

**Required Under Section 15-1502 of the Insurance Article**

*Study of Mandated Health Insurance Services:  
A Comparative Evaluation*



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Marilyn Moon, Ph.D.  
Chair

Rex W. Cowdry, M.D.  
Executive Director

# **Study of Mandated Health Insurance Services: A Comparative Evaluation**

**Report Prepared by Mercer**

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## **Introduction**

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The Maryland Health Care Commission (MHCC) engaged Mercer Health and Benefits (Mercer) to reevaluate the costs of existing mandated services in Maryland and the surrounding states. The previous report was completed in 2003.

This report contains four sections. The first section evaluates the full cost of each existing mandated health insurance service as a percentage of the State's average annual wage and of premiums for the individual, group, CSHBP, and state employee health insurance markets. The second section assesses the degree to which existing mandated health insurance services are covered in self-funded plans. The third section applies the voluntary compliance from the second section to estimate the marginal cost, as a percentage of group premiums, of the mandates. The last section compares the mandated health insurance services required in Maryland with those required in Delaware, the District of Columbia, Pennsylvania, and Virginia.

The following resources are used in the development of the estimates contained in this report:

- Mercer-conducted surveys of health plans as to current practices of the self-funded clients
- Surveys of the top eight self-funded Mercer clients in Maryland regarding their voluntary coverages of mandates
- Mercer proprietary databases, which include financial information on indemnity and managed care plans. These databases include data purchased from other sources, emerging experience for multiple health plans and several comprehensive surveys. Mercer updates the databases regularly.
- Statistics regarding the CSHBP provided by MHCC
- Public sources including, but not limited to, searches on the Internet
- Mandate-specific research by Mercer's consultants

While the use of surveys is very important in the evaluation of the prevalence and costs of mandates, they introduce a source of variation. For example, Mercer surveyed the same health plans in the current study that we queried in 2003; however, their client base of self-funded employers may have changed materially over that four-year period, resulting in differences attributable to a change in the mix of benefit plans, as opposed to employers increasing or decreasing their own benefit plans. The same is true for the survey of Mercer's top eight self-funded clients in Maryland. The actual clients included in the most recent survey are not the same as those included in the previous study. Therefore, at least part of the changes between this study and the previous study must be considered in this light.

## **Full Cost of Current Mandates**

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Section 15-1502 of the Maryland Insurance Article requires an assessment of the full cost of each existing mandated health insurance service as a percentage of the State's average annual wage and of premiums for the individual, group, CSHBP, and state employee health insurance markets. The mandates included in this requirement are the 42 mandates defined in Sections 15-801 through 15-842 of the Insurance Article. It should be noted that the CSHBP is exempt from mandates unless the Commission adopts the mandate for the CSHBP.

The full cost of the current mandates as a percentage of premium for each of the specified markets is summarized in the following table.

## Full Cost of Current Mandates

Mandate	Section	Full Cost			
		Percentage of Premium			
		Group	State Employee	CSHBP	Individual
Alzheimer's	15-801	0.0%	0.0%	0.0%	0.0%
Mental illness; drug & alcohol abuse	15-802	4.9%	5.0%	6.6%	5.9%
Blood products	15-803	0.1%	0.1%	0.2%	0.1%
Off-label use of drugs	15-804	0.2%	0.2%	0.0%	0.2%
Pharmaceutical products	15-805	0.0%	0.0%	0.0%	0.0%
Choice of pharmacy	15-806*	0.0%	0.0%	0.0%	0.0%
Medical foods & modified food products	15-807	0.0%	0.0%	0.0%	0.0%
Home health care	15-808	0.0%	0.0%	0.0%	0.0%
Hospice care	15-809	0.0%	0.0%	0.0%	0.0%
In vitro fertilization	15-810	0.8%	0.9%	0.0%	1.0%
Hospitalization benefits for childbirth	15-811	1.7%	1.7%	2.3%	2.0%
Length of stay for mothers of newborn	15-812	1.9%	1.9%	2.4%	2.3%
Disability due to pregnancy or childbirth	15-813	0.0%	0.0%	0.0%	0.0%
Mammograms	15-814	0.3%	0.3%	0.4%	0.4%
Reconstructive breast surgery	15-815	0.2%	0.2%	0.3%	0.2%
Routine gynecological care	15-816	0.0%	0.0%	0.0%	0.0%
Child wellness	15-817	1.3%	1.3%	1.7%	1.5%
Treatment of cleft lip and cleft palate	15-818	0.0%	0.0%	0.0%	0.0%
OP services and second opinions	15-819	0.0%	0.0%	0.0%	0.0%
Prosthetic devices & orthopedic braces	15-820**	0.0%	0.0%	0.0%	0.0%
Diagnostic & surgical procedures for bones of face, head, & neck	15-821	0.0%	0.0%	0.0%	0.0%
Diabetes equipment, supplies, & self management training	15-822	0.5%	0.5%	0.7%	0.6%
Osteoporosis treatment	15-823	0.1%	0.1%	0.1%	0.1%
Maintenance drugs	15-824	0.0%	0.0%	0.1%	0.1%
Detection of prostate cancer	15-825	0.3%	0.3%	0.4%	0.4%
Contraceptives	15-826	0.6%	0.6%	0.8%	0.7%
Clinical trials under specific conditions	15-827	0.3%	0.3%	0.4%	0.4%
General anesthesia for dental care under specified conditions	15-828	0.1%	0.1%	0.1%	0.1%
Chlamydia screening	15-829	0.0%	0.0%	0.0%	0.0%
Referrals to specialists	15-830	0.0%	0.0%	0.0%	0.0%
Prescription drugs and devices	15-831	0.0%	0.0%	0.0%	0.0%
Length of stay for mastectomies	15-832	0.2%	0.2%	0.3%	0.2%
Extension of benefits	15-833	0.1%	0.1%	0.2%	0.2%
Prosthesis following mastectomy	15-834	0.0%	0.0%	0.0%	0.0%
Habilitative services for children	15-835	0.1%	0.1%	0.1%	0.1%
Wigs for hair loss due to chemotherapy	15-836	0.0%	0.0%	0.0%	0.0%
Colorectal cancer screening	15-837	0.2%	0.2%	0.3%	0.2%
Hearing aids for a minor child	15-838	0.1%	0.2%	0.2%	0.2%
Treatment of morbid obesity	15-839	0.8%	0.8%	0.0%	1.0%
Residential crisis services	15-840	0.0%	0.0%	0.0%	0.0%
Smoking Cessation	15-841	0.4%	0.4%	0.0%	0.5%
Prescription drug cost-share limit	15-842	0.0%	0.0%	0.0%	0.0%
<b>Total</b>		<b>15.4%</b>	<b>15.8%</b>	<b>17.5%</b>	<b>18.6%</b>

\* Value excluded because mandate applies only to non-profit plans

\*\* Applies only to CSHBP and non-profit plans

## **Full Cost of Current Mandates**

The table on the previous page shows that the full cost of the mandates represents 15.4% of a typical group premium and 15.8% of the State employee plan premium. Considering all of the assumptions employed, the difference between 15.4% and 15.8% is not material. The full cost of the mandates is 17.5% of premium for the CSHBP and 18.6% of premium for the individual market. The differences in the costs for the individual market and the CSHBP compared to the typical group market reflect the richness in the underlying benefit plans and, in the case of the individual market, the allowance of medical underwriting. The cost sharing requirements for the CSHBP and the individual market are significantly greater than the cost sharing requirements for the large group markets. Thus, the full cost of the mandates as a percentage of premiums is higher for the CSHBP and the individual market than it is for the other two markets.

The previous study presented results regarding the full and marginal costs of mandates as a percentage of the group market only. Therefore, our comparisons with the previous report will be limited to this market. The value of the mandates increased from 15.2% of premium in 2003 to 15.4% of premium in 2007. Since the previous report, Maryland has enacted two new mandates: smoking cessation (§ 15-841) and prescription drug cost sharing limitations (§ 15-842). These new mandates represent 0.4% of the change in the full costs of the current mandates. Thus, the full cost of mandates that were in effect in 2003 decreased slightly, from 15.2% of premium to 15.0% of premium.

On a full cost basis, the most expensive mandates are:

- Mental illness and substance abuse, as covered under Section 15-802, with a cost ranging from 4.9% of premium to 6.6% of premium, depending on the market. The lowest percentage reflects the group market; the highest percentage reflects the CSHBP.
- Hospitalization benefits for childbirth and length of stay for mothers of newborns, as covered under Sections 15-811 and 15-812, with a full cost ranging from 3.6% of premium to 4.7% of premium, depending on the market.

When expressing the cost of the mandates as a percentage of the average annual wage, Mercer did not segregate the wage by type of contract; therefore, they used the same wage base for all types of contracts. Maryland's average annual wage in 2006 was \$46,165, according to statistics from the Maryland Department of Labor, Licensing and Regulation (DLLR).

The full cost of the current mandates as a percentage of wage is summarized in the following table.

