enrollment functions, but would instead ensure that a non-insured consumer is connected directly to the appropriate Connector Entity for such purpose.

1. Range of Insurance Programs/Payers

While state-regulated private insurance constitutes a relatively small portion of insurance coverage for Marylanders,[1] those plans are the central focus of state-agency activity apart from Medicaid enrollment activities conducted by MHBE.[2]

- MIA investigates complaints and issues determinations for state-regulated insurance matters;
- HEAU assists consumers in resolving insurance disputes and filing internal and external appeals for state-regulated commercial plans and works on some self-funded ERISA and non-ERISA matters, although the scope of that work is unclear.

CHAP would help Marylanders with MH and SUDs by addressing consumer questions and complaints regardless of their insurance program or payer, which would fill the gap for the millions of Medicaid and Medicare enrollees in Maryland who cannot get help from HEAU or MIA. CHAP would further ensure that consumers with MH and SUDs, who often do not know which entity regulates their insurance, will have one point of entry for assistance. This will be particularly helpful for consumers who are enrolled in multiple insurance programs, requiring coordination of benefits across different payers and enforcement by different state and federal agencies.

2. Scope of Activities

Similarly, CHAP would have authority to engage in the full scope of consumer assistance activities in order to help identify and troubleshoot coverage and access problems quickly and provide **seamless assistance** should a formal grievance or appeal or further legal action be needed. The MIA has noted that, based on House testimony:

[T]here is broad support for the establishment of a program to serve as a single access point for individuals and families in need to work with trained professionals to find the right treatment provider and coordinated coverage and payment for that treatment to the extent provided under any health plan or program available to the patient. MIA SB0460 Workgroup, Virtual Public Hearing Notice and Agenda at 1. Engagement with a consumer at the initial point of need via the navigator function establishes a foundation for assistance upon which *the delivery of all other needed services is built*. **Limiting CHAP's authority to the navigator function would interfere with continuity of assistance with a trusted partner at the very point at which prompt action is most needed to resolve a dispute.** Requiring CHAP to refer the consumer to the MIA, HEAU, or Departments of

[1] As of 2020, 16.3% of Marylanders under age 65 had fully funded health plans. Maryland Insurance Administration, 2020 Report on the Number of Insured and Self-Insured Lives (Dec. 1, 2020) at 5. On the other hand, 38.2% had group self-insured or federal employee health benefit plans. *Id.* As of 2019, 18% of Marylanders were covered by Medicaid or CHIP (KFF, Medicaid in Maryland (Oct. 2019) and more than 1 million residents have Medicare. Medicare in Maryland.

[2] The list of issues does not identify any concerns related to activities conducted by the Maryland Department of Health (MDH) regarding Medicaid, and MDH did not raise institutional or other concerns during the legislative process. Our comments, therefore, focus on state agencies involved in the private insurance market. The need for CHAP is no less critical among individuals enrolled in Medicaid.

Labor or Health and Human Services for further assistance with internal and external grievances would be analogous to requiring a physician who diagnosed a medical condition and started the patient's treatment to refer the patient to another provider with whom the patient has no relationship or trust to complete the care intervention. Furthermore, since those agencies cannot represent consumers fully in their appeals (discussed in greater detail below), a referral essentially means leaving them to navigate the grievance process without an advocate.

Apart from interfering with the individual's right to choose the source of legal assistance and inefficient service delivery, **the point of referral to other assistance is the juncture at which many consumers drop out,** according to a Parity Coalition member who is the Program Director of the Western Maryland connector entity. The risk of no follow-through is even greater when the consumer has a substance use or mental health problem; concerns regarding stigma and the perceived implications of sharing information about drug use with state entities are significant deterrents for Marylanders who need assistance the most.

Any proposed restrictions on client representation by CHAP, based on the MIA's and HEAU's work, also does not take into account the limitations in state agency functions (beyond the insurance programs/payers those agencies have authority to address). A comparison of proposed CHAP activities with the activities conducted by the MIA and HEAU (Attachment A) reveals the following limitations in state agency functions:

- The MIA investigates complaints that are filed with the agency, but as the arbiter of those complaints, it cannot provide legal assistance to the consumer.
- HEAU acts on complaints it receives but must refer any matters within the MIA's jurisdiction to that agency and does not assist consumers who are denied enrollment in Medicaid or Medicaid coverage appeals.
- HEAU *assists* consumers in filing internal and external grievances and resolving disputes through mediation, but it does not "represent" such individuals in the internal or external grievances.
- HEAU does not represent consumers in any legal action challenging denials of enrollment or coverage, including those related to federal and State mental health parity laws.
- HEAU does not have the authority to bring a civil action seeking review of a State agency determination.

