Maryland SB 518 and HB 1366: Ovarian Cancer Screening and Cervical Cancer Screening Bill Analysis

Prepared for Maryland Health Care Commission

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Agenda

- Executive Summary
- Bill Summary
- Medical Background
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- Financial Summary

Executive Summary

1. The US Preventive Services Task force recommends against routine ovarian cancer screening. Available screening methods do not reduce ovarian cancer mortality and are associated with significant harms.

2. Cervical cancer screening (pap smear) is already covered in Maryland.

3. We do not expect a large increase in screening utilization from the passing of one or both bills based on the points above.

4. If SB 518 and HB 1366 were to both pass, the total 2027 commercial premium and Medicaid cost impact would be approximately $1,647,000 or $0.625 PMPY across all markets.

Summary of House Bill 1366 and Senate Bill 518

House Bill 1366 (HB 1366) requires the following, summarized from the bill text:

1. Health insurance plans must provide coverage for annual cervical smear or Pap test, and for surveillance tests for ovarian cancer
   i. Any type of cost sharing is prohibited

Senate Bill 518 (SB 518) requires the following, summarized from the bill text:

1. Health insurance plans must provide coverage for preventive screenings for ovarian cancer for individuals aged 45 and older
   i. Coverage must include MRI and CT scans
   ii. Any type of cost sharing is prohibited

Medical Background – Ovarian Cancer

1

Ovarian Cancer

Ovarian Cancers are a heterogeneous group of malignancies with varying risk factors, histologic types, treatments, and patient outcomes. The incidence and mortality has been declining since the 1970s but these cancers are still the most common and fatal cancers for women.

Matulonis UA, Sood AK, Fallowfield L, Howitt BE, Sehouli J, Karlan BY. Ovarian cancer. *Nat Rev Dis Primers*. 2016;2:16061. Published 2016 Aug 25. doi:10.1038/nrdp.2016.61

American Cancer Society. American Cancer Society: Cancer Facts and Figures 2025. Accessed September 28, 2025

2

Medical Community Usage

The US Preventive Services Task Force (USPSTF) among other groups recommend **against** routine screening in asymptomatic women without a history of increased risk. The Task Force found that available screening methods, such as transvaginal ultrasound and serum CA-125 testing, do not reduce ovarian cancer mortality and are associated with significant harms, including false-positive results, unnecessary surgical procedures, and psychological distress. For those with increased risk the USPSTF suggests genetic counseling and risk-reducing strategies.

US Preventive Services Task Force, Grossman DC, Curry SJ, et al. Screening for Ovarian Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2018;319(6):588-594. doi:10.1001/jama.2017.21926

Medical Background – Cervical Cancer

1

Cervical Cancer

Cervical cancer is a largely preventable malignancy that arises from the transformation of cells in the cervix, most commonly due to persistent infection with high-risk human papillomavirus (HPV) types.

National Cancer Institute. Cervical Cancer. National Institutes of Health. Updated June 27, 2024. Accessed September 28, 2025. www.cancer.gov/types/cervical

2

Medical Community Usage

Screening for cervical cancer in the United States is guideline-recommended for individuals with a cervix, beginning at age 21 and continuing through age 65, although more recent guidelines recommend beginning at age 25. The frequency and type of screening depends on age and other risk factors according to the USPSTF.

US Preventive Services Task Force, Curry SJ, Krist AH, et al. Screening for Cervical Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2018;320(7):674-686. doi:10.1001/jama.2018.10897

American College of Obstetricians and Gynecologists. Updated Cervical Cancer Screening Guidelines. Updated April 2025. Accessed July 28, 2025. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2021/04/updated-cervical-cancer-screening-guidelines

National Prevalence of Ovarian and Cervical Cancer

- In 2022, the Surveillance, Epidemiologist and End Results (SEER) age-adjusted incidence rate of ovarian cancer among US women was 10.8 per 100,000.
  i. For women over 65 years of age, the incident rate was 34.1 per 100,000.
  ii. For women under 50 years of age, the incident rate was 4.4 per 100,000.
- The frequency of genetic mutations associated with ovarian cancer is low. In the US population, the frequency of the BRCA1 or BRCA2 mutation is within the range of 1:200 to 1:400.

- In 2022, the SEER age-adjusted incidence rate of cervical cancer among women was 7.8 per 100,000.
  i. For women between 50-64 years of age, the incident rate was 13.2 per 100,000.
  ii. For women under 50 years of age, the incident rate was 6.2 per 100,000.