## Full Cost of Current Mandates

Mandate	Section	Full Cost			
		Percentage of wage			
		Group	State Employee	CSHBP	Individual
Alzheimer's	15-801	0.0%	0.0%	0.0%	0.0%
Mental illness; drug & alcohol abuse	15-802	0.7%	0.8%	0.6%	0.4%
Blood products	15-803	0.0%	0.0%	0.0%	0.0%
Off-label use of drugs	15-804	0.0%	0.0%	0.0%	0.0%
Pharmaceutical products	15-805	0.0%	0.0%	0.0%	0.0%
Choice of pharmacy	15-806*	0.0%	0.0%	0.0%	0.0%
Medical foods & modified food products	15-807	0.0%	0.0%	0.0%	0.0%
Home health care	15-808	0.0%	0.0%	0.0%	0.0%
Hospice care	15-809	0.0%	0.0%	0.0%	0.0%
In vitro fertilization	15-810	0.1%	0.1%	0.0%	0.1%
Hospitalization benefits for childbirth	15-811	0.2%	0.3%	0.2%	0.1%
Length of stay for mothers of newborn	15-812	0.3%	0.3%	0.2%	0.1%
Disability due to pregnancy or childbirth	15-813	0.0%	0.0%	0.0%	0.0%
Mammograms	15-814	0.0%	0.1%	0.0%	0.0%
Reconstructive breast surgery	15-815	0.0%	0.0%	0.0%	0.0%
Routine gynecological care	15-816	0.0%	0.0%	0.0%	0.0%
Child wellness	15-817	0.2%	0.2%	0.1%	0.1%
Treatment of cleft lip and cleft palate	15-818	0.0%	0.0%	0.0%	0.0%
OP services and second opinions	15-819	0.0%	0.0%	0.0%	0.0%
Prosthetic devices & orthopedic braces	15-820**	0.0%	0.0%	0.0%	0.0%
Diagnostic & surgical procedures for bones of face, head, & neck	15-821	0.0%	0.0%	0.0%	0.0%
Diabetes equipment, supplies, & self management training	15-822	0.1%	0.1%	0.1%	0.0%
Osteoporosis treatment	15-823	0.0%	0.0%	0.0%	0.0%
Maintenance drugs	15-824	0.0%	0.0%	0.0%	0.0%
Detection of prostate cancer	15-825	0.0%	0.0%	0.0%	0.0%
Contraceptives	15-826	0.1%	0.1%	0.1%	0.0%
Clinical trials under specific conditions	15-827	0.0%	0.0%	0.0%	0.0%
General anesthesia for dental care under specified conditions	15-828	0.0%	0.0%	0.0%	0.0%
Chlamydia screening	15-829	0.0%	0.0%	0.0%	0.0%
Referrals to specialists	15-830	0.0%	0.0%	0.0%	0.0%
Prescription drugs and devices	15-831	0.0%	0.0%	0.0%	0.0%
Length of stay for mastectomies	15-832	0.0%	0.0%	0.0%	0.0%
Extension of benefits	15-833	0.0%	0.0%	0.0%	0.0%
Prosthesis following mastectomy	15-834	0.0%	0.0%	0.0%	0.0%
Habilitative services for children	15-835	0.0%	0.0%	0.0%	0.0%
Wigs for hair loss due to chemotherapy	15-836	0.0%	0.0%	0.0%	0.0%
Colorectal cancer screening	15-837	0.0%	0.0%	0.0%	0.0%
Hearing aids for a minor child	15-838	0.0%	0.0%	0.0%	0.0%
Treatment of morbid obesity	15-839	0.1%	0.1%	0.0%	0.1%
Residential crisis services	15-840	0.0%	0.0%	0.0%	0.0%
Smoking Cessation	15-841	0.1%	0.1%	0.0%	0.0%
Prescription drug cost-share limit	15-842	0.0%	0.0%	0.0%	0.0%
<b>Total</b>		<b>2.3%</b>	<b>2.5%</b>	<b>1.5%</b>	<b>1.2%</b>

\* Value excluded because mandate applies only to non-profit plans

\*\* Applies only to CSHBP and non-profit plans

## **Full Cost of Current Mandates**

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The full cost of the mandates as a percentage of wage is 2.3% for the typical group market; 2.5% for the State employee plan; 1.5% for the CSHBP, and 1.2% for the individual market. The difference between the group market and the State employee plan is immaterial, considering the assumptions employed in developing these estimates. The differences between the group market/State employee plan and the CSHBP and the individual market are, in Mercer's opinion, material and driven by the higher cost sharing provisions required in the CSHBP and the typical individual policy.

## **Voluntary Compliance in the Self-Funded Market**

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Another requirement under Section 15-1502 of the Maryland Insurance Article is to assess the degree to which existing mandated health insurance services are covered in self-funded plans. Through ERISA, employers who self-fund their health benefit plans are exempt from state-specific mandate requirements. This section examines if there are mandates which self-funded plans typically exclude. To address this question, Mercer used a custom survey for the MHCC to compare the benefits of an insured plan to self-funded benefits offered by large employers. The survey addressed the voluntary benefit mandate compliance of self-funded plans.

In an effort to obtain a reliable sample, Mercer surveyed the primary carriers that administer the health benefits for self-funded plans in Maryland. This included Aetna, CareFirst, Cigna, and United HealthCare<sup>1</sup>. The survey defined the Maryland health insurance mandates and asked the health plan administrators to report the rate of voluntary compliance and the typical level of benefits. While the administrators were not legally required to respond to the survey, they replied to almost all the questions. Mercer followed up on any missing or incomplete responses.

To check the reasonableness of the administrators' responses, Mercer compared their answers to the benefit plans of eight of their largest Maryland-based clients with self-funded plans. These eight employers cover roughly 100,000 employees or almost 300,000 individuals when including dependents. Mercer's comparison confirmed the reasonableness of the administrators' answers.

As a third source of benefit information, we used Mercer's 2006 National Survey of Employer-Sponsored Health Plans. This survey contains data from 2,303 employers on the scope of coverage but does not focus on the Maryland health insurance mandates. This survey did allow for a secondary reasonability check of the administrator's answers on some health benefits, such as in vitro fertilization (IVF).

Mercer used the following rankings of voluntary compliance by mandate:

- All comply – all employers with self-funded plans provide benefits that comply fully with the mandate requirement.
- Almost all comply – a small percentage of employers with self-funded plans provide benefits that do not comply fully with the mandate requirement.
- Most comply – significantly more than half but not all employers with self-funded plans provide benefits that comply fully with the mandate requirement.
- Half comply – about 50% of employers with self-funded plans provide benefits that comply fully with the mandate requirement.
- Some comply – significantly less than half of employers with self-funded plans provide benefits that comply fully with the mandate requirement.
- No compliance – no employers with self-funded plans provide benefits that comply fully with the mandate requirement.

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<sup>1</sup> As a result of consolidations, United HealthCare is now comprised of the following companies: UHC, Optimum Choice, MAMSI and MD IPA. All of these companies were included in the current and previous surveys.

## Voluntary Compliance in the Self-Funded Market

The following chart shows the compliance rate by mandate:

Subsection	Mandate Description	Compliance Rate
15-801	Benefits for Alzheimer's disease and care of elderly individuals	Almost All
15-802	Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse	Half
15-803	Payments for blood products	Almost All
15-804	Coverage for off-label use of drugs	Half
15-805	Reimbursement for pharmaceutical products	Half
15-806	Choice of pharmacy for filling prescriptions	Most
15-807	Coverage for medical foods and modified food products	Most
15-808	Benefits for home health care	All
15-809	Benefits for hospice care	All
15-810	Benefits for in vitro fertilization (IVF)	Some
15-811	Hospitalization benefits for childbirth	All
15-812	Impatient hospitalization coverage for mothers and newborn children	All
15-813	Benefits for disability caused by pregnancy or childbirth	All
15-814	Coverage for mammograms	Almost All
15-815	Coverage for reconstructive breast surgery	Almost All
15-816	Benefits for routine gynecological care	Almost All
15-817	Coverage for child wellness services	Almost All
15-818	Benefits for treatment of cleft lip and cleft palate	Almost All
15-819	Coverage for outpatient services and second opinions	Almost All
15-820	Benefits for prosthetic devices and orthopedic braces	Almost All
15-821	Diagnostic and surgical procedures for bones of face, neck and head	Almost All
15-822	Coverage for diabetes equipment, supplies, and self-management training	All
15-823	Coverage for osteoporosis prevention and treatment	Most
15-824	Coverage for maintenance drugs	Half
15-825	Coverage for detection of prostate cancer	Almost All
15-826	Coverage for contraceptive drugs and devices	Most
15-827	Coverage for patient cost for clinical trials	Most
15-828	Coverage for general anesthesia for dental care under specified conditions	Most
15-829	Coverage for detection of Chlamydia	Almost All
15-830	Referrals to specialists	All
15-831	Coverage of prescription drugs and devices	Half
15-832	Coverage for mastectomies	Almost All
15-833	Extension of benefits	Most
15-834	Coverage for prostheses	Almost All
15-835	Coverage for habilitative services for children under 19 years of age	Half
15-836	Hair prosthesis	Half
15-837	Colorectal cancer screening coverage	Almost All
15-838	Hearing aid coverage for a minor child	Half
15-839	Coverage for treatment of morbid obesity	Half
15-840	Coverage for medically necessary residential crisis services	Almost All
15-841	Coverage for nicotine replacement therapy	Half
15-842	Limit copay to cost of prescription drug if greater	Half

## **Voluntary Compliance in the Self-Funded Market**

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The voluntary compliance rate shows the difference between the responsibility of mandates put on employers with insured plans and the responsibility of mandates taken on voluntarily by self-funded plans. Overall, self-funded plans voluntarily cover 86% of the cost of mandated services, down from 90% in the previous survey. Part of this decrease may be attributable to a change in the mix of self-funded clients reflected in the health plan responses as well as the change in mix of Mercer's top eight clients.

Of the Maryland mandates, the most expensive group insurance mandate based on full cost is for mental health and substance abuse benefits (Section 15-802), at roughly 5% of premium. While about half of the employers with self-funded plans cover mental health and substance abuse benefits at or above the level required by the mandate, the other half cover the benefit at a lesser level.

The next most expensive mandate based on full cost is hospitalization for childbirth (Section 15-811), at over 3% of premium when including the mandate on the minimum length of stay (Section 15-812). Our survey shows that all employers with self-funded plans cover the benefit as mandated.

These two mandates also were the most expensive mandates on a full cost basis in the 2003 study.

The only mandate that the vast majority of employers with self-funded plans do not cover is benefits for in vitro fertilization (Section 15-810). The full cost of this mandate is almost 1% of premium for insured plans. The 2006 Mercer National Survey of Employer-Sponsored Health Plans shows that, nationally, only about 20% of employers cover IVF. In the 2003 study, about 13% of employers covered IVF.

