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January 6, 2023

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

Dear Commissioner Birrane:

I am writing on behalf of the Legal Action Center (Center) to provide comments on the Maryland Insurance Administration's (MIA) draft bill language for a consumer assistance program. The Center convenes the Maryland Parity Coalition, which developed and advocated for the Consumer Health Access Program (SB 460). The Center and other Coalition members have actively participated in the SB460 Workgroup, and we submitted extensive comments on the MIA's proposal for a consumer assistance program. **The MIA's draft bill tracks its proposal and does not alter the proposed framework, which, if adopted, would not achieve the key elements of autonomy, transparency, seamless assistance and client representation at the core of SB460.**

Based on our extensive comments to the proposal, the following summarizes our key concerns about the bill draft. We do not offer recommended revisions, as the proposed framework requires fundamental reworking and that would implicate most provisions. **While we regret that the Workgroup did not discuss or resolve the questions posed at the outset, we thank the MIA for convening the discussion and conveying to the Health and Government Operations Committee that no consensus has been reached.**

I. Name of Program

We object to the term "behavioral health" to describe the individuals for whom the program would be established. While "behavioral health" is commonly used to describe mental health (MH) and substance use disorders (SUD), it is an imprecise term that suggests that these medical conditions are essentially "behavioral" in etiology and progression. Science has long debunked that notion. Additionally, virtually all medical conditions are influenced by an individual's "behavior," which is closely related to the individual's life-circumstances, income, support system, societal factors, social constructs and personal choices. Yet, no other medical condition is labeled a "behavioral health" condition. Mental health and substance use disorders (or addiction) are the preferred terms.

II. Definitions – 34-101

The term "consumer assistance services" omits key activities that are performed by consumer assistance programs, identified as best practices, and contemplated under the Affordable Care Act's funding provision for a state "office of health insurance consumer assistance." 4(2. U.S.C. §300gg-93). Specifically, we note that definition would not include:

- Direct client representation in administrative or judicial forums, as permitted under the Peoples Insurance Counsel's authority (STATE GOV. § 6-301 et eq.); and
- Community engagement through outreach and education.

We also note that the proposed activities would be limited to assisting consumers in **administrative forums** alone. While we anticipate that most insurance disputes would be resolved through informal engagement with the carrier or through an administrative complaint process in order to expeditiously address the client's access problem, the authority to engage in judicial actions should be explicitly included.

Additionally, while data gathering and analysis would be a function of the program (34-202), it would be performed by the state entity, which have complete control over the scope of information that would be publicly disclosed, and would require disclosure only on an annual basis. **This approach fails to capture the critical sentinel function of independent consumer assistance programs that allows for early, transparent and on-going identification of barriers to care and broader disclosure to all policy makers and the public. We view this as a significant limitation in the MIA's draft bill.**

III. Creation of Consumer Assistance Program – 34-201

The bill draft does not define the meaning of an "independent division of the Maryland Insurance Administration." Based on the Workgroup discussion, the MIA views the Executive Director retention requirement (i.e. serves for a term and not at the pleasure of the Commissioner) as creating the "independence" of the office, even though the Commissioner would appoint the program director. *See* 34-204. **These personnel features, however, do not speak to the "independence" of the consumer assistance program that would:**

- live in the MIA;[1]
- share various administrative resources provided by the MIA;
- potentially rely on current "education" activities conducted by the MIA's Consumer Education and Advocacy Program (INS. § 2.301 et seq.); and

[1] The placement of a consumer assistance program in the MIA is of particular concern, as the agency regulates a very small portion of commercial insurance, and the smallest number of covered lives across private and public insurance. In 2022, the MIA regulated only 17% of commercial insurance purchased by Marylanders under 65 years of age and 34% of covered lives in commercial insurance. Commissioner Kathleen Birrane to Honorable Bill Ferguson and Honorable Adrienne Jones, Report on Number of Insured and Self-Insured Lives (Nov. 15, 2022). **The total number of covered lives – 895,528 – pales in comparison to Medicaid enrollment for 2022 – 1,483,613.** (*Id* at. 7). From a consumer's perspective, this framework is the "tail wagging the dog."

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- have the "Consumer Health Access Program" fund be administered by the MIA (34-301).

We also note that among the important roles of the SB460 Consumer Health Access Program would be to identify and address violations of the Mental Health Parity and Addiction Equity Act through both client representation and identification of system-wide problems. With the MIA responsible for Parity Act compliance in state-regulated commercial plans (INS. § 15-144), we have significant concerns about how a consumer assistance program based in the MIA would be permitted to independently assist clients on commercial health plan violations and identify system-wide problems. Indeed, the MIA's draft bill mentions the Parity Act only in the context of data gathering and analysis, i.e. 34-501(B)(6) ("Mental Health Parity issues and violations"). Depending on the ED's implementation, the source of that data could be based exclusively on the MIA's analysis of commercial insurance reports and the Maryland Department of Health's (MDH) annual Medicaid Compliance report.[2]

Finally, and most significantly, based on the Workgroup discussion, the consumer assistance program would be represented, at least initially, by the **same Attorney General** who represents the MIA. **This as a conflict of interest.** It is also inconsistent with previous Workgroup discussions in which the MIA's Attorney General indicated that the functions of a consumer assistance program would have to be "walled off" from its work on behalf of the MIA.