Notwithstanding HEAU's excellent work, its services do not align with the full scope of assistance and representation that many individuals and families with MH and SUD insurance-related insurance problems require. Unfortunately, the vast majority of Marylanders with these conditions do not seek HEAU's services. **A mere 3% of the 388 appeals and grievances cases that HEAU mediated and closed for FY 2021 (11 cases) involved mental health disputes.** Office of the Attorney General, Annual Report on the Health Insurance Carrier Appeals and Grievances Process, FY 2021 at 44 and 48. Even with the epic and unprecedented need for MH and SUD services in Maryland, HEAU did not identify enforcement of insurance coverage standards for MH and SUD care among its areas of concern. *See* Annual Report at 12-15.

Finally, a core function of CHAP and the federal model is to "collect, track and quantify problems and inquiries encountered by consumers." 42 U.S.C. § 300gg-93(c)(2) and *see* SB 460 Section 13-4402. This "sentinel function" is intended to provide timely information to state regulators and policy makers to identify the barriers that Marylanders face in accessing insurance-based MH and SUD treatment. Community Services Society and Community Catalyst, *Making Health Reform Work: State Consumer Assistance Programs* (Sept. 2010) at 1. Through this data collection function, consumer assistance programs are often able to detect patterns related to specific policies much

faster than state regulators, "serv[ing] as the eyes and ears of policy makers [and] identifying problems before they become headlines…." *Id*. at 7. In circumstances in which State agencies do not choose to or cannot resolve a systemwide problem, CHAP would be in a position to pursue those issues through education of the General Assembly and by other advocacy means. Absent independent control of the data and trend analysis, significant problems that affect access to MH and SUD care could not be resolved.

Historically, the MIA and carriers have relied on consumer and provider complaints as a key – and often sole – source of information about violations of state and federal law. And the absence of such complaints had, in the past, been viewed as an indication that problems did not exist, even though it was well recognized that individuals and families in the midst of a MH or SUD crisis have little capacity to file a complaint. Although the recent enactment of laws that require carriers to demonstrate compliance with quantitative network adequacy metrics and federal Parity Act standards will provide an important new source of information to identify and root out carrier violations, information derived from consumer experiences and individual complaints remains a critical source of information. **It is unclear why any state agency or policy maker would seek to limit the gathering and reporting of such information, which would be enhanced through CHAP's systematic outreach, plan navigation and consumer representation functions.** CHAP's data will strengthen the investigation and enforcement by such agencies to ensure that system-wide problems can be resolved in the most timely and effective manner.

State agencies, policy makers and the public would have the opportunity to evaluate the quality and value of that data, as SB 460 would require CHAP to make its data, trend analyses and recommendations available to those entities. *See* SB 460 Sec. 13-4405(C)(5). SB 460 would also require CHAP to "work with" state agencies to address systemic gaps and Parity Act violations (*see* Sec. 13-4405(C)(6)) and does not permit any interference with or supplanting of the MIA's or other federal agency work in this area. Indeed, the establishment the Consumer Health Access Advisory Council (SB 460, Sec. 2) would require the Council, which would be composed of all relevant state health agencies, to review the data on cases handled by CHAP and make recommendations based on those data. Sec. 2 (c)(3).

Questions arose during the legislative process regarding the scope of "investigations" that CHAP would conduct and its access to information gathered as part of an active state agency investigation. *See* SB 460 Sec. 13-4407(B). Clarifying amendments were adopted to ensure that CHAP's investigations relate exclusively to CHAP program participant.

B. Required Skills

In assessing the appropriate scope of activities of CHAP, the MIA's notice states that a range of skills are required to carry out the various activities, noting specifically that "connecting people to covered care requires very different skills than litigating coverage issues and both are different from data analytics." Notice at 3. We agree, and SB 460 accounts for the staff expertise required to conduct the various activities through the proposed hub and spoke model as well as designating the University of Maryland School of Social Work Center on Addiction Research, Education and Services (CARES) as the incubator.

