SB 774

Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 774 (Senator Augustine)
Finance

Health Insurance - Plan Benefits and Coverage - Annual Reporting (Transparency, Reporting, Understanding, Timeliness, and Honesty (TRUTH) in Mental Health Coverage Act)

This bill requires each carrier, by March 1, 2028, (and annually thereafter) to report certain data regarding claims and coverage to the Insurance Commissioner. The Commissioner must develop a template for carriers to report the data. Within three months of receiving data from carriers, the Commissioner must make the data publicly available by developing and maintaining an interactive virtual data dashboard accessible on a public website. The Commissioner may adopt regulations to carry out the bill, including to establish regulatory fees or assessments to cover the cost of implementing the bill. **The bill takes effect January 1, 2027.**

Fiscal Summary

State Effect: Maryland Insurance Administration (MIA) special fund expenditures increase by at least $54,200 in FY 2027 for staff. MIA special fund revenues increase by an indeterminate amount beginning as early as FY 2027 from any regulatory fees and assessments imposed on carriers.

(in dollars)	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
SF Revenue	-	-	-	-	-
SF Expenditure	$54,200	$90,600	$94,900	$99,200	$103,500
Net Effect	($54,200)	($90,600)	($94,900)	($99,200)	($103,500)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: Each carrier must report to the Commissioner the following information on the template developed by the Commissioner:

- claims data sufficient to evaluate, for each facility type and provider type, access to and coverage of (1) mental health services; (2) substance use services; (3) behavioral health services; (4) medical or surgical services; (5) youth and adult services (separately and combined); (6) in-person and telehealth services (separately and combined); and (7) geographic area;
- whether the facility or professional health care provider is affiliated with, owned by, or under common control with the carrier; and
- claims data, disaggregated, as specified, and sufficient to evaluate (1) network accuracy, availability, and participation; (2) network size and composition; (3) network admission and contracting practices; (4) in-network reimbursement; (5) out-of-network utilization; (6) access to evidence-based behavioral health care delivery models; and (7) any additional metrics the Commissioner determines necessary for public comparison and oversight.

Each carrier must submit a certification signed by the carrier's chief financial officer under penalty of perjury stating that the reported data are complete and accurate and calculations follow the template definitions and instructions.

Reported data is not proprietary or confidential but is subject to federal Centers for Medicare and Medicaid Services cell suppression standards, including for purposes of making the data publicly available.

The Commissioner must develop a uniform template for carriers to report the required information. In developing the template, the Commissioner must review and consider formats that are (1) used by insurance regulators in other states; (2) endorsed and used by one or more employer coalitions, human resources associations, or mental health nonprofit organizations; or (3) cited by the U.S. Department of Labor or the U.S. Department of Health and Human Services.

The Commissioner must ensure comparability across carriers by adopting uniform templates, definitions, audit procedures, and correction protocols. The Commissioner may refine, group, stratify, or not include diagnostic categories or conditions within mental health or substance use disorder (SUD) benefits to ensure meaningful, accurate, and comparable public reporting. The Commissioner may satisfy reporting requirements using data collected or maintained by MIA for other purposes, provided that the Commissioner makes the data used publicly available.

Within three months after receiving data from carriers, the Commissioner must make the data publicly available by developing and maintaining an interactive virtual dashboard to visually present the collected data.

The dashboard must include a separate display of adult outcomes and outcomes for individuals younger than 18, and allow comparisons between plans, carriers, and plan levels. Data must be posted in an easily accessible, consumer-friendly manner on a public website that includes downloadable files sufficient to allow public analysis, research, and independent comparison.

The Commissioner may adopt regulations to establish regulatory fees or assessments on carriers to recover the cost of implementing the bill, including maintaining the dashboard. Fees and assessments collected must be deposited into the Insurance Regulation Fund and may be used only for implementing the bill and maintaining the dashboard.

Failure to submit timely, complete, or accurate data constitutes an unfair or deceptive act or practice. The Commissioner may refer a carrier that fails to comply with the bill to the Attorney General for investigation or civil action.

Current Law: Maryland's mental health parity law (§ 15-802 of the Insurance Article) prohibits discrimination against an individual with a mental illness, emotional disorder, or SUD by failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply for the diagnosis and treatment of physical illnesses. Carriers must submit a demonstration of mental health parity compliance when they submit their form filings in the individual, small group, or large group fully insured markets. Self-insured plans are not required to submit documentation to MIA but rather are subject to federal fines and penalties for failure to comply.

The federal Parity Act requires group health plans of large employers, as well as qualified health plans sold in health insurance exchanges and in the small group and individual markets, to equalize health benefits for addiction and mental health care and medical and surgical services in many fundamental ways. Group health plans may not impose separate or more restrictive financial requirements or treatment limitations on mental health/SUD benefits than those imposed on other general medical benefits. The Parity Act also imposes nondiscrimination standards on medical necessity determinations.

Under Maryland law, carriers must demonstrate compliance with the Parity Act (including any related regulations) through submission of a biennial compliance report to the Commissioner that includes specified information. Failure of a carrier to submit complete Parity Act compliance information constitutes noncompliance with the Parity Act.

State Revenues: The bill authorizes the Commissioner to establish regulatory fees or assessments on carriers to recover the cost of implementing the bill, including maintaining the dashboard. Fees and assessments must be deposited into the Insurance Regulation Fund and may be used only for implementing the bill and maintaining the dashboard.

Thus, special fund revenues increase beginning as early as fiscal 2027 to the extent MIA imposes any regulatory fees or assessments on carriers. Any such fees and assessments would likely offset any costs associated with implementing the bill. MIA advises that the amount and number of these assessments cannot be determined until MIA sees the results of its first data call.

State Expenditures: To implement the bill, MIA must develop template forms and adopt regulations to establish uniform definitions, audit procedures, and correction protocols for the data reporting requirements. MIA must also develop and maintain an interactive virtual dashboard and procedures to post carrier data to the MIA website in a downloadable format. As noted above, MIA may also impose fees and assessments on carriers to recover the costs of implementing the bill.

Thus, MIA special fund expenditures increase by $54,188 in fiscal 2027, which accounts for the bill's January 1, 2027 effective date. This estimate reflects the cost of hiring one MIA analyst to fulfill the bill's regulatory and data gathering requirements. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Position	1.0
Salary and Fringe Benefits	$45,741
Operating Expenses	8,447
Total FY 2027 State Expenditures	**$54,188**

Future year expenditures reflect a full salary with annual increases and employee turnover as well as annual increases in ongoing operating expenses.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: HB 1157 (Delegate Guzzone, *et al.*) - Health.

Information Source(s): Maryland Insurance Administration; Department of Legislative Services

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jg/ljm

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