

December 6, 2022

Kathleen Birrane
Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
(Sent via email to andrew.tressl@maryland.gov).

RE: SB 460 CHAP Workgroup: Comments on the MIA's proposal

Dear Commissioner Birrane,

I am a third-year law student at the University of Maryland Francis King Carey School of Law. I am also a person with mental health diagnoses and other disabilities who has struggled to access appropriate mental health care under Maryland's existing consumer assistance models.

I sincerely appreciate the Maryland Insurance Administration's efforts to engage in conversations to improve consumer assistance for people with mental health and substance use conditions who are struggling to access appropriate healthcare. However, the proposal put forth by the MIA falls far short of the Consumer Health Access Program (CHAP) proposed in SB 460 and obliterates the values identified by the diverse group of stakeholders that contributed to CHAP. Consequently, the MIA's proposal reads more like a Carrier Assistance Program rather than a consumer assistance program. I fully support the concerns set forth in the Legal Action Center's comments. I only write separately to discuss two specific concerns with the MIA's proposal: the failure to include impacted people in the MIA's SB 460 CHAP Workgroup and the failure to meaningfully integrate people with lived experience in CHAP's program structure. The MIA's proposal for CHAP fails to acknowledge the shortcomings of Maryland's existing resources and dream of something better. CHAP must first and foremost value the humanity of people struggling to access mental health and substance use disorder care.

I. EXCLUDING PEOPLE WITH LIVED EXPERIENCE FROM THE SB 460 WORKGROUP REMOVED VALUABLE EXPERTISE ON MARYLAND'S EXISTING SERVICES AND OUTSTANDING NEEDS.

The MIA's choice to exclude direct representation of people with lived experience navigating the mental health system from the CHAP workgroup and instead emphasize the demands of insurance carriers, speaks volumes about who the State of Maryland values and deems creditable sources of information on people's most personal experiences. I recognize that many of the people representing professional roles in the workgroup also identified having lived experience, but few offered any specific details on barriers to care personally experienced. Thus, conflating workgroup members lived experience with the experiences of Marylanders currently struggling to navigate access to mental health and substance use services ignores the various social and political factors that contribute to structural and health inequity. Failing to directly include community members with lived experience in the workgroup ignored the inherent privilege held by most members of the workgroup due to the very nature of their professional advocacy roles. Even as a law student with the privilege to know how to submit a

comment on this process, I acknowledge my own privilege and power relative to many struggling to access mental health services, including honoring the many differing needs other consumers may have that conflict with my own. ***Designing an effective Consumer Health Access Program that meaningfully addresses barriers to mental health and substance use care must include a diverse group of people with lived experience to combat inequities prevalent throughout Maryland's healthcare systems.*** CHAP won't be suited to effectively tackle these issues, if the program design itself is perpetuating stigma and inequity experienced by people with mental health and substance use diagnoses.

A. The CHAP Workgroup failed to acknowledge the very real human experiences of people whose lives are impacted by their inability to access care, focusing instead on the needs of secondary stakeholders.

The CHAP workgroup primarily focused on insurance carriers' concerns about the existence of a strong consumer assistance program in Maryland, rather than identifying any substantive problems with the CHAP proposal. In doing so the workgroup excluded and devalued the very real human experiences of consumers who struggle to gain access to care every day and even lose their lives as a result of this systemic indignity. Thus, the program proposed by the MIA seemed to further the needs of insurance carriers rather than center consumers' needs.

I personally chose to participate in the coalition that helped design the CHAP program as originally proposed in SB 460 because I've encountered significant barriers to accessing mental health care in Maryland. My inability to access care that served my stated needs led to years of unnecessary hospitalizations that upended my life. When I moved to Maryland, I was desperate to access appropriate care because my life depended on it. I fought tirelessly for several months trying to identify a provider in my insurance network, and when that failed trying to identify any clinician who could provide appropriate care, and attempting to gain insurance coverage for those lifesaving services. I contacted my insurance carrier, every non-profit consumer advocacy organization I could find, and filed complaints with the Health Education and Advocacy Unit, at times spending 20 hours per week trying to navigate these barriers out of sheer terror of what would happen if I couldn't access the support I needed.

I eventually got the care I needed because I happened to reach the right person at the right time, but that struggle to access care without coordinated advocacy, was not without significant costs including unnecessary hospitalizations, delays in being able to complete my education, and tolls on my relationships. Even once the initial issues gaining access to care were resolved, I lived in fear of what might happen if I lost coverage for these services. Lo and behold, I did lose coverage for these services due to an insurance change that was beyond my control. I thought navigating these barriers on a state regulated private insurance plan was impossible, but when I tried to navigate these barriers on Medicare and Medicaid, they were truly insurmountable. I am extremely fortunate to have a psychologist who is willing to do whatever she can to make her services accessible to me, but I lost access to my psychiatrist, and I ended up having to accept a provider who doesn't have the experience or training to meet my needs due to a lack of consumer advocacy services for disabled Medicare beneficiaries. Valuing consumers' knowledge and listening to direct experience navigating existing systems is inherent to designing a successful CHAP program. My experience isn't the only experience, nor would I proclaim that it is representative of every consumer's experiences, but it is one experience that provides

information on gaps in the existing system that preclude access to appropriate care and it prompted me to consider various tools and services that would ease access. I know of many other people with lived experience that have similar stories about existing barriers and novel ideas of services that would help resolve these barriers, if only consumer voices were incorporated into the MIA's workgroup process.

B. The MIA perpetuated epistemic injustice by excluding direct representation of people with lived experience from the SB 460 workgroup.

