Study of Mandated Health Insurance Services as Required Under Insurance Article § 15–1502

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Summary

Every State has laws that require private health insurance to cover certain benefits and services.[1] Insurance Article § 15–1502, Annotated Code of Maryland, requires the Maryland Health Care Commission (MHCC) to publish a report estimating the costs of existing mandated health insurance services in Maryland and surrounding States.[2] Mandated health insurance benefits are benefits (mandates), (for example, coverage of treatment for a specific disease or condition) that Maryland State law requires health insurers operating in Maryland to provide. This report contains estimates of costs of health insurance mandates in effect in Maryland as of January 1, 2019.[3] NovaRest was engaged by MHCC to prepare this report. All data is as of 2018 and does not reflect new mandate requirements in 2019.

NovaRest estimated that the cost of Maryland mandates that are included in this report is 12.1% of premium for the non-grandfathered individual market, 11.6% of premium for the non-grandfathered small group market, 13.7% of premium for the large group fully-insured market, and 4.9% of premium for the State Employee Health Benefit Plans.

Many changes in the Maryland health insurance market have occurred since MHCC submitted the previous report on this topic to the legislature in 2012.[4] For example, the individual and small group health insurance markets have been impacted by Affordable Care Act (ACA) provisions that went into effect in 2014. The ACA created Essential Health Benefits (EHBs) requirements for the individual market and the small group market. All individual and small group health benefit plans must cover the ACA's ten essential health benefits.[5] States are required to select a benchmark plan from a list of acceptable options. The benchmark plan is the reference plan for determining benefits that must be covered in the individual and small group markets. Maryland's benchmark plan is CareFirst HMO/HRA $1500 from 2017 for both the individual market and the small group market.[6] This plan includes all EHBs required by the ACA.

The marginal cost is the cost impact of the mandate beyond what would be covered if there were no mandate either because of an ACA requirement or because the service would be covered by carriers regardless of the mandate. All mandates covered by the current benchmark plan will not increase the marginal cost because they are required for all individual and small group plans under the ACA .[7] For the large group market, the margin cost is zero either because the mandate is

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[1] National Conference of State Legislatures, "State Insurance Mandates and the ACA Essential Benefits Provisions", http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx.

[2] MHCC published the most recent report required under Insurance Article § 15–1502, Annotated Code of Maryland on January 12, 2012. https://mhcc.maryland.gov/mhcc/pages/plr/plr_Insurance/documents/Four_Year_Mandate_Report_FINAL.pdf

[3] The Mandated Benefits Chart as of January 1, 2019 from an Insurance Bulletin published by the Maryland Insurance Administration (MIA) was used to determine the mandates currently inforce in the State. https://insurance.maryland.gov/Consumer/Documents/publicnew/mandatedbenefits.pdf

[4] MHCC was required to submit a report in 2016, but funding limits did permit MHCC to contract with a vendor to conduct and the General Assembly waived the reporting requirement for that year.

[5] https://www.cms.gov/cciio/resources/data-resources/ehb.html

[6] The State Benchmark Plan offered on the exchange in the small group market excludes certain mandates such as coverage for IVF, hair prostheses, and other mandates enacted after 2011.

[7] Benefits covered by the ACA or that would be covered by carriers regardless of a mandate have a $0 marginal cost.

required by the ACA or a combination of being a low cost benefit that would be covered by most large group plans without the mandate.

The ACA requires that a State must pay the cost for all new State-legislated mandated benefits for individual and small group plans. Thus, there have been few new mandates enacted in any State since 2014, unless the mandate applies only to large group plans.

This report compares Maryland's mandates to those of its neighboring States. NovaRest compared the benefits of similar mandates in neighboring States to the benefits of Maryland's mandates. Often the benefits mandated in Maryland are more comprehensive such that, if Maryland matched the benefits in other States, Maryland would experience a cost reduction of approximately 3% due to the reduced level of benefits.

There are eleven (11) mandates required in the neighboring States that are not mandated in Maryland. Many of those mandates are also not covered by the ACA. There would be a cost increase of approximately 0.7% of premium if Maryland adopted these 11 mandates additional mandates.

Introduction

Background

Mandated benefits (mandated health insurance services or mandates) are required benefits that cover the treatment of specific health conditions by a certain type of health insurer (carrier, insurance company, or health carrier). Mandates can be required by State law, Federal law, or both. In Maryland, some mandates do not apply to Health Maintenance Organizations (HMOs).

The insurance market in Maryland includes fully-insured plans and self-insured plans (for definitions of terms, please see the glossary in Appendix III). Self-insured plans are regulated under Federal law (ERISA), and the State cannot mandate benefits for self-insured plans. Self-insured plans can elect to provide the services that are mandated by the State for fully-insured plans.

Fully-insured plans are divided into three market segments: large group, small group, and individual markets. Before 2013, State mandated benefit laws often applied to all three market segments.

This report fulfills the requirements of Insurance Article § 15–1502, Annotated Code of Maryland. Under section 15–1502, the Commission must 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.

Mandates Under the Affordable Care Act

Historically, State legislators enacted mandated benefits or required health coverage for specific treatments, benefits, providers and categories of dependents to ensure adequate protection for their constituents. The Affordable Care Act (ACA) was enacted in 2010 and key policies impacting the small group and individual markets went into effect for the 2014 calendar year. All individual and small group plans must cover the ACA's ten essential health benefits (EHBs). (This requirement does not apply to self-insured group plans, large group plans, or grandfathered plans).[8] All individual and small group plans with effective dates of January 1, 2014 or later must cover:[9]

1. Ambulatory patient services (outpatient care you receive without being admitted to a hospital)
2. Emergency services
3. Hospitalization (like surgery and overnight stays)
4. Pregnancy, maternity, and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
6. Prescription drugs

[8] https://www.cms.gov/cciio/resources/data-resources/ehb.html. Centers for Medicare and Medicaid Services. https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf "Frequently Asked Questions on Essential Health Benefits Bulletin." Accessed August 21, 2019

[9] HealthCare.gov. "What marketplace health insurance plans cover" https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ Accessed August 21, 2019.

7. Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (but adult dental and vision coverage are not essential health benefits)

Additional benefits
Under Federal law, plans also must include the following benefits:
1. Birth control coverage
2. Breastfeeding coverage

The ACA required inclusion of many benefits previously included as mandated benefits in Maryland through EHB requirements. (See Table 1a under Section 1: Mandates and the EHB).

The U.S. Department of Health and Human Services (HHS) has given States flexibility to implement the Affordable Care Act (ACA) coverage provisions for plans in the individual and small group insured markets. Under the ACA, States are required to pick a benchmark plan from a list of acceptable options.[10] The benchmark plan is the reference plan for determining what benefits must be covered in the individual and small group markets. The benchmark plan must include all EHBs. In this report, we refer to *ACA required benefits* to indicate the benefits required by ACA and we refer to *EHB-Benchmark plans* to indicate the Maryland benchmark plan that includes the EHBs required by the ACA.

In 2018, CMS provided each State with three new options that provide greater flexibility to the State to select its EHB-Benchmark plan for plan year 2020 and beyond. These options include:

1. Selecting the EHB-Benchmark plan that another State used for the 2017 plan year.
2. Replacing one or more categories of EHBs under its EHB-Benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-Benchmark plan that another State used for the 2017 plan year.
3. Otherwise selecting a revised set of benefits for the State's EHB-Benchmark plan.[11]

Under all three options, a State's new benchmark plan may not exceed the generosity of the most generous among a set of comparison plans. Comparison plans include the State's EHB-Benchmark plan used for the 2017 plan year, as well as other plans available as base-benchmark plan options for the 2017 plan year.

Under any of the available three options, a State can change its EHB-Benchmark plan in any given year, not only in the years specified by HHS. States that prefer to maintain their current EHB-

[10] In its December 16, 2011 bulletin, the HHS provided guidance on the types of health benefit plans each State could consider when determining a benchmark plan for its residents that covers the required EHBs. Centers for Medicare and Medicaid Services. "Essential Health Benefits: HSS Informational Bulletin." https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/essential-health-benefits12162011a.html Accessed August 21, 2019. We will refer to this plan as the EHB-Benchmark plan to acknowledge that it is the state benchmark plan and that it also meets the ACA required EHBs.
[11] Centers for Medicare and Medicaid Services. "Plan Year 2020 and Beyond EHB-Benchmark Plans." https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html Accessed September 25, 2019.

Benchmark plan can do so without action. The deadline to select a new EHB-Benchmark plan for the 2020 plan year was July 2, 2018. Maryland law does not permit the state to change the benchmark plan unless the HHS secretary requires a state to select a new benchmark plan. Since the new flexibility is optional for states, Maryland is unable to take advantage of this flexibility without a state law change.

Maryland's benchmark plan is the CareFirst HMO/HRA $1500 from 2017 for both the individual market and the small group market.[12] This plan includes all of the EHBs required by the ACA. This benchmark plan also includes all of the mandated benefits in Maryland that were in effect in the individual and small group markets as of January 2012.

A State may require a carrier in the individual or small group market to offer mandated benefits, in addition to the EHBs. If a State requires benefits that exceed the EHB-Benchmark plan, the State must make payments to individuals enrolled in the plan or to the plan (on behalf of enrolled individuals or the federal government) to defray the cost of the additional required benefits.[13]

Since 2013, in part as a result of the ACA requirements described above, all mandated benefits added to State law in Maryland have been limited to the large group fully-insured market, which is not impacted by the EHB requirements.

Report Contents

The remainder of this report is divided into seven (7) sections. The first section details the extent each mandate overlaps with an EHB, the market impacted, and if the mandate went into effect before 2012. The second section evaluates the full cost of each existing mandate as a percentage of the State's average annual wage and of average premiums for the individual, small group, large group, and State Employee Health Benefit Plans. The third section assesses the degree to which existing mandates are voluntarily covered in self-insured plans. The fourth section compares the mandates required in Maryland with those required in Delaware, the District of Columbia, Pennsylvania, and Virginia. The fifth section estimates the mandates' marginal cost as a percentage of annual premiums. The sixth section contains our conclusions. The final section includes *Appendix I - Mandate Overlaps with EHB-Benchmark Plan Detail*, *Appendix II – Required in Bordering States but Not Required in Maryland, and Appendix III – Glossary.*

Any distribution of this report does not constitute advice by NovaRest. NovaRest assumes no liability related to third party use of this report or any decisions in connection with the report. The report should be presented in its entirety.

Reliance and Resources

To study and project costs, NovaRest relied on information provided by multiple sources without independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may not be accurate and the

[12] The State Benchmark Plan offered on the exchange in the small group market excludes certain mandates such as coverage for IVF, hair prostheses, and other mandates enacted after 2011.
[13] Affordable Care Act § 1311(d)(3)(B) (42 U.S.C. 18031(d)(3)(B)); Department of Health and Human Services. "Federal Register/Vol. 78, No. 37." https://www.govinfo.gov/content/pkg/FR-2013-02-25/pdf/2013-04084.pdf Accessed October 16, 2019

report may require revision. While we have relied on the data without independent investigation or verification, we have reviewed the information for consistency and reasonableness.

The following resources were used to develop the estimates in this report:

- List of benefit mandates with current descriptions (provided by MHCC)
- List of mandates in the District of Columbia (provided by District of Columbia Department of Insurance, Securities and Banking)
- Health plan surveys (conducted by NovaRest) regarding current practices of self-insured clients: the health plan surveys (conducted by NovaRest) were sent to Aetna, CareFirst, Cigna, Kaiser, and United Healthcare Insurance
- Statistics on premiums and members in the individual and large group markets (provided by MHCC)
- Statistics on premiums for the State Employee Health Benefit Plans (made publicly available by Maryland's Department of Budget and Management)
- Public sources, including Internet searches
- Mandate-specific research by NovaRest's consultants
- Mandate cost studies done in other States
- Health care cost guidelines from a national actuarial firm
- Statutory statements and the Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)

None of the information or data provided should be considered as legal advice, be used to compare policies, or substitute for a Summary of Benefits and Coverage from a carrier.

NovaRest followed actuarial standards and utilized actuarial models to estimate the full cost of each mandate. These costs are based on our best estimate for a large, stable population. The actual cost experienced by any specific plan and/or insurer may vary significantly from our estimates. Variations can be caused by legislative changes, reimbursement levels, population morbidity, differences in how care is delivered, the degree to which care is managed, and other fluctuations.

Alfred Bingham FSA, MAAA, Donna Novak FCA, ASA, MAAA, MBA, Richard Diamond FSA, MAAA, Richard Cadwell, and Wayne Novak of NovaRest were the consultants involved in conducting surveys, modeling, and providing the analyses for this report. The named actuaries meet the Qualification Standards of the American Academy of Actuaries to perform such modeling and analyses.