None of these features suggests that the consumer assistance program would be independent of the MIA. In contrast, the framework for a truly independent entity that has authority to address on behalf of consumers other insurance matters that are regulated by the MIA is provided by the People's Insurance Counsel Division. *See* STATE. GOVT. § 6-301 et seq. The People's Insurance Counsel (PIC) is appointed by the Attorney General with the advice and consent of the Senate (§ 6-302(a)(2)). **Recognizing that the MIA regulates insurance, the PIC's authority vis-à-vis the MIA is clearly articulated.** The PIC is required to: "evaluate each medical professional liability insurance and homeowner's insurance matter pending before the Commissioner to determine whether the interests of consumers are affected" and review specific rate increases. Additionally, the PIC has authority to appear before the Commissioner on behalf of insurance consumers in matters in which the Commissioner has jurisdiction, conduct investigations and request that the Commissioner initiate actions to protect the interests of insurance consumers. § 6-306. Finally, the PIC has statutory authority to appear before any federal or state agency or in any judicial or administrative action to protect the interests of insurance consumers. § 6-307. **These are the hallmarks of an independent entity that is representing consumer interests on matters regulated by the MIA or any other state agency.**

Fundamentally, the MIA's proposal is a state agency-centric model in which government agencies would be responsible for addressing consumer access barriers, even though those very agency programs, regulatory procedures and oversight may be the problem. Far greater transparency and autonomy are needed to ensure that Marylanders will seek the

[2] The Legal Action Center has reviewed the MDH's 2022 Parity Act Compliance Report and identified numerous deficiencies in its analysis. *See* Legal Action Center Letter to Secretary Schrader (Dec. 22, 2022) available at https://www.lac.org/assets/files/LAC-Comment-Letter_Maryland-Medicaid-Parity-Compliance-Report-12.22.22.pdf.

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assistance of the consumer assistance program and trust that their individual interests and needs will guide the assistance that is rendered.

IV. Program Purpose – 34-202

The bill draft would require the consumer assistance program to "identify and coordinate efforts by the coordinating agencies."[3] **While coordination of MH and SUD care across Maryland's agencies is critical, that is not the role of a consumer assistance program.** A consumer assistance program must be singularly focused on resolving individual client access issues and identifying problematic trends based on the barriers that clients face. We can envision the diversion of significant resources from this central function if the consumer assistance program were required to undertake the time-consuming and undefined task of coordinating agency functions. The heads of each consulting agency are in the best position to carry out that function and, to the extent they do not currently have this responsibility, should be tasked with the coordination function.

V. Promoting Consumer Awareness and Access – 34-203

We agree that the resources must be devoted to ensuring that consumers are aware of the consumer assistance program and that a telephone hotline and website are available for consumer assistance. **The bill's description of the outreach raises significant questions about whether resources would be devoted to true "community outreach and engagement," which is necessary to reach individuals with MH and SUD and those not otherwise connected to existing health systems.** Hotlines and websites are important but not sufficient for this purpose.

We also note that the navigator function (34-401) is not sufficiently detailed to determine whether "outreach and engagement" is a core part of their role. While 34-401 contemplates that navigators will conduct "consumer assistance services," the definition of such services (34-101) does not include community engagement through outreach and education.

Finally, the bill language speaks in terms of the program "providing" a hotline and a website in contrast to "operating" both the hotline and website. This language reflects the MIA's proposal to rely on other existing hotlines and websites to carry out this critical function, and, as indicated in the Workgroup discussion, the program's ED would determine how to operationalize the requirement. As noted in the Center's previous letter, the existing 211 and Maryland Health Benefit Exchange call center are not suited to carry out this function.

VI. Miscellaneous Items

Although the bill would establish a fund for the consumer assistance program, it does not identify a funding amount. As noted in the Center's previous letter, we believe a state agency-centric model will increase costs without increasing consumer services. Additionally, the lack of a funding mark makes it impossible to evaluate whether sufficient resources will be devoted to the program.

[3] We assume that "coordinating agencies" is intended to be "consulting agencies" defined to include the Health Benefit Exchange, Maryland Department of Health and Behavioral Health Administration, Health Education and Advocacy Unit, and other state departments and units that provide MH or SUD services.

The bill does not state whether the consumer assistance program is intended to be permanent or a pilot program. If established appropriately, we support a permanent program.

The bill does not address health privacy standards and protections – a significant concern raised (and addressed) during the SB 460 legislative debate. Those concerns were never discussed in the Workgroup. Without greater guidance, it is impossible to understand why the SB 460 privacy provisions are not sufficient to protect the health privacy of those seeking program services.

Additionally, the carriers have consistently raised concerns about the **privacy of carrier information** but have not identified what information is at risk or in need of protections. All carrier information that relates to a member's health care condition or insurance claims are "owned" by the member, and they alone have the right to consent to the use and disclosure of their information, consistent with HIPAA, Part 2 Substance Used Disorder Confidentiality laws and state privacy protections.

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Thank you for considering our views.

Sincerely,

Ellen M. Weber
Sr. V.P. for Health Initiatives
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