MILLIMAN REPORT

Maryland Senate Bill 518 and House Bill 1366 Analysis (Ovarian and Cervical Cancer Screening)

Prepared for Maryland Health Care Commission

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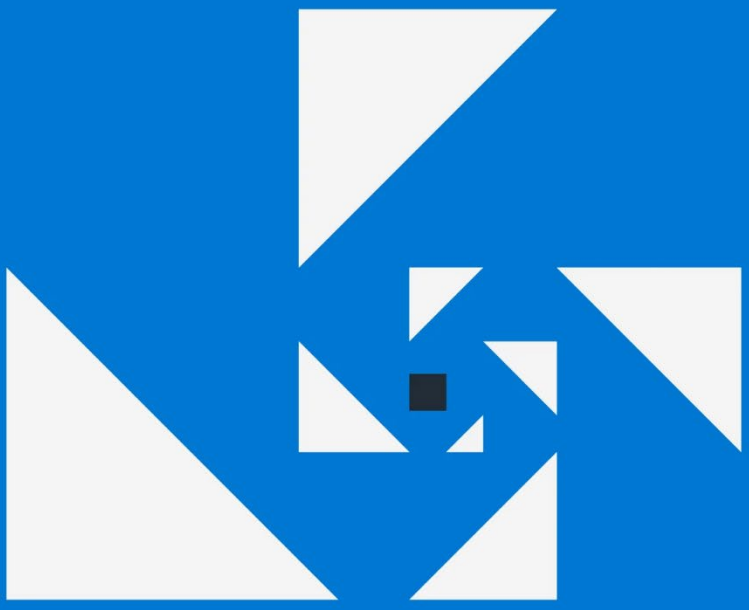

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Highlights

Support for the statements in the Highlights and Executive Summary sections may be found elsewhere in this report.

MEDICAL IMPACT

- Ovarian cancers are a heterogeneous group of malignancies with varying risk factors, histologic types, treatments, and patient outcomes.
- There are no USPSTF (United States Preventative Services Task Force) recommended screening tests for ovarian cancer among asymptomatic individuals or individuals at average risk.
- 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.
- Cervical cytology (pap smear) has been used in the diagnosis of cervical cancer since the 1940s. The USPSTF recommends screening for cervical cancer every 3-5 years with cervical cytology for certain populations.

SOCIAL IMPACT

- In 2022, the overall SEER (Surveillance, Epidemiology, and End Results program) age-adjusted incidence rate of ovarian cancer and cervical cancer among U.S. women was 10.8 per 100,000 and 7.8 per 100,000, respectively.
- Screening for ovarian cancer in asymptomatic women has not been shown to reduce mortality or increase earlier detection, and false positives may cause harm, including unnecessary surgeries and increased anxiety.
- Legislation that improves the coverage of ovarian cancer screening through removal of cost sharing will likely have a greater impact on low-income individuals who have an increased risk of ovarian cancer.
- Barriers to care may still exist even with increased insurance coverage, including coverage of follow-up treatment and access to services. There is evidence of disparities in use of screening cervical cytology based on insurance coverage and demographic characteristics, with lower screening rates among Black, Asian, and Hispanic women, as well as substantial variation in screening prevalence based on geography.
- For HB 1366, we expect no change in health benefits or financial barriers related to cervical cancer screening because it is recommended by USPSTF and is required by the Affordable Care Act (ACA).

FINANCIAL IMPACT

- For both bills, the estimated premium impact and ovarian cancer utilization impact reflect an increase in coverage and the elimination of cost-sharing. Carriers reported some coverage for ovarian cancer screening, ranging from 18% to 75% coverage across fully insured and state health plan, and 62% for Medicaid.
- Collectively in 2027, Senate Bill 518 (SB 518, ovarian cancer screening) and House Bill 1366 (HB 1366, ovarian and cervical cancer screening) are expected to increase premium in the commercial market by $910,000 increase premium by $662,000 for the state health plan or $0.258 PMPM and increase Medicaid costs by $75,000.
- Small group plans increases are higher than other fully insured commercial group sizes due to a large change in ovarian cancer screening coverage if the bills were to pass. Increases for HB 1366 are driven primarily by the ovarian cancer screening portions of the bill rather than the cervical cancer screening portion.

FIGURE 1: SUMMARY OF FINANCIAL IMPACT OF SB 518, HB 1366, INDVIDUALLY AND COLLECTIVELY, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Commercial premium/Medicaid cost increase due to SB 518	$268,000	$469,000	$84,000	$821,000	$569,000	$38,000
Commercial premium/Medicaid cost increase due to HB 1366	$65,000	$110,000	$45,000	$220,000	$207,000	$42,000
Commercial premium/Medicaid cost increase due to SB 518 and HB 1366	$294,000	$510,000	$106,000	$910,000	$662,000	$75,000

Introduction

Insurance Article §15–1501, Annotated Code of Maryland, requires the Maryland Health Care Commission (MHCC) to annually assess the medical, social, and financial impact of proposed mandated health insurance bills that failed to pass during the preceding legislative session. Senate Bill 518 (SB 518) and House Bill 1366 (HB 1366) introduced 2025 and did not pass, require the following, summarized from the bill text:

- SB 518 requires coverage for preventive screening tests for ovarian cancer for all individuals at least 45 years of age, including magnetic resonance imaging (MRI) and computed tomography (CT) scans.
- HB 1366 requires coverage for annual ovarian cancer screening tests with CA-125, transvaginal ultrasounds, and pelvic examinations for individuals of any age with either a positive test for BRCA1/BRCA2 mutations or a family history of ovarian, breast, or nonpolyposis colorectal cancer; requires coverage for annual screening for cervical cancer with cervical cytology testing.

At the request of MHCC, Milliman, Inc. was asked to assess the medical, social, and financial impact of SB 518 and HB 1366, individually and collectively.

The analysis requires a medical evaluation that includes the extent to which the medical community generally recognizes the services as being effective, the evidence of effectiveness from peer-reviewed literature, and the extent to which testing is available.

This analysis also requires a social evaluation that includes the extent to which the service is generally utilized by a significant portion of the population and to which insurance coverage is already generally available. If coverage is not generally available, the evaluation also includes the extent to which the lack of coverage results in individuals avoiding necessary healthcare treatments and to which the lack of coverage results in unreasonable financial hardship, as well as the impact to the level of public demand for the service, the level of public demand for insurance coverage of the service, the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts, and the extent to which the mandated health insurance service is covered by self-funded employer groups in the state of Maryland that employ at least 500 employees.

This report also requires a financial impact assessment that includes the extent to which the coverage will increase or decrease the cost and appropriate use of the service, will be a substitute for a more expensive service, and will increase or decrease the administrative expenses of insurers and the premium of policyholders. The impact analysis also includes the effect of this benefit mandate on the total cost of healthcare and the impact of all mandated health insurance services on employers' ability to purchase health benefits policies meeting their employees' needs.

Executive Summary

Ovarian cancers are a heterogeneous group of malignancies with varying risk factors, histologic types, treatments, and patient outcomes. While the incidence and mortality of ovarian cancer have been declining since the 1970s, it remains of the most common and fatal cancers among women, with approximately 21,000 women expected to be diagnosed and 13,000women expected to die of ovarian cancer in the US in 2025.

Individuals who are at increased risk because of genetic factors or family history may be offered genetic counselling and screening with certain biomarker (e.g., CA-125) and imaging tests (e.g., ultrasonography, computerized tomography [CT], and magnetic resonance imaging [MRI]). However, such screening tests have not demonstrated improvements in patient outcomes, even among individuals at increased risk of ovarian cancer. The US Preventive Services Task Force (USPSTF) recommends against routine screening for ovarian cancer in asymptomatic women whose personal or family history is not associated with increased risk for ovarian cancer.