The spoke entities – non-profit organizations with "feet on the ground" in each of the state's eight connector entity regions – would be trained to conduct education, outreach, linkage to care and assistance with plan navigation. The spokes would refer consumer matters that require representation in grievances and appeals and involve other legal analysis or intervention to the hub, which would be staffed with lawyers and other professionals trained to address such matters. CARES

has significant research and program evaluation expertise, and among its core aims are policy development, analysis and education. It would, among other functions, help build an infrastructure for the hub to collect and analyze data on the impact of CHAP. *See* SB 517 Testimony of Michelle Tuten, Ph.D. and Richard Barth, Ph.D, Co-Directors, Center for Addiction Research, Education, and Services (CARES) (Feb. 21, 2022). CARES is also well situated to conduct a thorough Request for Proposal process to select the hub and assist in selecting spoke organizations, in which it would ensure that these entities are qualified and appropriately staffed and resourced to fill these roles.

A differentiated staff is typical in consumer assistance programs. Indeed, HEAU describes its staff as composed of attorneys, Ombudsmen who staff HEAU's hotline, assist with grievances and complaints, and mediate consumer complaints, a case manager and an administrative assistant. *See* Office of the Attorney General's Health Education and Advocacy Unit, Testimony on HB 517 (Feb. 21, 2022). *See also*, SB 460 Sec. 13-4404(2)(III) (MIA amendment clarifying staff qualifications to be based on education, training and experience and, if applicable, licensure, certification or registration to provide consumer assistance services). The proposed staffing of CHAP is totally consistent with HEAU and other consumer assistance programs.

II. Nature of the HUB, Oversight and Budget

A. Nature of CHAP

The MIA and others have raised questions about the type of entity that CHAP would be – suggesting that it is a state agency, a quasi-state agency or some other entity. Some of the initial questions related to CHAP's status seem to have derived from imprecise language in the bill, as introduced, which the MIA and carriers interpreted as giving broad authority to CHAP; authority that was neither envisioned nor intended. Those elements have been clarified in SB 460.

CHAP, as proposed, is a consumer assistance program that is wholly independent of any state agency and is a program that would be operated by the non-profit corporation or organizations or public university that is selected as the hub along with the non-profit corporations or organizations that are selected as spoke and/or specialty entities. The selection of the hub and spoke entities would be conducted by CARES and guided by the qualification standards set out in SB 460. See Sec. 13-4404. Each of those entities has a "legal status" that would govern oversight and a range of legal obligations.

The CHAP model itself is based on best practices set out in federal statute as well as consumer assistance programs operating in several states. Several elements have been identified as best practices for consumer assistance programs, including.

- "Independence: programs should be independent of state regulatory agencies, but have strong feedback relationships with these entities;
- Breadth of services: programs should service consumers with all types of coverage;
- Community presence: programs should be based in the communities they serve, be culturally competent and have multiple language capacity…."

Making Health Reform Work, at 1. SB 460 proposes a non-governmental hub and spoke structure to ensure the "delivery of efficient, culturally competent health help to people in their own neighborhoods….[T]rusted messengers understand how to reach and assist diverse, low income, and vulnerable populations…." *Id*. at 4. The proposed structure will strengthen service delivery.

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B. Governance and Accountability of CHAP

SB 460 sets out specific entities that would carry out CHAP functions: University of Maryland Baltimore CARES as the incubator entity and state non-profit corporations or organizations as the hub and spoke entities. Each entity would be governed by a non-profit board or other entity or, in the case of CARES, the University of Maryland Baltimore. Those governing entities would be responsible for ensuring that their respective organization meets legal and other obligations. Each entity would carry the required insurance to cover liability, if any, for negligent action in the execution of CHAP activities.

Additionally, SB 460 calls for the creation of the Consumer Health Access Program Advisory Council, composed of representatives from all relevant state agencies (MIA, HEAU, Maryland Medicaid, Maryland Health Benefit Exchange, and the Behavioral Health Administration), that would advise CARES on the design and operation of CHAP, recommend improvements and review data on CHAP's cases. Such independent oversight would help identify and address deficiencies, if any, on an on-going basis.