## **Marginal Cost of Current Mandates**

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The financial cost of mandated health insurance services could be defined either as the full cost of the service or as the marginal or additional cost of the mandate. The marginal cost equals the full cost of the service minus the value of the services that would be covered in the absence of the mandate. For example, the full cost for requiring coverage of hospitalization for maternity equals the assumed number of maternity cases times the hospital cost per case. The vast majority of contracts would include coverage of maternity cases that satisfies the mandate requirements even without the mandate; therefore, the marginal cost equals the assumed number of cases that would not be covered without the mandate times the hospital cost per case. This section shows estimates for the marginal cost.

In the previous section, we looked at the voluntary compliance rate for self-funded plans. We assume that, in the absence of mandates, (1) insurance contract holders would request the same level of coverage as the level provided by self-funded plans; and (2) carriers would be willing to offer that level of coverage. In a competitive work environment, coverage in self-funded plans becomes the de facto coverage in other markets, with or without mandates, as fully-insured employers must provide similar benefits as they compete for the same workers. Under this assumption, the marginal cost of the mandate equals the portion of mandated coverage not picked up by self-funded plans.

The following table shows the marginal cost of each of the 42 existing mandated health insurance services as a percentage of the State's average annual wage and of premiums for the individual and group health insurance market.

## Marginal Cost of Current Mandates

Mandate	Section	Expected Portion of Cost Covered Without Mandate	Marginal Cost
			Percentage of Group Premium
Alzheimer's	15-801	95%	0.0%
Mental illness; drug & alcohol abuse	15-802	90%	0.5%
Blood products	15-803	95%	0.0%
Off-label use of drugs	15-804	65%	0.1%
Pharmaceutical products	15-805	40%	0.0%
Choice of pharmacy	15-806*	70%	0.0%
Medical foods & modified food products	15-807	70%	0.0%
Home health care	15-808	100%	0.0%
Hospice care	15-809	100%	0.0%
In vitro fertilization	15-810	25%	0.6%
Hospitalization benefits for childbirth	15-811	100%	0.0%
Length of stay for mothers of newborn	15-812	100%	0.0%
Disability due to pregnancy or childbirth	15-813	100%	0.0%
Mammograms	15-814	96%	0.0%
Reconstructive breast surgery	15-815	98%	0.0%
Routine gynecological care	15-816	90%	0.0%
Child wellness	15-817	96%	0.0%
Treatment of cleft lip and cleft palate	15-818	98%	0.0%
OP services and second opinions	15-819	97%	0.0%
Prosthetic devices & orthopedic braces	15-820**	97%	0.0%
Diagnostic & surgical procedures for bones of face, head, & neck	15-821	97%	0.0%
Diabetes equipment, supplies, & self management training	15-822	100%	0.0%
Osteoporosis treatment	15-823	80%	0.0%
Maintenance drugs	15-824	60%	0.0%
Detection of prostate cancer	15-825	95%	0.0%
Contraceptives	15-826	76%	0.1%
Clinical trials under specific conditions	15-827	76%	0.1%
General anesthesia for dental care under specified conditions	15-828	75%	0.0%
Chlamydia screening	15-829	96%	0.0%
Referrals to specialists	15-830	100%	0.0%
Prescription drugs and devices	15-831	67%	0.0%
Length of stay for mastectomies	15-832	95%	0.0%
Extension of benefits	15-833	83%	0.0%
Prosthesis following mastectomy	15-834	97%	0.0%
Habilitative services for children	15-835	50%	0.0%
Wigs for hair loss due to chemotherapy	15-836	65%	0.0%
Colorectal cancer screening	15-837	87%	0.0%
Hearing aids for a minor child	15-838	50%	0.1%
Treatment of morbid obesity	15-839	75%	0.2%
Residential crisis services	15-840	92%	0.0%
Smoking Cessation	15-841	33%	0.3%
Prescription drug cost-share limit	15-842	66%	0.0%
<b>Total</b>		<b>86%</b>	<b>2.2%</b>

\* Value excluded because mandate applies only to non-profit plans

\*\* Value excluded because mandate applies only to CSHBP and non-profit plans

## **Marginal Cost of Current Mandates**

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On a marginal cost basis, the most expensive mandate is for IVF, under Section 15-810, with a marginal cost equal to 0.6% of premium.

The next most expensive mandate on a marginal cost basis is mental illness and substance abuse, under Section 15-802, with a marginal cost equal to 0.5% of premium. The actual cost will vary by plan and will depend on how they manage mental health benefits. Some plans carve out these services to a specialty vendor who will manage the benefits. Under benefit management, there is a reduced probability of a policyholder ever utilizing the maximum level of the benefit; therefore, the marginal cost would be less.

These two mandates were the most costly on a marginal cost basis in the previously report as well.

## **Comparison to Other States**

Section 15-1502 of the Maryland Insurance Article requires a comparison of mandated health insurance services required in Maryland with those required in Delaware, the District of Columbia, Pennsylvania, and Virginia, including the:

- Number of mandated health insurance services;
- Type of mandated health insurance services;
- Level and extent of coverage for each mandated health insurance service; and
- Financial impact of differences in levels of coverage for each mandated health insurance service.

This report focuses on benefit requirements included under Subtitle 8 of Title 15 of Maryland’s Insurance Law. Mercer compared these mandates to mandates required in the following states, using the corresponding sources:

<b>State</b>	<b>Insurance Code</b>
Maryland	Maryland Code Annotated
Delaware	Delaware Code
District of Columbia	District of Columbia Code
Pennsylvania	Pennsylvania Unconsolidated Statutes
Virginia	Virginia Code Annotated & Virginia Administrative Code

While two states may have mandates that address the same health services, they may have significantly different mandates. A short description of each state's mandate is included in Exhibit 1. For the 42 Maryland mandates covered in this report, the following table summarizes how many are mandated in some form by Delaware, the District of Columbia, Pennsylvania, and Virginia.

<b>State</b>	<b>Number of Maryland Mandated Benefits Required in Neighboring States 2007</b>	<b>Number of Maryland Mandated Benefits Required in Neighboring States 2003</b>
Delaware	16	16
District of Columbia	12	11
Maryland	42	40
Pennsylvania	15	15
Virginia	23	22

## **Comparison to Other States**

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The table above would indicate that, given the number of benefits mandated, Maryland has the highest burden; however, this does not take into account the relative cost of the mandates.

To understand the difference in the financial burden, Mercer looked at the estimated financial impact if Maryland changed its existing mandate to match the mandate of one of these other states. Looking at just the 42 benefits mandated in Maryland, the following table shows the estimated full and marginal costs for each state.

## Comparison to Other States

MD Mandate	Value Relative to MD Mandate				Group Premium Impact to Revise Mandate to Match Other State								
					Full Cost				Marginal Cost				
	DE	DC	PA	VA	DE	DC	PA	VA	DE	DC	PA	VA	
15-801	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-802	110%	100%	80%	60%	0.5%	0.0%	-1.0%	-2.0%	0.0%	0.0%	-0.1%	-0.2%	
15-803	0%	0%	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	
15-804	0%	0%	0%	25%	-0.2%	-0.2%	-0.2%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	
15-805	100%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-806	100%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-807	0%	0%	50%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-808	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-809	0%	0%	0%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-810	0%	0%	0%	0%	-0.8%	-0.8%	-0.8%	-0.8%	-0.6%	-0.6%	-0.6%	-0.6%	
15-811	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-812	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-813	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-814	100%	110%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-815	95%	120%	95%	50%	0.0%	0.0%	0.0%	-0.1%	0.0%	0.0%	0.0%	0.0%	
15-816	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-817	40%	95%	40%	60%	-0.8%	-0.1%	-0.8%	-0.5%	0.0%	0.0%	0.0%	0.0%	
15-818	40%	0%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-819	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-820	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-821	0%	0%	0%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-822	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-823	0%	0%	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	
15-824	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-825	75%	100%	0%	90%	-0.1%	0.0%	-0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-826	100%	0%	0%	100%	0.0%	-0.6%	-0.6%	0.0%	0.0%	-0.1%	-0.1%	0.0%	
15-827	100%	0%	0%	70%	0.0%	-0.3%	-0.3%	-0.1%	0.0%	-0.1%	-0.1%	0.0%	
15-828	0%	0%	0%	85%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-829	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-830	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-831	0%	0%	0%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-832	0%	0%	90%	120%	-0.2%	-0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-833	0%	0%	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	
15-834	0%	0%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-835	0%	50%	0%	50%	-0.1%	0.0%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-836	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-837	100%	100%	0%	100%	0.0%	0.0%	-0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-838	0%	0%	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	
15-839	0%	0%	0%	100%	-0.8%	-0.8%	-0.8%	0.0%	-0.2%	-0.2%	-0.2%	0.0%	
15-840	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
15-841	0%	0%	0%	0%	-0.4%	-0.4%	-0.4%	-0.4%	-0.3%	-0.3%	-0.3%	-0.3%	
15-842	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
<b>Total</b>	<b>77%</b>	<b>73%</b>	<b>60%</b>	<b>69%</b>	<b>-3.6%</b>	<b>-4.1%</b>	<b>-6.2%</b>	<b>-4.7%</b>	<b>-1.4%</b>	<b>-1.6%</b>	<b>-1.8%</b>	<b>-1.4%</b>	
<b>2003 Report</b>	<b>73%</b>	<b>70%</b>	<b>57%</b>	<b>64%</b>	<b>-4.1%</b>	<b>-4.5%</b>	<b>-6.5%</b>	<b>-5.4%</b>	<b>-0.9%</b>	<b>-1.1%</b>	<b>-1.2%</b>	<b>-1.1%</b>	

## **Comparison to Other States**

When applying the differences, there are both increases and reductions in the level of the mandates. Overall, the value of the reductions exceeds the value of the increases in each state.