Individuals with increased risk of ovarian cancer due to genetic factors or family history may be offered screening but evidence suggests that screening has no demonstrated impact on ovarian cancer related health outcomes for those receiving usual care and those who have received annual screening. Additionally, there may be low awareness of individual risk of developing ovarian cancer among the general population. People often do not know about their inherited genetic mutations until time of cancer diagnosis, when genetic testing is conducted.

Screening that results in false positives may increase unnecessary health care services, including surgery which increases risk of surgical complications.

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. In 2025, it is estimated that approximately 13,000women in the US will be diagnosed with cervical cancer, and 4,000 will die from the disease. The incidence and mortality of cervical cancer have declined substantially over recent decades, primarily due to widespread uptake of screening tests and HPV vaccination.

Screening for cervical cancer in the United States is USPSTF 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 primary screening modalities include cervical cytology (Papanicolaou [Pap] test), high-risk HPV (hrHPV) testing, and co-testing (cervical cytology combined with hrHPV testing). The Affordable Care Act (ACA) mandates coverage of cervical cancer screening with cervical cytology with no cost-sharing, in line with USPSTF recommendations, ensuring broad access to the test in the US among insured individuals.

Carriers reported that between 21% - 75% of commercial enrollees have coverage for ovarian cancer screening, 18% of state health plan enrollees have coverage for ovarian cancer screening, and 62% of Medicaid enrollees have coverage for ovarian cancer screening. We assumed all enrollees have coverage for cervical cancer screening and ovarian cancer screening through pelvic floor exams (pelvic exams) as described by HB 1366.

If the legislation were to pass, we expect an increase in ovarian cancer screening utilization due to mandated coverage and the prohibition of cost-sharing as result of SB 518 or HB 1366, for both bills separately and collectively. We assumed cervical cancer screenings described by HB 1366 are already covered at baseline and expect no change to utilization as a result of increased coverage.

Legislation that improves the coverage of ovarian cancer screening through removal of cost sharing will likely have a greater impact on low-income individuals who are at increased risk of ovarian cancer. We do not anticipate HB 1366 having an impact on financial barriers to cervical cytology, as coverage is already mandated by the ACA. Barriers to care may still exist even with increased insurance coverage, including coverage of follow-up treatment and access to services.

If both bills were to pass in 2027, total fully insured commercial premiums are estimated to increase $910,000 or $0.082 per member per month (PMPM) ($0.987 Per member per year [PMPY]). State health plan premiums are estimated to increase $662,000 or $0.258 PMPM ($3.092 PMPY). Medicaid expenditures are estimated to increase by $75,000 or $0.004 PMPM ($0.050 PMPY).

If only SB 518 were to pass in 2027, total fully insured commercial premiums are estimated to increase $821,000. State health plan premiums are estimated to increase $569,000. Medicaid expenditures are estimated to increase by $38,000.

If only HB 1366 were to pass in 2027, total fully insured commercial premiums are estimated to increase $220,000. State health plan premiums are estimated to increase $207,000. Medicaid expenditures are estimated to increase by $42,000.

Medical Evaluation of Ovarian Cancer Screening

BACKGROUND

Ovarian cancers are a heterogeneous group of malignancies with varying risk factors, histologic types, treatments, and patient outcomes.[1] These neoplasms can be broadly divided into epithelial and non-epithelial histologic types, with epithelial ovarian cancers being the most prevalent type accounting for more than 90% of cases.[2] While the incidence and mortality of ovarian cancer have been declining since the 1970s, it remains of the most common and fatal cancers among women, with approximately 21,000women expected to be diagnosed and 13,000women expected to die of ovarian cancer in the US in 2025.[3]

While the etiology of ovarian cancer is not completely understood, certain factors are known to increase risk. These risk factors can be broadly categorized into genetic factors (e.g., BRCA1 and BRCA2 mutations, Lynch syndrome, and family history of breast or ovarian cancer), reproductive/hormonal factors (e.g., nulliparity, early menarche, late menopause), and lifestyle/environmental factors (e.g., smoking, obesity, and perineal talc powder use).[1,4]

Patients with ovarian cancer typically present with non-specific symptoms such as weight loss, abdominal discomfort, and bowel and urinary symptoms.[1,4] Additionally, the early stages of the disease are typically asymptomatic or mildly symptomatic, leading to late diagnosis or attribution to other disease processes.[4] Because of these factors, a comprehensive clinical history, family history, and physical examination are important in both risk stratification and diagnosis.

Currently, there are no recommended screening tests for ovarian cancer among asymptomatic individuals or individuals at average risk.[5-8] Individuals who are at increased risk because of genetic factors or family history may be offered genetic counselling and screening with certain biomarker (e.g., CA-125) and imaging tests (e.g., ultrasonography, CT and MRI).[5-8] However, such screening tests have not demonstrated improvements in patient outcomes, even among individuals at increased risk of ovarian cancer.[5,6]

RECOGNITION OF EFFECTIVENESS BY MEDICAL COMMUNITY

For individuals at high risk of ovarian cancer such as those with BRCA1 or BRCA2 mutations, Lynch syndrome, or a strong family history, the recommended approach to screening varies by recommending organization. This evaluation focuses on clinical guidelines from the US Preventive Services Task Force (USPSTF), the physician expert panel under the Department of Health and Human Services that develops evidence-based guidelines on preventive services; the American College of Obstetricians and Gynecologists (ACOG), the largest professional organization of obstetricians and gynecologists in the US; and the American College of Radiology (ACR), the largest professional radiology organization in the US.[6-8]

The USPSTF recommends against routine screening for ovarian cancer in asymptomatic women whose personal or family history is not associated with increased risk for ovarian cancer.[5] 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.[5] Instead, the USPSTF recommends risk assessment and genetic counseling for women with a family history suggestive of hereditary breast and ovarian cancer syndrome.[5,6] For women found to carry pathogenic mutations, the USPSTF highlights the importance of discussing risk-reducing strategies, such as prophylactic salpingo-oophorectomy, rather than relying on screening tests like CA-125 or TVUS. The Task Force notes that current evidence does not support the effectiveness of these screening modalities in reducing ovarian cancer mortality among high-risk women.[6]

The ACOG recommends against routine screening for ovarian cancer in women who are at average risk.[7] Currently available screening methods, such as transvaginal ultrasound and serum CA-125 testing, do not reduce mortality from ovarian cancer in this population and may result in unnecessary surgical interventions.[7] For women who are considered high risk due to hereditary factors such as those with BRCA1 or BRCA2 mutations, Lynch syndrome, or a strong family history of ovarian or breast cancer, transvaginal ultrasonography or serum CA 125 testing may be considered, particularly for women who decline risk-reducing surgery with bilateral salpingo-oophorectomy or for

short term surveillance starting at age 30-35 years and until the time patients choose to undergo risk-reducing surgery.[7]

The ACR does not recommend routine screening with ultrasonography, MRI, or CT for ovarian cancer in asymptomatic women whose personal or family history is not associated with increased risk for ovarian cancer.[8] The ACR recommends that screening may be considered for women at high risk such as those with BRCA1 or BRCA2 mutations, a strong family history of ovarian or breast cancer, or elevated CA 125.[8] In these individuals transvaginal ultrasound, transabdominal ultrasound, or color Doppler ultrasound of the ovaries are the recommended modalities, but their use should be individualized and based on shared decision-making between the patient and healthcare provider.[8] The ACR highlights that ultrasonography has not demonstrated clear benefit in terms of early detection or improved survival, even in high-risk populations.[8] These tests can result in false positives, unnecessary anxiety, and potentially harmful interventions.[8] Therefore, the ACR emphasizes that women at high risk should be counseled about the limitations and potential risks of screening, and that risk-reducing surgery (such as bilateral salpingo-oophorectomy after childbearing is complete) may be a more effective preventive strategy for those with confirmed genetic risk.[8]