The MIA's CHAP Workgroup perpetuated epistemic injustice by failing to directly represent people with lived experience in the deliberative workgroup process, limiting our involvement to quick comments at the end of meetings rather than meaningful inclusion in conversations. Epistemic injustice is used to describe when people are discriminated against and disempowered as knowers based on prejudices about their identity.¹ Existing stigma and discrimination towards people with mental health and substance use disorders is largely based on stereotypes about our capacity to contribute to our own care and society more broadly, leading to epistemic injustice that pervades existing payment and service delivery systems.²

Because of epistemic injustice people experiencing mental illness and people who use drugs are often deemed incapable of knowing their needs or identifying services that will best meet those needs. Consequently, systems intended to serve us often render us powerless due to the nature of our diagnoses.³ The MIA's failure to include a diverse cohort of people with lived experience accessing mental health services fails to acknowledge the various power disparities and social factors impeding consumers' access to care. *To successfully advance access to beneficial mental health and substance use disorder services, CHAP must combat epistemic injustice by empowering consumers access to the services and supports individuals need to thrive.* However, the MIA's failure to center consumers in designing the CHAP program, and instead focus on insurance carrier's needs, resulted in the MIA proposing a program that risks perpetuating stigma and injustice, rather than combatting it.

II. CHAP MUST VALUE PEOPLE WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS AND DEMONSTRATE THAT BY CENTERING LIVED EXPERIENCE IN THE PROGRAM'S STRUCTURE.

CHAP's success rests on its ability to prioritize the interests of individuals struggling to access services and supports for mental health and substance use conditions. *At its heart CHAP must value people with mental health and substance use concerns as people, worthy of dignity and respect as we navigate some of our most vulnerable moments. Yet, the MIA's CHAP proposal fails to demonstrate or embody these values in CHAP's programmatic structure.* Instead, the MIA's CHAP program proposal risks perpetuating stigma in its direct services and

¹ Morten Fibieger Byskov, [What Makes Epistemic Injustice an "Injustice"?](#), 52 J. SOCIAL PHILOSOPHY 114-31, 116 (May 18, 2020).

² Cindy Brach, *Making Informed Consent an Informed Choice*, HEALTH AFFAIRS (April 4, 2019) (true informed consent requires meaningful choice to access alternative treatments to the one being offered).

³ See Michael L. Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?*, 8 J. HEALTH 15, 33-34. (1993-1994) (discussing prejudices evidenced by both legal advocates and mental health providers when determining the care needs of people with mental illness).

systemic advocacy if the program itself doesn't model and outwardly value people with mental health and substance use disorders humanity, self-knowledge, dignity, and autonomy.

The program proposed by the MIA eschews lived experience, placing value on “government talking to government,” instead of a government that talks to and serves the people of Maryland. Such ideas perpetuate epistemic injustice by suggesting that only government can know what people need, contravening the intention of the original CHAP program proposed in SB 460. The MIA's choice to focus only on the knowledge of those with existing power is the antithesis of a vision for health equity. An effective consumer assistance program should honor consumers' voices and treat consumer choices as integral to health equity.⁴ After all, can people expect basic dignity and respect if such a program doesn't provide meaningful choices to access mental health and substance use care or honor their needs? People who've navigated barriers to healthcare care through direct experience are best prepared to understand the necessity of choice and honor consumers' stated needs.

CHAP must include people with lived experience throughout its structure, particularly in its leadership to be a meaningful and effective program. Merely appending peers at the lowest rung of CHAP's structural hierarchy, makes it seem that lived experience was an afterthought to the program design, rather than inherent to CHAP's success. Failing to meaningfully integrate impacted people in the program design risks tokenizing and further disempowering people with lived experience.⁵ Consumers' lived experience navigating barriers to care makes them uniquely qualified to serve as navigators and advocates in a program like CHAP, regardless of any professional credential validating that experience. People with lived experience navigating the mental health system have significant direct knowledge of existing systemic successes and failures that cannot be taught in educational programs nor replicated by working as a professional advocate. Thus, CHAP should intentionally integrate people with lived experience into all levels of its programmatic structures, including leadership roles, in order to enhance CHAP's capacity to serve people from all walks of life.

A common quote used within the disability rights movement states, “***nothing about us without us, is for us.***”⁶ CHAP is no different: for CHAP to effectively serve all Marylanders, a diverse cohort of impacted community members must be directly included in both the program design and implementation. The program proposed by the MIA fails to identify how it will provide services that meaningfully and equitably serve the entire community largely due to a process that failed to humanize people with lived experience and incorporate our needs. I hope the MIA will consider this feedback and support a fully independent CHAP program like the carefully designed proposal set forth in SB 460, which prioritized combatting injustice and addressing needs identified by people with lived experience.

Please don't hesitate to reach out to me should you have any questions about these comments.

⁴ See, e.g., Morgan Shields & Rinad S. Beidas, *The need to prioritize patient-centered care in inpatient psychiatry as a matter of social justice*, 3 JAMA HEALTH FORUM (Feb. 4, 2022) (mental health care services often fail to consider patient experiences and capturing individuals' experiences is essential to health equity).

⁵ See Jenny Logan and Justin Karter, *Psychiatrization of Resistance: The Co-option of Consumer, Survivor, and Ex-patient Movements in the Global South*, 7 FRONTIERS IN SOCIOLOGY (Mar. 2022) (discussing the co-option and appropriation of peer designed initiatives to serve the needs of institutions, and further marginalize people with mental health disabilities).

⁶ James I. Charleton, *Nothing About Us Without Us: Disability oppression and empowerment*, at 3 (Aug. 2020) (quoting Michael Masutha and William Rowland, leaders of Disabled People South Africa).

Respectfully,

A handwritten signature in black ink, reading "Courtney Bergan", followed by a long horizontal flourish line.