1. Mandates and the EHB

This section indicates the market impacted by each mandate, compares the extent each mandate overlaps with an EHB, and indicates if the mandate went into effect before 2012. The tables in this section contain the mandated health insurance services in Maryland under *Insurance Article Title 15, Subtitle 8, Required Health Insurance Benefits*. NovaRest used the Maryland Insurance Administration's (MIA) Mandated Benefits Chart as of January 1, 2019 from an Insurance Bulletin[14] as the basis for the list of mandated benefits in Maryland. One of these mandates, a limit on co-payment amounts for methadone maintenance treatment, will be repealed effective for insurance contracts beginning on or after January 1, 2020.[15]

The tables that follow include the following information:

1. Table 1a indicates the health insurance markets (individual, small group, and large group) that are impacted by each mandate.
2. Table 1b denotes the mandates that went into effect between calendar years 2012 and 2019.
3. Table 1c indicates each mandate that overlaps with the EHB-Benchmark Plan.

Table 1a lists the insured markets impacted by each mandate, indicating that most mandates impact all insured markets. The State Employee Health Benefit Plans is self-insured and therefore is not subject to state mandates, but many mandates are included voluntarily.

[14] Maryland Insurance Administration. "Maryland's Mandated Benefits for Large Group Plans and Grandfathered Plans." https://insurance.maryland.gov/Consumer/Documents/publicnew/mandatedbenefits.pdf Accessed August 21, 2019

[15] House Bill 599, Chapter 358, Acts of 2019

Table 1a Application of Maryland Mandates to the Individual, Small Group, and Large Group Fully-insured Health Insurance Markets

Citation	Mandate Benefit	Individual	Small Group	Large Group
15-801	Alzheimer's Disease Treatment		Offer	Offer
15-802	Mental Health/Substance Misuse Treatment - Coverage	Yes	Yes	Yes
15-802(d)	Mental Health/Substance Misuse Treatment - Methadone Maintenance Treatment	Yes	Yes	Yes
15-803	Blood Products	Yes	Yes	Yes
15-804	Prescription Drugs - Off-Label Use	Yes	Yes	Yes
15-805	Prescription Drugs - Reimbursement for Pharmaceutical Products	Yes	Yes	Yes
15-806	Prescription Drugs - Choice of Pharmacy	Yes	Yes	Yes
15-807	Medical Foods	Yes	Yes	Yes
15-808	Home Health Care	Yes	Yes	Yes
15-809	Hospice Care	Offer	Offer	Offer
15-810	Infertility Benefits	Yes	Excludes IVF (1)	Yes
15-810.1	Fertility Preservation Procedures			Yes
15-811	Pregnancy and Maternity Benefits - Hospitalization Benefits for Child Birth	Yes	Yes	Yes
15-812	Pregnancy and Maternity Benefits - Inpatient Hospital Coverage for Mothers and Newborns	Yes	Yes	Yes
15-813	Disability Benefits for Disabilities Caused by Pregnancy or Childbirth		Offer	Offer
15-814	Breast Cancer Screening (including mammograms)			Yes
15-815	Reconstructive Breast Surgery	Yes	Yes	Yes
15-816	Gynecological Care	Yes	Yes	Yes
15-817	Child Wellness	Yes	Yes	Yes
15-818	Cleft Lip/Cleft Palate	Yes	Yes	Yes
15-819	Second Opinions and Coverage of Outpatient Services	Yes	Yes	Yes
15-820	Orthopedic Braces	Yes	Yes	Yes
15-821	Temporo-Mandibular Joint Syndrome (TMJ) Treatment	Partial	Partial	Yes
15-822	Diabetic Equipment and Supplies	Yes	Yes	Yes
15-823	Osteoporosis Prevention and Treatment	Yes	Yes	Yes
15-824	Prescription Drugs - Maintenance Drug Coverage	Yes	Yes	Yes
15-825	Prostate Cancer Screening	Yes	Yes	Yes
15-826	Contraceptives Drugs or Devices	Yes	Yes	Yes
15-826.2	Male sterilization			Yes
15-826.3	Fertility Awareness-Based Methods			Yes
15-827	Clinical trials	Yes	Yes	Yes
15-828	Anesthesia for Dental Care	Yes	Yes	Yes
15-829	Chlamydia Screening	Yes	Yes	Yes
15-829	Human Papillomavirus Screening Test	Yes	Yes	Yes
15-830	Referral to Specialists	Yes	Yes	Yes
15-831	Prescription Drugs - Use of Formulary	Yes	Yes	Yes
15-832	Surgical Removal of Testicle	Yes	Yes	Yes
15-832.1	Mastectomies	Yes	Yes	Yes
15-833	Extension of Benefits	Yes	Yes	Yes
15-834	Breast Prosthesis	Yes	Yes	Yes
15-835	Habilitative Services	Yes	Yes	Yes
15-836	Hair Prosthesis	Yes		Yes
15-837	Colorectal screening	Yes	Yes	Yes
15-838	Hearing Aids for Minor Children	Yes	Yes	Yes
15-839	Morbid Obesity	Yes	Yes	Yes
15-840	Mental Health/Substance Misuse Treatment - Residential Crisis Services	Yes	Yes	Yes
15-841	Smoking Cessation	Yes	Yes	Yes
15-842	Prescription Drugs - Copayment/Coinsurance	Yes	Yes	Yes
15-843	Amino Acid	Yes	Yes	Yes
15-844	Prosthetic Devices	Yes	Yes	Yes
15-848	Ostomy Equipment and Supplies			Yes
15-849	Prescription Benefits - Abuse-Deterrent Opioid Products	Yes	Yes	Yes
15-853	Lymphedema Diagnosis, Evaluation and Treatment			Yes

(1) 15-810 does not require In Virtro Fertilization in the small group market

Offered indicates mandated benefits that only have to be offered and not covered

Table 1b shows which Maryland mandates were added to State law, changed, or amended after December 31, 2011. Under the ACA, the State is responsible for paying the cost of any State mandates added to the individual or small group market after December 31, 2011 and any additional costs for mandates that have been amended to require broader coverage (or otherwise increase actuarial costs for health insurance plans in those markets).

Fifteen (15) existing mandates were amended between 2012 and 2019.[16] MHCC confirmed that these changes or amendments did not add cost and therefore did not require a defrayal by the State. Most of the changes or amendments were to expand the scope of the mandate to include HMOs.

Three of the mandates studied in this report were added to Maryland State law during the 2012-2019 time period: Ostomy Equipment and Supplies[17]; Prescription Benefits - Abuse-Deterrent Opioid Products[18]; and Lymphedema Diagnosis, Evaluation and Treatment.[19] Two of these new mandates apply to the large group market only, as noted in Table 1a. The addition of these mandates to Maryland law has no ACA required costs to the State because these mandates do not apply to the small group or individual market.

[16] NovaRest looked through the sessions of the General Assembly and noted when a citation changed. For example: http://mgaleg.maryland.gov/webmga/frmLegislation.aspx?pid=legisnpage&tab=subject3&ys=2013rs

[17] Md. Code, Insurance Article § 15-848.

[18] Md. Code, Insurance Article § 15-849. Opioid abuse-deterrent was added to the individual and small group markets since federal law permitted drug treatment benefits be added without defrayal of costs by the states.

[19] Md. Code, Insurance Article § 15-853.

Table 1.b Benefits Added to State Law or Amended After 2011		
Citation	Mandate Benefit	Added or Amended
15-801	Alzheimer's Disease Treatment	
15-802	Mental Health/Substance Misuse Treatment - Coverage	Amended
15-802(d)(5)	Mental Health/Substance Misuse Treatment - Methadone Maintenance Treatment	Amended
15-803	Blood Products	Amended
15-804	Prescription Drugs - Off-Label Use	
15-805	Prescription Drugs - Reimbursement for Pharmaceutical Products	
15-806	Prescription Drugs - Choice of Pharmacy	
15-807	Medical Foods	
15-808	Home Health Care	
15-809	Hospice Care	
15-810	Infertility Benefits	
15-810.1	Fertility Preservation Procedures	Added
15-811	Pregnancy and Maternity Benefits - Hospitalization Benefits for Child Birth	
15-812	Pregnancy and Maternity Benefits - Inpatient Hospital Coverage for Mothers and Newborns	
15-813	Disability Benefits for Disabilities Caused by Pregnancy or Childbirth	
15-814	Breast Cancer Screening (including mammograms)	Amended
15-815	Reconstructive Breast Surgery	
15-816	Gynecological Care	
15-817	Child Wellness	
15-818	Cleft Lip/Cleft Palate	
15-819	Second Opinions and Coverage of Outpatient Services	
15-820	Orthopedic Braces	
15-821	Temporo-Mandibular Joint Syndrome (TMJ) Treatment	
15-822	Diabetic Equipment and Supplies	Amended
15-823	Osteoporosis Prevention and Treatment	
15-824	Prescription Drugs - Maintenance Drug Coverage	
15-825	Prostate Cancer Screening	
15-826	Contraceptives Drugs or Devices	Amended
15-826.2	Male sterilization	Added
15-826.3	Fertility Awareness-Based Methods	Added
15-827	Clinical trials	
15-828	Anesthesia for Dental Care	
15-829	Chlamydia Screening	
15-829	Human Papillomavirus Screening Test	
15-830	Referral to Specialists	Amended
15-831	Prescription Drugs - Use of Formulary	Amended
15-832	Surgical Removal of Testicle	
15-832.1	Mastectomies	
15-833	Extension of Benefits	
15-834	Breast Prosthesis	
15-835	Habilitative Services	Amended
15-836	Hair Prosthesis	
15-837	Colorectal screening	
15-838	Hearing Aids for Minor Children	
15-839	Morbid Obesity	
15-840	Mental Health/Substance Misuse Treatment - Residential Crisis Services	
15-841	Smoking Cessation	
15-842	Prescription Drugs - Copayment/Coinsurance	
15-843	Amino Acid	
15-844	Prosthetic Devices	
15-848	Ostomy Equipment and Supplies	Added
15-849	Prescription Benefits - Abuse-Deterrent Opioid Products	Added
15-853	Lymphedema Diagnosis, Evaluation and Treatment	Added

Table 1c shows which mandates are covered by similar requirements in the EHB-Benchmark plan. The EHB-Benchmark plan[20] covers most of the Maryland mandates implemented prior to 2012.[21] The Alzheimer's disease treatment mandate[22] was enacted prior to 2012 but is not covered by the Benchmark plan. The Alzheimer's disease treatment mandate is a mandate to offer coverage of services but not a coverage requirement. The Benchmark plan summary sheet did not provide sufficient level of detail to determine if the mandates related to referrals to specialists[23], use of a formulary for prescription drugs[24], and/or extension of benefits[25] were covered in the benchmark plan. Table 1c assumes that these three mandates are covered under the Benchmark plan. Appendix I - Mandate Overlaps with EHB-Benchmark Plan Detail includes a chart with further definitions of the mandate and the related EHB.

[20] https://insurance.maryland.gov/Consumer/Documents/publicnew/essentialbenefitschart.pdf

[21] All mandates except 15-848, 15-849 and 15-853 were implemented prior to 2012.

[22] Md. Code, Insurance Article § 15-801

[23] Md. Code, Insurance Article § 15-830

[24] Md. Code, Insurance Article § 15-831

[25] Md. Code, Insurance Article § 15-833.

