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Public Meeting on the Mental Health Parity and Addiction Equity Act Regulations
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Maryland Insurance Administration

Good afternoon. Commissioner Grant, thank you for the opportunity to provide comments today on parity regulations which implement S.B. 205 of 2026, the new state law codifying the 2024 federal Mental Health Parity and Addiction Equity Act (MHPAEA) regulations. My name is Alana Aronin, and I am the Program Manager for the Community Mental Health CORE at Children's National Hospital. Children's National has been serving the nation's children since 1870. Nearly 60% of our patients are residents of Maryland, and we maintain a network of community-based pediatric practices, surgery centers, and regional outpatient centers in Maryland to serve the diverse needs of our Maryland patients.

We appreciate the effort that the Maryland Insurance Administration (MIA) is undertaking to develop regulations that guide insurance parity adherence and meaningfully design guardrails that protect Maryland residents. My comments will focus on the unique protections that children require, and where parity regulations can support children in accessing mental health and substance use services when and where they need them.

Q1. 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?

Children's National wants to ensure MIA defines and establishes consistent and reliable data which facilitates objective comparisons. First and foremost, relevant data must include data specially for children, and within that data sub-stratification for age ranges such as infant/early childhood, children ages 5-12, and adolescents. Children's needs vary greatly across age

ranges, and cannot be combined as one data point. For instance, a secret shopper[1] study we conducted two years ago found that provider age-range information was often inaccurate. Many providers listed as treating "all ages" did not actually see children, resulting in overestimation of available pediatric providers and highlighting the need for child-specific data. Another secret shopper study conducted last year found autism patients elementary age had a significantly harder time finding applied behavior analysis (ABA) services than preschool autism patients.[2]

Data should also include tracking a variety of subspecialists within behavioral health care. A 17-year-old with first episode psychosis may need access to different mental health specialists than a 5-year-old with Autism or a 10-year-old with PTSD. Children's National Hospital has psychology and psychiatry clinics across eight of our specialty clinics and psychologists embedded in and serving as consultants to 16 divisions and programs, responding to the unique mental health needs of those patients. Each of these specialties requires tailored knowledge, and each should be accessible for children who need them. Measuring the network composition can and should begin with identifying mental health specialists and subspecialists, both by ages served and health care need.

This also includes coverage of mental health services across the continuum of care. Children's National believes there should be increased efforts to finance prevention and early intervention of mental health disorders among children and adolescents, and that this is therefore a crucial measure of parity between physical health and mental health. Preventive approaches are paramount in ensuring the success of young children at risk for developing behavioral and developmental disorders. Prevention services are a distinct mental health offering, and should therefore be measured separately.

Children with autism diagnoses often struggle with difficulties navigating insurance coverage between physical and mental health care coverage. Eating disorders offer additional examples with difficulties that warrant measuring parity violations. These conditions are both commonly diagnosed and treated in children and adolescents, and serve as effective conduits for access in measuring for parity.

[1] A secret shopper study is a research method in which trained individuals pose as regular customers or patients to evaluate the quality, compliance, and customer experience of a service, product, or healthcare delivery process.
[2] The secret shopper study for children's mental health access is currently being considered for publication.

Data should also be divided by other types of needs, such as the intersectionality of neurodivergence, race, ethnicity, and other minoritized populations. All of these aspects of culturally competent care converge to allow a provider to meet an individual's needs. The TRUTH in Mental Health Coverage Act data is a starting point, though more is needed, as many of these data elements are already being collected. The MIA should also track out-of-network use as part of this effort. In addition, MIA should compare prior authorizations against medical standards, including how often renewals are required, how long the review takes, and how often prior authorizations are denied.

We recommend separating mental health and substance use disorders to ensure that both are included in terms of network adequacy. These services require focused efforts and are not interchangeable, particularly for children and adolescents.

Finally, we recommend that network adequacy should distinguish between those who are not billing from those providers who bill infrequently, as the former may not be considered reliably accessible providers for the sake of measuring network adequacy. Secret shopper studies and insurance billing reports are two possible ways to measure this.

Q2. 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?

Children's National Hospital defers to community partners with relevant experience and expertise on material differences in access.

Q3. Whether and how the proposed regulations should define "bias" and "objective in a manner that discriminates"?

Children's National believes that MIA should consider historical bias that impacts evidentiary standards. Subpopulations can be impacted differently by bias, since access can be less favorable to begin with.

Third party administrators (TPAs) are inherently at risk of parity violations given that there is already segregated access. Higher levels of scrutiny are therefore needed, due to the potential

for additional bias stemming from this separation of mental health and substance use disorder services from medical care. Again, I will call attention to the limited modes of accessing highly specialized children's mental health and substance use services, particularly when TPAs manage entry into care.

Children's National recommends Maryland and MIA use all possible avenues to hold TPAs accountable for MHPAEA compliance. For instance, TPAs should not be allowed to refuse to provide essential information, including data, to the plan sponsor by claiming that such information is "proprietary" or has "commercial value." This refusal to provide information and data on plan design and access to benefits fundamentally inhibits parity compliance and increases bias, and therefore cannot be allowed to stand. Both 2015 MHPAEA FAX XXIX (question 12) and the 2023 MPHAEA Proposed Rule's preamble clearly stated information related to compliance must be provided, including NQTL analyses.

Q4. 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"?

Children's National recommends that MIA should define "meaningful benefits" as the full continuum of generally accepted care, and recognize the full range of services, not just screenings. Mental health patients need to access care across the continuum, from promotion and prevention services and early intervention, which includes dyadic care[3], to therapy, intermediate levels of care, and crisis and inpatient services.

For children, this care occurs in the primary care provider setting, in school-based settings, in hospitals, and in community services settings, such as mobile crisis response units. Therefore, benefits delivered for children and families at traditional, community, school, and crisis settings should all be included when measuring access.

We applaud MIA for moving these parity regulations forward with care and thoughtfulness. Children's National stands ready to support this work. I am happy to answer any questions.

[3] Dyadic care is a family-centered approach that supports both children and their caregivers together, emphasizing the interconnectedness of a child and their caregiver, and recognizing that a child's development and health are deeply influenced by the caregiver and the caregiving environment.

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