Courtney Bergan

(they/them)

cbergan@umaryland.edu

To Whom It May Concern:

My assessment of the new MIA proposal:

- it appears to be more expensive than SB460
- it is unclear that it could actually serve all the consumers served by SB460
- it is unclear that it can reach deep enough into the community
- it lacks recourse for consumers who cannot afford legal representation
- it overstates the effectiveness of existing resources
- it relies on the Maryland Health Benefit Exchange to provide services beyond its current mandate.
 - I am curious if MHBE has been consulted.
- it is unclear that the necessary outreach will happen in the MIA proposal
 - There are different types of outreach. One is for the purpose of providing information. There is also outreach for true engagement. SB460 is designed to promote engagement. I lack confidence in the MIA being able to oversee and accomplish this.
- it lacks a mandate for certain disaggregated data to become available for review
 - which could be used to monitor change over time
 - help with future proposals for legislation
 - evaluate the success of the program itself
- it lacks the larger “voice” envisioned by SB460 that could speak with the freedom that comes from not being attached to an agency
 - for me, a very important aspect of SB460

I also want to express some concerns about the workgroup itself. My understanding was that this group was meant to discuss SB460 in order to address concerns with it and possibly make improvements based on a larger group of stakeholders. And while issues were raised early on and those of us supporting SB460 did respond, that is where the discussion ended. No real engagement or responses were provided by those with concerns about SB460. I have participated in many organizing efforts where a diverse group has to make something happen. There is always a significant back and forth with a bunch of “what about...” on all sides. That did not happen with this workgroup.

So to me this process failed because not everyone was participating with a willingness to truly engage. Looking back, it seems to me that the intention on some parts was always to propose an alternative. I can only speak for myself, but I imagine other SB460 supporters would also have welcomed a real discussion with the goal of addressing concerns and improving the bill.

I am left having to guess what the true motivation is for the new proposal. And, my guess is that it is the autonomy afforded to CHAP, the advocacy role specified and the data transparency required of the carriers. All of these could have been openly discussed but weren't.

SB460 was designed with the expertise and experience of consumer advocates who currently assist with the issues addressed. Consumers also had input into the proposed legislation. I did not feel like this expertise and experience was taken into appropriate account. Given the response by other consumer advocates in the workgroup, I am not alone in this concern.

Bottomline, I don't think the discussion that happened was the discussion that was needed.

While I believe that almost everyone participating in these discussions saw the need to make access to appropriate care readily available, I do not have the faith that a government agency can break down the barriers to care that were largely (if unintentionally) created by government agencies. The way the CHAP Workgroup played out only reinforced this for me. Nothing in the process so far gives me the belief that consumer voices would be given the weight they deserve when those voices were discounted so easily by the workgroup.

I got the sense that there was a concern that CHAP would somehow “go rogue.” This could have been easily addressed as SB460 proponents clearly welcomed a discussion on this. However, no clear suggestions were given in response.

To sum it all up, I am concerned that the MIA proposal would become yet another part of the obstacle course consumers face when seeking care. Even if it is well-intentioned.

Sincerely,

David Stewart (he/him)
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NOTE: Please feel free to schedule time with me by using this link: [Book time with David Stewart](#) this link works for both virtual and in-person.

To: Maryland Insurance Administration (MIA)
From: Deb Steinberg
Re: MIA's CHAP Proposal
Date: December 5, 2022

My name is Deborah Steinberg and I am a Health Policy Attorney at the Legal Action Center (LAC). I have several mental health conditions, which led me to become a lawyer to advocate for other individuals like me. Before joining LAC, I worked and volunteered in several positions in Massachusetts assisting consumers with health insurance-related matters and mental health crises. These comments represent my personal beliefs and experiences, which I appreciate the opportunity to share as you consider the proposal to house the Consumer Health Access Program (CHAP) within the Maryland Insurance Administration (MIA).

First, I need to tell you why this matters so much to me. It matters because I have been in crisis. I have needed help and not known where to go. I have had good health insurance that did not cover what my doctors said I needed and I lacked the knowledge and resources to challenge those decisions. I know what I wish I had in those moments, what would have actually helped. And now all I want to do is make those resources available to other people. As Commissioner Birrane said at the last meeting, we get one shot to launch this right, otherwise we lose the trust of the public. So I am sharing my story with you today, so that we can get this right.

I. Crisis Counseling & 988

As a former crisis counselor of over 10 years, I urge you not to attempt to collocate CHAP with 988 or 211. When I was 16 years old, I started volunteering for Samaritans, a suicide prevention helpline in Massachusetts. As someone who suffered from mental illness and had lost loved ones to suicide, I wanted to get trained to help others and give back to my community. In addition to operating its own telephone number, Samaritans was also a call center for the National Suicide Prevention Lifeline – now 988. I continued to volunteer at other peer helplines throughout college and law school, accumulating over a decade of experience as a certified crisis counselor. As crisis counselors, our main job is to listen. We listen to the stories and validate the concerns of those who are in crisis and we try to deescalate that crisis by reminding the caller of their strengths, their ability to get through difficult moments in the past, and that they have other choices in that moment so that they feel less helpless. We are not trained in health insurance-related matters. We may share resources, but only if they are requested by the caller. Above all, we do not give advice. That is not our role.

I stress these components of being a crisis counselor because they make it highly inappropriate for CHAP to operate out of 988 or 211, as was suggested during the most recent workgroup meeting. Maryland has eight call centers for 988, so it is already decentralized, defeating the purpose of such a proposal. More importantly, 988 has a distinct and critical function that could be jeopardized if combined with CHAP. That being said, when callers do ask for resources about navigating their health insurance, or if they express concerns about the cost of mental health care or finding a provider, I wish I could have had an organization like CHAP to offer as a resource. An independent CHAP entity with similarly empathetic individuals who are trained in health insurance-related matters would be an excellent resource to provide these individuals to help them get the long-term care and support they need and deserve.

II. State Government

Based on my experience working in state government, I encourage you not to place CHAP within the MIA or another state agency. Upon graduating from college, I worked as a Program Assistant in the Office of Patient Protection of the Health Policy Commission, an independent state agency in Massachusetts. I managed our helpline and facilitated the external review process for individuals with fully-insured health insurance who had exhausted their internal grievances with their carriers and wished to pursue medical necessity appeals with an independent reviewing organization. My callers were often incredibly tired and frustrated by the time they got to our office, because they felt like they were fighting a losing battle against their health plan. They felt betrayed by their insurance companies to whom they were paying thousands of dollars every year and yet who were making decisions that went against the recommendations of their trusted providers.