EVIDENCE OF EFFECTIVENESS FROM PEER-REVIEWED LITERATURE

Over the past several decades, there has been interest in various screening tools, most notably transvaginal ultrasound, and serum CA-125 testing, in the early identification of ovarian cancer. Evidence has shown, however, that these approaches do not significantly reduce mortality for most women and are associated with high rates of false positives, leading to unnecessary surgeries and anxiety.[6,8]

Among women of average risk for ovarian cancer, the largest study on screening to date is the UK Collaborative Trial of Ovarian Cancer Screening (UKCTOCS), a randomized clinical trial of 202,638 postmenopausal women aged 50 to 74 years.[11] This study evaluated ovarian cancer screening using CA-125 testing and transvaginal ultrasound compared to no screening and found no statistically significant differences between the groups in terms of ovarian cancer mortality risk after a median follow-up of 11.1 years. On the other hand, intensive screening for ovarian cancer is associated with high rates of false-positive results, additional unnecessary imaging tests, and unnecessary surgery for women without cancer.[12,13]

Among women at high risk for ovarian cancer, there is more evidence supporting screening with certain modalities. Phase 1 of United Kingdom Familial Ovarian Cancer Screening Study, which evaluated the performance of transvaginal ultrasound and CA-125 screening among 3,563 women at high risk of ovarian cancer on the basis of family history or predisposing mutations, found that the sensitivity of detection of incident ovarian cancers was high at 81-87%, and that patients who had not undergone screening within 1 year of their diagnosis were more likely to have stage IIIc or higher cancer compared to patients who had received screening within the past year.[14] Phase 2 of the study found that screening with transvaginal ultrasound and CA-125 among 4,348 women at high risk of ovarian cancer showed high sensitivity and significantly higher proportions of cancers diagnosed at lower stages, suggesting that screening may be useful in high-risk populations, particularly for those patients those who defer or decline risk-reducing salpingo-oophorectomy.[14]

There is no literature to support the use of CT for ovarian cancer screening, which has high rates of incidental findings of adnexal lesions that are later confirmed to be benign and no protective benefit against developing ovarian cancer among patients who had prior negative CT results.[15] Likewise, there is no literature to support the use of MRI in ovarian cancer screening, with evidence showing that the ability of MRI to detect and differentiate between benign and malignant adnexal masses is limited.[16]

AVAILABILITY OF SERVICES

Ultrasound services are widely available in the US in a range of settings, including hospital radiology departments, emergency departments, and other ambulatory settings.[17-19] Due to its diverse applications across medical specialties, diseases, and diagnostic and therapeutic domains, ultrasound adoption continues to grow in the US.[20,21] Despite widespread availability, however, studies have shown disparities in ultrasound access and utilization based on demographic factors. Black adults receive significantly lower rates of ultrasound imaging compared to white patients for abdominal pain in the emergency department.[22] Additionally, female sex, Medicaid coverage, and Medicare coverage were associated with lower odds of receiving point-of-care ultrasound.[23]

CA-125 testing is likewise widely available in the US, having no significant additional requirements in either advanced equipment or personnel apart from what is typically found in diagnostic laboratories nationwide. Despite this, there is evidence of disparities in tumor marker testing for different cancer types based on race, geographic location, and insurance coverage.[24,25]

CT scans and MRIs are both widely available imaging procedures in the US, with 428 CT scans performed per 1,000 person years in 2016, and 139 MRIs performed per 1000 person years in 2016.[26] Despite evidence of increasing utilization nationwide, however, there is evidence of persistent disparities in CT and MRI access based on race and geographic location.[27-30]

Medical Evaluation of Cervical Cancer Screening

BACKGROUND

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.[31,32] The majority of cervical cancers are squamous cell carcinomas, but adenocarcinomas account for a significant minority of cases.[32] In 2025, it is estimated that approximately 13,000 women in the US will be diagnosed with cervical cancer, and 4,000will die from the disease.[3] The incidence and mortality of cervical cancer have declined substantially over recent decades, primarily due to widespread uptake of screening tests and HPV vaccination.[3]

Known risk factors for cervical cancer include persistent infection with high-risk HPV, early onset of sexual activity, multiple sexual partners, immunosuppression, and smoking.[31] Most individuals with early-stage cervical cancer are asymptomatic, while others may present with abnormal vaginal bleeding, pelvic pain, or dyspareunia.[31] Symptoms of advanced cervical cancer include bowel movement changes, hematochezia, dysuria, and hematuria.[31] Given the often asymptomatic nature of early cervical cancer and the slow progression from pre-cancerous lesions to invasive disease, regular screening is essential for early detection and prevention.

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.[33-35] The primary screening modalities include cervical cytology (Papanicolaou [Pap] test), high-risk HPV (hrHPV) testing, and co-testing (cervical cytology combined with hrHPV testing).[33-35] For individuals aged 21–29 years cytology alone every three years is recommended, while for those aged 30–65 years options include cytology every three years, hrHPV testing every five years, or co-testing every five years.[33-35] Screening intervals and modalities are designed to maximize early detection while minimizing unnecessary procedures and harms.[34]

The effectiveness of cervical cancer screening is well-established, with substantial reductions in both incidence and mortality observed in populations with regular screening.[33-35] However, disparities in access, uptake, and follow-up remain, particularly among uninsured, underinsured, and minority populations.[33,36] The Maryland House Bill (HB) 1366 seeks to improve access to cervical cancer screening by requiring insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for annual screening for cervical cancer with cervical cytology testing.[10] While coverage for hrHPV testing and co-testing are not included under HB 1366, this evaluation includes these tests in addition to cervical cytology even though they are not identified specifically in HB 1366 but are included when discussing guideline-based screening since all major guidelines on cervical cancer screening recommend all three modalities as options.

RECOGNITION OF EFFECTIVENESS BY MEDICAL COMMUNITY

Guideline-based screening for cervical cancer in the US includes three modalities (cervical cytology, hrHPV, and co-testing), with variation in terms of screening interval and recommended age for initiation of screening. This evaluation focuses on clinical guidelines from the USPSTF and the American Cancer Society (ACS), a large US non-profit organization engaging in research, advocacy, and patient support that publishes clinical guidelines for oncologic conditions.[33,34] The ACOG has endorsed the USPSTF cervical cancer screening recommendations as a replacement for its own cervical cancer screening and prevention practice guidelines so the ACOG's perspective is not discussed separately.[35]

The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years.[33] For women aged 30 to 65 years, screening every 3 years with cervical cytology alone, every 5 years with hrHPV testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing) is recommended.[33] The USPSTF recommends against cervical cancer screening with any modality for women younger than 21 years, women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer, and women of any age who have had a hysterectomy with removal of the cervix and do not have a personal history of high-grade precancerous lesions or cervical cancer.[33]

The ACS recommends screening for cervical cancer every 5 years with hrHPV testing alone for women aged 25 to 65 years as the preferred screening modality, but also recommends cytology alone every 3 years or co-testing every 5 years as acceptable options.[34] The ACS recommends against cervical cancer screening with any modality in women younger than 25 years, women aged 65 years and older who have no history of cervical intraepithelial neoplasia (CIN) grade 2 or more severe disease within the past 25 years, and who have documented adequate negative prior screening in the prior 10 years, and women of any age who have undergone hysterectomy with removal of the cervix and who have no history of CIN grade 2 or more severe disease.[34] The ACS based its recommendation to initiate cervical cancer screening at 25 years of age, in contrast to 21 years of age in the USPSTF and ACOG guidelines, due to the low disease burden at younger ages and the risk of adverse outcomes associated with overtreatment of precursor lesions.[34]