SEER Cancer Stat Explorer. National Cancer Institute. https://seer.cancer.gov/statistics-network/explorer/application.html?site=61. Accessed October 30, 2025.

Insurance Coverage for Ovarian Cancer Screening in Maryland

Individual	Small Group	Fully Insured Large Group	State Health Plan	Medicaid
46%	21%	75%	18%	62%

1. We surveyed insurance carriers in Maryland about current ovarian cancer screening coverage. No carrier specifically stated it covered ovarian cancer screening as a preventive service.
2. Four out of five carriers stated that ovarian cancer screening using MRI and CT scans are covered when medically necessary.

Public Demand for Ovarian and Cervical Cancer Screenings

Ovarian Cancer

- In a 2006 survey among women aged 40 years and older, only 15% of respondents were familiar with ovarian cancer symptoms.

Cervical Cancer

- In 2023, about 75% of women aged 21-65 in the US received a cervical cancer screening based on clinical guidelines.
- Lower rates of screening have been found among low-income and uninsured women.

Lockwood-Rayermann S, Donovan HS, Rambo D, Kuo CW. Women's awareness of ovarian cancer risks and symptoms. Am J Nurs. 2009 Sep;109(9):36-45; quiz 46. doi: 10.1097/01.NAJ.0000360309.08701.73.

Centers for Disease Control and Prevention. Pap Tests. https://www.cdc.gov/nchs/fastats/pap-tests.htm. Accessed October 30, 2025.

Akinlotan MA, Weston C, Bolin JN. Individual- and county-level predictors of cervical cancer screening: a multi-level analysis. Public Health. 2018;160:116-124. doi: 10.1016/j.puhe.2018.03.026.

Financial Analysis Approach

Financial evaluation projections for the 2027 calendar year is estimated under four scenarios:

1. Baseline: *Neither* proposed legislation goes into effect
2. Post-mandate: *Only* proposed legislation SB 518 (ovarian cancer) goes into effect.
3. Post-mandate: *Only* proposed legislation HB 1366 (ovarian cancer and cervical cancer) goes into effect.
4. Post-mandate: *Both* proposed legislations, SB 518 and HB 1366, go into effect.

Note: There is overlap in proposed benefits of each bill. The scenario of both legislations going into effect is not the summation of individual legislation effects.

Financial Summary - Total Premium and Medicaid Cost Impact

	Total Fully Insured Commercial	State Health Plan	Medicaid
PMPY Increase due to SB 518 (ovarian)	$0.890	$2.661	$0.025
PMPY Increase due to SB 1366 (cervical and ovarian)	$0.238	$0.967	$0.028
PMPY Increase due to SB 518 + HB 1366	$0.987	$3.092	$0.050
Total Increase due to SB 518 (ovarian)	$821,000	$569,000	$38,000
Total Increase due to HB 1366 (cervical and ovarian)	$220,000	$207,000	$42,000
Total Increase due to SB 518 + HB 1366	$910,000	$662,000	$75,000

Considerations and Limitations

- Routine ovarian cancer screening is not recommended for asymptomatic individuals by the USPSTF and other organizations. The increase in post-mandate utilization reflects only an increase in coverage and elimination of cost-sharing as a result of SB 518 or HB 1366.
- Cervical cancer is currently recommended by the USPSTF and required by the ACA. We assumed 100% coverage baseline and no change in utilization as a result of HB 1366.

Caveats

- Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in this model. It is almost certain that actual experience will not conform exactly to the assumptions used in this model. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected
- Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the impact of bill SB 518 and HB 1366. We have reviewed this model, including its inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).
- The models rely on data and information as input to the models. We have relied upon certain data and information for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. Milliman's data and information reliance includes: data from Maryland's All Payer Claims Database, US Census data and projections, and all other sources mentioned inline and in references, including survey and studies.
- The models, including all input, calculations, and output may not be appropriate for any other purpose.
- We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our investigation.

Caveats (continued)

- Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. One of the developers of this model and presenter, Katie Matthews, is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses supported by this model.
- Milliman does not intend to benefit any third-party recipient of its work product and assumes no duty or liability to other parties who receive this work.