Similar to the statistics in Maryland, as demonstrated by HEAU's most recent annual report, adverse decisions relating to mental health and substance use disorder treatment were modified or overturned very infrequently during the internal grievance stage of the process. Unlike Maryland though, we had an extremely high rate of mental health and substance use disorder cases that came to us for external review – often close to half of our cases. One of the main reasons that we received such a high number of these cases was because these individuals were more likely to need help with their appeals, and we had a resource available for them. We could refer these individuals and their loved ones to Health Law Advocates, a non-profit organization made up of lawyers who would directly represent clients with their cases for free. They had a designated attorney who worked on mental health and substance use disorder cases in private insurance, so I could make a warm hand-off to ensure these callers would get as much support and assistance as possible, knowing how difficult it is for a parent of a suicidal child or someone in the midst of withdrawal to take on this task independently.

I appreciate HEAU's comments at the recent workgroup meeting – that these are often not the easiest callers. They are typically in absolute terror and they need help desperately. Yet I was the primary point of contact for them, starting at age 22, not because I was a licensed social worker who was going to solve their mental health problems, but because I had phone-based crisis de-escalation training and experience, empathy, and sufficient knowledge of state resources to ensure that my callers would be directed to legal assistance as appropriate. These kinds of things are possible to stand up in a small program – there were only three of us in the Office of Patient Protection – when the vision behind the organization is to provide comprehensive support for consumers, and when people with lived experiences are employed by the program and in leadership roles.

Like Maryland, only a small portion of individuals in Massachusetts have fully insured plans. While I could help many of my callers, there were a significant number that I had to turn away because they had Medicaid, Medicare, or ERISA plans. We did not have the statutory authority to assist them. However, the average consumer does not care about statutory authority when they are in crisis and in desperate need of assistance. All they know is that they need help, and on paper, my office did exactly what they were seeking. My offers to connect them with our contacts at other state and federal agencies did not come across as helpful. Rather, they were perceived as attempts to pass the buck, to make them someone else's problem. They were already calling the government, and I was failing them, so why would another part of the government be able to help? Many of these individuals have been harmed by the government and have a more than reasonable distrust of government actors, and here was one more person from the government who was denying responsibility for their problems. So those people gave up. They did not pursue appeals to which they had a legal right, and often a compelling case. I can

empathize with those of you at the MIA and HEAU who must face these callers every day as I did. Unfortunately, it is just a reality of working within a state agency that does not have the authority over all types of insurance. This is the same problem CHAP will undoubtedly face if it is housed in an existing state agency.

III. Non-Profit Organization that Provides Legal Representation

As an attorney with lived experience who has directly represented individuals with mental health and substance use disorders in health insurance-related coverage and appeal matters, I strongly encourage you to place CHAP within an independent non-profit organization. When I graduated law school, I received a fellowship to work at Health Law Advocates – the legal assistance organization to where I had referred my callers when I was working in state government. While the same attorney who worked on private health insurance cases was still there, the organization lacked an attorney who could specialize in mental health and substance use disorder cases for public insurance. My project involved assisting low-income individuals with mental health and substance use disorders with their Medicaid coverage issues, ranging from enrollment to coverage denials to medical debt resulting from lack of coverage. Within a few months, I expanded my project to include Medicare appeals as well, because so many of clients were dually-eligible for Medicaid and Medicare that it was doing them a disservice not to represent them in those hearings as well when they had a legal right to both.

My project model was very similar to SB 460, which is not surprising because both were developed by people with lived experiences and knowledge of the existing resources in the state. A critical component of my project was the education and outreach that I did to make my services available and known. At first, I did not do as good of a job as I would have liked, because our organization served people across the entire state and I was located in Boston. I was not only limited in my ability to get to the far corners of the state, but I also did not have the relationships with communities to earn their trust or get invited into their spaces, rather than inviting them into mine. I was fortunate that, through a different program at my organization, we had an attorney in a Family Resource Center in each county across the state. Leveraging these relationships, I went into these spaces to give presentations about how I could assist individuals in these communities, and I listened to the types of barriers they faced. I met mental health and substance use disorder providers in these settings, who would then invite me to come speak to their practice so they could learn more about the parity laws and better support their patients, and so they could provide referrals to me when appropriate. This community outreach and education was time consuming, but it was critical to making sure I was addressing the real issues in the communities and that I was not limiting my representation to certain populations or certain areas of the state. **The hub and spoke model, comprised of non-profit organizations, really does work, and I encourage you to leverage it.**

In my role, I had a lawyer-client relationship with everyone I assisted, even if ultimately they did not need me to represent them in an appeal or court matter. It signified that we had discussed their goals, that I would be faithful to them, and that we had a specified scope of our relationship that we would not exceed unless discussing it further, thereby setting appropriate expectations for both parties. They often needed additional support beyond what I could provide, and having volunteered in the community for so long, I was well equipped to share those referrals and make warm handoffs. In addition to wrap around services for my clients, I developed relationships with specialist organizations to help with me with my casework. For enrollment related matters, I worked closely with our partner organization, Health Care For All, which acted similar to a navigator entity like those in Maryland. With appeals and medical debt, I often received subject matter guidance and technical advice from other organizations

like the Mass Law Reform Institute for Medicaid issues, the Medicare Rights Project at Legal Aid for Medicare issues, and the National Consumer Law Center for medical debt issues.