EVIDENCE OF EFFECTIVENESS FROM PEER-REVIEWED LITERATURE

Cervical cytology has been used in the diagnosis of cervical cancer since the 1940s, when Dr. George Papanicolaou and Dr. Herbert Traut published their landmark book on what would later be widely known as the Papanicolaou (or Pap) smear.[37] Due to its low cost, low technical requirements, and long track record of effectiveness, cervical cytology has been considered the gold standard in cervical cancer screening for decades.[37] Cervical cytology has been shown to have high sensitivity and specificity when used as a screening test for cervical cancer, although this varies by disease severity with sensitivity being lower for mild to moderate dysplasia (approximately 78%) and higher for severe dysplasia, carcinoma in situ, and invasive carcinoma (approximately 81-82%).[38] High-income countries that have instituted cervical cancer screening programs using cervical cytology have seen substantial declines in both cervical cancer incidence and mortality.[39,40]

AVAILABILITY OF SERVICES

Cervical cytology does not require technically advanced equipment for both collection at the clinic and specimen processing in the laboratory. It is widely available in the US in a variety of settings such as physicians' offices, outpatient clinics, and community health centers. The Affordable Care Act (ACA) mandates coverage of cervical cancer screening with cervical cytology with no cost-sharing, in line with USPSTF recommendations, ensuring broad access to the test in the US among insured individuals.[41] However, since the test is typically performed by obstetrician-gynecologists or primary care physicians, access to the test may also be impacted by known disparities in access to these physician specialties.[42,43] There is also evidence of disparities in use of screening cervical cytology based on insurance coverage and demographic characteristics, with lower screening rates among Black, Asian, and Hispanic women, as well as substantial variation in screening prevalence based on geography.[36,44-46]

Social Evaluation

PREVALENCE AND RISK FACTORS

In 2022, the overall Surveillance, Epidemiology, and End Results Program (SEER) age-adjusted incidence rate of ovarian cancer among U.S. women was 10.8 per 100,000. Incidence rates are positively correlated with age, with the highest rates among women over 65 years (34.1 per 100,000) and lowest among women under 50 (4.4 per 100,000). When disaggregated by race, incidence rates are highest among non-Hispanic American Indian/Alaska Native women (12.5 per 100,000) and Hispanic women (all races) (11.2 per 100,000) and lowest among non-Hispanic Asian/Pacific Islander women (9.9 per 100,000) and non-Hispanic Black women (10.1 per 100,000).[47]

Overall, a high percentage of people present with late-stage ovarian cancer (state III or IV), primarily due to early stages of the disease presenting as asymptomatic or mildly symptomatic. [4] There are disparities in stage at diagnosis by race and socioeconomic status. For example, SEER data shows that Black women have 20% higher odds of diagnosis at late-stage cancer compared with white women.[48]

The frequency of genetic mutations associated with ovarian cancer risk is low in the general population. Estimates of BRCA1/2 frequency in the US population range from 1:200 to 1:400.[49-50] The frequency of Lynch Syndrome, a condition also caused by a genetic mutation, is estimated to be 1:279 in the general population.[51]

In 2022, the overall SEER age-adjusted incidence rate of cervical cancer among U.S. women was 7.8 per 100,000. Incidence rates vary by age, with the highest rates among women ages 50 to 64 (13.2 per 100,000) and lowest among women under 50 (6.2 per 100,000). When disaggregated by race, incidence rates are highest among non-Hispanic American Indian/Alaska Native women (15.1 per 100,000) and lowest among non-Hispanic Asian/Pacific Islander women (5.8 per 100,000) and non-Hispanic White women (6.9 per 100,000).[47]

BENEFIT COVERAGE

To determine benefit coverage of ovarian cancer screening, we surveyed the insurance carriers across Maryland's fully insured individual, fully insured small group, and fully insured large group markets, the Maryland state health plan, and the managed Medicaid population (see Appendix A for the survey sent to carriers).

No carrier specifically stated that it covered ovarian cancer screening as a preventative service. Of the carriers surveyed, three out of five respondents indicated that ovarian cancer screening is covered for Maryland enrollees across all markets with MRIs and CT scans being covered when medically necessary, one carrier indicated coverage for MRIs and CT scans being covered when medically necessary but no coverage generally for ovarian cancer screening, and the last carrier indicated no coverage for any ovarian cancer screening. We assumed carriers that noted coverage for MRIs or CT scans included broader coverage for more common biomarker tests as well as ultrasounds. We assumed ovarian cancer screening done through pelvic exams were fully covered at baseline.

As discussed above, cervical cancer screening is recommended by USPSTF and required as part of the ACA and we assumed all carriers had coverage for cervical cancer screening as described in HB 1366.

Figure 2 shows current coverage of ovarian cancer screening by source of healthcare coverage, based on carrier survey results weighted by reported enrollment in the carrier surveys. Carriers did not indicate any limitations based on age, family history, or high-risk factors.

FIGURE 2: ENROLLEES WITH COVERAGE FOR OVARIAN CANCER SCREENING, 2025 SURVEY

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

Figure 3 shows assumed current coverage of cervical cancer screening by source of healthcare coverage.

FIGURE 3: ENROLLEES WITH COVERAGE FOR CERVICAL CANCER SCREENING, ASSUMED

Individual	Small Group	Fully Insured Large Group	State Health Plan	Medicaid
100%	100%	100%	100%	100%

PUBLIC DEMAND AND UTILIZATION

Ovarian Cancer Screening

Among individuals with elevated risk, utilization may be affected by awareness of risk factors and symptoms among the public and clinical communities. We were unable to find evidence about the current level of public awareness of ovarian cancer risk factors or screening. In a survey conducted in 2006 among women ages 40 and older, 15% of respondents were familiar with ovarian cancer symptoms, 80% of respondents had never had a conversation with a physician about symptoms or risk factors, 59% identified family history of breast ovarian or colon cancer as a risk factor, and 50% identified genetic predisposition as a risk factor.[52] In this survey, about two-thirds of respondents incorrectly believed that a PAP smear would diagnose ovarian cancer.

Additionally, there may be low awareness of individual risk of developing ovarian cancer among the general population. People often do not know about their inherited genetic mutations until time of cancer diagnosis, when genetic testing is conducted. Among BRCA1/BRCA2 positive women diagnosed with breast cancer, one study found that less than half were aware of their BRCA mutation prior to the cancer diagnosis[53] and another study found that 25% of BRCA1/BRCA2 positive women diagnosed with ovarian cancer were aware of their genetic mutation prior to their diagnosis.[54]

As described in the medical section above, because there are no recommended screening tests for ovarian cancer among asymptomatic individuals or individuals at average risk, and such screening tests have not demonstrated improvements in patient outcomes, there is low ovarian cancer screening utilization at baseline.

We expect no change in provider practice patterns or ovarian cancer screening guidelines as a result of the proposed legislation. Post-mandate, we expect a small increase in ovarian cancer screening utilization due to mandated coverage and the prohibition of cost-sharing as a result of SB 518 or HB 1366, both separately and collectively. This increased utilization would likely be among women with elevated risk of ovarian cancer.