C. Requested Budget and Oversight

Consumer assistance programs may be funded in many different ways, including through state and federal funding, foundation funding, fees imposed on carriers, and/or penalties imposed on carriers for violations of federal and state parity laws. Maryland has created funds, like that proposed for CHAP, that authorize a non-state entity, such as the Legal Services Corporation, to administer state and other funds. This funding model was proposed by the Finance Committee staff and was vetted for legality prior to bill introduction.

We do not understand the MIA's question regarding the impact of the requested budget on FY 2024 – 2026 budgets. Appropriation decisions rest with the Governor and General Assembly. That said, the cost of untreated MH and SUDs to individuals, families and Maryland far exceeds the requested budget. We also note that CHAP fits squarely within the activities that may be funded through the Opioid Restitution Fund, which will receive a significant infusion of funds from the opioid litigation settlement.

For purposes of oversight, the bill sets out the required activities that must be performed during each year of the 3-year pilot program. SB 460 would require the submission of an annual report that includes, among other information, a complete fiscal accounting, description of all program activities and program performance evaluation. The hub entity – a non-profit corporation or organization or public university– would be subject to the same oversight imposed on recipients of state funds. Finally, both the hub entity and CARES, which receives state and federal funds, are responsible for administering the Consumer Health Access Program for Mental Health and Addiction Care fund. *See* SB 460 Sec. 13-4403(C).

III. Privacy

Federal and state laws regarding the privacy of consumer health and financial records would apply to information obtained by the hub, spoke and specialty entities and the subsequent maintenance, use and disclosure of such information in carrying out consumer assistance and representation. A brief overview of relevant laws is identified below, and LAC is continuing to examine these standards and the implementation of privacy protections by consumer assistance programs to ensure the adoption of best practices.

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Strong privacy protections for health and financial information are at the core of effective consumer assistance. SB 460 provides numerous layers of protection to ensure compliance with federal and state laws. The entities that run the CHAP program would be subject to the following requirements set out in SB 460:

- the selection of a hub entity that would adopt and maintain a health information security system program (Sec. 13-4404(2)(IX));
- the use of deidentified information about program participants when collecting and analyzing data about program services (Sec. 13-4405(C)(2));
- the use of consent forms to request, obtain and use consumer medical records (Sec. 13-4407(A)(1));
- compliance with HIPAA, the Confidentiality of Alcohol and Drug Patient Records Regulations and state health privacy standards, as applicable (Sec. 13-4407(A)(2));
- prohibition on the disclosure of any personally identifying information about a consumer in a public document except in the form of aggregate data.

In identifying how relevant federal and state privacy standards would apply to CHAP activities, we offer the following brief overview:

A. Health Information Protection and Accountability Act (HIPAA)

Although CHAP would request, use and disclose protected health information (PHI) with the authorization of the consumer it assists, neither CHAP, nor the entities operating CHAP, are covered entities, as defined in HIPAA. A covered entity is “(1) A health plan. (2) A health care clearinghouse. (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter." 45 C.F.R. § 160.103. CHAP is also not a "business associate” under HIPAA, as CHAP does not provide certain enumerated services to a covered entity. *See* 45 C.F.R. § 160.103. CHAP is, therefore, not subject to the HIPAA Privacy or Security Rules, as they only apply to covered entities and business associates. 45 C.F.R. § 164.500(a) and (c); 45 C.F.R. § 164.302. CHAP would be required to request PHI from a covered entity in accordance with HIPAA privacy regulations.

B. Confidentiality of Alcohol and Drug Patient Records Regulations, 42 C.F.R. Part 2

Similarly, in representing consumers who have sought or received alcohol or drug treatment from a program, as defined in Part 2, CHAP would request, use and redisclose patient identifying information with the consent/authorization of the consumer it assists. Neither CHAP, nor the entities operating CHAP are a covered “program” (*see* 2 C.F.R. § 2.1) and is not a “qualified service organization” for a Part 2 program. As noted above, the hub and spoke entities would be required to obtain the individual’s written consent to obtain, use or redisclose patient identifying information, with very limited exceptions, in compliance with Part 2. See 42 C.F.R. §§ 2.13, 2.31, 2.32 and 2.51-2.53. In addition, as a “lawful holder of patient identifying information,” CHAP would be required to have “formal policies and procedures to reasonably protect against unauthorized uses and disclosures of patient identifying information and to protect against reasonably anticipated threats or hazards to the security of patient identifying information.” 42 C.F.R. § 2.16. These security provisions in addition to those required under the Maryland Personal Information Protection Act (discussed below) would guide security measures that CHAP would adopt.

