ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

January 27, 2026

Chair Heather Bagnall
House Health and Government Operations Committee
Taylor House Office Building
6 Bladen St., Room 241
Annapolis, Maryland 21401

Re: Maryland House Bill 280

Dear Chair Bagnall:

The Association for Behavioral Health and Wellness (ABHW) writes to oppose House Bill 280 concerning mental health and substance use disorder benefits and parity requirements.

ABHW is the national voice for payers managing behavioral health (BH) insurance benefits. Our member companies provide coverage to 200 million people in the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness. Since its inception, ABHW has been at the forefront of and an advocate for MH and SUD parity. We were instrumental in drafting the federal legislation for the initial Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, and our members have worked tirelessly over the past 16 years to implement parity for behavioral health services.

Our organization aims to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes. Furthermore, through our policy work, we strive to promote equal access to quality treatment and address the stark inequities created by historic structural and systemic disparities in access and quality of care. We are deeply concerned about health disparities in MH and SUD services in this country.

We appreciate Maryland's ongoing efforts to ensure parity in MH and SUD benefits. Still, we have concerns that the proposed legislation will only confuse and complicate the legal patchwork of laws attempting to enforce parity. ABHW urges the Senate Finance Committee not to advance HB 280 until the federal parity landscape is settled and a clear, stable compliance framework is established.

Please see our detailed comments below for more information.

I. Legislation will Lead to Confusion and Conflicting Obligations:

House 280 would create significant legal and operational confusion by codifying parity requirements that are currently unsettled at the federal level. If portions of the federal rules are

invalidated or modified through ongoing litigation or administrative action, this bill would leave carriers facing conflicting and potentially irreconcilable obligations.

In May 2025, the U.S. Department of Justice announced that it would not enforce the 2024 Mental Health Parity and Addiction Equity Act (MHPAEA) Final Rule while the Administration considers whether to modify or rescind it. Consistent with that position, the U.S. Departments of Health and Human Services (HHS), Labor (DOL), and Treasury issued a formal Non-Enforcement Policy on May 15, 2025. This action reflects the federal government's recognition that the 2024 Final Rule, including the meaningful benefits, material differences in access, provisions, and expanded comparative analysis obligations, raises serious statutory and legal concerns.

Those concerns are underscored by ongoing litigation. In January 2025, the ERISA Industry Committee (ERIC) filed suit challenging the 2024 MHPAEA Final Rule, arguing that several of its provisions exceed statutory authority and risk undermining employers' ability to offer affordable, high-quality MH/ SUD coverage. That litigation is currently stayed, but its outcome will directly shape the federal parity framework going forward.

Maryland should not move forward with passing HB 280, which effectively locks in requirements drawn from a paused and legally uncertain federal rule. Even if Maryland elects not to mirror the federal non-enforcement policy, it should refrain from creating new compliance and reporting mandates until the federal government has finalized its approach to parity enforcement. Maryland should promote uniformity between state and federal parity requirements to streamline efficiency and reduce state administrative burden.

If HB 280 is enacted now, its provisions are likely to diverge from the eventual federal standard, forcing carriers to navigate misaligned expectations between state law and federal requirements. Multiple, inconsistent parity standards will not improve access to care for consumers. Instead, they will increase compliance costs, create confusion for plans and providers, and ultimately divert resources away from patient care.

II. Meaningful Benefits

The "meaningful benefits" provision in this legislation goes beyond existing parity requirements by effectively creating a new mandate to cover specific MH/SUD services in every benefit classification. MHPAEA is explicit that it cannot be interpreted to require plans to provide *any* particular MH or SUD benefits, nor does it establish a scope-of-services mandate.

By contrast, the meaningful benefits provision in HB 280 would require coverage even where no evidence-based standard of care exists. As a result, health plans could be compelled to cover treatments that have not been shown to improve outcomes and, in some cases, may expose patients to unnecessary risk.

In addition, key terms used in this provision, such as "material difference" and "core" or "primary" treatment lack clear definitions. In practice, "core treatment" may encompass multiple services or modalities, such as prescription drugs and psychotherapy for major depressive disorder. In other cases, a condition may not have a universally accepted "core

treatment" within a particular benefit classification. These ambiguities make consistent implementation and enforcement extremely difficult.

This provision is one example of how this legislation directly conflicts with the intent of the federal MHPAEA statute and underscores why the Senate Finance Committee should not advance HB 280.

III. Material Difference

The material difference provision raises significant legal and practical concerns because it goes beyond the requirements of the federal MHPAEA statute and is therefore vulnerable to legal challenge. MHPAEA does not require health plans to identify, remedy, or eliminate disparate impacts on access to mental health or substance use disorder benefits when the same terms and conditions apply to both medical/surgical and MH/SUD benefits.

This provision would instead impose an outcomes-based standard that holds plans responsible for differences in access that may be outside their control. Even when a health plan takes reasonable and good-faith steps to improve access, data may continue to reflect differences due to factors such as workforce shortages, geographic limitations, or provider practice patterns, not plan design or administrative decision-making. In these circumstances, health plans should not be deemed non-compliant when they can demonstrate documented efforts to address access challenges. Penalizing health plans for conditions driven by market realities rather than plan actions would not improve access to care and would create legal uncertainty and compliance risk without delivering meaningful benefits to patients.

The material difference provision further illustrates how HB 280 departs from the federal MHPAEA framework, creates statutory conflict and raises significant concerns about advancing HB 280.

IV. Focus Should Be on Addressing the Primary Barriers to Accessing MH/SUD Services

MH/SUD parity was never intended to function as an access framework. Rather, it is designed to ensure that behavioral health benefits are not subject to more restrictive limitations than medical and surgical benefits. Efforts to use parity law to resolve underlying access challenges risk stretching the statute beyond its purpose without meaningfully improving care for patients.

There are more targeted, effective approaches Maryland can pursue to expand access MH/SUD services. The state can make a far greater impact through focused legislation, regulation, and funding investments that directly increase the availability of care—such as improving access to high-quality, affordable, and evidence-based behavioral health services for children and adolescents.

In addition, Maryland should prioritize strengthening an evidence-based continuum of behavioral health crisis care. This includes ensuring timely care coordination and follow-up services for individuals experiencing a behavioral health crisis, regardless of whether they

initially access care through 988, a health plan crisis line, or an emergency department. Investments in crisis stabilization, care transitions, and workforce capacity will do more to improve real-world access than expanding parity requirements beyond their statutory intent. By focusing on these targeted strategies, Maryland can advance meaningful improvements in access and outcomes.

ABHW is committed to improving access to behavioral health treatment for all Americans. Thank you for considering our feedback regarding HB 280. Please reach out to Kathryn Cohen, ABHW's Senior Director of Regulatory Affairs, at cohen@abhw.org with any questions.

Sincerely,

Debbie Witchey, MHA
President and CEO