Cervical Cancer Screening

In 2023, 75.4% of women ages 21-65 in the US received a cervical cancer screening based on recent clinical guidelines (Pap of HPV test every three years for women ages 21-29 and 5 years for women ages 29-65).[55] Lower rates of screening have been found among uninsured and low-income women.[56-57]

As described in the medical section above, cervical cytology for cervical cancer screening is recommended by the USPSTF and required by the ACA. We assumed cervical cancer screenings described by HB 1366 are already covered at baseline and expect no change in utilization due to coverage post-mandate.

Figures 4 to 6 show 2027 baseline and post-mandate utilization of SB 518, HB 1366, and the two bills collectively.

Estimates for ovarian cancer screening for SB 518 are different from estimates for ovarian cancer screening for HB 1366 due to the differences in language and coverage between the two bills. Both include tumor marker testing and ultrasounds, but SB 518 utilization includes MRIs and CT scans and is limited to patients aged 45 and over. HB 1366 does not include MRIs and CT scans but does include pelvic exams for high-risk individuals of all ages.

Estimates for additional cervical cancer screening utilization rounds to 0 but we expect a very small increase in utilization due to the removal of cost sharing.

FIGURE 4: UTILIZATION PER 1,000 RATES OF SB 518 OVARIAN CANCER SCREENINGS AT BASELINE AND POST-MANDATE, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Baseline ovarian cancer screening per 1,000	1.5	1.0	0.7	1.0	1.3	0.2
Additional ovarian cancer screening per 1,000	2.1	4.4	0.3	1.8	6.3	0.1
Post-mandate ovarian cancer screening per 1,000	3.7	5.4	1.0	2.8	7.5	0.3

FIGURE 5: UTILIZATION PER 1,000 RATES OF HB 1366 OVARIAN CANCER AND CERVICAL CANCER SCREENINGS AT BASELINE AND POST-MANDATE, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Baseline ovarian cancer screening per 1,000	6.2	5.0	5.2	5.5	4.4	0.6
Additional ovarian cancer screening per 1,000	1.2	2.6	0.3	1.0	3.8	0.1
Post-mandate ovarian cancer screening per 1,000	7.4	7.5	5.5	6.5	8.2	0.7
Baseline cervical cancer screening per 1,000	5.4	1.0	2.0	2.8	2.1	3.6
Additional cervical cancer screening per 1,000	0.0	0.0	0.0	0.0	0.0	0.0
Post-mandate cervical cancer screening per 1,000	5.4	1.0	2.0	2.8	2.1	3.6

FIGURE 6: UTILIZATION PER 1,000 RATES OF SB 518 AND HB 1366 OVARIAN CANCER AND CERVICAL CANCER SCREENINGS AT BASELINE AND POST-MANDATE, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Baseline ovarian cancer screening per 1,000	7.1	5.6	5.6	6.0	5.2	0.8
Additional ovarian cancer screening per 1,000	2.5	5.4	0.4	2.1	7.8	0.2
Post-mandate ovarian cancer screening per 1,000	9.6	11.0	6.0	8.2	13.0	0.9
Baseline cervical cancer screening per 1,000	5.4	1.0	2.0	2.8	2.1	3.6
Additional cervical cancer screening per 1,000	0.0	0.0	0.0	0.0	0.0	0.0
Post-mandate cervical cancer screening per 1,000	5.4	1.0	2.0	2.8	2.1	3.6

POTENTIAL HEALTH BENEFITS

As discussed in the medical section, there are no recommended screening tests for ovarian cancer among asymptomatic individuals or individuals at average risk.[7-8] Individuals with increased risk due to generic factors or family history may be offered screening but evidence suggests that screening tests have no demonstrated impact on ovarian cancer related health outcomes for those receiving usual care and those who have received annual screening.[5-6]

Evidence suggests there are potential harms due to increased screening for the early detection of ovarian cancer. The USPSTF reviewed benefits and harms of screening for ovarian cancer in asymptomatic women not known to

have a high risk for ovarian cancer. This review found screening does not reduce ovarian cancer mortality and may increase unnecessary health care services, including surgery for those who do not need surgery due to false positives.[5] A randomized control trial examining the outcomes for women undergoing annual CA-125 screening and transvaginal ultrasound found that of the 39,105 women in the intervention group, 8.4% had false positive results, 33% of those with false positives underwent surgical follow up, and 15% women who underwent surgery had complications.[58] False positives may also lead to anxiety in patients.[59-62]

We do not anticipate any change in health outcomes due to HB 1366 because the ACA already mandates the coverage of cervical cancer screening with no cost-sharing.

FINANCIAL BARRIERS

Legislation that improves the coverage of ovarian cancer screening through removal of cost sharing will likely have a greater impact on low-income individuals who are at increased risk of ovarian cancer.

Improved identification of ovarian cancer at earlier stages could reduce cost of cancer care[63]; however, the services specified in this bill have not been shown to be effective at detecting early disease.[8] Barriers to care may still exist even with increased insurance coverage, including coverage of follow-up treatment and access to services. Further details on the availability ultrasound, CA-125 testing, CT scans and MRIs can be found in the Clinical Evaluation section.

We do not anticipate HB 1366 having an impact on financial barriers to cervical cytology, as coverage is already mandated by the ACA. There may still be barriers to the service beyond insurance coverage of cervical cytology. For example, follow up treatment related to an abnormal Pap smear may not be covered and availability of services can be limited. Further details on the availability of cervical cytology screening, including disparities by insurance coverage and demographic characteristics in care can be found in the medical section.

Financial Evaluation

The financial evaluation projects the population, cost of benefits, commercial premium, Medicaid cost, and enrollee cost sharing for the 2027 calendar year under the following four scenarios:

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

The difference between the baseline and post-mandate scenario values is the impact of either or both of the proposed legislations. There is overlap in the proposed benefits of each bill and the collective scenario with both proposed legislations going into effect is not the summation of the individual legislations.

COST AND ENROLLEE COST SHARING PER SERVICE

Ovarian Cancer Screening

We estimate the average baseline allowed cost of ovarian cancer screening for SB 518 in 2027 to be $275 to $395 per test for commercially insured enrollees, $355 for the state health plan, and $210 for Medicaid enrollees. Enrollee cost sharing for ovarian cancer screening for SB 518 is estimated to be $85 to $120 per screening for commercially insured enrollees, $15 for the state health plan, and $0 for Medicaid enrollees at baseline.

Similarly, we estimate the average baseline allowed cost of ovarian cancer screening for HB 1366 in 2027 to be $155 to $190 per screening for commercially insured enrollees, $170 for the state health plan, and $175 for Medicaid enrollees. Enrollee cost sharing for ovarian cancer screening for HB 1366 is estimated to be $5 per screening for commercially insured enrollees and $0 for the state health plan and Medicaid enrollees at baseline.

Combined, we estimate the average baseline allowed cost of ovarian cancer screening if both bills were to pass in 2027 to be $185 to $205 per screening for commercially insured enrollees, $210 for the state health plan, and $195 for Medicaid enrollees. Enrollee cost sharing for ovarian cancer screening for both bills is estimated to be $15 to $25 per test for commercially insured enrollees, $5 for the state health plan, and $0 for Medicaid enrollees at baseline.

Variations in cost for screenings are driven by service mixture differences between different enrollee coverage types. The difference in average cost by scenario is explained by the differences in the underlying specific services and populations of each proposed bill.

Estimates for ovarian cancer screening for SB 518 are different from estimates for ovarian cancer screening for HB 1366 due to the differences in language and coverage between the two bills. Both include tumor marker testing and ultrasounds, but SB 518 utilization includes MRIs and CT scans and is limited to patients aged 45 and over. HB 1366 does not include MRIs and CT scans but does include pelvic exams, for high-risk individuals of all ages.