C. Graham Leach Bliley Act (GLBA)

CARES and the hub, spoke, and specialty entities are not financial institutions under the GLBA. The

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GLBA would only apply to CHAP in circumstances in which it seeks and receives certain nonpublic personal information (NPI) directly from a financial institution, including an insurer. Generally, CHAP may comply with the GLBA by only redisclosing NPI "with the consent or at the direction of the consumer." *See* 16 C.F.R. § 313.11(a)(1)(iii); 16 C.F.R. § 313.15(a)(1). CHAP would receive and use such information only in connection with client representation and with the written consent/authorization of that individual.

D. Maryland Confidentiality of Medical Records Act

Maryland's state health privacy law is more restrictive than HIPAA's privacy standards and does not govern medical records subject to Part 2. Md. Code Ann., Health-Gen. §§ 4-302(b), 8-601(c). In order for CHAP to access medical records for purposes of consumer assistance, under the Maryland Confidentiality of Medical Records Act, the consumer must, in writing, authorize disclosure to CHAP. CHAP may not redisclose records without authorization from the consumer, except in certain limited circumstances. *See* Md. Code Ann., Health-Gen. § 4-302.

E. Maryland Personal Information Protection Act

The incubator, hub, spoke, and specialty entities are businesses subject to the Maryland Personal Information Act. Md. Code Ann. Comm. Law §§ 14-3501 to 1-3508. CHAP would be obligated to "implement and maintain reasonable security procedures and practices that are appropriate to the nature of the personal information owned, maintained, or licensed and the nature and size of the business and its operations." Md. Code Ann., Com. Law § 14-3503(b)(1) (as amended by 2022 Maryland Laws Ch. 502 (H.B. 962), effective October 1, 2022). CHAP would also be required to investigate security breaches and notify, as soon as practicable, the owner or licensee of the personal information affected by the breach. *See* Md. Code Ann., Com. Law § 14-3504(c)(1) (as amended by 2022 Maryland Laws Ch. 502 (H.B. 962)). These provisions, in addition to requirements under Part 2, would guide the security measures that CHAP would adopt.

Finally, we also note that any ambiguous language related to CHAP's access to active state agency investigation materials has been revised to clarify that requests for information would be specifically related to a program participant's complaint for health care services and pursuant to the individual's consent/authorization. See Sec. 13-4407(B).

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Thank you for considering our views and we look forward to participating in the SB 460 Workgroup.

Sincerely,

Ellen M. Weber, J.D.
Sr. Vice President for Health Initiatives

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Attachment A

CHAP Functions and MIA and HEAU Activities
Legal Action Center 6.14.22

Function	CHAP	MIA	HEAU
Outreach in community to reach individuals and families with SUD and MH and link to care	• On-going outreach in communities via spoke entities (by individuals with lived experience); • local presence of non-profit entity available to serve as targeted resource; • specialty entities may provide outreach/education.	• Calendar of events in Maryland – not specific to SUD/MH care or health insurance; • Periodic meetings on specific topics (several meetings in past have addressed SUD/MH issues) conducted during business day.	• Not aware of community outreach. At one time went to annual SUD conference (Tuerk), but suspended based on resource limitations. • HEAU identified on state-regulated carrier adverse and coverage decisions as available to mediate the dispute with the carrier or help consumer file a grievance or appeal. • Hotline – health billing issues • Website references assistance for billing dispute with provider or coverage dispute with HMO or health insurance company.
Education – insurance coverage with targeted focus on MH and SUD benefits; Rights under state and federal parity laws; network adequacy protections; telehealth. Additional rights to be addressed including No Surprises Act	• Full range of community education re: MH/SUD treatment, available services, insurance coverage and access to care, Parity Act rights and other protections • Development of print and web materials – focused on culturally appropriate and language accessibility • On-going capacity – readily available	• Periodic education sessions – recall several re: accessing MH/SUD benefits • On-line video and print materials for consumers (e.g. Video-Understanding Insurance Coverage MH/SUD benefits; print materials – 3 MH/SUD Know Your Rights documents. • Written materials in Spanish and Korean	• Not aware of any community education • Authorized to implement education programs to enable consumers to make informed choices in "health marketplace" (Comm. Law § 13-4A-02)
Receive consumer and provider complaints related to accessing insurance coverage and MH and SUD benefits.	• On-the-ground assistance (8 spokes) • virtual helpline (hub). • Staff include Individuals with lived experience. • CHAP fills out the complaint and initiatives the process.	• MIA Complaint Form available on-line – consumer fills out; identifies HEAU as providing assistance and indicates that a provider or other individual can assist in filing a complaint.	• Receives complaints if consumer contacts HEAU based on dispute. • Website has complaint forms – consumer must fill out online or in hard copy and mail. Health care provider can file a complaint.