Table 1c. Inclusion of Maryland Mandates in Maryland's EHB-Benchmark Plan for the Individual and Small Group Fully-Insured Markets

Citation	Mandate	Covered by EHB-Benchmark Plan
15-801	Alzheimer's Disease Treatment	Offered
15-802	Mental Health/Substance Misuse Treatment - Coverage	Yes
15-802(d)	Mental Health/Substance Misuse Treatment - Methadone Maintenance Treatment	Yes
15-803	Blood Products	Yes
15-804	Prescription Drugs - Off-Label Use	Yes
15-805	Prescription Drugs - Reimbursement for Pharmaceutical Products	Yes
15-806	Prescription Drugs - Choice of Pharmacy	Yes
15-807	Medical Foods	Yes
15-808	Home Health Care	Yes
15-809	Hospice Care	Offered
15-810	Infertility Benefits	Yes *
15-810.1	Fertility Preservation Procedures	Added after 2011
15-811	Pregnancy and Maternity Benefits - Hospitalization Benefits for Child Birth	Yes
15-812	Pregnancy and Maternity Benefits - Inpatient Hospital Coverage for Mothers and Newborns	Yes
15-813	Disability Benefits for Disabilities Caused by Pregnancy or Childbirth	Offered
15-814	Breast Cancer Screening (including mammograms)	Yes
15-815	Reconstructive Breast Surgery	Yes
15-816	Gynecological Care	Yes
15-817	Child Wellness	Yes
15-818	Cleft Lip/Cleft Palate	Yes
15-819	Second Opinions and Coverage of Outpatient Services	No
15-820	Orthopedic Braces	No
15-821	Temporo-Mandibular Joint Syndrome (TMJ) Treatment	Yes
15-822	Diabetic Equipment and Supplies	Yes
15-823	Osteoporosis Prevention and Treatment	Yes
15-824	Prescription Drugs - Maintenance Drug Coverage	Yes
15-825	Prostate Cancer Screening	Yes
15-826	Contraceptives Drugs or Devices	Yes
15-826.2	Male sterilization	Yes
15-826.3	Fertility Awareness-Based Methods	Yes
15-827	Clinical trials	Yes
15-828	Anesthesia for Dental Care	Yes
15-829	Chlamydia Screening	Yes
15-829	Human Papillomavirus Screening Test	Yes
15-830	Referral to Specialists	Yes
15-831	Prescription Drugs - Use of Formulary	Yes
15-832	Surgical Removal of Testicle	Yes
15-832.1	Mastectomies	Yes
15-833	Extension of Benefits	Yes
15-834	Breast Prosthesis	Yes
15-835	Habilitative Services	Yes
15-836	Hair Prosthesis	Yes *
15-837	Colorectal screening	Yes
15-838	Hearing Aids for Minor Children	Yes
15-839	Morbid Obesity	Yes
15-840	Mental Health/Substance Misuse Treatment - Residential Crisis Services	Yes
15-841	Smoking Cessation	Yes
15-842	Prescription Drugs - Copayment/Coinsurance	Yes
15-843	Amino Acid	Yes
15-844	Prosthetic Devices	Yes
15-848	Ostomy Equipment and Supplies	Added after 2011
15-849	Prescription Benefits - Abuse-Deterrent Opioid Products	Yes
15-853	Lymphedema Diagnosis, Evaluation and Treatment	Partial

* For individual plans only

Offered indicates mandated benefits that only have to be offered and not covered

2. Cost of Current Mandates

This section provides an assessment of the full cost of each existing mandated health insurance service expressed as a percentage of the State's average annual wage and as a percentage of premiums for the individual health insurance market, group health insurance markets, and State Employee Health Benefit Plans.[26] For this report we have separated the small group and large group markets since ACA requirements impact these markets differently.

This reporting requirement applies to the Maryland mandates defined in Sections §15–801 through §15–853 of the Insurance Article. NovaRest used the NAIC Supplemental Health Care Exhibits to determine the individual and group market premiums. For the State Employee Health Benefit Plans, NovaRest received data from the Maryland Medical Care Data Base (Maryland's All Payer Claims Database).[27] The Maryland State Employee Health Benefit Plans are self-insured, public/non-ERISA plans that include coverage for retirees. The Maryland State Employee Health Benefit Plans are not subject to State mandates, but many mandates are included voluntarily.

Table 2a summarizes the full cost of the current mandates as a percentage of premium for each of the specified markets. The total cost, expressed as a percent of premium for each market, is as follows:

- 12% of premium for the individual market;
- 14.8% of premium for the small group market;
- 13.7% of premium for the large group market; and
- 4.9% for the State Employee Health Benefit Plans.

The average 2018 per member per month (PMPM) premiums for individual, small group, large group, and the State Employee Health Benefit Plans are $547.45; $448.10; $484.86; and $1,349.73, respectively.

Although NovaRest believes that the costs for population morbidity, benefit richness, and medical management will vary by market due to differences in carrier medical management and care coordination, without information from the carriers, we are unable to quantify any such differences and therefore used the same estimated per member per month (PMPM) premium impact for each market.

[26] Reporting this information is a requirement of Md Code Ann., Insurance Article § 15–1502(a)(2)(i). This provision of law also requires that MHCC report on the cost of mandates in the Comprehensive Standard Health Benefit Plan (CSHBP) in the small group market. The CSHBP is authorized under Md Code Ann., Insurance Article § 15–1207. As of January 1, 2014, the requirements for the CSHBP only apply to grandfathered health benefit plans as defined in Section 1251 of the ACA (Insurance Article § 15–1207(h). As of 2019, grandfathered plans represent a relatively small portion of the small group market. Therefore, analysis of the cost of manadates for the CSHBP is not included in this report.

[27] More information on the Maryland Medical Care Database is available here: https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx

The mandate that has the most impact on cost is the mandate for mental health and substance misuse treatment (Insurance Article §15-802).

Three benefits must be offered yet are not mandated to be covered and therefore the cost of these mandates are estimated to be $0. Because the cost estimate for these mandates is zero, they are shown as 0.0% impact or N/A in this section. Services that are mandated to be offered but not covered include: Alzheimer's disease treatment (Insurance Article §15-801); Hospice Care (Insurance Article §15-809); and Disability Benefits for Disabilities Caused by Pregnancy or Childbirth (Insurance Article §15-813).

Table 2a. - Full Cost of Current Mandates As a Percentage of Premium					
Mandate	Section	Individual	Small Group	Large Group	State Employee Plan
Alzheimer's Disease Treatment	15-801	0.00%	0.00%	0.00%	0.00%
Mental Health/Substance Misuse Treatment - Coverage	15-802	2.61%	3.19%	2.95%	1.06%
Mental Health/Substance Misuse Treatment - Methadone Maintenance Treatment	15-802(d)(5)	0.00%	0.00%	0.00%	0.00%
Blood Products	15-803	0.54%	0.66%	0.61%	0.22%
Prescription Drugs - Off-Label Use	15-804	0.27%	0.33%	0.30%	0.11%
Prescription Drugs - Reimbursement for Pharmaceutical Products	15-805	0.00%	0.00%	0.00%	0.00%
Prescription Drugs - Choice of Pharmacy	15-806	0.00%	0.00%	0.00%	0.00%
Medical Foods	15-807	0.00%	0.00%	0.00%	0.00%
Home Health Care	15-808	0.00%	0.00%	0.00%	0.00%
Hospice Care	15-809	0.00%	0.00%	0.00%	0.00%
Infertility Benefits	15-810	0.17%	0.21%	0.19%	0.07%
Fertility Preservation Procedures	15-810.1	0.03%	0.03%	0.03%	0.01%
Pregnancy and Maternity Benefits - Hospitalization Benefits for Child Birth	15-811	1.65%	2.01%	1.86%	0.67%
Pregnancy and Maternity Benefits - Inpatient Hospital Coverage for Mothers and Newborns	15-812	0.33%	0.40%	0.37%	0.13%
Disability Benefits for Disabilities Caused by Pregnancy or Childbirth	15-813	0.00%	0.00%	0.00%	0.00%
Breast Cancer Screening (including mammograms)	15-814	0.43%	0.52%	0.48%	0.17%
Reconstructive Breast Surgery	15-815	0.14%	0.17%	0.16%	0.06%
Gynecological Care	15-816	0.09%	0.11%	0.10%	0.04%
Child Wellness	15-817	0.04%	0.05%	0.05%	0.02%
Cleft Lip/Cleft Palate	15-818	0.20%	0.25%	0.23%	0.08%
Second Opinions and Coverage of Outpatient Services	15-819	0.00%	0.00%	0.00%	0.00%
Orthopedic Braces	15-820	0.05%	0.06%	0.05%	0.02%
Temporo-Mandibular Joint Syndrome (TMJ) Treatment	15-821	0.14%	0.17%	0.16%	0.06%
Diabetic Equipment and Supplies	15-822	0.35%	0.42%	0.39%	0.14%
Osteoporosis Prevention and Treatment	15-823	0.00%	0.00%	0.00%	0.00%
Prescription Drugs - Maintenance Drug Coverage	15-824	0.00%	0.00%	0.00%	0.00%
Prostate Cancer Screening	15-825	0.09%	0.11%	0.10%	0.04%
Contraceptives Drugs or Devices	15-826	0.71%	0.87%	0.80%	0.29%
Male sterilization	15-826.2	0.01%	0.01%	0.01%	0.00%
Fertility Awareness-Based Methods	15-826.3	0.00%	0.00%	0.00%	0.00%
Clinical trials	15-827	0.17%	0.21%	0.19%	0.07%
Anesthesia for Dental Care	15-828	0.12%	0.14%	0.13%	0.05%
Chlamydia Screening	15-829	0.00%	0.00%	0.00%	0.00%
Human Papillomavirus Screening Test	15-829	0.01%	0.01%	0.01%	0.00%
Referral to Specialists	15-830	0.00%	0.00%	0.00%	0.00%
Prescription Drugs - Use of Formulary	15-831	0.09%	0.11%	0.10%	0.04%
Surgical Removal of Testicle	15-832	0.00%	0.00%	0.00%	0.00%
Mastectomies	15-832.1	1.25%	1.52%	1.41%	0.51%
Extension of Benefits	15-833	0.00%	0.00%	0.00%	0.00%
Breast Prosthesis	15-834	0.14%	0.17%	0.16%	0.06%
Habilitative Services	15-835	0.80%	0.98%	0.90%	0.33%
Hair Prosthesis	15-836	0.01%	0.01%	0.01%	0.00%
Colorectal screening	15-837	0.64%	0.78%	0.72%	0.26%
Hearing Aids for Minor Children	15-838	0.18%	0.22%	0.20%	0.07%
Morbid Obesity	15-839	0.77%	0.95%	0.87%	0.31%
Mental Health/Substance Misuse Treatment - Residential Crisis Services	15-840	0.00%	0.00%	0.00%	0.00%
Smoking Cessation	15-841	0.00%	0.00%	0.02%	0.01%
Prescription Drugs - Copayment/Coinsurance	15-842	0.00%	0.00%	0.00%	0.00%
Amino Acid	15-843	0.00%	0.00%	0.00%	0.00%
Prosthetic Devices	15-844	0.07%	0.09%	0.08%	0.03%
Ostomy Equipment and Supplies	15-848	0.00%	0.00%	0.00%	0.00%
Prescription Benefits - Abuse-Deterrent Opioid Products	15-849	0.00%	0.00%	0.00%	0.00%
Lymphedema Diagnosis, Evaluation and Treatment	15-853	0.00%	0.00%	0.08%	0.03%
Total		12.1%	14.8%	13.8%	4.9%

Maryland's Department of Labor, Licensing and Regulation (DLLR) estimated the State's 2018 average annual wage at approximately $58,769.[28] This wage was used for all insurance markets.

Table 2b summarizes the full cost of the current mandates as a percentage of the average wage for each of the specified markets. Many of the cost percentages have a minimal impact that rounds to zero (0%). Although we believe that the costs for population morbidity, benefit richness, and medical management will vary by market due to differences in carrier medical management and care coordination, without information from the carriers, we are unable to quantify any such differences. Based on this limitation, the full cost for all markets is 1.4% of the average wage.

[28] Maryland Department of Labor. "Maryland 2018 Occupational Wage Estimates." https://www.dllr.state.md.us/lmi/wages/page0001.htm Retrieved August 21, 2019