Post-mandate, we assumed the allowed cost for individual ovarian cancer screening services would not change as a result of either bill, but the average allowed cost for combined ovarian cancer screenings may change slightly due to service utilization mixture changes as a result of the proposed legislation. There would be no enrollee cost sharing post-mandate.

The table in Figure 7 shows the average baseline allowed cost and enrollee cost sharing of ovarian cancer screening by source of coverage.

FIGURE 7: ESTIMATED BASELINE COST PER OVARIAN CANCER SCREENING, 2027

		INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	STATE HEALTH PLAN	MEDICAID
SB 518	Average cost	$275	$395	$300	$355	$210
SB 518	Average enrollee cost-sharing	$95	$120	$85	$15	$0
HB 1366	Average cost	$155	$165	$190	$170	$175
HB 1366	Average enrollee cost-sharing	$5	$5	$5	$0	$0
SB 518 and HB 1366	Average cost	$185	$205	$205	$210	$195
SB 518 and HB 1366	Average enrollee cost-sharing	$25	$25	$15	$5	$0

Cervical Cancer Screening

We estimate the average post-mandate allowed cost of cervical cancer screening for HB 1366 in 2027 to be $25 to $45 per screening for commercially insured enrollees, $45 for the state health plan, and $5 for Medicaid enrollees. Enrollee cost sharing for cervical cancer screening for HB 1366 is estimated to be $0 to $5 per screening for commercially insured enrollees, $0 for the state health plan, and $0 for Medicaid enrollees at baseline.

Post-mandate, we assumed the allowed cost for individual cervical cancer screening services would not change as a result of either bill, but the average allowed cost for all cervical cancer screenings combined may change slightly due to service utilization mixture changes as a result of the proposed legislation. There would be no enrollee cost sharing post-mandate.

Figure 8 shows the average cost and cost sharing of cervical cancer screening by source of coverage.

FIGURE 8: ESTIMATED BASELINE COST PER CERVICAL CANCER SCREENING, 2027

		INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	STATE HEALTH PLAN	MEDICAID
HB 1366	Average cost	$25	$45	$35	$45	$5
HB 1366	Average enrollee cost-sharing	$0	$5	$5	$0	$0

ADMINISTRATION OF BENEFITS

Carriers did not report any undue burden from administering this additional benefit. Administration costs will increase in proportion to the cost of additional mandated benefits. We do not expect SB 518 or HB 1366 to impact individuals or employers' ability to purchase health benefits policies meeting their own or employees' needs.

STATE BENEFIT DEFRAYAL EXCEEDING ESSENTIAL HEALTH BENEFIT

SB 518 and HB 1366 may exceed essential health benefits (EHBs) and may require the state to defray costs of exceeding essential health benefits if Maryland does not include ovarian cancer screening in its 2027 EHB benchmark plan. In addition to ovarian cancer screening, HB 1366 includes cervical cancer screening services that are already included in the EHB and would not require the state to defray the costs of exceeding EHBs for those cervical cancer screening services.

In "Final 2025 HHS Notice of Benefits and Payment Parameters," the Centers for Medicare and Medicaid Services (CMS) finalized an amendment to codify that benefits covered in a state's EHB benchmark plan will not be considered in addition to EHBs, even if they had been required by state action taking place after December 31, 2011, other than for purposes of compliance with federal requirements. Under this policy, there would be no obligation for the state to defray the cost of a state mandate enacted after December 31, 2011, that requires coverage of a benefit if that benefit is included in the state's EHB benchmark plan. Benefits that are covered in a state's EHB benchmark plan will not be considered in addition to EHBs and will remain subject to the various rules applicable to the EHBs.

COMMERCIAL PREMIUM AND MEDICAID EXPENDITURE IMPACT

The estimated commercial premium and Medicaid expenditure impact from passing SB 518, HB 1366, or both bills is shown in Figures 9 to 11.

For both bills, total fully insured commercial premiums are estimated to increase $910,000 or $0.082 PMPM ($0.987 PMPY). State health plan premiums are estimated to increase $662,000 or $0.258 PMPM ($3.092 PMPY). Medicaid expenditures are estimated to increase by $75,000 or $0.004 PMPM ($0.050 PMPY).

Due to overlap between services and populations addressed within each bill, the combined table for commercial premium and Medicaid expenditures is less than the total of each individual bill table.

Both commercial premium and Medicaid expenditures include administrative fees.

FIGURE 9: ESTIMATED COMMERCIAL PREMIUM AND MEDICAID EXPENDITURE IMPACT OF SB 518, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Total Dollars	$268,000	$469,000	$84,000	$821,000	$569,000	$38,000
PMPM	$0.080	$0.195	$0.016	$0.074	$0.222	$0.002
PMPY	$0.954	$2.346	$0.189	$0.890	$2.661	$0.025

FIGURE 10: ESTIMATED COMMERCIAL PREMIUM AND MEDICAID EXPENDITURE IMPACT OF HB 1366, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Total Dollars	$65,000	$110,000	$45,000	$220,000	$207,000	$42,000
PMPM	$0.019	$0.046	$0.008	$0.020	$0.081	$0.002
PMPY	$0.232	$0.550	$0.101	$0.238	$0.967	$0.028

FIGURE 11: ESTIMATED COMMERCIAL PREMIUM AND MEDICAID EXPENDITURE IMPACT OF SB 518 AND HB 1366, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Total Dollars	$294,000	$510,000	$106,000	$910,000	$662,000	$75,000
PMPM	$0.087	$0.213	$0.020	$0.082	$0.258	$0.004
PMPY	$1.045	$2.550	$0.241	$0.987	$3.092	$0.050

ENROLLEE OUT-OF-POCKET IMPACT

The estimated enrollee out-of-pocket cost impact post-mandate for SB 518, HB 1366, or both bills is shown in Figures 12 to 14.

For both bills, total fully insured commercial out-of-pocket costs are estimated to decrease by $110,000 or $0.010 PMPM ($0.120 PMPY). State health plan enrollee out-of-pocket costs are estimated to decrease $5,000 or $0.002 PMPM ($0.025 PMPY). Medicaid enrollee out-of-pocket costs are estimated to not change.

FIGURE 12: ESTIMATED POST-MANDATE ENROLLEE OUT-OF-POCKET IMPACT OF SB 518, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Total Out-of-Pocket	-$42,000	-$25,000	-$25,000	-$92,000	-$5,000	$0
Out-of-Pocket PMPM	-$0.012	-$0.010	-$0.005	-$0.008	-$0.002	$0.000
Out-of-Pocket PMPY	-$0.148	-$0.124	-$0.056	-$0.099	-$0.021	$0.000

FIGURE 13: ESTIMATED POST-MANDATE ENROLLEE OUT-OF-POCKET IMPACT OF HB 1366, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Total Out-of-Pocket	-$10,000	-$7,000	-$19,000	-$36,000	-$2,000	$0
Out-of-Pocket PMPM	-$0.003	-$0.003	-$0.004	-$0.003	-$0.001	$0.000
Out-of-Pocket PMPY	-$0.037	-$0.036	-$0.042	-$0.039	-$0.009	$0.000

FIGURE 14: ESTIMATED POST-MANDATE ENROLLEE OUT-OF-POCKET IMPACT OF SB 518 AND HB 1366, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Total Out-of-Pocket	-$46,000	-$28,000	-$36,000	-$110,000	-$5,000	$0
Out-of-Pocket PMPM	-$0.014	-$0.012	-$0.007	-$0.010	-$0.002	$0.000
Out-of-Pocket PMPY	-$0.165	-$0.141	-$0.082	-$0.120	-$0.025	$0.000

TOTAL COST OF CARE IMPACT

The total estimated cost of care impact, including out-of-pocket costs, from passing SB 518, HB 1366, or both bills is shown in Figures 15 to 17.