Not only are Medicaid and Medicare different areas of law, as HEAU described during the meeting, but they have significantly different benefit coverage of mental health and substance use disorder treatment, and the latter is not even subject to the Mental Health Parity and Addiction Equity Act. But it was my job to represent my clients, to learn the law and to consult other experts when I ran into problems. Even before they get to the fair hearing stage where you need an oral advocate, these clients needed legal counsel because they were navigating contractual disputes about whether their services should be covered. They could tell you why it should be covered based on their own experience and what their doctors could document, but they did not have the legal knowledge to formulate a cohesive argument citing Medicaid or Medicare's obligations under federal and state law and regulation. I cannot emphasize enough how sincerely I wish my clients did not need a lawyer to help them get the treatment they so obviously and desperately needed, but that was the reality. They needed someone to represent them and their interests, to navigate their health plan contracts and the legal standards, and to try to resolve their problems with the knowledge and authority to do so.

In both Medicare and Medicaid, consumers have a right to a fair hearing before an Administrative Law Judge after their internal grievances are denied. If the concept of the hearing alone does not dissuade the consumer, then it is a terrifying process and one that does not lend itself well to *pro se* representation, especially for people with mental health conditions and substance use disorders. These hearings are adversarial, and the health plan brings in multiple representatives to speak to why the service is not medically necessary, often in a way that feels dehumanizing and delegitimizing to individuals who are suffering. Very few consumers can even get their provider to join, because these hearings are scheduled at the entire discretion of the Administrative Law Judge without consulting the consumer or the provider and with limited notice. The plans often raise new reasons for denying the service that were not outlined in the initial denial or internal grievance response, and only a very generous Administrative Law Judge will tell the consumer that they have a right to request an extension to submit more documentation from their provider to respond to new issues. Obviously, this process is very different from the external review process in commercial insurance, and one for which consumers – especially those with mental health conditions and substance use disorders – need and deserve free legal representation. However, the key benefit to securing them with legal representation earlier in the process means that they have a stronger chance of avoiding this often traumatizing hearing through negotiation and internal grievances.

Even when we were ultimately unsuccessful in getting the clients what they needed, they were extremely grateful to have this kind of representation. I spoke their language, but I also spoke the language of their health plans, so I could amplify their voices and their needs in a way that the carrier would understand. I often advocated for out-of-network access, especially in more rural areas of the state, because I understood how difficult it was to find a mental health therapist that my clients would trust – and that this trust is necessary for positive health outcomes – and that the one or two providers their plan had available (Massachusetts does not have an any willing provider standard in Medicaid) had not been able to meet my clients' needs and that was not their fault. Often the first or second therapist someone tries is not the right fit, because therapists have different treatment approaches and methodologies and connect to people on different levels. But health plans typically do not take that into consideration when making decisions about coverage, so this is a concern that often goes unheard, if not minimized. I understood that this concern was valid no matter what their health plan said, and how important it is to continue to try new therapists despite that denial and not being dissuaded from

therapy and mental health care altogether, which is what often happens all too often when health plans deny these out-of-network providers, because I have been in that situation too.

My clients had an individual who was following their case the whole time, helping them understand the pros and cons of continuing their grievances through each stage of the process. I want to stress that one of the reasons most of these cases do not make it to court is because these are mental health and substance use disorder services that these individuals needed months ago, when they were initially denied, not a year from now when their case would be resolved through the judicial system. This was always a difficult decision, because my clients were angry at their health plans and wanted their day in court, and many of them even wanted to set a precedent so other individuals would not suffer the way they had (the administrative law decisions do not set precedent). As the lawyer, these are considerations that I discussed with my clients, and typically their provider would submit a new request for the service with additional documentation and support rather than continue with a timely and exhausting legal battle. I had the authority to represent them in judicial proceedings, but I also had the professional responsibility to work in the best interest of my client, and this allowed us to resolve all of our cases in the most timely and efficient way possible, almost always outside of court.

IV. Non-State Agencies Can Work with Carriers Effectively and Engage in Systemic Reform

I was surprised to see how quickly I identified contacts and established positive relationships with the managed care organizations. As HEAU identified, calls with these consumers are not easy, and my clients often complained that their health plans would not call them back at all or they would have a social worker or someone outside of the appeals department call them back, misunderstanding what they needed because they were in such a state of crisis when they reached out. As an advocate for my clients, the health plans spoke with me instead, and I was in a position to negotiate for my clients to try to get the outcomes that they desired. Unsurprisingly, none of us wanted the process to be lengthy or more expensive than necessary, so they were grateful that we could cut through some of the “red tape” of the appeals process together. It does not need to be “government talking to government” to break down these barriers. That may work too, but the client is less likely to be satisfied with that result because they will not have felt heard in the process or trust the outcome. They will not learn from the experience so they can self-advocate in the future. Even when we lost cases, my clients felt like they had gotten a fair chance. The carriers actually appreciated this as well, and one of the managed care plans trusted me to the point of actually referring their consumers who were especially challenging to me. It saved everyone time and money.

Working with the state Medicaid agency and other policy makers, I was able to shed light on policies that were being interpreted incorrectly or harmfully based on my casework. For example, I received a significant number of medical debt cases from individuals who were transported by ambulance from a hospital or emergency department to an inpatient psychiatric facility and who were being charged the full cost of the ambulance ride. The managed care companies claimed that ambulance transportation from the hospital was not an emergency, and therefore it did not need to be covered. However, on a practical matter, these individuals were not given a choice in transportation, and they were still in crisis or at risk of harm because otherwise they would not have needed inpatient psychiatric treatment. I shared the de-identified and aggregate data with the state to advocate for policy change, and the Department issued sub-regulatory guidance clarifying that rides from hospitals to inpatient psychiatric facilities by ambulance must be covered, thereby saving each consumer thousands of dollars while keeping them safe.

We know there are countless problems in Maryland that are contributing to the lack of access to and unaffordability of mental health and substance use disorder care. With a designated and independent consumer health access program, that is built on the trust and experience of the people, we can identify these issues and work together to get everyone the treatment they need. Thank you.