Thank you

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Appendix

SB 518 Utilization per 1,000

	Individual	Small Group	Fully Insured Large Group	**Total Fully Insured Commercial**	State Health Plan	Medicaid
Total enrollees subject to state mandates	281,000	200,000	441,000	922,000	214,000	1,498,000
Baseline ovarian cancer screening utilization	1.5	1.0	0.7	1.0	1.3	0.2
Additional ovarian cancer screening utilization	2.1	4.4	0.3	1.8	6.3	0.1
Post-mandate ovarian cancer screening utilization	**3.7**	**5.4**	**1.0**	**2.8**	**7.5**	**0.3**

HB 1366 Utilization per 1,000

	Individual	Small Group	Fully Insured Large Group	**Total Fully Insured Commercial**	State Health Plan	Medicaid
Total enrollees subject to state mandates	281,000	200,000	441,000	922,000	214,000	1,498,000
Baseline ovarian cancer screening utilization	6.2	5.0	5.2	5.5	4.4	0.6
Additional ovarian cancer screening due to mandate	1.2	2.6	0.3	1.0	3.8	0.1
Post-Mandate ovarian cancer screening utilization	**7.4**	**7.5**	**5.5**	**6.5**	**8.2**	**0.7**
Baseline cervical cancer screening utilization	5.4	1.0	2.0	2.8	2.1	3.6
Additional cervical cancer screening due to mandate	**0.0**	0.0	0.0	0.0	0.0	0.0
Post-Mandate cervical cancer screening utilization	**5.4**	**1.0**	**2.0**	**2.8**	**2.1**	**3.6**
Total Utilization Post-Mandate	**12.8**	**8.6**	**7.4**	**9.3**	**10.3**	**4.3**

SB 518 + HB 1366 Utilization per 1,000

	Individual	Small Group	Fully Insured Large Group	**Total Fully Insured Commercial**	State Health Plan	Medicaid
Total enrollees subject to state mandates	281,000	200,000	441,000	922,000	214,000	1,498,000
Baseline ovarian cancer screening utilization	7.1	5.6	5.6	6.0	5.2	0.8
Additional ovarian cancer screening due to mandate	2.5	5.4	0.4	2.1	7.8	0.2
Post-Mandate ovarian cancer screening utilization	**9.6**	**11.0**	**6.0**	**8.2**	**13.0**	**0.9**
Baseline cervical cancer screening utilization	5.4	1.0	2.0	2.8	2.1	3.6
Additional cervical cancer screening due to mandate	0.0	0.0	0.0	0.0	0.0	0.0
Post-Mandate cervical cancer screening utilization	**5.4**	**1.0**	**2.0**	**2.8**	**2.1**	**3.6**
Total Utilization Post-Mandate	**15.0**	**12.0**	**8.0**	**11.0**	**15.2**	**4.5**

Commercial Premium and Medicaid Cost Increase due to SB 518

	Individual	Small Group	Fully Insured Large Group	**Total Fully Insured Commercial**	State Health Plan	Medicaid
PMPM Increase due to SB 518	$0.080	$0.195	$0.016	$0.074	$0.222	$0.002
PMPY Increase due to SB 518	$0.954	$2.346	$0.189	$0.890	$2.661	$0.025
Total Increase due to SB 518	$268,000	$469,000	$84,000	$821,000	$569,000	$38,000

Commercial Premium and Medicaid Cost Increase due to HB 1366

	Individual	Small Group	Fully Insured Large Group	**Total Fully Insured Commercial**	State Health Plan	Medicaid
PMPM Increase due to HB 1366	$0.019	$0.046	$0.008	$0.020	$0.081	$0.002
PMPY Increase due to HB 1366	$0.232	$0.550	$0.101	$0.238	$0.967	$0.028
Total Increase due to HB 1366	$65,000	$110,000	$45,000	$220,000	$207,000	$42,000

Commercial Premium and Medicaid Cost Increase due to SB 518 + HB 1366

	Individual	Small Group	Fully Insured Large Group	**Total Fully Insured Commercial**	State Health Plan	Medicaid
PMPM Increase due to SB 518 + HB 1366	$0.087	$0.213	$0.020	$0.082	$0.258	$0.004
PMPY Increase due to SB 518 + HB 1366	$1.045	$2.550	$0.241	$0.987	$3.092	$0.050
Total Increase due to SB 518 + HB 1366	$294,000	$510,000	$106,000	$910,000	$662,000	$75,000