Table 2b. - Full Cost of Current Mandates As a Percentage of Wages ($58,769)					
Mandate	Section	Individual	Small Group	Large Group	State Employee Plan
Alzheimer's Disease Treatment	15-801	0.0%	0.0%	0.0%	0.0%
Mental Health/Substance Misuse Treatment - Coverage	15-802	0.3%	0.3%	0.3%	0.3%
Mental Health/Substance Misuse Treatment - Methadone Maintenance Treatment	15-802(d)(5)	0.0%	0.0%	0.0%	0.0%
Blood Products	15-803	0.1%	0.1%	0.1%	0.1%
Prescription Drugs - Off-Label Use	15-804	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Reimbursement for Pharmaceutical Products	15-805	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Choice of Pharmacy	15-806	0.0%	0.0%	0.0%	0.0%
Medical Foods	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%
Infertility Benefits	15-810	0.0%	0.0%	0.0%	0.0%
Fertility Preservation Procedures	15-810.1	0.0%	0.0%	0.0%	0.0%
Pregnancy and Maternity Benefits - Hospitalization Benefits for Child Birth	15-811	0.2%	0.2%	0.2%	0.2%
Pregnancy and Maternity Benefits - Inpatient Hospital Coverage for Mothers and Newborns	15-812	0.0%	0.0%	0.0%	0.0%
Disability Benefits for Disabilities Caused by Pregnancy or Childbirth	15-813	0.0%	0.0%	0.0%	0.0%
Breast Cancer Screening (including mammograms)	15-814	0.0%	0.0%	0.0%	0.0%
Reconstructive Breast Surgery	15-815	0.0%	0.0%	0.0%	0.0%
Gynecological Care	15-816	0.0%	0.0%	0.0%	0.0%
Child Wellness	15-817	0.0%	0.0%	0.0%	0.0%
Cleft Lip/Cleft Palate	15-818	0.0%	0.0%	0.0%	0.0%
Second Opinions and Coverage of Outpatient Services	15-819	0.0%	0.0%	0.0%	0.0%
Orthopedic Braces	15-820	0.0%	0.0%	0.0%	0.0%
Temporo-Mandibular Joint Syndrome (TMJ) Treatment	15-821	0.0%	0.0%	0.0%	0.0%
Diabetic Equipment and Supplies	15-822	0.0%	0.0%	0.0%	0.0%
Osteoporosis Prevention and Treatment	15-823	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Maintenance Drug Coverage	15-824	0.0%	0.0%	0.0%	0.0%
Prostate Cancer Screening	15-825	0.0%	0.0%	0.0%	0.0%
Contraceptives Drugs or Devices	15-826	0.1%	0.1%	0.1%	0.1%
Male sterilization	15-826.2	0.0%	0.0%	0.0%	0.0%
Fertility Awareness-Based Methods	15-826.3	0.0%	0.0%	0.0%	0.0%
Clinical trials	15-827	0.0%	0.0%	0.0%	0.0%
Anesthesia for Dental Care	15-828	0.0%	0.0%	0.0%	0.0%
Chlamydia Screening	15-829	0.0%	0.0%	0.0%	0.0%
Human Papillomavirus Screening Test	15-829	0.0%	0.0%	0.0%	0.0%
Referral to Specialists	15-830	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Use of Formulary	15-831	0.0%	0.0%	0.0%	0.0%
Surgical Removal of Testicle	15-832	0.0%	0.0%	0.0%	0.0%
Mastectomies	15-832.1	0.1%	0.1%	0.1%	0.1%
Extension of Benefits	15-833	0.0%	0.0%	0.0%	0.0%
Breast Prosthesis	15-834	0.0%	0.0%	0.0%	0.0%
Habilitative Services	15-835	0.1%	0.1%	0.1%	0.1%
Hair Prosthesis	15-836	0.0%	0.0%	0.0%	0.0%
Colorectal screening	15-837	0.1%	0.1%	0.1%	0.1%
Hearing Aids for Minor Children	15-838	0.0%	0.0%	0.0%	0.0%
Morbid Obesity	15-839	0.1%	0.1%	0.1%	0.1%
Mental Health/Substance Misuse Treatment - Residential Crisis Services	15-840	0.0%	0.0%	0.0%	0.0%
Smoking Cessation	15-841	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Copayment/Coinsurance	15-842	0.0%	0.0%	0.0%	0.0%
Amino Acid	15-843	0.0%	0.0%	0.0%	0.0%
Prosthetic Devices	15-844	0.0%	0.0%	0.0%	0.0%
Ostomy Equipment and Supplies	15-848	0.0%	0.0%	0.0%	0.0%
Prescription Benefits - Abuse-Deterrent Opioid Products	15-849	0.0%	0.0%	0.0%	0.0%
Lymphedema Diagnosis, Evaluation and Treatment	15-853	0.0%	0.0%	0.0%	0.0%
Total		1.4%	1.4%	1.4%	1.4%

3. Compliance in the Self-Insured Market

This section provides an assessment of the degree to which existing mandated health insurance services are voluntarily covered by self-insured plans.[29] This analysis allows for a comparison of voluntary coverage of services in the self-insured market to coverage of services in the fully-insured market, where the services are mandated by State law.

Private employer self-insured plans are regulated under the Employee Retirement Income Security Act of 1974 (ERISA) rather than State law. Thus, self-insured plans are exempt from State mandates. Public employers, such as federal, state and local government plans are also exempt from State mandates, but these employers are more likely to include these mandates compared to the private employer self-insured plans.

This section examines whether there are mandates that self-insured plans decide to offer. NovaRest developed a survey to compare the benefits of a fully-insured plan with benefits offered by large employers in self-insured plans. The survey addressed self-insured plans' voluntary compliance with the Maryland mandates.

To get a reliable sample, NovaRest surveyed the primary carriers that administer health benefits for their self-insured clients in Maryland. The survey listed Maryland's mandates and asked the health plan administrators to report the rate of compliance and the level of benefits. The administrators were not legally required to respond to the survey. Five administrators responded to the survey, representing more than 57% of covered members in the self-insured market in Maryland,[30] as shown in Table 3a below.

Table 3a Carriers and Covered Members	
Payor	**Covered Members Reported[31]**
CareFirst	969,407
CIGNA	122,048
Group Benefit Services, Inc.	8,000
Harrington Health and Health Plan Services	1,450
The Loomis Company	1,708

The survey asked administrators to categorize, in three categories, the number of employer-sponsored self-insured plans that covered each mandate required in the fully-insured market. The survey included the following categories:

[29] This assessment is required under Md. Code, Insurance Article §15-1502(a)(2)((ii).

[30] Survey responses related to almost 1,103,000 self-insured members. The MIA reported an estimated 1,917,000 covered lives under age 65 in the self-insured market in Maryland as of June 30, 2018. Maryland Insurance Administration, "2018 Report on The Number of Insured and Self-Insured Lives: MSAR # 7797", December 1, 2018, https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2018-Report-on-the-Number-of-Insured-and-Self-Insured-Lives-MSAR7797.pdf

[31] As reported by the carriers that responded to the survey.

- *Usually or always comply* – More than half to all of the employers with self-insured plans choose to cover the mandate.
- *Sometimes comply* – Some but less than 50% of the employers with self-insured plans choose to cover the mandate.
- *Never or seldom comply* – Few or none of the employers with self-insured plans choose to cover the mandate.

NovaRest then assigned percentages to each category and converted the responses to weighted average percentages (with weighting based on the number of covered members). Table 3b shows the extent of voluntary coverage of mandated benefits in the self-insured market in Maryland, based on the survey responses received. No percentage was calculated for mandates that only require that a benefit be offered, not covered.

Most self-insured plans voluntarily cover most of the benefits that are mandated in the fully-insured market. However, the twelve highlighted benefits that are mandated in the fully-insured market are covered less than one-third of the time in the self-insured market in Maryland.

Table 3b - Voluntary Compliance Self-Insured Market (*)		
Subsection	Mandate Description	Compliance Rate
15-801	Alzheimer's Disease Treatment	#N/A
15-802	Mental Health/Substance Misuse Treatment - Coverage	90%
15-802(d)(5	Mental Health/Substance Misuse Treatment - Methadone Maintenance Treatment	83%
15-803	Blood Products	81%
15-804	Prescription Drugs - Off-Label Use	12%
15-805	Prescription Drugs - Reimbursement for Pharmaceutical Products	19%
15-806	Prescription Drugs - Choice of Pharmacy	13%
15-807	Medical Foods	90%
15-808	Home Health Care	90%
15-809	Hospice Care	#N/A
15-810	Infertility Benefits	90%
15-810.1	Fertility Preservation Procedures	90%
15-811	Pregnancy and Maternity Benefits - Hospitalization Benefits for Child Birth	13%
15-812	Pregnancy and Maternity Benefits - Inpatient Hospital Coverage for Mothers and Newborns	11%
15-813	Disability Benefits for Disabilities Caused by Pregnancy or Childbirth	#N/A
15-814	Breast Cancer Screening (including mammograms)	90%
15-815	Reconstructive Breast Surgery	90%
15-816	Gynecological Care	83%
15-817	Child Wellness	90%
15-818	Cleft Lip/Cleft Palate	20%
15-819	Second Opinions and Coverage of Outpatient Services	90%
15-820	Orthopedic Braces	90%
15-821	Temporo-Mandibular Joint Syndrome (TMJ) Treatment	1%
15-822	Diabetic Equipment and Supplies	90%
15-823	Osteoporosis Prevention and Treatment	90%
15-824	Prescription Drugs - Maintenance Drug Coverage	19%
15-825	Prostate Cancer Screening	81%
15-826	Contraceptives Drugs or Devices	90%
15-826.2	Male sterilization	90%
15-826.3	Fertility Awareness-Based Methods	30%
15-827	Clinical trials	90%
15-828	Anesthesia for Dental Care	83%
15-829	Chlamydia Screening	83%
15-829	Human Papillomavirus Screening Test	83%
15-830	Referral to Specialists	83%
15-831	Prescription Drugs - Use of Formulary	90%
15-832	Surgical Removal of Testicle	1%
15-832.1	Mastectomies	81%
15-833	Extension of Benefits	89%
15-834	Breast Prosthesis	90%
15-835	Habilitative Services	83%
15-836	Hair Prosthesis	83%
15-837	Colorectal screening	90%
15-838	Hearing Aids for Minor Children	90%
15-839	Morbid Obesity	90%
15-840	Mental Health/Substance Misuse Treatment - Residential Crisis Services	90%
15-841	Smoking Cessation	1%
15-842	Prescription Drugs - Copayment/Coinsurance	90%
15-843	Amino Acid	81%
15-844	Prosthetic Devices	0%
15-848	Ostomy Equipment and Supplies	90%
15-849	Prescription Benefits - Abuse-Deterrent Opioid Products	90%
15-853	Lymphedema Diagnosis, Evaluation and Treatment	90%

(*) The mandates indicated by #N/A are mandates for benefits that have to be offered rather than covered

4. Marginal Cost as Percentage of Annual Premium

The cost of mandated health insurance services can be analyzed utilizing the full cost of the service or as the marginal cost of the mandate. The marginal cost equals the full cost of the service minus the value of the service that would be covered either because carriers typically cover the service now or, in the individual and small group markets, because the service is covered under the EHB-Benchmark plan. For example, prescription drug coverage is an EHB requirement under federal law and included in the Maryland EHB-Benchmark plan. A general mandate for prescription drug coverage for the individual and small group market would have no marginal cost because this cost is already built into small group and individual plans because of the EHB requirement.[32] However, a hypothetical mandate to cover a specific drug, which is not already required under the general prescription drug EHB requirement, would result in a marginal cost to the plans in these markets.

To calculate the marginal cost of the Maryland mandates, NovaRest made the following assumptions for the mandates that are not included in the EHB-Benchmark plan:

1. Insureds would require a level of coverage that was no less than coverage offered by self-insured plans in Maryland.
2. Insurers would be willing to sell coverage that is similar to the coverage offered by the self-insured plans in Maryland.

These assumptions were used to be consistent with marginal cost calculations included in MHCC's 2012 "Study of Mandated Health Insurance Services: A Comparative Evaluation."

Table 4 shows estimates for the marginal cost of each Maryland mandate as a percent of premium. The marginal cost is displayed separately for the individual, small group, and large group fully-insured markets as well as the State Employee Health Benefit Plans. The marginal cost is the expected portion of cost covered without a mandate times the full cost of the mandate, (refer to Table 2a). The marginal cost for all mandates is less than 0.2% of premium.

The marginal cost of most mandates is 0.00% of premium, since so many mandates are covered by the EHB-Benchmark plan in the small group and individual markets. Of those mandated services that are not covered by the EHB-Benchmark plan, a large percentage of the self-insured plans cover the services, and the full cost of these services is low. The percent of premium for the State Employee plans is less than the percent of premium for the individual, small group, and large group markets due to the relatively high premium for the State employee plans.

[32] Note that this example is not applicable to grandfathered plans in these markets.

