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

Re: MHPAEA Regulation Public Meeting, July 21, 2026

Dear Ms. Fountain,

Thank you for the opportunity to provide comments on the Maryland Insurance Administration's (MIA) implementation of the Maryland mental health and substance use disorder parity law, as amended by Maryland Senate Bill 205 (2026). The Legal Action Center (LAC) is a non-profit law and policy organization that fights discrimination, builds health equity, and restores opportunity for people with substance use disorders, arrest and conviction records, and HIV/AIDS. LAC convenes the Maryland Parity Coalition, which works to improve Maryland's coverage of mental health (MH) and substance use disorder (SUD) care and ensure effective enforcement of anti-discrimination laws like the Mental Health Parity and Addiction Equity Act (MHPAEA).

The Maryland Parity Coalition commends the MIA for its leadership on SB 205 and is grateful for the opportunity to work with the agency on implementing regulations that will help improve compliance with federal and state parity laws. The undersigned 11 organizations offer the following recommendations in response to the discussion questions posed by the MIA.

1. Whether and how the proposed regulations should define "relevant data" and "relevant outcomes"? What types of data should be collected and evaluated with regard to network composition?

We encourage the MIA to specify the "relevant data" Maryland carriers should collect and evaluate for their non-quantitative treatment limitation (NQTL) comparative analyses, and to develop guidance and templates that will facilitate consistent and streamlined data collection, to the greatest extent possible. We commend the MIA for the guidance and templates it developed in 2024 and 2026 to evaluate compliance with several NQTLs, and we agree with the MIA that data supplements are useful to identify areas where further inquiry is necessary to enforce MHPAEA.[1] As such, we encourage the MIA to continue using the process it has already developed for identifying and collecting the data elements that carriers should submit, and can build on this effort by leveraging forms and supplements developed or used by federal and other state agencies. In addition, MIA may wish to consider adopting gap filling regulations to

[1] Maryland Insurance Administration, "Report required by SB 684/Ch. 223, 2024 and HB 1074/Ch. 234, 2024 (MSAR 15467) – Final Report on Nonquantitative Treatment Limitations and Data 14 (Dec. 1, 2025), https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/Nonquantitative-Treatment-Limitations-and-Data-2025-Final-Report.pdf.

instruct carriers on the minimum requirements for collecting and evaluating relevant data for any NQTLs for which the MIA has not developed forms and guidance.

We encourage the MIA to clarify that "relevant data" should be multi-faceted and comprehensive, recognizing that multiple data points may be necessary to illuminate different aspects of the same NQTL, or how multiple NQTLs interact. For example, prior authorization data should include not just the number of benefits subject to prior authorization, but also how often the prior authorization needs to be renewed, how long the carriers take to respond to prior authorization requests, how often these requests are denied or limited…etc. We encourage the MIA to approach each NQTL holistically, and consider each point at which an NQTL may create additional burdens and access barriers for Maryland consumers.

One of the ways we encourage the MIA to define "relevant data" and "relevant outcomes" is to clarify that both should be meaningfully disaggregated so as to prevent disparities from being masked. First and foremost, we encourage the MIA to ensure that all carriers are separating out MH from SUD benefits, and comparing each of these to the medical/surgical benefits. This is the best reading of the federal MHPAEA statute – which uses the word "or" – and is necessary because while there is some overlap in the benefits used for treating these conditions, their treatment is not interchangeable. Maryland carriers' network adequacy reports have revealed disparities for addiction physicians and opioid treatment programs (OTPs), and federal data further supports that out-of-network use is higher for SUD treatment than for MH treatment across benefit classifications.[2] We further encourage the MIA to require data be disaggregated by age and other key demographics to ensure carriers demonstrate non-discriminatory access to appropriate sub-specialties of care, such as child/youth psychiatrists and geriatric psychiatrists, similar to how the MIA separates these out for network adequacy reporting.

We believe that the data elements proposed in SB 774 (2026), the Truth in Mental Health Coverage Act, are a helpful starting point for the data that carriers should be required to collect and evaluate with regard to network composition. At a minimum, the MIA should require carriers to report on out-of-network usage, recognizing that this often reflects network composition deficiencies, as well as the carriers' compliance with Maryland's network adequacy metrics and reimbursement rates. These data elements are included in the federal parity regulations, on which SB 205 is based, and are nationally recognized metrics in which there are existing disparities in access to MH and SUD treatment, as compared to medical/surgical treatment, particularly in Maryland.[3] We urge the MIA to ensure that network composition data focus on providers who are actively submitting claims, and screen out those who are not

[2] Tami L. Mark, Miku Fujita & William J. Parish, "Disparities in Use of Out-of-Network Mental Health and Substance Use Treatment Versus Medical or Surgical Treatment," Psychiatry Online (Mar. 11, 2025), https://psychiatryonline.org/doi/10.1176/appi.ps.20240448.