On a full cost basis, the majority of the reductions to premiums come from the following mandates:

- Mental illness and substance abuse (§ 15-802) in PA and VA (1.0% - 2.0%)
- In vitro fertilization (§ 15-810) in DE, DC, PA, and VA (0.8%)
- Child wellness services (§ 15-817) in DE, PA, and VA (0.5% - 0.8%)
- Contraceptives (§ 15-826) in DC, and PA (0.6%)
- Morbid obesity treatment (§ 15-839) in DE, DC, and PA (0.8%)
- Smoking cessation (§ 15-841) in DE, DC, and PA (0.4%)

On a full cost basis for these 42 Maryland mandates, the other states have a lower financial burden. Based on a percentage of premium, the difference ranges from 3.6% of premium lower in Delaware to 6.2% lower in Pennsylvania. The 2003 study had differences ranging from -4.1% in Delaware to -6.5% in Pennsylvania, so there appears to be a slight compression of the differences in the full cost of the mandates from the previous report.

Also, on a marginal cost basis for these 42 Maryland mandates, the other states have a lower financial burden, but the picture is significantly different. Based on a percentage of premium, the difference ranges from 1.4% of premium lower in Delaware and Virginia to 1.8% lower in Pennsylvania. The marginal cost differences on the current report are slightly greater than on the previous report, which showed a range of -0.9% in Delaware to -1.2% in Pennsylvania. A majority of this change is attributable to the two new Maryland mandates. The following mandates contribute the most to the marginal financial difference:

- Mental illness and substance abuse (§ 15-802) in PA and VA
- IVF (§ 15-810) in DE, DC, PA, and VA
- Morbid obesity treatment (§ 15-839) in DE, DC, and PA
- Smoking cessation (§ 15-841) in DE, DC, PA, and VA

Of these four mandates, IVF stands out with a 0.6% of premium difference under the marginal cost basis. Although all these mandates were passed with the intention of improving access to medically necessary care, many self-funded plans do not view IVF as medically necessary; therefore, the marginal cost is almost as high as the full cost. The other three mandates do not have a significantly higher marginal cost in Maryland, and it can be argued that these benefits will actually reduce future health care costs.

Next, we look at the financial impact of adopting either the most generous or least generous mandate in the surrounding states. The impact is summarized in the following table:

## Comparison to Other States

MD Mandate	Value Relative to MD Mandate		Group Premium Impact to Revise Mandate to Match Other State			
			Full Cost		Marginal Cost	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
15-801	0%	0%	0.0%	0.0%	0.0%	0.0%
15-802	60%	110%	-2.0%	0.5%	-0.2%	0.0%
15-803	0%	0%	-0.1%	-0.1%	0.0%	0.0%
15-804	0%	25%	-0.2%	-0.1%	-0.1%	-0.1%
15-805	0%	100%	0.0%	0.0%	0.0%	0.0%
15-806	0%	100%	0.0%	0.0%	0.0%	0.0%
15-807	0%	50%	0.0%	0.0%	0.0%	0.0%
15-808	0%	0%	0.0%	0.0%	0.0%	0.0%
15-809	0%	100%	0.0%	0.0%	0.0%	0.0%
15-810	0%	0%	-0.8%	-0.8%	-0.6%	-0.6%
15-811	100%	100%	0.0%	0.0%	0.0%	0.0%
15-812	100%	100%	0.0%	0.0%	0.0%	0.0%
15-813	0%	0%	0.0%	0.0%	0.0%	0.0%
15-814	100%	110%	0.0%	0.0%	0.0%	0.0%
15-815	50%	120%	-0.1%	0.0%	0.0%	0.0%
15-816	100%	100%	0.0%	0.0%	0.0%	0.0%
15-817	40%	95%	-0.8%	-0.1%	0.0%	0.0%
15-818	0%	100%	0.0%	0.0%	0.0%	0.0%
15-819	0%	0%	0.0%	0.0%	0.0%	0.0%
15-820	0%	0%	0.0%	0.0%	0.0%	0.0%
15-821	0%	100%	0.0%	0.0%	0.0%	0.0%
15-822	100%	100%	0.0%	0.0%	0.0%	0.0%
15-823	0%	0%	-0.1%	-0.1%	0.0%	0.0%
15-824	0%	0%	0.0%	0.0%	0.0%	0.0%
15-825	0%	100%	-0.3%	0.0%	0.0%	0.0%
15-826	0%	100%	-0.6%	0.0%	-0.1%	0.0%
15-827	0%	100%	-0.3%	0.0%	-0.1%	0.0%
15-828	0%	85%	-0.1%	0.0%	0.0%	0.0%
15-829	0%	0%	0.0%	0.0%	0.0%	0.0%
15-830	100%	100%	0.0%	0.0%	0.0%	0.0%
15-831	0%	100%	0.0%	0.0%	0.0%	0.0%
15-832	0%	120%	-0.2%	0.0%	0.0%	0.0%
15-833	0%	0%	-0.1%	-0.1%	0.0%	0.0%
15-834	0%	100%	0.0%	0.0%	0.0%	0.0%
15-835	0%	50%	-0.1%	0.0%	0.0%	0.0%
15-836	0%	0%	0.0%	0.0%	0.0%	0.0%
15-837	0%	100%	-0.2%	0.0%	0.0%	0.0%
15-838	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%
15-839	0%	100%	-0.8%	0.0%	-0.2%	0.0%
15-840	0%	0%	0.0%	0.0%	0.0%	0.0%
15-841	0%	0%	-0.4%	-0.4%	-0.3%	-0.3%
15-842	0%	0%	0.0%	0.0%	0.0%	0.0%
<b>Total</b>			<b>-7.5%</b>	<b>-1.5%</b>	<b>-1.9%</b>	<b>-1.1%</b>

## Comparison to Other States

This table shows that by going to the lowest level - which may be no mandate - for each of the 42 benefits, the full cost would be reduced by 7.5% of premium, resulting in the full cost of the mandates decreasing from 15.4% of premium to 7.9% of premium. Similarly, the marginal cost of current mandates would be reduced by 1.9% of premium, resulting in the marginal cost of the mandates decreasing from 2.2% of premium to 0.3% of premium.

The following mandates have a full cost of 0.5% of premium or greater when the minimum level of coverage in another state is considered:

- Mental illness and substance abuse
- In vitro fertilization
- Child wellness
- Coverage for contraceptive drugs
- Morbid obesity treatment

When looking at the lowest level, it should be noted that none of the surrounding states in this study have mandates similar to the following 13 Maryland mandates:

Maryland Mandate	Cost as a Percentage Group of Premium	
	Full	Marginal
15-801: Alzheimer's disease and care of elderly individuals	0.0%	0.0%
15-810: In vitro fertilization	0.8%	0.6%
15-813: Disability caused by pregnancy or childbirth	0.0%	0.0%
15-819: Outpatient services and second opinions	0.0%	0.0%
15-820: Prosthetic devices and orthopedic braces	0.0%	0.0%
15-823: Osteoporosis prevention and treatment	0.1%	0.0%
15-824: Maintenance prescription drugs	0.0%	0.0%
15-829: Chlamydia screening	0.0%	0.0%
15-833: Extension of benefits	0.1%	0.0%
15-836: Hair prosthesis	0.0%	0.0%
15-838: Hearing aid coverage for children	0.1%	0.1%
15-841: Smoking Cessation	0.4%	0.3%
15-842: Limit Copay to cost of prescription drug	0.0%	0.0%
<b>Total</b>	<b>1.7%</b>	<b>1.0%</b>

By going to the highest level outside of Maryland - which still may be no mandate - for each of the 42 benefits, the full cost would be reduced by 1.5% of premium. Therefore, the full cost would be 13.9% of premium, instead of the current 15.4%. Similarly, the marginal cost of current mandates would be reduced by 1.1% of premium and drop to 1.1% of premium instead of the current 2.2%. This does NOT include benefit mandates required outside of Maryland if a similar mandate is not required in Maryland.

## Comparison to Other States

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Following is a summary of mandated benefits required outside of Maryland where a similar mandate is not required in Maryland:

### Delaware:

Mandate	Description	Statutory Citation
Ovarian Cancer	Ovarian cancer screening (CA-125) subsequent to treatment must be covered for enrollees residing or having their principal place of employment in Delaware.	18-3555
Hemophilia	Coverage for treatment of congenital defects, including hemophilia	Administrative Code: 16 - 4408 - 6.2.1.3.9
Pap smears	Mandatory annual benefit for Pap smears for all females age 18 and over.	18-3559B; 18-3552

### District of Columbia:

Mandate	Description	Statutory Citation
AIDS	Coverage required; insurer may not limit coverage or impose a deductible or coinsurance provision related to the care of AIDS or related diseases unless it applies to all covered diseases.	31-1603
Pap smears	Mandatory coverage for Pap smear annually and when medically necessary. Coverage may not be subject to an annual deductible or coinsurance.	35-2402

### Pennsylvania:

Mandate	Description	Statutory Citation
Pap smears	Required coverage for an annual gynecological examination and routine Pap smears.	40 P.S. s 1574

### Virginia:

Mandate	Description	Statutory Citation
AIDS	Insurers may not exclude or limit coverage or treatment of HIV infection or AIDS or related complications.	38.2-3401; 14 VAC 5-180-60
Hemophilia	Coverage required for the treatment of hemophilia and other congenital bleeding disorders; must include home treatment coverage.	38.2-3418.3
Hospital Stay for Hysterectomy	Mandatory coverage for hysterectomy with a 23 hour post-op stay.	38.2-3418.9
Lymphedema	Mandatory coverage for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema.	38.2-3418.14
Pap smears	Coverage required for annual Pap smears.	38.2-3418.1:2

## Comparison to Other States

Adding these additional mandates to the Maryland mandates covered in other states, the neighboring states come somewhat closer to the 42 mandates required in Maryland. The following table summarizes the number of mandates in each state:

State	Total Number of Mandated Benefits
Delaware	18
District of Columbia	13
Maryland	42
Pennsylvania	16
Virginia	27

Six mandates are required by one or more neighboring states but are not required in Maryland. If Maryland would adopt these additional mandates, it would increase the full cost of mandates by up to 1.8% of premium. Mercer's survey of carriers in the Maryland market shows that insured health plans in Maryland already comply with these mandates, with the exception of waiving the deductible and coinsurance on Pap smears, as required under the District of Columbia mandate. As a result, there is no marginal cost associated with these six mandates. The potential cost of these six additional mandates in their respective states is summarized in the following table:

Mandate Not Required in Maryland	Group Premium Impact to Add Mandate to Match Other State					
	Full Cost					
	DE	DC	PA	VA	Minimum	Maximum
AIDS treatment	-	1.1%	-	1.1%	0.0%	1.1%
Lymphedema treatment	-	-	-	0.0%	0.0%	0.0%
Hemophilia treatment	0.3%	-	-	0.3%	0.0%	0.3%
Hysterectomy post-op stay	-	-	-	0.0%	0.0%	0.0%
Ovarian cancer screening	0.0%	-	-	-	0.0%	0.0%
Pap smears/gynecological exams	0.3%	0.4%	0.3%	0.3%	0.3%	0.4%
<b>Total</b>	<b>0.6%</b>	<b>1.5%</b>	<b>0.3%</b>	<b>1.7%</b>	<b>0.3%</b>	<b>1.8%</b>

When combining the mandates required in Maryland and these six additional mandates, the difference in the full cost of mandates between Maryland and its neighboring states decreases. The marginal cost difference remains the same. The following table shows the cost difference expressed as a percentage of premium:

## Comparison to Other States

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Mandate	Group Premium Impact to Revise Mandate to Match Other State							
	Full Cost				Marginal Cost			
	DE	DC	PA	VA	DE	DC	PA	VA
Required in MD	-3.6%	-4.1%	-6.2%	-4.7%	-1.4%	-1.6%	-1.8%	-1.4%
Not required in MD	0.6%	1.5%	0.3%	1.7%	0.0%	0.0%	0.0%	0.0%
<b>Total</b>	<b>-3.0%</b>	<b>-2.6%</b>	<b>-5.9%</b>	<b>-3.0%</b>	<b>-1.4%</b>	<b>-1.6%</b>	<b>-1.8%</b>	<b>-1.4%</b>

After including these six additional mandates, on a full cost basis for all mandates, the other states still have a lower financial burden. The difference ranges from 2.6% of premium lower in the District of Columbia to 5.9% lower in Pennsylvania. The range in the 2003 report was 2.2% in District of Columbia to 5.6% in Pennsylvania. A majority of this change is attributable to the two new Maryland mandates (smoking cessation and prescription drug cost-sharing limits).

Also, on a marginal cost basis for all mandates, the other states still have a lower financial burden, but the difference is much lower than under the full cost basis. The difference ranges from 1.4% of premium lower in Delaware and Virginia to 1.8% lower in Pennsylvania. This compares to analogous statistics in the 2003 report of 0.9% lower in Delaware to 1.2% lower in Pennsylvania.

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
801	15-801: Benefits for Alzheimer's disease and care of elderly individuals	Health insurers must offer the option of including benefits for the expenses arising from the care of victims of Alzheimer's disease and the care of the elderly to all group purchasers.				
802	Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse	Mandatory coverage on the same terms as physical illness; minimum 60 days partial hospitalization; 80% coverage for first 5 visits; 65% coverage of 6-30 visits; 50% coverage for visits beyond 30. Lifetime limits same as physical illness.	18-3343: Mandatory coverage for drug and alcohol dependencies. Terms of the coverage cannot place a greater financial burden on an insured than for covered services of any other illness or disease.  18-3566: Mandatory coverage for serious mental illnesses. Terms of the coverage cannot place a greater financial burden on an insured than for covered services of any other illness or disease.	31-3102; 31-3103: Alcohol/ Substance Abuse - Minimum yearly inpatient coverage of 28 days, plus 12 days for detoxification; 30 days minimum outpatient visits.  35-2302; 35-2304; 35-2305: Mental Health - Mandatory coverage of 45 days inpatient. Outpatient coverage must be at least 75% for the first 40 visits during the year; 60% after that. Lifetime maximum of the greater of \$80,000 or 1/3 the lifetime max for physical illness.	40 P.S. 908-3; 908-4; 908-5: Alcohol/ Substance Abuse - Mandatory coverage of 7 days per inpatient admission, 30 days non-hospital residential treatment coverage, and 30 days minimum outpatient visits.  40 P.S. 764q: Mental Health - Mandatory coverage of 30 days inpatient coverage and 60 days minimum outpatient visits. Lifetime maximum cannot be less than lifetime coverage for physical illness.	38.2-3412.1: Alcohol/ Substance Abuse - Minimum yearly inpatient coverage of 20 days for adults and 25 days for children; 20 days minimum outpatient visits. Mental Health - Minimum yearly inpatient coverage of 20 days for adults and 25 days for children; 20 days minimum outpatient visits. Lifetime maximum cannot be more restrictive than that for physical illness; coinsurance cannot exceed 50% for outpatient visits.

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
803	Payments for blood products	Health insurers may not exclude payments for blood products except whole blood or concentrated red blood cells				38.2-3418.3: blood products for home treatment of hemophilia must be covered
804	Coverage for off-label use of drugs	Requires coverage for approved off-label drugs				38.2-3407.5; 38.2-3407.6: Mandatory coverage of off-label cancer drugs and excess dosages of drugs to relieve cancer pain.
805	Reimbursement for pharmaceutical products	Subject policies cannot establish varied reimbursement based on the type prescriber and cannot vary copayments based on community pharmacy vs. mail order	18 s 7303: Insurers and HMOs cannot impose on a beneficiary any co-payment or condition that is not equally imposed with all contracting pharmacy providers the beneficiary may utilize. Nor can they require an enrollee to prescription drugs exclusively through a mail-order pharmacy.			
806	Choice of pharmacy for filling prescriptions	The non-profit health service plan shall allow the member to fill prescriptions at the pharmacy of choice	18 s 7303: Enrollees must be able to select the pharmacy of their choice as long as the pharmacy agrees to participate in the plan according to its terms			

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
807	Coverage for medical foods and modified food products	Mandatory coverage of medically necessary, low protein modified medical food products.			40 P.S. 3904: Mandatory coverage for the cost of medically necessary nutritional supplements and formulas in the treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.	
808	Benefits for home health care	Mandatory home health care coverage for enrollees who would have otherwise required institutionalization up to 40 visits per year for up to 4 hours per visit.			40 P.S. s 764d: Mandatory coverage for a medically necessary home health care visit within 48 hours after a mastectomy. 40 P.S. s 1583: Mandatory and visit within 48 hours after discharge for childbirth when discharge occurs prior to 48-96 guidelines.	
809	Benefits for hospice care	Health insurers must offer individuals and groups benefits for hospice care services				38.2-3418.11: Coverage mandatory for hospice services including psychological, psychosocial, and other health services.

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
810	Benefits for in vitro fertilization (IVF)	If pregnancy is covered, all outpatient procedures associated with in vitro fertilization must be covered. Exempts religious organizations.				
811	Hospitalization benefits for childbirth	Every insurance policy that provides benefits for normal pregnancy must provide hospitalization benefits to the same extent as that for any covered illness	See section 812	See section 812	See section 812	See section 812
812	Inpatient hospitalization coverage for mothers and newborn children	If pregnancy covered, hospitalization for childbirth and postpartum stay of 48 to 96 hours must also be covered.	18-3553: Maternity coverage is not required. If it is covered, post delivery stay must meet federal standards. Services by a licensed certified nurse midwife must be covered.	35-1102.1: Plans that provide maternity coverage must cover inpatient postpartum stay of a minimum of 48 hours after a vaginal delivery, and 96 hours after a Cesarean delivery.	40 P.S. 1583; 3002: If maternity care is covered, post delivery inpatient care must be covered for 48-96 hours. Must also cover services by a licensed certified nurse midwife. Mandatory coverage for one home health care visit within 48 hours after discharge for childbirth when discharge occurs prior to 48-96 guidelines.	38.2-3414.2; 38.2-3418: Maternity coverage not required except in the case of rape or incest, but must be an employer option. If it is covered, post delivery stay must be covered for 48-96 hours.

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
813	Benefits for disability caused by pregnancy or childbirth	Insurers must offer to groups purchasing a <u>temporary disability policy</u> the option of extending these benefits to temporary disabilities caused by pregnancy or childbirth				
814	Coverage for mammograms	All hospital and major medical insurance policies must include coverage for a baseline mammogram for women who are 35 to 39, a biannual mammogram for women who are 40 to 49, and an annual mammogram for women who are at least 50	18-3552: Mandatory coverage for one mammogram for women age 35 or older, every 1 to 2 years for women age 40 to 50, every year for women age 50 and over and for any woman who is at high risk for breast cancer.	31-2902: Mandated baseline and annual mammogram for women. Coverage may not be subject to an annual or coinsurance deductible.	40 P.S. 764c: Required coverage for all costs associated with a mammogram every year for women age 40 or older or when medically necessary.	38.2-3418.1: Coverage required includes one mammogram for women ages 35-39, one every other year for those 40-49, and one annually for women 50 and older.
815	Coverage for reconstructive breast surgery	Requires carriers to provide coverage for reconstructive breast surgery resulting from a mastectomy to reestablish symmetry between the two breasts	18-3559: Mandatory benefits for reconstructive surgery following mastectomies including surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses.	2000 Act 13-541: If mastectomies are covered, reconstructive surgery, including surgery of the healthy breast to produce a symmetrical appearance and prosthetic devices must also be covered.	40 P.S. 764d: If mastectomies are covered, coverage is also required for prosthetic devices and breast reconstruction, including surgery of the healthy breast to achieve symmetry. Coverage may be limited to six years following the date of the mastectomy.	38.2-3418.4: Reconstructive surgery coverage is required for breast surgery.