Deborah Rivkin
Vice President
Government Affairs – Maryland

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December 5, 2022

Mr. Andrew Tress
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Baltimore, Maryland 21202

Sent via email: andrew.tress1@maryland.gov

RE: Mental and Behavioral Health Ombudsman Program

CareFirst appreciates the opportunity to comment on the Maryland Insurance Administration's (MIA) Concept Draft outlining potential legislation to establish a Mental Health Ombudsman program in Maryland.

CareFirst is committed to working collaboratively with State legislators and regulators to advance our shared goal of ensuring all Marylanders have ready access to behavioral health care services whenever and wherever they are needed.

During the 2022 Legislative Session, we were supportive of the policy goals of SB 460—which we understood to be the creation of an entity to coordinate, assist, and advocate for Marylanders in need of behavioral health care who encounter obstacles in accessing their benefits—however, the structure of the program outlined in SB 460 created confusion as to the role of the program in regulatory oversight and enforcement of various insurance laws, and did not contain adequate protections over the consumer health data and proprietary payer data needed to carry out the program.

The MIA's in-concept draft significantly addresses these concerns by housing the entity within an existing regulatory agency, subjecting the entity to the data protection and confidentiality laws that exist today in our agency interactions. Further, the MIA is the agency with enforcement authority over payers in violation of laws affecting behavioral health such as mental health parity and network adequacy, and by housing the entity within this agency, ambiguities over the regulatory authority of a third-party entity are eliminated.

CareFirst offers the following recommendations on the concept draft for consideration as the MIA moves forward:

- **The Program should incorporate existing payer resources into consumer assistance resources and referrals.** Payers like CareFirst have a number of member-focused resources designed to help navigate the behavioral health system to streamline services for

our members, including collaborating with Headway, a tech-enabled solution, that shows members real time provider availability along with treatment areas and provider demographics, when known, and partnering with 7 Cups to provide a digital health resource to help members get emotional support 24/7 and connect with a licensed therapist on demand or virtually. Staff for the new Program should be familiar with and leverage the various payer programs available as a resource to members who reach out for assistance.

- **On a technical note, the MIA should align new statutory and regulatory terminology with existing terminology for “peer support counselors.”** Many jurisdictions use the term “specialist” rather than “counselor.” MDH refers to these professionals as “certified peer specialists” or “certified peer recovery specialists” and D.C. uses the term “peer specialist” or “certified peer specialist.” As the MIA develops the role of these individuals within the Program, precise terminology consistent with the expected scope of services for the Program and any state licensing and certification schemes is important.
- **CareFirst requests clarification on the breadth of data that the Program will collect and analyze for sharing with other state agencies—**will this data strictly include Program experience, or will it also include other MIA regulatory data? We would caution that any data sharing with other agencies be subject to appropriate confidentiality and data security rules, particularly with respect to agencies that do not have regulatory authority over this payer information.
- **There should be express payer representation on the Consumer Health Access Program Advisory Council.**

CareFirst appreciates your consideration of these comments and we are happy to discuss should you have any questions. We look forward to working the with MIA as this Concept Draft as it evolves.

Sincerely,



Deborah R. Rivkin

About CareFirst BlueCross BlueShield

In its 84th year of service, CareFirst, an independent licensee of the Blue Cross and Blue Shield Association, is a not-for-profit healthcare company which, through its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products and administrative services to 3.4 million individuals and employers in Maryland, the District of Columbia and Northern Virginia. In 2019, CareFirst invested \$43 million to improve overall health, and increase the accessibility, affordability, safety, and quality of healthcare throughout its market areas. To learn more about CareFirst BlueCross BlueShield, visit our website at www.carefirst.com and our transforming healthcare page at www.carefirst.com/transformation, or follow us on [Facebook](#), [Twitter](#), [LinkedIn](#) or [Instagram](#)

SB0460 HEAU's Comments Draft Proposal

The HEAU thanks the Commissioner for facilitating the workgroup's thorough review of existing resources and other state's programs, and consideration of the intended goals of the 2021 Consumer Health Access Program for Mental Health and Addiction Care proposed legislation. Like all other stakeholders on the workgroup, the HEAU recognizes the need to provide a centralized location and local navigators for Marylanders with mental health and substance use disorders, and others acting on their behalf, to seek help accessing care, obtaining payment for care, and obtaining other information necessary to facilitate care.

The HEAU looks forward to working with the Program to accomplish the goals of the Program and, among other things, to assisting consumers whose health plans have denied coverage for behavioral health/substance use disorder services. As noted in the last workgroup meeting, further consideration must be given to Medicaid and Medicare denials because the HEAU does not have the specific legislative authority, funding or current expertise to assist pursuit of such appeals. Maryland's federally funded State Health Insurance Assistance Programs should be consulted about being a referral source for Medicare denials, because these consumer-based programs have existing Medicare coverage expertise. With the appropriate legislative authority and funding, the HEAU could certainly undertake providing grievance assistance to Medicaid participants denied coverage for these services. For purposes of evaluating resource needs, it would be helpful to know how many coverage denials (for all or part of a claim) were issued by Optum, or its predecessor, in the last five years, and how many Level I and Level II grievances were filed with Optum, or its predecessor, in the last five years broken down by year and the outcomes of those grievances.

We have appreciated the opportunity to participate in this vitally important effort for Maryland consumers. Thank you.

Sincerely,

Kimberly S. Cammarata
Assistant Attorney General
Director, Health Education and Advocacy Unit

and

Patricia O'Connor
Assistant Attorney General
Deputy Director, Health Education and Advocacy Unit

Maryland Office of the Attorney General
200 St. Paul Place
Baltimore, MD 21202
(410) 576-7038

Establishment:

There is a Consumer Health Access Program for Mental Health and Addiction Care.