Table 4 Marginal Cost of Current Mandates as a Percent of Premium						
Mandate	Section	Expected Portion of Cost Covered Without a Mandate	Percentage of Premium			
			Individual	Small Group	Large Group	State Employee
Mental Health/Substance Misuse Treatment - Coverage	15-802	100%	0.0%	0.0%	0.0%	0.0%
Mental Health/Substance Misuse Treatment - Methadone Maintenance Treatment	15-802(d)(5)	100%	0.0%	0.0%	0.0%	0.0%
Blood Products	15-803	100%	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Off-Label Use	15-804	100%	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Reimbursement for Pharmaceutical Products	15-805	100%	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Choice of Pharmacy	15-806	100%	0.0%	0.0%	0.0%	0.0%
Medical Foods	15-807	100%	0.0%	0.0%	0.0%	0.0%
Home Health Care	15-808	100%	0.0%	0.0%	0.0%	0.0%
Infertility Benefits	15-810	100%	0.0%	0.0%	0.0%	0.0%
Fertility Preservation Procedures	15-810.1	90%	0.0%	0.0%	0.0%	0.0%
Pregnancy and Maternity Benefits - Hospitalization Benefits for Child Birth	15-811	100%	0.0%	0.0%	0.0%	0.0%
Pregnancy and Maternity Benefits - Inpatient Hospital Coverage for Mothers and Newborns	15-812	100%	0.0%	0.0%	0.0%	0.0%
Breast Cancer Screening (including mammograms)	15-814	100%	0.0%	0.0%	0.0%	0.0%
Reconstructive Breast Surgery	15-815	100%	0.0%	0.0%	0.0%	0.0%
Gynecological Care	15-816	100%	0.0%	0.0%	0.0%	0.0%
Child Wellness	15-817	100%	0.0%	0.0%	0.0%	0.0%
Cleft Lip/Cleft Palate	15-818	100%	0.0%	0.0%	0.0%	0.0%
Second Opinions and Coverage of Outpatient Services	15-819	100%	0.0%	0.0%	0.0%	0.0%
Orthopedic Braces	15-820	90%	0.0%	0.0%	0.0%	0.0%
Temporo-Mandibular Joint Syndrome (TMJ) Treatment	15-821	1%	0.1%	0.2%	0.2%	0.1%
Diabetic Equipment and Supplies	15-822	100%	0.0%	0.0%	0.0%	0.0%
Osteoporosis Prevention and Treatment	15-823	100%	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Maintenance Drug Coverage	15-824	100%	0.0%	0.0%	0.0%	0.0%
Prostate Cancer Screening	15-825	100%	0.0%	0.0%	0.0%	0.0%
Contraceptives Drugs or Devices	15-826	100%	0.0%	0.0%	0.0%	0.0%
Male sterilization	15-826.2	100%	0.0%	0.0%	0.0%	0.0%
Fertility Awareness-Based Methods	15-826.3	30%	0.0%	0.0%	0.0%	0.0%
Clinical trials	15-827	100%	0.0%	0.0%	0.0%	0.0%
Anesthesia for Dental Care	15-828	100%	0.0%	0.0%	0.0%	0.0%
Chlamydia Screening	15-829	100%	0.0%	0.0%	0.0%	0.0%
Human Papillomavirus Screening Test	15-829	100%	0.0%	0.0%	0.0%	0.0%
Referral to Specialists	15-830	83%	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Use of Formulary	15-831	90%	0.0%	0.0%	0.0%	0.0%
Surgical Removal of Testicle	15-832	100%	0.0%	0.0%	0.0%	0.0%
Mastectomies	15-832.1	100%	0.0%	0.0%	0.0%	0.0%
Extension of Benefits	15-833	89%	0.0%	0.0%	0.0%	0.0%
Breast Prosthesis	15-834	100%	0.0%	0.0%	0.0%	0.0%
Habilitative Services	15-835	100%	0.0%	0.0%	0.0%	0.0%
Hair Prosthesis	15-836	100%	0.0%	0.0%	0.0%	0.0%
Colorectal screening	15-837	100%	0.0%	0.0%	0.0%	0.0%
Hearing Aids for Minor Children	15-838	100%	0.0%	0.0%	0.0%	0.0%
Morbid Obesity	15-839	100%	0.0%	0.0%	0.0%	0.0%
Mental Health/Substance Misuse Treatment - Residential Crisis Services	15-840	100%	0.0%	0.0%	0.0%	0.0%
Smoking Cessation	15-841	100%	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Copayment/Coinsurance	15-842	100%	0.0%	0.0%	0.0%	0.0%
Amino Acid	15-843	81%	0.0%	0.0%	0.0%	0.0%
Prosthetic Devices	15-844	90%	0.0%	0.0%	0.0%	0.0%
Ostomy Equipment and Supplies	15-848	90%	0.0%	0.0%	0.0%	0.0%
Prescription Benefits - Abuse-Deterrent Opioid Products	15-849	90%	0.0%	0.0%	0.0%	0.0%
Lymphedema Diagnosis, Evaluation and Treatment	15-853	90%	0.0%	0.0%	0.0%	0.0%
Total			0.17%	0.20%	0.19%	0.07%

5. Comparison with Other States

This section contains a comparison of mandated health insurance services provided by the State with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia.[33]

The comparison includes the following:

1. The number of mandated health insurance services.
2. The type of mandated health insurance services.
3. The level and extent of coverage for each mandated health insurance service.
4. The financial impact of different levels of coverage for each mandated health insurance service.

Table 5a summarizes the total number of health benefit mandates in Maryland that are also mandated in Delaware, the District of Columbia, Pennsylvania, and Virginia. (A brief comparison of each State's mandate is included in Appendix II.)

Table 5a - Number of Maryland Mandated Benefits Required by State

State	2019
Delaware	20
District of Columbia	12
Maryland	53[34]
Pennsylvania	15
Virginia	22

For each service that is mandated in Maryland, NovaRest determined if a similar service was mandated in Delaware, the District of Columbia, Pennsylvania, or Virginia, or required under Federal EHB requirements. For each State and service, NovaRest determined if the mandate was more or less generous than Maryland's mandate for that service. NovaRest then determined the full cost and relative value of each mandate in each State relative to Maryland. This comparison is reported in Table 5b. When the value of the Maryland mandate and the mandate in another State is equal, 100% is reported in the "Value Relative to Maryland" column. When the other State does not cover a benefit mandated in Maryland, the "Value Relative to Maryland" equals 0%. Three mandates (coverage for ostomy equipment and supplies; coverage for abuse-deterrent opioid

[33] This comparison is required by Md. Code, Insurance Article § 15–1502(a)(2)(iii).

[34] There are fifty three (53) required health insurance benefits in Maryland codified under Title 15, Subtitle 8 of the Insurance Article but only forty seven (47) of those mandates were included in the scope of this report.

analgesic drug products; and coverage for lymphedema diagnosis, evaluation, and treatment) were added to Maryland law after 2011 and only apply to the large group market in Maryland.[35]

Premiums would be reduced by approximately 3% if the lesser benefit level of each mandate required in the other States were mandated in Maryland. However, since most of these benefits are already covered by the EHB-Benchmark plan, the marginal cost would be $0.

[35] Md. Code, Insurance Article §§ 15-848, 15-849 and 15-853

Table 5b - Percent of Premium Impact to Reduce the Maryland Mandate to Match the Similar Mandated Richness in Other States								
MD Mandate Description	Value Relative to MD Mandate				Cost for Modified Maryland Mandate			
	DE	DC	PA	VA	DE	DC	PA	VA
Alzheimer's Disease Treatment	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Mental Health/Substance Misuse Treatment - Coverage	80%	100%	80%	100%	-0.6%	0.0%	-0.6%	0.0%
Mental Health/Substance Misuse Treatment - Methadone Maintenance Treatment	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Blood Products	0%	0%	0%	100%	-0.6%	-0.6%	-0.6%	0.0%
Prescription Drugs - Off-Label Use	100%	0%	0%	0%	0.0%	-0.3%	-0.3%	-0.3%
Prescription Drugs - Reimbursement for Pharmaceutical Products	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Choice of Pharmacy	0%	0%	0%	100%	0.0%	0.0%	0.0%	0.0%
Medical Foods	100%	0%	100%	0%	0.0%	0.0%	0.0%	0.0%
Home Health Care	0%	0%	10%	0%	0.0%	0.0%	0.0%	0.0%
Hospice Care	0%	0%	0%	100%	0.0%	0.0%	0.0%	0.0%
Infertility Benefits	100%	0%	0%	0%	0.0%	-0.2%	-0.2%	-0.2%
Fertility Preservation Procedures	100%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Pregnancy and Maternity Benefits - Hospitalization Benefits for Child Birth	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Pregnancy and Maternity Benefits - Inpatient Hospital Coverage for Mothers and Newbor	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Disability Benefits for Disabilities Caused by Pregnancy or Childbirth	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Breast Cancer Screening (including mammograms)	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Reconstructive Breast Surgery	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Gynecological Care	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Child Wellness	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Cleft Lip/Cleft Palate	0%	0%	100%	100%	-0.2%	-0.2%	0.0%	0.0%
Second Opinions and Coverage of Outpatient Services	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Orthopedic Braces	100%	0%	0%	0%	0.0%	-0.1%	-0.1%	-0.1%
Temporo-Mandibular Joint Syndrome (TMJ) Treatment	0%	0%	0%	100%	-0.2%	-0.2%	-0.2%	0.0%
Diabetic Equipment and Supplies	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Osteoporosis Prevention and Treatment	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Maintenance Drug Coverage	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Prostate Cancer Screening	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Contraceptives Drugs or Devices	100%	100%	0%	100%	0.0%	0.0%	-0.8%	0.0%
Male sterilization	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Fertility Awareness-Based Methods	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Clinical trials	100%	100%	0%	70%	0.0%	0.0%	-0.2%	-0.1%
Anesthesia for Dental Care	0%	0%	100%	85%	-0.1%	-0.1%	0.0%	0.0%
Chlamydia Screening	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Human Papillomavirus Screening Test	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Referral to Specialists	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Use of Formulary	100%	0%	0%	100%	0.0%	-0.1%	-0.1%	0.0%
Surgical Removal of Testicle	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Mastectomies	0%	0%	50%	100%	-1.4%	-1.4%	-0.7%	0.0%
Extension of Benefits	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Breast Prosthesis	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Habilitative Services	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Hair Prosthesis	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Colorectal screening	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Hearing Aids for Minor Children	90%	0%	0%	0%	0.0%	-0.2%	-0.2%	-0.2%
Morbid Obesity	0%	0%	0%	100%	-0.9%	-0.9%	-0.9%	0.0%
Mental Health/Substance Misuse Treatment - Residential Crisis Services	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Smoking Cessation	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Prescription Drugs - Copayment/Coinsurance	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%
Amino Acid	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Prosthetic Devices	100%	0%	0%	100%	0.0%	-0.1%	-0.1%	0.0%
Ostomy Equipment and Supplies	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Prescription Benefits - Abuse-Deterrent Opioid Products	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%
Lymphedema Diagnosis, Evaluation and Treatment	0%	0%	0%	100%	0.0%	0.0%	0.0%	0.0%
Total					-4%	-4%	-5%	-1%

* Not expressly defined in mandate, EHBs, or benchmark, but generally covered

** Covered under ACA EHBs

Services mandated in other States but not mandated in Maryland include:

- Autism spectrum disorder applied behavior treatment
- Cancer monitoring test
- Coverage for treatment of pediatric autoimmune neuropsychiatric disorders
- Coverage for victims of rape and incest
- Dental services for children with severe disabilities
- Emergency department HIV screening
- Hormone replacement therapy
- Minimum hospital stays for hysterectomy
- Pap smear
- Scalp hair prosthesis as a result of alopecia areata, resulting from an autoimmune disease
- School-based health centers

Table 5c shows the estimated cost, expressed as a percent of premium, to include these mandates in Maryland. The mandates that are highlighted in the table are covered by the EHB-Benchmark plan in Maryland; therefore, covering these benefits in the individual and small group market would have no additional cost. Other benefits mandated in other States may be covered by the Maryland EHB-Benchmark plan; however, NovaRest was unable to precisely determine if these benefits are covered due to the level of detail provided in the EHB-Benchmark plan documentation. If Maryland adopted these 11 additional mandates, the full cost of the mandates in Maryland would increase by up to 0.7% of premium.

Mandates Not Required in MD	Full Cost				Total Change
	DE	DC	PA	VA	
Autism spectrum disorders applied behavior treatment services	0.30%		0.30%	0.30%	0.3%
Cancer monitoring test	0.00%				0.0%
Coverage for treatment of pediatric autoimmune neuropsychiatric disorders	0.12%				0.1%
Coverage for victims of rape and incest				0.00%	0.0%
Dental services for children with severe disabilities	0.10%				0.1%
Emergency department HIV screening		0.01%			0.0%
Hormone replacement therapy		0.01%			0.0%
Minimum hospital stays for hysterectomy				0.13%	0.1%
Pap smear	0.00%	0.00%	0.00%	0.00%	0.0%
Scalp hair prosthesis as a result of alopecia areata, resulting from an autoimmune disease	0.00%				0.0%
School-based health centers	0.00%				0.0%
Total	0.52%	0.02%	0.30%	0.43%	0.7%

A complete description of these mandates can be found in *Appendix II - Mandates Required in Bordering States but Not in Maryland*.

6. Conclusion

Based on our analyses, the cost of providing the Maryland mandated benefits was significant before the ACA required many of the Maryland mandated benefits to be covered.

Because of the ACA coverage, the marginal cost – the extra cost above that which plans are already covering without the mandates, is nearly zero. The ACA, primarily through its EHB requirements, has resulted in non-grandfathered individual and small group plans covering benefits equal to and beyond the Maryland mandated benefits.

The self-insured employer groups cover most of the Maryland mandated benefits to a large extent: from 81% to 90% by membership. There are twelve mandated benefits in the fully-insured market that are covered less than one-third of the time in the self-insured market in Maryland. NovaRest used the percent of self-insured coverage as a substitute for the portion of the market that would cover a mandated benefit in the absence of a mandate.