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
816	Benefits for routine gynecological care	Requires carriers to permit a woman to have direct access to gynecological care from an in-network obstetrician/ gynecologist or other non-physician, including a certified nurse midwife, who is not her primary care physician; requires an obstetrician/ gynecologist to confer with a primary care physician	18 s 3556 carrier must provide direct access to ob/gyn	44-302.03: Health plans must permit women direct access for gynecological care to a gynecologist or advance practice registered nurse without referral by a primary care provider	40 P.S. s 991.2111: Managed care organizations must provide direct access to obstetrical and gynecological services without prior approval from a primary care provider	38.2-3407.11 carrier must provide direct access to ob/gyn
817	Coverage for child wellness services	Insurers must include child wellness services in a family policy. Minimally, this must include coverage for immunizations, PKU test, screening tests (tuberculosis, anemia, lead toxicity, hearing & vision), universal hearing screening of newborns; a physical exam, developmental assessment & parental anticipatory guidance services at each visit; and lab tests. Insurers may impose copayments but no deductible	18-3554 & 18-3558: Childhood immunizations must be covered to age 18. Mandatory coverage for lead screening tests for children at age 1, with additional tests to age 6 for those at high risk.	35-530; 35-1101; 35-1102: Immunizations and blood tests for newborns; unlimited visits to age 12; three annual visits age 12 to 18.	40 P.S. 3503: Immunizations must be covered.	38.2-3411: Immunizations must be covered. Well child care to age 6 must be covered and exempt from deductibles and coinsurance.

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
818	Benefits for treatment of cleft lip and cleft palate	Every hospital or major medical insurance policy must include benefits for inpatient or outpatient expenses arising from the management of cleft lip, palate, or both	DPH Reg. 69.4: Managed care organizations must have a policy assuring access to specialty pediatric outpatient centers for treatment of cleft lip and palate as determined to be medically necessary.		40 P.S. 772: Mandatory coverage for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.	38.2-3411: Health policies must cover Inpatient and outpatient dental, oral surgical, and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia.
819	Coverage for outpatient services and second opinions	Health insurers must cover a second opinion when required by a utilization review program and outpatient coverage for a service for which a hospital admission is denied				
820	Benefits for prosthetic devices and orthopedic braces.	Individual and group contracts written by a non-profit health service plan must provide benefits for prosthetic devices and orthopedic braces				

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
821	Diagnostic and surgical procedures for bones of face, neck, and head	Health insurers must cover face, neck, and head bone and joint conditions if other skeletal bones and joints are covered, and if the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.				38.2-3418.2: Head / neck bone disorders, including face and jaw must be covered.
822	Coverage for diabetes equipment, supplies, and self-management training	Mandatory coverage for all medically necessary diabetes equipment, supplies, and outpatient self-management training and educational services, including medical nutrition therapy.	18-3559A: If prescription drugs are covered, equipment and supplies for the treatment of diabetes must also be covered.	31-3002: Requires health benefit plans to provide coverage for the equipment, supplies and other outpatient self-management training and education, including medical nutritional therapy.	40 P.S. 764e: Mandatory coverage for all medically necessary diabetes equipment, supplies, and outpatient self-management training and educational services, including medical nutrition therapy.	38.2-3418.10: Coverage required for equipment, supplies and self-management training.
823	Coverage for osteoporosis prevention and treatment	Carrier shall include coverage for qualified individuals for bone mass measurement when requested by a health care provider				

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
824	Coverage for maintenance drugs	Carrier shall allow the insured to receive up to a 90-day supply of a prescribed maintenance drug in a single dispensing, except for new prescriptions or changes in prescriptions. If carrier increases copayment, they shall proportionally increase the dispensing fee.				
825	Coverage for detection of prostate cancer	Mandatory coverage for prostate screening for men who are between 40 and 75 years of age or who are at high risk for prostate cancer	18-3552: Mandatory prostate cancer screening for enrollees age 50 or above.	A14-491: Mandatory prostate cancer screening benefits that comply with the guidelines established by the American Cancer Society.		38.2-3418.7: Coverage required for annual PSA test for men age 50 and older and those age 40 and older at high risk.
826	Coverage for contraceptive drugs and devices	Mandatory coverage for any FDA-approved, prescription contraceptive drug or device and related services. Exempts religious organizations.	18-3559: Mandatory coverage for FDA-approved prescription contraceptive drugs, devices and outpatient contraceptive services; exempts religious employers.			38.2-3407.5: If prescription drugs are covered, all FDA-approved, prescription contraceptives must be covered.

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
827	Coverage for patient cost for clinical trials	Mandatory coverage for routine costs to an enrollee in a clinical trial for a life-threatening condition or prevention and early detection of cancer	18-3559G: Mandatory coverage for routine patient care costs for covered items and services for enrollees engaging in clinical trials for treatment of life threatening diseases.			38.2-3418.8: Mandatory coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer.
828	Coverage for general anesthesia for dental care under specified conditions	Coverage must be provided for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to an enrollee or insured under specified conditions.				38.2-3418.12: Mandatory coverage of anesthesia for dental procedures for children.
829	Coverage for detection of chlamydia	Coverage shall be provided for an annual routine chlamydia screening test for women who are under the age of 20 if they are sexually active and at least 20 if they have multiple risk factors; and for men who have multiple risk factors				

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
830	Referrals to specialists	Plans that don't allow direct access to health care specialists must establish and implement a procedure by which insureds can obtain a standing referral to a health care specialist, including an OB/GYN	18 s 3348: Plans that don't allow direct access to health care specialists must establish and implement a procedure by which insureds can obtain a standing referral to a health care specialist	44-302.01 Plans must permit a member with a chronic disabling or life threatening condition to have direct access to a specialist qualified to treat the condition, subject to initial referral and a treatment plan approved by the primary care provider.	40 P.S. s 991.2111: Managed care plans must adopt procedures by which an enrollee with a life-threatening, degenerative or disabling disease or condition may receive a standing referral to a specialist with clinical expertise in treating the disease or condition.	38.2-3407.11:1: Health plans must permit any covered individual to obtain a standing referral, to a specialist if the determined by the primary care physician to be appropriate
831	Non-formulary drugs or devices	Health plans that limit prescription coverage to a formulary must establish & implement a procedure for an enrollee to obtain a drug or device that isn't on the plan's formulary when there is no equivalent drug or device in the formulary, an equivalent drug is ineffective or has caused an adverse reaction			40 P.S. s 991.2136: Plans using a drug formulary must have a written policy that includes an exception process by which a health care provider may prescribe and obtain coverage for the enrollee for specific drugs and medications not included in the formulary when the formulary's equivalent has been ineffective in the treatment of the enrollee's disease or if the drug causes adverse reactions.	38.2-3407.9:01: Plans must establish a process to allow an enrollee to obtain, without additional cost-sharing non-formulary prescription drugs if the formulary drug is determined by the plan and the prescribing physician, to be an inappropriate therapy for the enrollee's medical condition

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
832	Coverage for mastectomies	Requires carriers to cover at least 1 home health visit within 24 hrs. after discharge for a patient who had <48 hrs. of inpatient hospitalization after a mastectomy or surgical removal of a testicle, or who undergoes either procedure on an outpatient basis			40 P.S. 764d: If mastectomy is covered, post surgical hospital stay must be covered. Required coverage for a medically necessary home health care visit within 48 hours after a mastectomy.	38.2-3418.6: If mastectomy is covered, post surgical hospital stay of 48 hours must be covered. Plan must cover complications related to a mastectomy.
833	Extension of benefits	If an individual's coverage terminates, the plan must continue coverage for up to 12 months for treatment begun before termination related to disability, a claim in progress, or hospital confinement, up to 30 days for already ordered glasses or contact lenses, up to 90 days for an accident occurs while the individual is covered or a course of treatment begun before termination; up to 60 days or the end of the billing quarter for orthodontia				

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
834	Coverage for prostheses	Requires carriers to provide coverage for a prosthesis prescribed by a physician for a member who has undergone a mastectomy & has not had breast reconstruction	18 s 3563: If mastectomy is covered, breast prostheses must be covered	31-3832: If mastectomy is covered, breast prostheses must be covered	40 P.S. 764d: Required coverage for breast prosthesis after mastectomy.	38.2-3418.6: Plan must cover medically necessary prostheses related to a mastectomy.
835	Coverage for habilitative services for children under 19 years of age	Requires carriers to provide coverage of habilitative services for children under the age of 19 years with a congenital or genetic birth defect, including autism & cerebral palsy, and may do so through a managed care system; carriers must provide notice annually to its members about the required coverage; carriers are not required to reimburse for habilitative services delivered through early intervention or school services; carriers denying payment for services because it is not a congenital or genetic birth defect is considered an adverse decision.		Requires carriers to provide coverage for autism as a congenital birth defect.		Requires carriers to provide coverage for autism as a biologically based mental illness.