Identifying available services and linking individuals to care based on applicable insurance coverage	• Would offer these services for all payer types	• Doesn't offer these services	• Doesn't offer these services
Identifying MH and SUD benefits under applicable insurance coverage – state-regulated private plans; Medicaid and CHIP; state- employer plans; Medicare; TRICARE; Federal Employee Health Benefit Plans	• Would offer these services for all payer types.	• Video and brochure may identify basic rights for SUD/MH services for **state-regulated commercial plans (only)** • Refer to carrier for specific plan information and resolution of complaint.	• **May be involved if receive questions/dispute from consumer related to private- not public - insurance**. • Jurisdiction – Annual Report on the Health Insurance Carrier Appeals and Grievances Process (FY 2021) indicates it handles state-regulated as well as self-funded plans (ERISA and non-ERISA). *More information needed on scope of work on ERISA plan and non-ERISA self-funded plans*.
Help member **navigate insurance coverage and resolve problems informally** – all insurance types	• Would offer these services to help navigate insurance – regardless of type - and would intervene with carrier to resolve informally when problems are identified. • Can assist client enrolled in multiple types of insurance (e.g. Medicaid and Medicare; private plan and Medicare).	• **Acts only when consumer files a complaint related to state-regulated commercial insurance.** Internal grievance must be exhausted. • Investigates complaint and issues decisions on complaints **but, as arbiter of complaint, does not represent the claimant;** • Assistance limited to state-regulated plans; will refer matters to HEAU if MIA doesn't have jurisdiction over	• **Post ACA – helps resolve problems enrolling in Exchange and obtaining premium tax credits and cost-sharing reductions (commercial insurance not Medicaid) (HEAU Annual Report at 7)** • **Gets involved when dispute arises and HEAU receives a request for help.** • Assistance for state-regulated insurance plans – mediate and assist with filing appeal or grievance. • Must refer questions related to adequacy or propriety of service/treatment to

		complaint or if internal grievance process hasn't been exhausted.	appropriate professional, licensing or disciplinary body. (Comm. Law § 13-4A-02). • **Required to refer to MIA if any billing or coverage question involves a matter within MIA's jurisdiction** (Comm. Law § 13-4A-02) • "Shall" work with MD Dept of Health to assist with resolving billing or coverage questions. (Comm. Law § 13-4A-02) – no indication of assistance to the consumer.
Directly represent clients in filing complaints, internal appeals, and judicial complaints with health plans (all types), external reviews (all types)	• Would offer these services regardless of payer	• Doesn't represent clients because resolves disputes between parties. • Refers matter to HEAU if internal grievance not filed.	• Prepares and files written grievance or appeal on behalf of the consumer (HEAU Annual Report at 8.) Prepares external appeal. • **HEAU "does not assist consumers denied enrollment in Medicaid or Medicaid coverage appeals."** (HEAU HB 517 Testimony) • HEAU "**does not represent consumers in any legal action challenging denials of enrollments or coverage, including those related to federal and State mental health parity laws."** (HEAU HB 517 Testimony).