The Program is an independent Division of the Maryland Insurance Administration

Purposes:

The purposes of the Program are to:

- Identify and coordinate consumer access to public and private behavioral health care resources;
 - *Catalogue care and assistance organizations*
 - *Maintain updated resource guide on website*
 - *Assist program participants to access resources*
- Assist consumers to access behavioral health care services;
 - *Establish a centralized digital intake, tracking, task management, and reporting system for persons seeking assistance from the Program*
 - *Identify and access behavioral health provider appointment systems established by Maryland Department of Health, other governmental agencies, health insurers, and commercial entities*
- Assist consumers to obtain payment for behavioral health care services from commercial and governmental health plans and public or private financial assistance programs for which they qualify;
 - *Assist consumers to enroll in health plans and assistance programs for which they qualify*
 - *Direct to MHBE for insurance coverage and Medicaid enrollment*
 - *Direct to Navigators to apply for private assistance programs*
 - *Direct consumers to Navigators to interface with behavioral health providers and health plans in which consumers are enrolled to confirm or coordinate coverage*
 - *In the event of coverage denials, refer the consumer to HEAU and/or the Appeals and Grievance Unit of the MIA to pursue contractual and administrative remedies for coverage denials*
 - *In the event that administrative options are not successful, refer consumers to legal resources to pursue judicial remedies for coverage denials*
- Provide a toll free telephone hotline to respond to requests for assistance by consumers, providers who are acting on behalf of consumers, and individuals within the state's

behavioral health crisis response system in accessing behavioral health care services and obtaining health plan coverage for behavioral health care services;

- *Leverage existing hot-line, call center operations such as 211 or MHBE to perform intake and triage emergencies*
- Provide a website through which consumers, providers who are acting on behalf of consumers, and individuals within the state's behavioral health crisis response system may obtain information about available behavioral health care services and health plan coverage for behavioral health care services and may request assistance in accessing behavioral health care services and obtaining health plan coverage for behavioral health care services;
 - *Establish a stand-alone website and app branded as the Program, linked from State Agency sites, advocacy sites, etc.*
 - *Request for assistance form available on line (multi-lingual and smart phone friendly), directed into the intake system for rapid referral to Navigator*
 - *Links to educational materials and resources*
- Contract with a qualified entity to act as a Behavioral Health Care Navigator in each Connector Entity Region;

Behavioral Health Care Navigators:

- *Follow-up and maintain contact with consumers*
 - *Assist consumers to find available qualified behavioral health providers*
 - *Direct consumers to MHBE Navigators and the Connector to obtain coverage or Medicaid*
 - *Track and report information regarding the consumer's experience in securing care and coverage*
 - *Supervise certified peer support counselors*
 - *Refer consumers to HEAU or MIA to assist with the resolution of health plan coverage issues and participate as necessary in the resolution of such issues*
- In conjunction with one or more institutions of higher learning in the state, develop a cost-free certification program to train and certify Peer Support Counselors to assist consumers seeking behavioral health services and health plan coverage for such services and assign compensation and volunteer certified Peer Support Counselors to contracted Behavioral Health Care Navigators;
- Carry out a public relations and advertising campaigns to promote the Program;
- Collect and analyze data related to:
 - Gaps in behavioral health care resources

- Gaps in coverage for behavioral health care in existing commercial and government plans
 - Bases of coverage denials
 - Results of contractual and administrative appeals
 - Results of judicial actions
 - Mental health parity issues and violations
 - Network provider adequacy issues and violations
 - Provider directory issues and violations;
 - Gaps in the availability of behavioral health providers
- Share data and analysis with state agencies; and
- Submit an annual report to the Maryland General Assembly on the Program, the analysis performed on Program data (as described above) and recommendations to improve access to affordable compensated behavioral health care

Executive Director and Staffing

- The Commissioner shall appoint the Executive Director in consultation with the Coordinating Agencies (MHBE, MDH/BHA, HEAU)
- The Executive Director shall report directly to the Commissioner.
- The Executive Director shall serve for a term of two years and can only be removed during a term for cause.
- The Executive Director:
 - Shall direct, administer and manage the operations of the Program
 - Shall employ and retain staff to perform services unique to the operation of the Program
 - May retain independent contractors, attorneys, consultants, and other professionals or consultants necessary to carry out unique operations of the Program
- The Administration shall provide the Executive Director and Program with operational support services (HR, routine IT, PIO, Admin, Legal, Procurement, Equipment, Office space, transportation) and may enter into Memorandums of Understanding with federal, state and local governmental units in order to facilitate the provision of services on behalf of the Program.

Funding

- There is a Consumer Health Access Program for Mental Health and Addiction Care Fund.

- The purpose of the Fund is to provide funding for the operations of the Program that are not required to be provided by the Administration, including functions delegated by the Executive Director to a third party under law or by contract.
- The Administration shall administer the Fund.
- The fund is a special, non-lapsing fund that is not subject to § 7–302 of the state finance and procurement article.
- The Fund consists of:
 - An annual contribution from the Administration in an amount equal to [] of the Administration’s final approved budget without consideration of any approved budget amendments in the prior fiscal year; *[this reflects the notion that some of the work that is done by the Program would overlap with the work of the Administration, but would make sense to budget within the Program in order to take advantage of the expertise within the Program]*
 - Any funds designated by the State to fund the activities of the Program;
 - Income from investments made on behalf of the Fund;
 - Interest on deposits or investments of money in the Fund;
 - Money donated to the Fund;
 - Money awarded to the Fund through grants; and
 - any other money from any other source accepted for the benefit of the Fund.
- The Fund may only be used for the operation and administration of the Program in carrying out the purposes authorized under this subtitle.