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
836	Hair prosthesis	Requires carriers to provide one hair prosthesis at a cost not to exceed \$350 for a member whose hair loss results from chemotherapy or radiation treatment for cancer				
837	Colorectal cancer screening coverage	As of July 1, 2001, carriers shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society (ACS)	18-3559C: Mandatory coverage for colorectal cancer screening for persons 50 years of age or older and those at high risk for colon cancer.	Act 14-233: Mandatory coverage for colorectal cancer screening for policyholders residing in the District in accordance with the American Cancer Society guidelines.		38.2-3418.7: Coverage required for risk groups established by the American College of Gastroenterology.
838	Hearing aid coverage for a minor child	As of October 1, 2001, carriers shall provide coverage for hearing aids for a minor child covered under a policy if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. Carriers may limit the benefit to \$1,400 per hearing aid for each hearing-impaired ear every 36 months				

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
839	Coverage for treatment of morbid obesity	Carriers must provide coverage for the treatment of morbid obesity through gastric bypass surgery or another surgical method that is: recognized by the NIH as effective for the long-term reversal of morbid obesity;				38.2-3418.13: Mandatory morbid obesity coverage for those 100lbs over their recommended weight, or with a specified body mass index in conjunction with obesity-related illnesses.
840	Coverage for medically necessary residential crisis services	Carriers must provide coverage for medically necessary residential crisis services that are intensive mental health & support services, provided to someone with a mental illness at risk of a psychiatric crisis; designed to prevent, shorten, or provide an alternative to an inpatient admission; provided on a short-term basis; and provided by licensed entities.			40 P.S. s 908-4 Must cover alcoholism or drug addiction residential treatment program	

## Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
841	Coverage for Nicotine replacement therapy	Carriers shall provide coverage for nicotine replacement therapy defined as a product that: 1 is used to deliver nicotine to an individual attempting to cease the used of tobacco products; and 2. is obtained under a prescription written by an authorized prescriber.				
842	Member prescription drug cost share cannot exceed the retail price of prescription drug	Carriers that provide prescription drug coverage may not impose a copayment or coinsurance requirement for a covered drug or devise that exceeds the retail price of the prescription drug or devise.				

## Exhibit 2 – Insurance Law Subtitle 8

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Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
801	Benefits for Alzheimer's disease and care of elderly individuals		X	X		Health insurers must offer the option of including benefits for the expenses arising from the care of victims of Alzheimer's disease and the care of the elderly to all group purchasers.	Not specifically addressed as covered or excluded; could be covered by .03 A (28): "Any other service approved by a carrier's case management program"

**Exhibit 2 – Insurance Law Subtitle 8**

802	Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse	19-703.1	X	X	X	<p>All policies providing coverage for health care may not discriminate against any person with a mental illness, emotional disorder, or drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions that apply under the contract or policy for treatment of physical illness.</p> <p><b>Inpatient:</b> Physical illness parity with a minimum of at least 60 days of partial hospitalization;</p> <p><b>Outpatient:</b> 80% coverage for first 5 visits in any calendar year or benefit period; 65% coverage for 6-30 visits; 50% coverage for 31st visit and any subsequent visits.</p> <p><b>Scope:</b> medically necessary; one set of benefits covering mental illness, emotional disorders, drug abuse and alcohol abuse; may be delivered under a managed care system; cannot maintain separate out-of-pocket limits; medication management visit same as physical illness office visit</p>	<p><b>.03 A (4):</b> Inpatient mental health and substance abuse services provided through a carrier’s managed care system, including residential crisis services, up to a maximum of 60 days per covered person per year in a hospital or related institution</p> <p><b>.03 A (5):</b> “Outpatient mental health and substance abuse services provided through a carrier’s managed care system”</p> <p><b>.03 A (7):</b> “Detoxification in a hospital or related institution”</p> <p><b>.03 C:</b> “All mental health and substance abuse services described in § A (4) and (5) of this regulation shall be delivered through a carrier’s managed care system”</p> <p><b>.05 A:</b> “General Cost-Sharing Arrangement for Outpatient Mental Health and Substance Abuse Services.” Except for out-of-network services of this regulation, “...the carrier shall pay for each service 70 percent of allowable charges”</p>
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**Exhibit 2 – Insurance Law Subtitle 8**

803	Payments for blood products	X 19- 706(r)	X	X	X	Health insurers may not exclude payments for blood products	Covered; .03 A (24): “All cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin”
804	Coverage for off-label use of drugs	X 19- 706(i)	X	X	X	Requires coverage for approved off-label drugs	
805	Reimbursement for pharmaceutical products		X	X	X	Subject policies cannot establish varied reimbursement based on the type of prescriber and cannot vary copayments based on community pharmacy vs. mail order	
806	Choice of pharmacy for filling prescriptions		X			The non-profit health service plan shall allow the member to fill prescriptions at the pharmacy of choice	
807	Coverage for medical foods and modified food products	X 19- 705.5	X	X	X	All insurers shall include under family member coverage, coverage for medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical foods or low protein modified food products are: (1) prescribed as medically necessary for therapeutic treatment of inherited metabolic diseases; and, (2) administered under the direction of a physician	Covered; .03 A (21): “Medical food for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders”

## Exhibit 2 – Insurance Law Subtitle 8

808	Benefits for home health care		X	X	X	Health insurance policies that provide coverage for inpatient hospital care on an expense-incurred basis must provide coverage for home health care. The minimum benefit is 40 visits in any calendar year.	Covered; .03 A (11): “Home health care services...as an alternative to otherwise covered services in a hospital or related institution;...”
809	Benefits for hospice care services		X	X	X	Health insurers must offer individuals and groups benefits for hospice care services	Covered; .03 A (12): “Hospice care services”
810	Benefits for in vitro fertilization (IVF)	X 19- 706 (oo)	X	X	X	Carriers that provide pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from IVF procedures. The benefits shall be provided to the same extent as benefits provided for other pregnancy-related procedures. The patient or the patient’s spouse must have a history of infertility of at least 2 years or have become infertile from endometriosis, exposure to DES, blockage or removal of fallopian tubes, or abnormal male factors. Carriers may limit coverage of these benefits to 3 IVF attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000.	Excluded; .06 B (11): “In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures”
811	Hospitalization benefits for childbirth	X 19- 703 (g)	X	X	X	Every insurance policy that provides hospitalization benefits for normal pregnancy must provide hospitalization benefits for childbirth to the same extent as that provided for any covered illness.	Covered; .03 A (25): “Pregnancy and maternity services, including abortion;” §15-811 adopted as mandate

## Exhibit 2 – Insurance Law Subtitle 8

812	Inpatient hospitalization coverage for mothers and newborn children	X 19-706(i)	X	X	X	Requires carriers to provide inpatient hospitalization coverage for a mother and newborn child for a minimum of 48 hours after an uncomplicated vaginal delivery and 96 hours after an uncomplicated caesarean section; authorizes a home visit by an experienced registered nurse if the mother requests a shorter hospital stay and an additional home visit if prescribed by the provider; authorizes coverage for up to four additional days for a newborn when the mother continues to be hospitalized; and prohibits sanctions against a provider who advocates a longer stay	Covered; Required by §19-1305.4; effective 7/1/96; §15-812 adopted as mandate
813	Benefits for disability caused by pregnancy on childbirth			X		Insurers must offer to groups purchasing a <u>temporary disability policy</u> the option of extending these benefits to temporary disabilities caused by pregnancy or childbirth	Disability caused by pregnancy/childbirth: Not addressed.
814	Coverage for mammograms		X	X	X	Carriers must include coverage for a baseline mammogram for women who are 35 to 39, a biannual mammogram for women who are 40 to 49, and an annual mammogram for women who are at least 50; carriers may not impose a deductible	Covered; .03 A (10): “Mammography services for persons ages 40 to 49 once every other calendar year, and for ages 50 and above once per calendar year”
815	Coverage for reconstructive breast surgery	X 19-706 (d)(2)	X	X	X	Requires carriers to provide coverage for reconstructive breast surgery resulting from a mastectomy to reestablish symmetry between the two breasts	Covered; .03 A (30): “Breast reconstructive surgery as specified in Insurance Article, § 15-815, Annotated Code of Maryland, and breast prosthesis”

**Exhibit 2 – Insurance Law Subtitle 8**

816	Benefits for routine gynecological care	X 19-706 (l)	X	X	X	Requires carriers to permit a woman to have direct access to gynecological care from an in-network obstetrician/ gynecologist or other non-physician, including a certified nurse midwife, who is not her primary care physician; requires an obstetrician/ gynecologist to confer with a primary care physician	§15-816 adopted as mandate
817	Coverage for child wellness services		X	X	X	Insurers must include child wellness services in a family policy. Minimally, this must include coverage for immunizations, PKU test, screening tests (tuberculosis, anemia, lead toxicity, hearing & vision), universal hearing screening of newborns; a physical exam, developmental assessment & parental anticipatory guidance services at each visit; and lab tests. Insurers may impose copayments but no deductible	Covered; in accordance with the schedule in the U.S. Preventive Services Task Force Guidelines
818	Benefits for treatment of cleft lip and cleft palate	X 19-706 (bb)	X	X	X	Carriers must include benefits for inpatient or outpatient expenses arising from the management of cleft lip, cleft palate, or both	Covered; .03 A (23): “...habilitative services for children 0 to 19 years old for the treatment of congenital or genetic birth defects”
819	Coverage for outpatient services and second opinions		X	X	X	Health insurers must provide reimbursement for a second opinion when denied hospital admission by a utilization review program and when required by a utilization review program and outpatient coverage for a service for which an admission is denied	No specific references.