			• **HEAU does not have authority to bring a civil action seeking review of a State agency determination. (Comm. Law § 13-4A-02)**
Collect data on system-wide barriers to MH/SUD care and identify solutions	• Would perform this function based on the information and data gathered through education and outreach, resolution of informal matters, and client representation.	• Performs as part of regulatory oversight, using traditional insurance regulation tools – (plan review, individual complaints, market conduct surveys/exams). **Investigatory Information is not available to consumers for trend identification and advocacy.** • Oversight activities as result of legislative mandates (and external consumer advocacy) – e.g. network adequacy reporting requirements; Parity Compliance Reporting	• Submits annual report on appeals and grievances, documenting data reported by the carriers and MIA and reporting HEAU's activities. • Monitors and offers consumer-centric input to state agencies involved in health policy; serves as consumer rep or in *ex officio* capacity on MHBE Standing Advisory Comm. and Maryland Easy Enrollment Group; Gen'l Ass. Health Insurance Consumer Protections Workgroup, MHCC's Health Information Exchange Advisory Workgroup, MHCC Surgical Services Workgroup. (HEAU Annual Report) • Litigation support to defend consumer protections under ACA.

ATTACHMENT B

Powering a more equitable New York

CSS Testimony in Support of Maryland Consumer Health Access Program (SB460/HB517)

Senate Finance Committee
February 22, 2022

The Community Service Society of New York (CSS) would like to thank the Maryland House and Senate for the opportunity to submit testimony on the proposed creation of a Consumer Health Access Program (CHAP) (SB460/HB517). CSS supports the passage of SB460/HB517 and the creation of CHAP.

CSS has worked with and for New Yorkers since 1843 to promote economic opportunity and champion an equitable city and state. We power change through a strategic combination of research, services, and advocacy to make New York more livable for people facing economic insecurity. By expanding access to health care, affordable housing, employment, opportunities for individuals with conviction histories, debt assistance, and more, we make a tangible difference in the lives of millions. Our health programs help New Yorkers enroll into health insurance coverage, find health care if they are ineligible or cannot afford coverage, and help them use their coverage or otherwise access the healthcare system. We do this through a live-answer helpline and through our partnerships with over 50 community-based organizations working in every county of New York State. Annually, CSS and its partners serve approximately 130,000 New Yorkers.

In March 2018, Section 33.27 of the New York State Mental Hygiene Law was enacted to establish the independent statewide ombudsman program, also known as the Community Health Access to Addiction and Mental Healthcare Project (CHAMP). CHAMP is designed to help consumers and providers with health insurance coverage for substance use disorder and mental health services and is overseen by the New York Office of Addiction Services and Supports (OASAS), in consultation with the New York Office of Mental Health (OMH). CHAMP was established with an initial operating budget of $1.5 million.

In 2018, OASAS and OMH designated CSS and its Specialist partner organizations (the "Specialists")—The Legal Action Center, the NYS Council for Community Behavioral Healthcare, and Medicare Rights Center—as the entities that would carry out the objectives of the Ombudsman program, under the supervision of the Ombudsman Project Director. In 2019, five community-based organizations (CBOs), serving different regions of the state, were added to the network: Adirondack Health Institute; Community Health Action of Staten Island; Family and Children's Association; Family Counseling Services of Cortland County; and Save the Michaels of the World. CSS operates the CHAMP toll-free live-answer Helpline, administers Specialist and CBO subcontracts, coordinates the CHAMP learning community, maintains the CHAMP database, and conducts quality assurance. The Specialists provide ongoing training and technical assistance to the five CBOs and handle complex cases that demand high levels of expertise. The CBOs conduct outreach and provide services to clients in the community.

CHAMP's mission is to help New Yorkers overcome insurance barriers and get the substance use disorder and mental health care they need—and have the right to receive. Since CHAMP launched in October 2018, it has handled 4,207 cases on behalf of consumers and providers needing help with health insurance for substance use disorder and mental health care. CHAMP has served clients in 58 of New York's 62 counties. CHAMP helps New Yorkers of all ages, incomes, races, and ethnicities, and serves clients regardless of insurance status. The most common reason people contact CHAMP is because they need help accessing treatment, and the most common barrier they face is insurer denials. CHAMP provides a wide range of services to our clients, from information and informal advocacy to filing appeals and regulatory complaints. In 86% of the cases where CHAMP knows the final resolution of the case, CHAMP was able to get clients the result they were looking for. To date, CHAMP has reached over 300,000 stakeholders through outreach and education.