Behavioral Health Navigators

- Functions
- Qualifications/Selection Criteria/Contracting
- Duties
- Compensation
- Termination

Peer Support Counselors

- Certification
- Functions
- Qualifications/Appointments/Assignments
- Duties
- Termination

Advisory Council

- There is a Consumer Health Access Program Advisory Council.
- The Council shall, to the extent practicable:
 - reflect the gender, racial, ethnic, and geographic diversity of the State;
 - constitute a diverse cross-section of stakeholders broadly representative of the individuals and entities described [below]; and
 - are appointed by the Board for a term of no more than 3 years in a manner that provides continuity and rotation;
- The Council consists of no more than 15 members, including:
 - One representative of the Behavioral Health Administration, designated by the Secretary of Health;
 - One representative of the Maryland Medicaid Administration, designated by the Secretary of Health;
 - One representative of the Health Education and Advocacy Unit of the Office of the Attorney General, designated by the head of the Unit;
 - One representative of the Maryland Health Benefit Exchange, designated by the Executive Director of the Exchange;
 - One representative of the Maryland Insurance Administration, designated by the Commissioner;
 - One expert in the interpretation and application of the Mental Health Parity and Addiction Act; and
 - Nine persons designated by the Executive Director, including persons who are members of each of the following stakeholder groups:
 - Consumers of behavioral health treatment services;
 - Mental and behavioral health treatment providers;
 - Organizations that provide mental and behavioral health crisis services;
 - Organizations that work on behalf of marginalized individuals to achieve health equity;
 - Organizations that conduct outreach to individuals with mental and behavioral health disorders;
 - Certified Peer Support Counselors;
 - Local health departments;
 - Health insurance carriers; and
 - Managed Care Organizations.
- The Council shall meet quarterly and perform the following functions:
 - Advise the Executive Director on the administration and operation of the Program
 - Recommend improvements to the administration and operation of the Program;
 - Review the de-identified and aggregated Program data to be included in the Annual Report and advise the Executive Director on recommendations to be included in the Annual Report; and
 - Provide the Executive Director with such advice as the Executive Director may seek on policy issues related to the Program.

Annual Reporting

- The Executive Director shall annually report on the effectiveness of the program to the MD General Assembly on or before December 31st. The report shall include;
 - A detailed summary and accounting of all Program activities;
 - An evaluation of the performance of the Program;
 - A complete fiscal accounting;
 - De-identified and/or aggregated data summarizing
 - The number of consumers seeking services from the Program
 - The number of successful treatment referrals
 - The number of Program participants seeking assistance with health plan coverage issues
 - Bases of health plan coverage denials
 - Results of contractual and administrative appeals
 - Results of judicial actions
 - Mental health parity issues and violations identified
 - Network provider adequacy issues and violations identified
 - Provider directory issues and violations identified
 - Identification of treatment and coverage gaps; and
 - Recommendations to improve access to mental and behavioral health treatment and enforcement of state and federal laws related to the provision of mental and behavioral health services and health plan coverages.



15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

For information, contact:
Matthew Celentano, Executive Director

December 5, 2022

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

Re: MIA CHAP Program Draft Outline

Dear Commissioner Birrane:

On behalf of the League of Life and Health Insurers of Maryland, Inc. (League), thank you for the opportunity to provide comments on the conceptual draft of the mental and behavioral health ombudsmen program (Program). The League is the state trade association representing life and health insurance companies in Maryland.

We are appreciative of the time and resources that the Maryland Insurance Administration (MIA) has offered during the 2022 interim to address concerns raised regarding Senate Bill 460, which as introduced during the 2022 legislative session, would have created the Consumer Health Access Program for Mental Health and Addiction Care (CHAP). As we stated during the public hearings for Senate Bill 460 and during the interim workgroup sessions, though the goals of the CHAP are laudable, we share many of the same concerns the MIA outlined in its February 22, 2022 letter of information to the Senate Finance Committee.

We believe that the Program's conceptual draft is an excellent framework that we can build upon to best assist consumers navigate the mental health system in Maryland. The conceptual draft addresses one of the key concerns we had in Senate Bill 460, which would have permitted CHAP to assume to role of the regulator in certain instances. The assumption of the regulatory role would have significant consequences related to regulatory enforcement authority, privacy, and a litany of other regulations that the CHAP would not be subject to as a private entity. The conceptual draft instead houses the entity that would provide consumer services within an existing regulatory agency, ensuring that data protection and confidentiality laws would apply. Furthermore, given that the MIA is the agency with enforcement authority over carriers, any confusion or ambiguities associated with regulatory oversight is addressed by this framework.

The League of Life and Health Insurers of Maryland, Inc.
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www.leaguemaryland.com

The conceptual draft addresses many of goals of the CHAP program while being considerate of the concerns raised during the 2022 legislative session. We truly appreciate the time and thought that went into this conceptual draft and offer the following recommendations to build upon it:

- The program should incorporate existing carrier resources into consumer assistance resources and referrals. It will be critical for the Program's staff to be trained on resources that carriers currently provide consumers.
- MIA should align new statutory and regulatory terminology with existing terminology for "peer support counselors." Many jurisdictions use the term "specialist" rather than "counselor." MDH refers to these professionals as "certified peer specialists" or "certified peer recovery specialists" and Washington D.C. uses the term "peer specialist" or "certified peer specialist." As the MIA develops the role of these individuals within the Program, precise terminology consistent with the expected scope of services for the Program and any state licensing and certification schemes is important.
- The League requests clarification on the breadth of data that the Program will collect and analyze for sharing with other agencies. Will the data collected exclusively include Program experience, or will it also include other MIA regulatory data?
- The League requests that there is carrier representation on the Advisory Council.

Thank you once again for the opportunity to comment on the conceptual draft. We look forward to our continued work together on this issue.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew Celentano", with a long horizontal flourish extending to the right.

Matthew Celentano
Executive Director
The League of Life and Health Insurers of Maryland, Inc.

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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

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)).

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 (O OCC), 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 O OCC 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.

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).

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.

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.

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.

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

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VP of State Strategy & Reentry

Abigail Woodworth
VP of External Affairs

Adela Prignal
Chief Financial Officer

Sharon X. Hayes
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.

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.

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

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).

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

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; <u>print materials</u> – 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 initiates 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.

CHAP Functions and MIA and HEAU Activities
Legal Action Center 6.14.22

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). <i>More information needed on scope of work on ERISA plan and non-ERISA self-funded plans.</i>
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 <i>ex officio</i> 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

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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