NovaRest also reviewed the mandated benefits in Delaware, the District of Columbia, Pennsylvania, and Virginia. Comparing the mandates in neighboring states that are similar to Maryland, the degree to which the mandate is covered in Maryland is often richer than in its neighboring states. Maryland has more mandates than the neighboring states but there are eleven (11) mandated benefits in the neighboring states that are not mandated in Maryland. If Maryland matched the mandated benefits of its neighboring states, Maryland could decrease the full cost of the mandates by approximately 2.3% of premium.

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7a. Appendix I - Mandate Overlaps with EHB-Benchmark Plan Detail

Mandate Overlaps with EHB-Benchmark Plan			
Citation	**Mandate Benefit**	**Description of Benefit (Maryland)**	**EHB Description**
15-801	**Alzheimer's Disease Treatment**	This optional benefit covers expenses arising from the care of individuals with Alzheimer's Disease and includes nursing home care and intermediate or custodial nursing care. Only group insurers and nonprofit health service group plans must offer this coverage.	Optional benefit only required to be offered
15-802	**Mental Health/ Substance Misuse Treatment - Coverage**	*Coverage* – Coverage shall be provided for at least the following benefits for the diagnosis and treatment of a mental illness, emotional disorder, drug use disorder or alcohol use disorder: (1) Inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient and residential treatment center benefits; (2) Partial hospitalization benefits (min 60 days) (period less than 24 hours but more than 4 hours in day); and (3) Outpatient and intensive outpatient benefits, including all office visits, diagnostic evaluation, opioid treatment services, medication evaluation and management, and psychological and neuropsychological testing for diagnostic purposes.	A. Professional services by licensed, registered, or certified professional mental health and substance use practitioners when acting within the scope of their license, registration, or certification. Services include: (1) Diagnostic evaluation; (2) Crisis intervention and stabilization for acute episodes; (3) Medication evaluation and management (pharmacotherapy); (4) Treatment and counseling (including individual or group therapy visits); (5) Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling; (6) Professional charges for intensive outpatient treatment in a provider's office or other professional setting; (7) Electroconvulsive therapy; (8) Inpatient professional fees; (9) Outpatient diagnostic tests provided and billed by a licensed, registered, or certified mental health and substance abuse practitioner; (10)Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility; (11)Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment. B. Inpatient hospital and inpatient residential treatment centers services, which includes: (1) Room and board, such as: (i) Ward, semi-private, or intensive care accommodations (Private room is covered only if medically necessary. If private room is not medically necessary, the contract covers only the hospital's average charge for semiprivate accommodations.); (ii) General nursing care; (iii)Meals and special diets. (2) Other facility services and supplies—services provided by a hospital or residential treatment center. C. Outpatient—services such as partial hospitalization or intensive day treatment

			programs. D. Emergency room—Outpatient services and supplies billed by a hospital for emergency room treatment. Although Federal law does not require a plan to provide coverage for mental health benefits, when such coverage is provided, the Mental Health Parity Act generally requires that the mental health benefits not be more restrictive than medical and surgical benefits provided under the plan.
15-802(d)(5)	**Mental Health/Substance Misuse Treatment - Methadone Maintenance Treatment**	*Methadone Maintenance Treatment* – a copayment that is greater than 50% of the daily cost for methadone maintenance treatment may not be charged.	Methadone maintenance covered with no copayment or coinsurance
15-803	**Blood Products**	Payment for blood products, other than whole blood or concentrated red blood cells, may not be excluded.	All cost recovery expenses for blood, blood derivatives, components, biologics, and serums, to include autologous services, whole blood, red blood cells, plasma, immunoglobin and albumin

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-804	**Prescription Drugs - Off-Label Use**	*Off-Label Use of Drugs* – A policy or contract that provides coverage for drugs may not exclude coverage of a drug for an off-label use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug.	Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst BlueChoice
15-805	**Prescription Drugs - Reimbursement for Pharmaceutical Products**	*Reimbursement for Pharmaceutical Products* – If a policy provides reimbursement for a pharmaceutical product (i.e. a drug or medicine prescribed by an authorized prescriber), it cannot establish varied reimbursement based on the type of prescriber and cannot request different copayments, deductibles, or any other condition when a community pharmacy is utilized rather than a mail order program. A policy issued to an employer under a collective bargaining agreement is not required to include this benefit.	Covers prescriptions written by authorized prescriber.
15-806	**Prescription Drugs - Choice of Pharmacy**	*Choice of Pharmacy.* A nonprofit health service plan is required to allow the member to fill prescriptions at the pharmacy of choice.	If the Member purchases a covered Prescription Drug from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. Except in cases of Emergency Services or Urgent Care received outside of the Service Area, the difference between the non-Contracting Pharmacy's actual charge and the Prescription Drug Allowed Benefit is a non-covered service
15-807	**Medical Foods**	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 for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-808	**Home Health Care**	Health insurance policies that provide coverage for inpatient hospital care on an expense-incurred basis must provide coverage for home health care if institutionalization would have been required without the use of home health care. The carrier may limit visits to 40 visits in any calendar year; up to 4 hours of home health care services is considered one home health care visit. The service provider must be licensed under the Health Occupations Article.	Home Health Care or Home Health Care Services means the continued care and treatment of a Member in the home by a licensed Home Health Agency if: A. The institutionalization of the Member in a hospital or related institution, or Skilled Nursing Facility would otherwise have been required if Home Health Care Services were not provided; and B. The Plan of Treatment covering the Home Health Care Service is established and approved in writing by the health care provider, and determined to be Medically Necessary by CareFirst BlueChoice. Home Health Care Visits mean: A. Each visit by a member of a Home Health Care team is considered one (1) Home Health Care Visit; and B. Up to four (4) hours of Home Health Care Service is considered one (1) Home Health Care Visit.
15-809	**Hospice Care**	This optional benefit covers the services of hospice, a coordinated care program for people who are dying and their family members. By law, all health carriers are required to offer this benefit.	Optional benefit only required to be offered

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-810	**Infertility Benefits**	In Vitro Fertilization – Carriers that provide pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from IVF procedures. · For insurers and nonprofit health service plans, benefits provided must be the same as for other pregnancy-related procedures. · For HMOs, the benefits provided must be the same as provided for other infertility services. · For all insurers, nonprofit health service plans and HMOs that provide infertility benefits, the coverage must be provided: (a) for a patient whose spouse is of the opposite sex, the patient's oocytes are fertilized with the patient's spouse's sperm; unless: ▪ the patient's spouse is unable to produce and deliver functional sperm; and ▪ the inability to produce and deliver functional sperm does not result from: - a vasectomy; or - another method of voluntary sterilization; (b) the patient and the patient's spouse have a history of involuntary infertility, which may be demonstrated by a history of: ▪ If the patient and the patient's spouse are of opposite sexes, intercourse of at least 2 years' duration failing to result in pregnancy; or ▪ If the patient and the patient's spouse are of the same sex, six attempts of artificial insemination over the course of 2 years failing to result in pregnancy. (c) the infertility is associated with any of the following medical conditions: ▪ Endometriosis; ▪ Exposure in utero to diethylstilbestrol, commonly known as DES; ▪ Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or ▪ Abnormal male factors, including oligospermia, contributing to the infertility. (d) the patient has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy or contract; and (e) the procedure must be performed at medical facilities that meet the minimum guidelines for in vitro fertilization established by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine. · Carriers may limit the benefit to $100,000 per lifetime and three attempts per live birth. · Carriers are not responsible for any cost incurred by the patient or the patient's spouse in obtaining donor sperm.	Artificial & Intrauterine Insemination. Limited to 6 attempts per live birth.

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-810.1	**Fertility Preservation Procedures**	Coverage for "standard fertility preservation procedures" that are medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility. Standard fertility preservation procedures are those that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Gynecologists, or the American Society of Clinical Oncology. Coverage includes sperm/oocyte cryopreservation and associated laboratory assessments, medications, and treatments, but does not include the storage of sperm or oocytes. Health coverage provided through a religious organization may exclude this mandated health benefit if it conflicts with the organizations *bona fide* religious beliefs and practices.	
15-811	**Pregnancy and Maternity Benefits - Hospitalization Benefits for Child Birth**	*Hospitalization Benefits for Child Birth* – Every insurance policy that provides hospitalization benefits for normal pregnancy must provide hospitalization benefits to the same extent as that for any covered illness. In addition, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, the insurer or nonprofit health service plan must pay the cost of additional hospitalization for the newborn for up to 4 days.	Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, coverage includes additional hospitalization for the newborn for up to four (4) days.
15-812	**Pregnancy and Maternity Benefits - Inpatient Hospital Coverage for Mothers and Newborns**	*Inpatient Hospital Coverage for Mothers and Newborns* – Requires carriers that provide inpatient hospitalization coverage on an expense-incurred basis 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; if the mother requests a shorter hospital stay, the carrier must provide coverage for one home visit by a registered nurse within 24 hours after discharge from the hospital, and if prescribed by the attending provider, an additional home visit.	Coverage will be provided for a minimum hospital stay of not less than: 1. Forty-eight (48) hours for both the mother and newborn following a routine vaginal delivery; and 2. Ninety-six (96) hours for both the mother and newborn following a routine cesarean section.

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-813	**Disability Benefits for Disabilities Caused by Pregnancy or Childbirth**	Insurers offering group policies that provide benefits for temporary disability must offer the policyholder the option to purchase coverage for temporary disability caused or contributed by pregnancy or childbirth.	Optional benefit only required to be offered
15-814	**Breast Cancer Screening (including mammograms)**	Coverage for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. Coverage shall include digital tomosynthesis that, under accepted standards in the practice of medicine, the treating physician determines is medically appropriate and necessary for an enrollee or insured. This may include screening mammograms. A copayment or coinsurance requirement for digital tomosynthesis may not be greater than a copayment or coinsurance requirement for other breast cancer screenings for which coverage is required.	Covers with no cost sharing , evidence–based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force: The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older with a B recommendation.
15-815	**Reconstructive Breast Surgery**	Coverage for reconstructive breast surgery resulting from a mastectomy to reestablish symmetry between the two breasts. Coverage includes surgery on the nondiseased breast to establish symmetry when reconstructive breast surgery is performed on the diseased breast. Coverage of physical complications of all stages of mastectomy, including lymphedemas, is also mandatory.	Includes (1) reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast; and (2) physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient.
15-816	**Gynecological Care**	Requires that an obstetrician/gynecologist may be classified as a primary care provider or that a woman may receive services from an in-network obstetrician/gynecologist without first requiring a visit to a primary care provider for routine care. In the instances where the patient belongs to a health plan that requires the member to receive a referral prior to receiving treatment from a specialist, the law provides that women must 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.	Benefits are available for Medically Necessary and preventive gynecological care.

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-817	**Child Wellness**	Requires coverage of certain preventative services, including well child visits, immunizations and screening tests for hearing, vision, tuberculosis, anemia and lead toxicity. For newborns, coverage of hereditary and metabolic screening also included.	Covered with no cost sharing (deductibles, copayment amounts or cost-sharing). (1) Except as provided below, evidence–based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; (2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; (3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
15-818	**Cleft Lip/Cleft Palate**	Coverage for inpatient or outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological, and speech/language treatment involved in the management of cleft lip and/or cleft palate.	Coverage for health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. For children up until the end of the month in which they turn 19 years old, includes medically necessary services for cleft lip and cleft palate, orthodontics, oral surgery, otologic, audiological, and speech therapy, physical therapy, and occupational therapy
15-819	**Second Opinions and Coverage of Outpatient Services**	If the policy provides coverage for an inpatient service in an acute general hospital, and coverage for an inpatient admission is denied, the carrier must cover the expenses of: (1) Corresponding outpatient service that is provided to the insured instead of the inpatient service; and (2) An objective second opinion, given to the insured when requested by a utilization review program under § 19-319 of the Health-General Article.	If the Member disagrees with a prescribed course of treatment, the Member shall be permitted to receive a second opinion from another Contracting Physician. If the second physician disagrees with the prescribed course of treatment, CareFirst BlueChoice may not refuse to provide services or benefits for that particular condition, subject to this [In-Network] Evidence of Coverage and CareFirst BlueChoice's utilization review protocols and policies.
15-820	**Orthopedic Braces**	Each health insurance contract that is delivered or issued for delivery in the State by a nonprofit health service plan and that provides hospital benefits shall provide benefits for orthopedic braces.	
15-821	**Temporo-Mandibular Joint Syndrome (TMJ) Treatment**	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. Coverage for intraoral prosthetic devices is not mandatory.	Benefits include: Medically Necessary surgical treatment, as determined by CareFirst BlueChoice, for Temporomandibular Joint Syndrome (TMJ). Except as provided in Section 2, Pediatric Dental Services, all other treatments or procedures for the treatment of TMJ are excluded.