For both bills, total fully insured commercial cost of care is estimated to increase by $800,000 or $0.072 PMPM ($0.867 PMPY). State health plan total estimated cost of care impact is estimated to increase $657,000 or $0.256 PMPM ($3.067 PMPY). Medicaid costs are estimated to increase by $75,000, or $0.004 PMPM ($0.050 PMPY).

FIGURE 15: ESTIMATED POST-MANDATE TOTAL COST OF CARE IMPACT OF SB 518, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Total Cost of Care	$226,000	$444,000	$59,000	$729,000	$564,000	$38,000
Total Cost of Care PMPM	$0.067	$0.185	$0.011	$0.066	$0.220	$0.002
Total Cost of Care PMPY	$0.806	$2.221	$0.133	$0.791	$2.640	$0.025

FIGURE 16: ESTIMATED POST-MANDATE TOTAL COST OF CARE IMPACT OF HB 1366, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Total Cost of Care	$55,000	$103,000	$26,000	$184,000	$205,000	$42,000
Total Cost of Care PMPM	$0.016	$0.043	$0.005	$0.017	$0.080	$0.002
Total Cost of Care PMPY	$0.195	$0.514	$0.059	$0.199	$0.958	$0.028

FIGURE 17: ESTIMATED POST-MANDATE TOTAL COST OF CARE IMPACT OF SB 518 AND HB 1366, 2027

	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	TOTAL FULLY INSURED COMMERCIAL	STATE HEALTH PLAN	MEDICAID
Total Cost of Care	$248,000	$482,000	$70,000	$800,000	$657,000	$75,000
Total Cost of Care PMPM	$0.073	$0.201	$0.013	$0.072	$0.256	$0.004
Total Cost of Care PMPY	$0.880	$2.409	$0.159	$0.867	$3.067	$0.050

See Appendix C and D for more detailed information on PMPM and total cost of care.

Methodology and Assumptions

As noted in the prior section, the financial evaluation projects the population, cost of benefits, commercial premium and Medicaid costs, and enrollee cost sharing for the 2027 calendar year under the following four scenarios:

1. Baseline: Proposed legislation *does not* go into effect.
2. Post-mandate: *Only* proposed legislation SB 518 goes into effect.
3. Post-mandate: *Only* proposed legislation HB 1366 goes into effect.
4. Post-mandate: *Both* proposed legislations, SB 518 and SH 1366, go into effect.

The difference between the baseline and post-mandate values is the impact of the proposed legislations.

MARYLAND POPULATION

We used the Maryland population changes from the 2020 census to the 2030 census projection to trend 2024 enrollment data from Maryland's All-Payer Claims Database (APCD) to 2027. We adjusted our initial 2027 population estimate for Medicaid redetermination, which began in Maryland in April 2023, based on Maryland Medicaid redetermination enrollment estimates as of June 2025.

BENEFIT COVERAGE

We surveyed insurance carriers in Maryland about current coverage of ovarian cancer screening in Maryland. We received responses from five carriers. These five carriers represent over 95% of commercial enrollees, including the state health plan, and 24% of the Medicaid enrollees.

No carrier specifically stated that it covered ovarian cancer screening as a preventative service. Of the carriers surveyed, three out of five respondents indicated that ovarian cancer screening is covered for Maryland enrollees across all markets with MRIs and CT scans being covered when medically necessary, one carrier indicated coverage for ovarian cancer screening MRIs and CT scans being covered when medically necessary and no coverage for ovarian cancer screening, and the last carrier indicated no coverage for any ovarian cancer screening. We assumed carriers that noted coverage for MRIs or CT scans included broader coverage for more common biomarker tests as well as ultrasounds.

As discussed above, cervical cancer screening is recommended by USPSTF and required as part of the ACA and we assumed all carriers had coverage for cervical cancer screening as described in HB 1366.

BASELINE AND POST-MANDATE OVARIAN CANCER AND CERVICAL CANCER SCREENING UTILIZATION

For SB 518, we identified four types of ovarian cancer screenings in the APCD for adults age 45 and older: tumor marker tests, ultrasounds, MRIs, and CT scans, all requiring ovarian cancer diagnosis codes to be attached to the claim.

For HB 1366, we identified three types of ovarian cancer screenings in the APCD: tumor marker tests, ultrasounds, and pelvic exams through specific pelvic exams claims and well visit claims with specific providers, all requiring ovarian cancer diagnosis codes to be attached to the claim for patients with a family history or gene mutation. We also identified cervical cancer screenings through pap smear claims.

We applied 0% utilization trend to the 2024 APCD data to trend it to 2027.

At baseline, we assumed utilization per 1,000 of ovarian cancer screening for each source of healthcare coverage corresponds to the results of the benefit coverage survey. Post-mandate, we made an adjustment for ovarian cancer screening by increasing utilization proportionally to full coverage from the surveyed coverage at baseline. Because we assumed cervical cancer screening is 100% covered at baseline, we applied no coverage adjustment to cervical cancer screening utilization from baseline to post-mandate. For services with cost sharing at baseline, we applied induced utilization adjustments to account for the increase in utilization of services due to the elimination of cost sharing.

OVARIAN CANCER SCREENING AND CERVICAL CANCER SCREENING COST

For the utilization identified above, we trended the 2024 APCD average allowed cost and cost sharing of each category of ovarian cancer and cervical cancer screening to calculate the costs in 2027. We used a 4.5% annual cost trend based on the Milliman Health Cost Guidelines for commercial sources of healthcare coverage and 3.3% annual cost trend for Medicaid based on CMS trend history.

Post-mandate, we assumed the allowed cost for individual cancer screening services would not change as a result of either bill, but the average allowed cost for all screenings combined may change slightly due to service utilization mixture changes as a result of the proposed legislation. There would be no enrollee cost sharing post-mandate and utilization for expensive screenings may increase differently than less expensive screenings due to the removal of cost sharing.

MHCC reported issues in the APCD regarding claims dollars for Medicaid enrollees and we applied a calculated commercial to Medicaid cost ratio for some services instead of using the APCD data.

COMMERCIAL PREMIUM, MEDICAID COST, AND RETENTION

We assumed a medical loss ratio of 80% for fully insured commercial individual and small group plans, a medical loss ratio of 85% for fully insured large group plans and the state health plan, and a medical loss ratio of 92% for the Medicaid population.

We assumed no additional administrative costs due to this mandate beyond the typical proportional increase in retention costs when applied to medical cost increases.

Considerations and Limitations

As discussed in the Medical Evaluation section above, ovarian cancer screening is not recommended for asymptomatic individuals and 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. On the other hand, cervical cancer screening is recommended by the USPTF, required by the ACA, and we assumed 100% coverage baseline and post-mandate and no change in utilization as a result of HB 1366 beyond elimination of cost-sharing.

Some ovarian cancer screenings through pelvic exams were identified through proxy as performed during annual well visits with a provider whose specialties would perform pelvic exams during well visits. If pelvic exams were not performed during those visits, the utilization of HB 1366 ovarian cancer screening may be overstated.

The results from the coverage survey for ovarian cancer screening show 64% of the Medicaid population has coverage for ovarian cancer screening. Coverage by some carriers but not others is noteworthy due to the nature of Medicaid coverage but we have accepted the results of the coverage survey as is. The five coverage survey respondents represent approximately 24% of Maryland Medicaid enrollees as compared to over 95% of commercial fully insured enrollees. For this analysis, we assumed the remaining 76% of Medicaid enrollees have the same 64% coverage for ovarian cancer screening at baseline. If the remaining 76% of Medicaid enrollees have an ovarian cancer screening coverage that is higher or lower than 64%, our results may be lower or higher than projected.