[3] Tami L. Mark & William J. Parish, "Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue," RTI International (Apr. 17, 2024), https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf.

billing the plans or who bill infrequently, recognizing that Maryland carriers frequently include higher rates of these "ghost" MH and SUD providers.[4]

One additional way the MIA can gain data on network composition, particularly with respect to provider network inaccuracies, would be through requiring carriers to contract with third-party entities to conduct secret shopper surveys on their network directories, as the Centers for Medicare & Medicaid Services (CMS) require for qualified health plans (QHPs) on the federally-facilitated exchange.[5]

2. Whether and how the proposed regulations should define "material differences" in access? How could the material difference standard be defined so that it could be translated into statistical analysis? What are useful metrics to determine parity of access? Should the proposed regulations include exceptions that would not be considered material?

The MIA should set a uniform standard for a "material difference," rather than leave it up to the carriers. We believe that any difference that affects an individual's access to MH or SUD care as compared to medical/surgical care should be considered material. Any difference in relevant data should be fully examined in the comparative analysis, consistent with the 2024 federal regulations.[6] In this reasoned justification, we believe carriers should have to show that this difference does not affect access to MH or SUD care in order for it not to be considered material, such as if the difference is driven by a single outlier unlikely to occur again, or the difference is so small it could reasonably be attributed to a rounding error. However, for anything beyond that, the facts and circumstances could lead to even a small difference in the data having a significant impact on enrollees' access to care, and that is why we believe it is necessary to adopt this approach.

If the MIA does feel the need to set a numeric standard, then we believe no more than 5% should be used as the minimum difference that must be treated as material, such that carriers must fully explain and justify the disparity, demonstrate that it is not attributable to the NQTL, and make corrective actions as appropriate. Ultimately though, we believe the comparative analyses should treat all differences in outcomes data as potentially material, recognizing that the determination as to whether there is a parity violation still comes down to the attribution to the NQTL.

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[4] Maryland Insurance Administration, "Report required by SB 684/Ch. 223, 2024 and HB 1074/Ch. 234, 2024 (MSAR 15467) – Final Report on Nonquantitative Treatment Limitations and Data 13-14 (Dec. 1, 2025), https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/Nonquantitative-Treatment-Limitations-and-Data-2025-Final-Report.pdf.

[5] "2025 Final Letter to Issuers in the Federally-facilitated Exchanges," U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight 17 (Apr. 10, 2024), https://www.cms.gov/files/document/2025-letter-issuers.pdf; *see also* "Appointment Wait Time Secret Shopper Survey Technical Guidance for Qualified Health Plan (QHP) Issuers in the Federally-facilitated Exchanges (FFEs)," Centers for Medicare & Medicaid Services (Apr. 2024), https://www.cms.gov/files/document/2025-letter-issuers.pdf.

[6] 45 C.F.R. § 146.137(c)(5)(iii)(B).

We do not believe it is appropriate for the proposed regulations to include exceptions that would not be considered material. The only circumstances in which disparities in outcomes data should persist are when carriers can truly and adequately demonstrate that the data disparities are not attributable to the NQTL – or any other treatment limitations – and that the factors and evidentiary standards underlying the design and application of the NQTL are not biased and are objective. To the extent that Maryland carriers may argue that disparities are driven by generally recognized independent professional medical standards or efforts to curb fraud, waste, and abuse, we believe these are separate NQTLs that carriers must analyze in their comparative analyses, rather than be used as exceptions. For example, if carriers contend they are using generally accepted standards of care for their utilization review criteria, they must at least analyze the sources used to develop those criteria, the extent to which their coverage criteria deviate from those sources, the discretion afforded to reviewers, and the frequency at which those reviews are denied or limited. If they argue that disparities are driven by efforts to curtail fraud, they should demonstrate that the design and application of those efforts are no more restrictive for MH or SUD as they are for medical/surgical benefits. Adopting exceptions may mask these types of disparities, which would not be consistent with this law or the purpose of MHPAEA.