## Exhibit 2 – Insurance Law Subtitle 8

820	Benefits for prosthetic devices and orthopedic braces		X			Individual and group contracts written by a non-profit health service plan must provide benefits for prosthetic devices and orthopedic braces	Covered; .03 A (13): “Durable medical equipment, including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses”
821	Diagnostic and surgical procedures for bones of face, neck, and head		X	X	X	Health insurers that provide coverage for a diagnostic or surgical procedure involving a bone or joint of the skeletal structure may not exclude or deny coverage for the same diagnostic or surgical procedure involving a bone or joint of the face, neck, or head if the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.	Covered; .06 B (43): “TMJ treatment and treatment for CPS” are excluded, <u>EXCEPT</u> “for surgical services for TMJ and CPS, if medically necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury”
822	Coverage for diabetes equipment, supplies, and self-management training	X 19-706(x)	X	X	X	Carriers shall provide coverage for all medically appropriate and necessary diabetes equipment, diabetes supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy for insulin users, non-insulin users, or elevated blood glucose levels induced by pregnancy	Provides coverage for all medically necessary supplies and equipment; includes 6 nutritional visits. Does not include other educational services.
823	Coverage for osteoporosis prevention and treatment	X 19-706(p)	X	X	X	Carrier shall include coverage for qualified individuals for bone mass measurement when requested by a health care provider	Covered under terms of “medical necessity” as of July 1, 1998; §15-823 adopted as mandate
824	Coverage for maintenance drugs	X 19-706(q)	X	X	X	Carrier shall allow the insured to receive up to a 90-day supply of a prescribed maintenance drug in a single dispensing, except for new prescriptions or changes in prescriptions. If carrier increases copayment, they shall proportionally increase the dispensing fee.	Covered

## Exhibit 2 – Insurance Law Subtitle 8

825	Coverage for detection of prostate cancer	X 19-706(u)	X	X	X	Coverage shall be provided for a medically recognized diagnostic examination including a digital rectal exam (DRE) and prostate – specific antigen (PSA) test for: 1) men between 40 & 75; 2) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; 3) when used for staging in determining the need for a bone scan in patients with prostate cancer; or 4) when used for male patients who are at high risk for prostate cancer.	As of July 1, 1998 adopts American Cancer Society recommendations: 1) annual DRE for both prostate and colorectal cancer beginning at age 40; 2) annual PSA for African American men and all men age 40 or older with a family history of prostate cancer; and 3) an annual PSA screening for all other men age 50 and older.
826	Coverage for contraceptive drugs and devices	X 19-706(i)	X	X	X	Coverage shall be provided for 1) any contraceptive drug or device that is approved by the U.S. F.D.A. for use as a contraceptive and that is obtained under a prescription written by an authorized prescriber; 2) the insertion or removal, and any medically necessary exam associated with the use of such drug or device. An entity may not impose a different copay or coinsurance for a contraceptive drug or device than is imposed for any other Rx.	Covered, effective July 1, 1999; .03 A (22): “Family planning services, including: (a) Prescription contraceptive drugs or devices; (b) Coverage for the insertion or removal of contraceptive devices; (c) Medically necessary exam associated with the use of contraceptive drugs or devices; and (d) voluntary sterilization”
827	Coverage for patient cost for clinical trials	X 19-706 (aa)	X	X	X	Coverage shall be provided for patient cost to a member in a clinical trial as a result of 1) treatment provided for a life-threatening condition; or 2) prevention , early detection, and treatment studies on cancer.	Covered; .03 A (27): “Controlled clinical trials”
828	Coverage for general anesthesia for dental care under specified conditions	X 19-706 (i)	X	X	X	Coverage shall be provided for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to an enrollee or insured under specified conditions.	Covered, effective July 1, 1999; .03 A (32): “General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to the following...”

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829	Coverage for detection of chlamydia	X 19-706 (ff)	X	X	X	Coverage shall be provided for an annual routine chlamydia screening test for: women who are under the age of 20 if they are sexually active; women who are at least 20 if they have multiple risk factors; and men who have multiple risk factors	Covered, effective July 1, 2000; .03 A (33): An annual chlamydia screening test for women who are younger than 20 years old who are sexually active or at least 20 years old who have multiple risk factors and men who have multiple risk factors.
830	Referrals to specialists	X 19-706 (gg)	X	X	X	Requires carriers that do not allow direct access to specialists to establish & implement a procedure by which a member may receive under certain circumstances a standing referral to a participating specialist & under certain circumstances to a non-participating specialist; provides pregnant members with a standing referral to an OB	§15-830 adopted as part of the “Patients’ Bill of Rights Act,” effective Nov. 1, 1999; standing referral for pregnancy adopted, effective October 1, 2000
831	Coverage of prescription drugs and devices	X 19-706 (gg)	X	X	X	Each entity limiting its coverage of Rx drugs or devices to those in a formulary shall establish & implement a procedure for a member to receive a Rx drug or device that is not in the entity’s formulary when there is no equivalent Rx drug or device in the entity’s formulary, an equivalent Rx drug is ineffective or has caused an adverse reaction	§15-831 adopted as part of the “Patients’ Bill of Rights Act,” effective Nov. 1, 1999
832	Coverage for mastectomies	X 19-706 (gg)	X	X	X	Requires carriers to cover at least 1 home health visit within 24 hrs. after discharge for a patient who had <48 hrs. of inpatient hospitalization after a mastectomy or surgical removal of a testicle, or who undergoes either procedure on an outpatient basis	§15-832 adopted as part of the “Patients’ Bill of Rights Act,” effective Nov. 1, 1999
833	Extension of benefits	X 19-706 (hh)	X	X	X	Requires carriers to extend certain benefits under specific circumstances except when coverage is terminated because of specified conditions. Charging of premiums is prohibited when benefits are extended	Law impacted CSHBP; effective Oct. 1, 1999

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834	Coverage for prostheses	X 19-706 (ii)	X	X	X	Requires carriers to provide coverage for a prosthesis prescribed by a physician for a member who has undergone a mastectomy & has not had breast reconstruction	Covered; .03 A (30): “Breast reconstructive surgery as specified in Insurance Article, § 15-815, Annotated Code of Maryland, and breast prosthesis
835	Coverage for habilitative services for children under 19 years of age	X 19-706 (nn)	X	X	X	Requires carriers to provide coverage of habilitative services for children under the age of 19 years with a congenital or genetic birth defect, including autism & cerebral palsy, and may do so through a managed care system; carriers must provide notice annually to its members about the required coverage; carriers are not required to reimburse for habilitative services delivered through early intervention or school services; carriers denying payment for services because it is not a congenital or genetic birth defect is considered an adverse decision.	Covered; .03 B: “The services described in § A (23) of this regulation shall be delivered through a carrier’s managed care system...”
836	Hair prosthesis	X 19-706 (i)	X	X	X	Requires carriers to provide one hair prosthesis at a cost not to exceed \$350 for a member whose hair loss results from chemotherapy or radiation treatment for cancer	Excluded; .06 B (40); “Wigs or cranial prosthesis”
837	Colorectal cancer screening coverage	X 19-706 (rr)	X	X	X	As of July 1, 2001, carriers shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society (ACS)	As of July 1, 2001, adopted ACS recommendations: colorectal screening covered for men & women ages 50 and older as follows: a) a yearly FOBT w/DRE, plus flexible sigmoidoscopy every 5 years; b) colonoscopy w/DRE every 10 years; or c) a double contrast barium enema w/DRE every 5 years

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838	Hearing aid coverage for a minor child	X 19-706 (tt)	X	X	X	As of October 1, 2001, carriers shall provide coverage for hearing aids for a minor child covered under a policy if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. Carriers may limit the benefit to \$1,400 per hearing aid for each hearing-impaired ear every 36 months	Covered; .03 A (34), effective July 1, 2002: "...hearing aids for persons ages 0 to 18 years of age, up to \$1,400 per hearing aid for each hearing-impaired ear every 36 months"
839	Coverage for treatment of morbid obesity	X 19-706 (uu)	X	X	X	As of October 1, 2001, carriers shall provide coverage for the surgical treatment of morbid obesity that is recognized by the NIH as effective for the long-term reversal of morbid obesity and consistent with guidelines approved by the NIH. Carriers shall provide coverage for this benefit to the same extent as for other medically necessary surgical procedures under the insured's policy.	Excluded; .06 B (14): "Medical or surgical treatment for obesity, unless otherwise specified in the covered services"
840	Coverage for medically necessary residential crisis services	X 19-706 (yy)	X	X	X	As of October 1, 2002, carriers shall provide coverage for medically necessary residential crisis services defined as intensive mental health & support services 1) provided to a child or an adult with a mental illness at risk of a psychiatric crisis; 2) designed to prevent or provide an alternative to a psychiatric inpatient admission, or shorten the length of inpatient stay; 3) provided at the residence on a short-term basis; and 4) provided by DHMH-licensed entities.	Covered, effective July 1, 2003; .03A(4): "Inpatient mental health and substance abuse services provided through a carrier's managed care system, including residential crisis services, up to a maximum of 60 days per covered person per year in a hospital, related institution, or entity licensed by DHMH to provide residential crisis services"

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841	Coverage for smoking cessation treatment	X 19-706 (fff)	X	X	X	Effective October 1, 2005, carriers shall provide coverage for any prescription (not OTC) drug that is approved by the FDA to aid in the cessation of tobacco use; carriers may not impose a different copay or coinsurance for a drug or nicotine replacement therapy than is imposed for any other comparable prescription.	
842	Copayment or coinsurance for prescription drugs and devices limited	X	X	X	X	Effective October 1, 2007, carriers may not impose a copayment or coinsurance that exceeds the retail price of the prescription drug or device.	

### **Exhibit 3 – Maryland Insurance Article Section 15-1502**

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#### **§ 15-1502.**

(a) (1) The Commission shall conduct an evaluation of existing mandated health insurance services and make recommendations to the General Assembly regarding decision making criteria for reducing the number of mandates or the extent of coverage.

(2) The evaluation shall include:

(i) an assessment of the full cost of each existing mandated health insurance service as a percentage of the State's average annual wage and of premiums:

(1) under a typical group and individual health benefit plan in the State;

(2) under the State employee health benefit plan; and

(3) under the Comprehensive Standard Health Benefit Plan;

(ii) an assessment of the degree to which existing mandated health insurance services are covered in self-funded plans; and

(iii) a comparison of mandated health insurance services provided by the State with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia.

(3) The comparison described in paragraph (2)(iii) of this subsection shall include:

(i) the number of mandated health insurance services;

(ii) the type of mandated health insurance services;

(iii) the level and extent of coverage for each mandated health insurance service; and

(iv) the financial impact of differences in levels of coverage for each mandated health insurance service.

(4) On or before January 1, 2004, and every 4 years thereafter, the Commission shall submit a report of its findings to the General Assembly, subject to § 2-1246 of the State Government Article.

(b) The General Assembly may consider the information provided under subsection (a) of this section in determining:

(1) whether to enact proposed mandated health insurance services; and

(2) whether to repeal existing mandated health insurance services.