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-822	**Diabetic Equipment and Supplies**	Coverage for all medically appropriate and necessary diabetes equipment, diabetic supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy necessary for the treatment of insulin-using diabetes; noninsulin-using diabetes; elevated or impaired blood glucose levels induced by pregnancy; or consistent with the American Diabetes Association's standards, elevated or impaired blood glucose levels induced by prediabetes. A deductible, copayment, or coinsurance requirement on diabetes test strips may not be imposed; however, if an insured or enrollee is covered under a high-deductible health plan, may subject diabetes test strips to the deductible requirement of the high-deductible health plan.	Diabetes equipment includes glucose monitoring equipment under the durable medical equipment coverage for insulin using beneficiaries. Insulin pumps are included. Diabetes supplies include coverage for insulin syringes and needles and testing strips for glucose monitoring equipment under the prescription coverage for insulin-using beneficiaries.
15-823	**Osteoporosis Prevention and Treatment**	Coverage for qualified individuals for reimbursement for bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a health care provider for the qualified individual.	Benefits for Bone Mass Measurement for the prevention, diagnosis, and treatment of osteoporosis are covered when requested by a health care provider for a Qualified Individual.
15-824	**Prescription Drugs - Maintenance Drug Coverage**	*Maintenance Drug Coverage* – 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. An insured or enrollee who is a resident of a nursing home is not entitled to this mandatory benefit.	Includes prescription drugs and insulin. Must permit a 90- day supply for a maintenance drug (except for first prescription of the maintenance drug).
15-825	**Prostate Cancer Screening**	Coverage for the expenses incurred in conducting a medically-recognized diagnostic examination including a digital rectal exam and prostate-specific antigen (PSA) test for: (1) Men between 40 and 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.	Prostate Cancer Screening. Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal exams: a) For men who are between forty (40) and seventy-five (75) years of age; b) When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; c) When used for staging in determining the need for a bone scan for patients with prostate cancer; or, d) When used for male Members who are at high risk for prostate cancer.

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-826	**Contraceptives Drugs or Devices**	This mandate only applies to individuals that have prescription coverage. Coverage of FDA-approved drugs or devices that are prescribed for use as a contraceptive. Coverage for the insertion or removal of contraceptive devices as well as any medically necessary examination associated with the use of a contraceptive drug or device. Health coverage provided through a religious organization may exclude this mandated health benefit if it conflicts with the organizations *bona fide* religious beliefs and practices.	Includes: (a) Prescription contraceptive drugs or devices; (b) Coverage for the insertion or removal of contraceptive devices; (c) Medically necessary examination associated with the use of contraceptive drugs or devices; and (d) Voluntary sterilization.
15-826.2	**Male sterilization**	Coverage for male sterilization. No deductible, copayment, or coinsurance requirement may be imposed unless it is a grandfathered plan. If it is a high-deductible health plan, the benefit may be subject to the deductible requirement of the high-deductible health plan. Health coverage provided through a religious organization may exclude this mandated health benefit if it conflicts with the organizations *bona fide* religious beliefs and practices.	Includes: (d) Voluntary sterilization.
15-826.3	**Fertility Awareness-Based Methods**	Coverage for instruction by a licensed health care provider on fertility awareness-based methods which can be used to identify times of fertility and infertility by an individual to avoid pregnancy.	Although this is not specifically described in the benchmark plan, the ACA preventive care essential health benefit covers this.
15-827	**Clinical trials**	Coverage for patient cost for participation in a clinical trial approved by specified institutions including National Institutes of Health, U.S. Food and Drug Administration or the U.S. Department of Veteran's Affairs, for treatment provided for a life-threatening condition, or prevention, early detection and treatment studies on cancer.	"Controlled clinical trial" means a treatment that is: (a) Approved by an institutional review board; (b) Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and (c) Approved by: (i) An institute or center of the National Institutes of Health, (ii) The U.S. Food and Drug Administration, (iii) The U.S. Department of Veterans' Affairs, (iv) The U.S. Department of Defense; (v) The Centers for Disease Control and Prevention; (vi) The Agency for Health Care Research and Quality; (vii) The Centers for Medicare and Medicaid Services; (viii) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or (ix) The U.S. Department of Energy

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-828	**Anesthesia for Dental Care**	Limited coverage for individuals age 7 or younger or individuals with developmental disabilities for general anesthesia and associated hospital or ambulatory charges in conjunction with dental care when a successful result cannot be expected without anesthesia.	General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to the following: (a) Individuals who are 7 years old or younger or developmentally disabled and for whom a: (i) Successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or insured; and (ii) Superior result can be expected from dental care provided under general anesthesia; (b) Individuals 17 years old or younger who: (i) Are extremely uncooperative, fearful, or uncommunicative; (ii) Have dental needs such as magnitude that treatment should not be delayed or deferred; and (iii) Are individuals for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity
15-829	**Chlamydia Screening**	Coverage for annual screening Chlamydia for sexually active women under the age of 20, and for men and women 20 years and older who have multiple risk factors.	Covers with no cost sharing , evidence–based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force: The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection with a B recommendation.
15-829	**Human Papillomavirus Screening Test**	Coverage for annual screening for Human Papillomavirus for sexually active women under the age of 20, and for men and women 20 years and older who have multiple risk factors.	Covers with no cost sharing , evidence–based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force: The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting) with an A recommendation.
15-830	**Referral to Specialists**	Requires carriers that do not allow direct access to specialists to establish and implement a procedure by which a member may receive, under certain circumstances, a standing referral to a participating specialist and under certain circumstances to a non-participating specialist (including a physician or nonphysician specialist); provides pregnant members with a standing referral to an obstetrician.	

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-831	**Prescription Drugs - Use of Formulary**	*Use of Formulary* – Each entity limiting its coverage of Rx drugs or devices to those in a formulary shall establish & implement a procedure by which a member can 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, or an equivalent Rx drug listed on the entity's formulary is ineffective or has caused an adverse reaction.	
15-832	**Surgical Removal of Testicle**	Coverage for at least 1 home health visit within 24 hours after discharge for a patient who had less than 48 hours of inpatient hospitalization after surgical removal of a testicle, or who undergoes the procedure on an outpatient basis and an additional visit must be covered if ordered by the treating physician.	Covered as an alternative to otherwise covered services in a hospital or other related institution. Also includes for covered persons who receive less than 48 hours of inpatient hospitalization following a mastectomy or removal of a testicle or who undergo a mastectomy or removal of a testicle on an outpatient basis: (a) One home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and (b) An additional home visit if prescribed by the covered person's attending physician.
15-832.1	**Mastectomies**	Coverage for a minimum 48-hour inpatient hospital stay following a mastectomy. The patient may request a shorter length of stay. A carrier must provide a patient that receives less than a 48 hour stay, or who undergoes a mastectomy on an outpatient basis, one home visit scheduled to occur within 24 hours after discharge and an additional home visit if prescribed.	Covered as an alternative to otherwise covered services in a hospital or other related institution. Also includes for covered persons who receive less than 48 hours of inpatient hospitalization following a mastectomy or removal of a testicle or who undergo a mastectomy or removal of a testicle on an outpatient basis: (a) One home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and (b) An additional home visit if prescribed by the covered person's attending physician.
15-833	**Extension of Benefits**	Unless coverage is terminated due to non-payment or fraud or misrepresentation, requires carriers that provide benefits on an expense incurred basis to extend certain benefits according to the terms of the policy. Charging of premiums is prohibited when benefits are extended.	
15-834	**Breast Prosthesis**	Coverage for a prosthesis prescribed by a physician where the member has had a mastectomy but has not had reconstructive surgery.	Includes (1) reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast; and (2) physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient.

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-835	**Habilitative Services**	Coverage for services and devices, including occupational therapy, physical therapy, and speech therapy, that help a child keep, learn, or improve skills and functioning for daily living. Coverage must be kept in effect until the end of the month in which the child turns 19 years old. Coverage is not required for services delivered through early intervention or school services.	Coverage for health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. For children up until the end of the month in which they turn 19 years old, includes medically necessary services for cleft lip and cleft palate, orthodontics, oral surgery, otologic, audiological, and speech therapy, physical therapy, and occupational therapy. Coverage for health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. For adults (those 19 and older), covers outpatient habilitative services provided through a carrier's managed care system; or when provided by a federally qualified health maintenance organization, the outpatient rehabilitation service coverage specified in 42 CFR §417.101(a)(2)(iii).
15-836	**Hair Prosthesis**	Coverage for a hair prosthesis where the hair loss results from chemotherapy or radiation treatment for cancer and when prescribed by the treating oncologist. The coverage is for one prosthesis and the benefit may be limited to $350.	Hair Prostheses for covered persons whose hair loss results from chemotherapy or radiation treatment for cancer
15-837	**Colorectal screening**	Coverage for colorectal screening.	Covers with no cost sharing , evidence–based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force: The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years with an A recommendation.
15-838	**Hearing Aids for Minor Children**	Coverage for hearing aids for a child under the age of 19 years that are prescribed, fitted and dispensed by a licensed audiologist. The benefit may be limited to $1,400 per hearing aid for each impaired ear every 36 months; an insured or enrollee can choose a more expensive unit and pay the difference between the actual cost and benefit maximum if she or he so elects.	Covered for each hearing-impaired ear, every 36 months
15-839	**Morbid Obesity**	Coverage for surgical treatment that is: (1) Recognized by the National Institutes of Health as effective for the long- term reversal of morbid obesity; and (2) Consistent with guidelines approved by the National Institutes of Health. Coverage must be to the same extent as for other medically necessary surgical procedures under the policy.	Surgical treatment of morbid obesity

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-840	**Mental Health/Substance Misuse Treatment - Residential Crisis Services**	*Residential Crisis Services* – Coverage for medically necessary residential crisis services, defined as intensive mental health and support services: (1) Provided to a child or an adult with a mental illness who is experiencing or is 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 out of the individual's residence in a community-based residential setting; and (4) Provided by DHMH-licensed entities.	A. Professional services by licensed, registered, or certified professional mental health and substance use practitioners when acting within the scope of their license, registration, or certification. Services include: (1) Diagnostic evaluation; (2) Crisis intervention and stabilization for acute episodes; (3) Medication evaluation and management (pharmacotherapy); (4) Treatment and counseling (including individual or group therapy visits); (5) Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling; (6) Professional charges for intensive outpatient treatment in a provider's office or other professional setting; (7) Electroconvulsive therapy; (8) Inpatient professional fees; (9) Outpatient diagnostic tests provided and billed by a licensed, registered, or certified mental health and substance abuse practitioner; (10)Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility; (11)Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment. B. Inpatient hospital and inpatient residential treatment centers services, which includes: (1) Room and board, such as: (i) Ward, semi-private, or intensive care accommodations (Private room is covered only if medically necessary. If private room is not medically necessary, the contract covers only the hospital's average charge for semiprivate accommodations.); (ii) General nursing care; (iii)Meals and special diets. (2) Other facility services and supplies—services provided by a hospital or residential treatment center. C. Outpatient—services such as partial hospitalization or intensive day treatment programs. D. Emergency room—Outpatient services and supplies billed by a hospital for emergency room treatment.
15-841	**Smoking Cessation**	Plans that provide prescription coverage must provide coverage for any drug that is not an over-the-counter product which is approved by the FDA as an aid for the cessation of the use of tobacco products; and is obtained under a prescription written by an authorized prescriber. The plan must also provide coverage for two 90-day courses of nicotine replacement therapy during each policy year. Copayments or coinsurance amounts for drugs provided must be the same as that for comparable prescriptions.	Benefits will be provided for Prescription Drugs, including but not limited to: Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preferred Preventive Drug List.

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-842	**Prescription Drugs - Copayment/Coinsurance**	*Copayment/Coinsurance* – Carriers may not impose a copayment or coinsurance that exceeds the retail price.	Prescription Drug Allowed Benefit means the lesser of: A. The Pharmacy's actual charge; or B. The benefit amount, according to the CareFirst BlueChoice fee schedule, for covered Prescription Drugs that applies on the date that the service is rendered.
15-843	**Amino Acid**	Coverage for amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of: (I) Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; (II) Severe food protein induced Enterocolitis Syndrome; (III) Eosinophilic disorders, as evidenced by the results of a biopsy; and (IV) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. Provided that the ordering physician issues a written order that states the amino acid-based elemental formula is medically necessary for treatment of one of the above listed diseases or disorders.	
15-844	**Prosthetic Devices**	Coverage for prosthetic devices, components of prosthetic devices and repairs to prosthetic devices. Copayment and coinsurance requirements for these devices may not be higher than those required for any primary care benefit. No annual or lifetime dollar maximum on coverage for the device can be applied that is separate from the aggregate maximum applicable total benefit.	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
15-848	**Ostomy Equipment and Supplies**	Coverage for all medically appropriate and necessary equipment and supplies used for the treatment of ostomies, including flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts, and catheters used for drainage of urostomies. The annual deductibles or coinsurance requirements may not be greater than the annual deductibles or coinsurance requirements for similar coverages.	