3. Whether and how the proposed regulations should define "bias" and "objective in a manner that discriminates"?

Factors and evidentiary standards should be considered biased or not objective in a manner that discriminates against MH/SUD benefits as compared to medical/surgical benefits in the same way that NQTLs are tested – that is, if they are more restrictive or not comparable for MH/SUD as for medical/surgical benefits. For example, the Medicare physician fee schedule (PFS) is often used as a benchmark for setting reimbursement rates, but Medicare reimburses non-physician MH and SUD counselors at 75% of the PFS while reimbursing non-physician medical/surgical providers (such as nurse practitioners and physician assistants) at 85% of the PFS. Since Medicare is not subject to parity, and this greater reduction in reimbursement is applied solely to MH and SUD providers, Maryland carriers should have to cure or supplement this evidentiary source when designing and applying reimbursement rates to ensure that this NQTL complies with MHPAEA.

We encourage the MIA to be explicit that this requirement includes historical factors and evidentiary standards, as the 2024 federal regulations detail.[7] That is, a plan should not be able to use factors and evidentiary standards from a time when the plan was not compliant with MHPAEA or that predated MHPAEA, unless such historical information is corrected, supplemented, or cured for bias and lack of objectivity.

We encourage the MIA to extend this requirement to sub-populations where access may be less favorable, such as if there are certain pools of underserved enrollees or certain conditions

[7] 45 C.F.R. § 146.136(c)(4)(i)(B)(2).

or levels of complexity that are disfavored. For example, factors or evidentiary standards that systematically disfavor certain MH or SUD diagnoses or co-occurring disorders, or regions of the state where there is less access to MH and SUD care, should be considered biased or not objective in a manner that discriminates.

We strongly encourage the MIA to impose a heightened level of scrutiny on third party administrators (TPAs), with potentially additional rules or audit requirements, recognizing the inherent potential for additional bias that comes from segregating out MH/SUD from medical/surgical care since there is necessarily an additional level of variation that is harder to assess.

4. Whether and how proposed regulations should define, clarify, and measure "meaningful benefits"? How should the proposed regulations implement the core treatment requirement? How should the proposed regulations define "standard treatment or course of treatment," "therapy," "service," and "intervention"?

The MIA should define "meaningful benefits" as the full continuum of generally accepted care, as developed by the non-profit professional societies for the relevant clinical specialties, including the ASAM Criteria, LOCUS, CALOCUS, ESCII, and others. Maryland law already requires these criteria to be used for medical necessity and utilization review,[8] so we believe this interpretation would be the most appropriate in our state. The goal of the "meaningful benefits" standard is to ensure that the scope of MH and SUD services covered by carriers is as comprehensive as that for medical/surgical conditions, and that carriers cannot fulfill their "scope of service" obligations by merely covering "only one or a few isolated ancillary benefits."[9] Yet, carriers rarely fail to cover the full scope of services that are necessary for medical/surgical conditions, and instead narrowly impose these types of coverage exclusions on MH and SUD. To ensure that Marylanders have access to the full range of treatment they need to address their MH and SUD – recognizing that carriers can still impose treatment limitations on these benefits, so long as they are comparable to and no more restrictive than those imposed on medical/surgical benefits – the MIA should adopt this definition of meaningful benefits that aligns with our other existing laws.

We also encourage the MIA to recognize that certain types of team-based care and certain settings of care are considered core treatments for specific conditions or sub-populations, for example coordinated specialty care (CSC) for early psychosis and assertive community treatment (ACT) for severe MH conditions, school-based mental health for youth, and dyadic care for young kids. This should also include mobile crisis response teams and crisis receiving and stabilization services, as these are the core treatments for MH and SUD in the "emergency services" classification, and we commend the MIA for including this treatment limitation in the 2026 data call.

[8] Md. Ins. Code §§ 15-802(d)(5); 15-10B-05(a)(11)(iv).
[9] 89 Fed. Reg. 77586, 77634 (Sept. 23, 2024).

Thank you for considering our comments. We would be happy to speak with you further about these recommendations. Please do not hesitate to contact Deb Steinberg at dsteinberg@lac.org.

Sincerely,

Legal Action Center
AHEC West
Community Behavioral Health Association of Maryland (CBH)
Inseparable
James' Place Inc.
Maryland Association for the Treatment of Opioid Dependence (MATOD)
Maryland-DC Society of Addiction Medicine (MDDCSAM)
Maryland Heroin Awareness Advocates
Maryland Psychological Association
Mental Health Association of Maryland
Montgomery Goes Purple