Studies have shown that people in need of mental health (MH) and substance use disorder (SUD) care must go out-of-network to receive care far more often than people in need of other types of health care.[1] Studies have also show that mental

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[1] *See* Milliman, "Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Reimbursement" (Nov. 19, 2019), p. 65, available at https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p; Milliman, "Addiction and Mental Health vs. Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates" (Nov. 30, 2017), available at https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-analyzing-disparities-in-network-use-and.

health and substance use disorder treatment providers are paid less than other health care providers for the exact same procedure codes.[2] Federal lawsuits like *Wit v. United Behavioral Health* have laid bare deep-rooted, unlawful insurer policies and practices that prevent people from accessing MH and SUD care.[3] In New York, analysis of a public database of external appeal decisions reveals that health plan denials of MH and SUD care are overturned on external review far more often than denials of medical/surgical care, suggesting rampant inappropriate denials by insurers.[4] The New York Office of the Attorney General has found widespread violations of state and federal parity laws by New York health plans.[5] Most recently, a 2022 report to the United States Congress by the United States Departments of Labor, Health and Human Services, and Treasury on the federal Mental Health Parity and Addiction Equity Act also found widespread insurer violations of federal parity laws nationwide.[6]

CHAMP sees the disproportionate insurance barriers faced by people in need of MH and SUD care firsthand, and helps clients overcome them and access lifesaving care. CHAMP's services range from: enrolling clients into insurance; helping clients find in-network providers; advocating for plans to pay for out-of-network care when no appropriate in-network provider is available; assisting with prior authorizations; appealing insurer denials; filing complaints with plans and regulators; and more. CSS also operates several other health insurance ombudsman programs and an insurance navigator network for the State of New York, and CHAMP partners with these programs when our clients can benefit from their services, such as insurance enrollment through the navigator network.

[2] *Id.*
[3] *See Wit v. United Behavioral Health*, Remedies Order, Case No. 14-cv-02346-JCS (N.D. Cal. Nov. 3, 2020).
[4] *See* N.Y. Dept. of Financial Services, External Appeals Searchable Archive, available at https://www.dfs.ny.gov/public-appeal/search.
[5] *See People of the State of New York v. UnitedHealth Group Inc.*, No. 1:21-cv-04533, Stipulation of Settlement (E.D.N.Y. Aug. 11, 2021), available at https://ag.ny.gov/sites/default/files/nyag_united_settlements.pdf; *In the Matter of HealthNow New York, Inc.*, Assurance No. 16-105 (Aug. 2016); *In the Matter of Excellus Health Plan, Inc.*, Assurance No. 14-201 (Mar. 2015); *In the Matter of ValueOptions, Inc.*, Assurance No. 14-176 (Mar. 2015); *In the Matter of EmblemHealth, Inc.*, Assurance No. 14-031 (Aug. 2014); *In the Matter of MVP Health Care, Inc.*, Assurance No. 14-006 (Mar. 2014); *In the Matter of Connecticut General Life Insurance Company Cigna Health and Life Insurance Company, Assurance* No. 13-474 (Jan. 2014).
[6] U.S. Dept. of Labor, U.S. Dept. of Health & Human Svcs., and U.S. Dept. of Treasury, *2022 MHPAEA Report to Congress*, available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

The insurance needs of CHAMP's clients are especially complex, and highlight how critical it is for our clients to have dedicated advocates. Compared with other the ombudsman programs, CHAMP clients are more likely to need help appealing insurer denials, and CHAMP's insurance appeals are typically two to three times longer than appeals related to medical/surgical care. Many CHAMP clients are impacted by social determinants of health, including unemployment, difficulties with housing and transportation, and involvement in the legal system. These social determinants of health, combined with clients who are often in crisis, mean CHAMP clients are especially likely to need intensive, hands-on assistance with their insurance issues. Finally, many clients experience issues that may signify violations of state and federal parity laws. Parity analyses are complex and time-consuming, and few clients undertake them on their own. CHAMP not only helps clients overcome insurance barriers, but it also surfaces systemic issues and reports them to our State partners, enabling the State to address these systemic issues in a timely manner and improve access to care for all New Yorkers.

CSS believes that the Maryland Consumer Health Access Program will, like CHAMP, help people access lifesaving care. CSS supports the passage of SB460/HB517 and the creation of the Consumer Health Access Program.

Thank you for your consideration.

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