Citation	Mandate Benefit	Description of Benefit (Maryland)	EHB Description
15-849	**Prescription Benefits - Abuse-Deterrent Opioid Products**	Coverage or Abuse-Deterrent Opioid Analgesic Drug Products – A policy or contract that provides coverage for prescription drugs shall provide coverage for: 1. At least two brand name abuse-deterrent opioid analgesic drug products, each containing different analgesic ingredients, on the lowest cost tier for brand name prescription drugs on the entity's formulary for prescription drug coverage; and 2. If available, at least two generic abuse-deterrent opioid analgesic drug products, each containing different analgesic ingredients, on the lowest cost tier for generic drugs on the entity's formulary for prescription drug coverage. Carriers may not require an insured or an enrollee to first use an opioid analgesic drug product without abuse-deterrent labeling before providing coverage for an abuse- deterrent opioid analgesic drug product covered on the entity's formulary for prescription drug coverage. Carriers may undertake utilization review, including preauthorization, for an abuse- deterrent opioid analgesic drug product covered by the carrier, if the same utilization review requirements are applied to non-abuse-deterrent opioid analgesic drug products covered by the carrier in the same formulary tier as the abuse-deterrent opioid analgesic product.	
15-853	**Lymphedema Diagnosis, Evaluation and Treatment**	Coverage for the medically necessary diagnosis, evaluation, and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education. **The annual deductible, copayment or coinsurance requirements imposed may not be more than those imposed for similar coverages**.	Only covered when complication from mastectomy

7b. Appendix II – Required in Bordering States but Not Required in Maryland

Delaware		
Mandate	Description	Statutory Citation
Autism	(a) All individual health benefit plans as defined in § 3343(a) and all group and blanket health benefit plans as defined in § 3578(a) of this title shall provide coverage for the screening and diagnosis of autism spectrum disorders and the treatment of autism spectrum disorders in individuals less than 21 years of age. To the extent that the diagnosis of autism spectrum disorders and the treatment of autism spectrum disorders are not already covered by a health benefit plan, coverage under this section shall be included in health benefit plans that are delivered, issued, executed or renewed in this State pursuant to this title after December 11, 2012. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual or a family member is diagnosed with 1 of the autism spectrum disorders or has received treatment for autism spectrum disorders. Coverage under this section shall not be denied on the basis that the treatment is habilitative or nonrestorative in nature. (b) Coverage for applied behavior analysis services under this section by an insurer shall be subject to a maximum benefit of $36,000 per 12-month period per person, but shall not be subject to any limits on the number of visits an individual may make to an autism services provider or that a provider may make to an individual regardless of the locations in which services are provided. After December 31, 2012, the Insurance Commissioner shall, on or before April 1 of each calendar year, publish in the Delaware Register of Regulations an adjustment to the maximum benefit equal to the change in the United States Department of Labor Consumer Price Index for all Urban Consumers (CPI-U) in the preceding year and the published adjusted maximum benefit shall be applicable to all health insurance policies issued or renewed thereafter. Payments made by an insurer on behalf of a covered individual for treatment unrelated to applied behavior analysis shall not be applied toward any maximum benefit established under this subsection. (c) The coverage required under this section shall not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the health benefit plan, except as otherwise provided in subsection (b) of this section. (d) This section shall not be construed as limiting benefits that are otherwise available to an individual or family member under their health benefit plan.	18 Del. C. §3366 18 Del. C. §3570A

Mandate	Description	Statutory Citation
Cancer monitoring test	Every individual health, sickness or accident insurance policy, contract or certificate, and all group and blanket health insurance policies which is delivered or issued for delivery in this State by any health insurer, health service corporation or health maintenance organization, and which provide benefits for outpatient services, shall provide to covered persons residing in this State a benefit for CA-125 monitoring of ovarian cancer subsequent to treatment. Such monitoring shall be deemed a covered service, notwithstanding any policy exclusions for services which are considered experimental or investigative; provided however, that nothing contained herein shall be deemed to provide coverage for routine screening.	18 Del. C. §3338 18 Del. C. §3555
Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome	(a) All individual/group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State by any health insurer, health service corporation, or health maintenance organization shall provide coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.	18 Del. C. §3370B 18 Del. C. §3571T
Dental services for children with severe disabilities	This mandate authorizes payment to a licensed practitioner for dental services to a child with a severe disability irrespective of lack of contractual or network status. Unless otherwise negotiated with the practitioner in advance, such payment shall be in an amount at least equal to the insurer's reasonable and customary compensation for the same or similar services in the same geographical area. This section applies to every group or blanket health insurance contract, including each policy or contract issued by a health service corporation, which is delivered, issued for delivery, or renewed in this State which provides coverage for dental services for a child.	18 Del. C. §3571C 18 Del. C. §3358

Mandate	Description	Statutory Citation
Pap smear	All individual/group and blanket health insurance policies which are delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization or any health services and facilities reimbursement program operated by the State and which provide a benefit for outpatient services shall also provide a benefit for an annual benefit for 1 cervical cancer screening, known as a “pap smear,” for all females aged 18 and over.	18 Del. C. §3345 18 Del. C. §3552 18 Del. C. §3561
Scalp hair prosthesis	Every individual/group and blanket health insurance policy, contract or certificate that is delivered or issued for delivery in this State by any health insurer, health service corporation or managed care organization which provide for medical or hospital expenses and also provide coverage for other prostheses, shall provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. Such coverage shall be subject to the same limitations and guidelines as other prostheses, provided that such coverage for alopecia areata shall not exceed $500 per year	18 Del. C. §3356 18 Del. C. §3571B
School-based health centers	Benefits provided under insurance contracts delivered, issued for delivery, or renewed in this State shall reimburse SBHCs for covered services provided by SBHCs as if those services were provided by a network provider under the relevant contract of insurance. In the absence of an agreement between a carrier and an SBHC on reimbursement, reimbursement for such services shall be at the rate established by the Division of Medicaid and Medical Assistance for those services. Any insurance contract term purporting to exclude otherwise covered services on the basis that they are performed by an SBHC shall be void except as specifically permitted under this chapter.	18 Del. C. §3365 18 Del. C. §3571G

District of Columbia		
Mandate	Description	Statutory Citation
Emergency department HIV screening.	Under this mandate insured patients in the District have the right to a free voluntary HIV screening test while be treated in the emergency room regardless of what they are being treated for.	Chapter 28, § 31-2803
Hormone replacement therapy	An individual or group health plan, and a health insurer offering health care coverage that provides coverage for prescription drugs, shall provide benefits which cover any hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause	Chapter 38A, § 31-3834

Pennsylvania		
Mandate	Description	Statutory Citation
Autism spectrum disorders	(a) A health insurance policy or government program covered under this section shall provide to covered individuals or recipients under twenty-one (21) years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders. (b) Coverage provided under this section by an insurer shall be subject to a maximum benefit of thirty-six thousand dollars ($36,000) per year but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders. After December 30, 2011, the Insurance Commissioner shall, on or before April 1 of each calendar year, publish in the Pennsylvania Bulletin an adjustment to the maximum benefit equal to the change in the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U) in the preceding year, and the published adjusted maximum benefit shall be applicable to the following calendar years to health insurance policies issued or renewed in those calendar years. Payments made by an insurer on behalf of a covered individual for treatment of a health condition unrelated to or distinguishable from the individual's autism spectrum disorder shall not be applied toward any maximum benefit established under this subsection. (c) Coverage under this section shall be subject to copayment, deductible and coinsurance provisions and any other general exclusions or limitations of a health insurance policy or government program to the same extent as other medical services covered by the policy or program are subject to these provisions. (d) This section shall not be construed as limiting benefits which are otherwise available to an individual under a health insurance policy or government program.	40 P.S. § 764h

Virginia		
Mandate	Description	Statutory Citation
Coverage for autism spectrum disorder	Notwithstanding the provisions of § 38.2-3419 and any other provision of law, each insurer proposing to issue accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall, as provided in this section, provide coverage for the diagnosis of autism spectrum disorder and the treatment of autism spectrum disorder, in individuals (i) from January 1, 2012, until January 1, 2016, from age two years through age six years; (ii) from January 1, 2016, until January 1, 2020, from age two years through age 10 years; and (iii) from and after January 1, 2020, of any age, subject to the annual maximum benefit limitation set forth in subsection K and to the provisions of subsection G. If an individual who is being treated for autism spectrum disorder becomes older than the applicable maximum age set forth in the preceding sentence and continues to need treatment, this section does not preclude coverage of treatment and services. In addition to the requirements imposed on health insurance issuers by § 38.2-3436, an insurer shall not terminate coverage or refuse to deliver, issue, amend, adjust, or renew coverage of an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder.	§ 38.2-3418.17
Minimum hospital stays for hysterectomy	This mandate provides coverage for laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy as provided in this section. Such coverage shall include benefits for a minimum stay in the hospital of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. Nothing in this subsection shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the patient, determines that a shorter period of hospital stay is appropriate.	§38.2-3418.9
Coverage of dependent children	Any group or individual accident and sickness insurance policy or subscription contract delivered or issued for delivery in this Commonwealth which provides that coverage of a dependent child shall terminate upon that child's attainment of a specified age, shall also provide in substance that attainment of the specified age shall not terminate the child's coverage during the continuance of the policy while the dependent child is and continues to be both: (i) incapable of self-sustaining employment by reason of intellectual disability or physical handicap, and (ii) chiefly dependent upon the policyowner for support and maintenance.	§ 38.2-3409

7c. Appendix III – Glossary

Fully-Insured Plan: A plan where the employer contracts with another organization to assume financial responsibility (or risk) for the enrollees' medical claims and for all incurred administrative costs.[36]

Grandfathered Plan: A health insurance policy in the individual or small group market in which an individual was enrolled on March 23, 2010 and which has not made certain significant changes that reduce benefits or increase costs to consumers since that time. These plans may not include some rights and protections provided under the Affordable Care Act (such as EHBs). Plans may lose "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers since that time. A health plan must disclose to consumers whether it considers itself a grandfathered plan. New employees and family members may be added to existing grandfathered plans after March 23, 2010 without that plan losing grandfathered status. Individual market plans sold after March 23, 2010 are not grandfathered plans and are subject to ACA regulations.[37]

Group Market: The health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.[38]

Health Maintenance Organization: A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.[39]

Individual Market: The market for health insurance coverage offered to individuals other than in connection with a group health plan.[40]

Large Group Market: The health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.[41]

[36] Federal Government's Interdepartmental Committee on Employment-based Health Insurance Surveys, "DEFINITIONS OF HEALTH INSURANCE TERMS", Bureau of Labor Statistics, https://www.bls.gov/ncs/ebs/sp/healthterms.pdf

[37] Definition based on "Grandfathered Health Plan" on healthcare.gov: https://www.healthcare.gov/glossary/grandfathered-health-plan/

[38] Affordable Care Act § 1304(a) (42 U.S.C. 18024(a).

[39] Federal Government's Interdepartmental Committee on Employment-based Health Insurance Surveys, "DEFINITIONS OF HEALTH INSURANCE TERMS", Bureau of Labor Statistics, https://www.bls.gov/ncs/ebs/sp/healthterms.pdf Maryland law contains a more detailed and specific definition of this term in Md. Code Ann., Health – General § 19-701(g).

[40] Affordable Care Act § 1304(a) (42 U.S.C. 18024(a).

[41] Affordable Care Act § 1304(a) (42 U.S.C. 18024(a) and (b).

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Self-Insured Plan: A plan offered by employers who directly assume the cost (and risk) of health insurance for their employees. Some self-insured plans bear the entire risk. Self-insured employers may contract with insurance carriers or third party administrators for claims processing and other administrative services.[42]

Small Group Market: The health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.[43]

State Employee Health Benefit Plans: A self-insured health insurance plan offered to State employees and retirees by the State of Maryland. State Employee Health Benefit Plans are not regulated under ERISA. The State of Maryland employee plans are not subject to State mandates, but many mandates are included voluntarily.

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[42] Federal Government's Interdepartmental Committee on Employment-based Health Insurance Surveys, "DEFINITIONS OF HEALTH INSURANCE TERMS", Bureau of Labor Statistics, https://www.bls.gov/ncs/ebs/sp/healthterms.pdf

[43] Affordable Care Act § 1304(a) (42 U.S.C. 18024(a) and (b).