The utilization and cost of surgery or cancer treatment as a result of additional screening was beyond the scope of this analysis.

Variability of Results

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.

Model and Data Reliance

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the impact of bills 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 summaries from Maryland's All-Payer Claims Database provided by Maryland Health Care Commission
- U.S. Census data and projections
- All other sources mentioned inline and in references, including surveys and studies.

The models, including all input, calculations, and output, may not be appropriate for any other purpose.

MHCC reported issues in the APCD regarding claims dollars for Medicaid enrollees. We have chosen to use data for some services as is and applied the commercial to Medicaid cost ratio in the data to other services as needed.

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.

Qualifications to perform analysis

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Two of the developers of this model and authors of this paper, Susan Pantely and Norman Yu, are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses supported by this model.

Distribution and usage

We understand that MHCC intends to distribute this report to the commissioners and it may be published on their website. We consent to this distribution as long as the work is distributed in its entirety. Milliman does not intend to benefit any third-party recipient of its work product and assumes no duty or liability to other parties that receive this work.

Appendix A: Carrier Coverage Survey

COVERAGE SURVEY FOR THE OVARIAN CANCER SCREENING

Insurance Article §15–1501, Annotated Code of Maryland, requires the Maryland Health Care Commission (MHCC) to annually assess the medical, social, and financial impact of proposed mandated health insurance services that failed to pass during the preceding legislative session. The Maryland General Assembly via letter on April 8th, 2025 has requested MHCC to study the cost of requiring health insurers, nonprofit health service plans, and health maintenance organizations to cover the cost of conducting magnetic resonance imaging and computed tomography scans to screen for ovarian cancer.

This survey is intended to inform this analysis. Please return this survey to Jason Caplan via email at Jason.Caplan3@maryland.gov by Friday, August 1st, 2025.

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1) What is the name of the insurance carrier?

2) Please complete the following table with **how many people** are enrolled in the following lines of business as of June 1, 2025?

Individual Market	Small Group Market	Large Group Market	State Employee Health Plan	Medical Assistance Program

3) Please complete the following table with **average monthly premium** in the following lines of business as of June 1, 2025?

Individual Market	Small Group Market	Large Group Market	State Employee Health Plan	Self-Funded Employer Plan[1]	Medical Assistance Program

4) Please complete the following table with the percentage of enrollees who currently have coverage for ovarian cancer screening.

[1] DO NOT include State Health Plan

Individual Market	Small Group Market	Large Group Market	State Employee Health Plan	Self-Funded Employer Plan[2]	Medical Assistance Program

5) For enrollees with coverage for ovarian cancer screening:

   Is magnetic resonance imaging covered? Are there any benefit limitations? Please include any conditions/risk factors that are required for coverage.

   Are computed tomography scans covered? Are there any benefit limitations? Please include any conditions/risk factors that are required for coverage.

6) Do you expect any additional administrative burden resulting from this benefit mandate?

7) Is there any additional information you would like to share as we consider mandating coverage of this benefit?

[2] DO NOT include State Health Plan

Appendix B1: SB 518 Utilization per 1,000

SB 518	Individual	Small Group	Fully Insured Large Group	Total Fully Insured Commercial	State Health Plan	Total Commercial	Medicaid
Total enrollees subject to state mandates	**281,000**	**200,000**	**441,000**	**922,000**	**214,000**	**1,136,000**	**1,498,000**
Baseline ovarian cancer screening utilization per 1,000 enrollees	1.5	1.0	0.7	1.0	1.3	1.1	0.2
Additional ovarian cancer screening utilization attributable to mandated benefits	2.1	4.4	0.3	1.8	6.3	2.6	0.1
Post-mandate ovarian cancer screening utilization per 1,000 enrollees	3.7	5.4	1.0	2.8	7.5	3.7	0.3

Appendix B2: HB 1366 Utilization per 1,000

HB 1366	Individual	Small Group	Fully Insured Large Group	Total Fully Insured Commercial	State Health Plan	Total Commercial	Medicaid
Total enrollees subject to state mandates	**281,000**	**200,000**	**441,000**	**922,000**	**214,000**	**1,136,000**	**1,498,000**
Baseline ovarian cancer screening utilization per 1,000 enrollees	6.2	5.0	5.2	5.5	4.4	5.3	0.6
Baseline cervical cancer screening utilization per 1,000 enrollees	5.4	1.0	2.0	2.8	2.1	2.7	3.6
Total baseline utilization per 1,000 enrollees	**11.6**	**6.0**	**7.2**	**8.3**	**6.5**	**8.0**	**4.2**
Additional ovarian cancer screening utilization attributable to mandated benefits	1.2	2.6	0.3	1.0	3.8	1.6	0.1
Additional cervical cancer screening utilization attributable to mandated benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Additional screening utilization attributable to mandated benefits	**1.2**	**2.6**	**0.3**	**1.0**	**3.8**	**1.6**	**0.1**
Post-mandate ovarian cancer screening utilization per 1,000 enrollees	7.4	7.5	5.5	6.5	8.2	6.8	0.7
Post-mandate cervical cancer screening utilization per 1,000 enrollees	5.4	1.0	2.0	2.8	2.1	2.7	3.6
Total post-mandate utilization per 1,000 enrollees	**12.8**	**8.6**	**7.4**	**9.3**	**10.3**	**9.5**	**4.3**

Appendix B3: SB 518 and HB 1366 Utilization per 1,000

SB 518 and HB 1366	Individual	Small Group	Fully Insured Large Group	Total Fully Insured Commercial	State Health Plan	Total Commercial	Medicaid
Total enrollees subject to state mandates	**281,000**	**200,000**	**441,000**	**922,000**	**214,000**	**1,136,000**	**1,498,000**
Baseline ovarian cancer screening utilization per 1,000 enrollees	7.1	5.6	5.6	6.0	5.2	5.9	0.8
Baseline cervical cancer screening utilization per 1,000 enrollees	5.4	1.0	2.0	2.8	2.1	2.7	3.6
Total baseline utilization per 1,000 enrollees	**12.5**	**6.6**	**7.6**	**8.9**	**7.3**	**8.6**	**4.3**
Additional ovarian cancer screening utilization attributable to mandated benefits	2.5	5.4	0.4	2.1	7.8	3.2	0.2
Additional cervical cancer screening utilization attributable to mandated benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Additional screening utilization attributable to mandated benefits	**2.5**	**5.4**	**0.4**	**2.1**	**7.8**	**3.2**	**0.2**
Post-mandate ovarian cancer screening utilization per 1,000 enrollees	9.6	11.0	6.0	8.2	13.0	9.1	0.9
Post-mandate cervical cancer screening utilization per 1,000 enrollees	5.4	1.0	2.0	2.8	2.1	2.7	3.6
Total post-mandate utilization per 1,000 enrollees	**15.0**	**12.0**	**8.0**	**11.0**	**15.2**	**11.8**	**4.5**

Appendix C1: SB 518 Baseline and post-mandate PMPM

COMMERCIAL PREMIUM, MEDICAID COST, AND ENROLLEE OUT-OF-POCKET PMPM

SB 518	Individual	Small Group	Fully Insured Large Group	Total Fully Insured Commercial	State Health Plan	Total Commercial	Medicaid
Total enrollees subject to state mandates	281,000	200,000	441,000	922,000	214,000	1,136,000	1,498,000
Baseline							
Commercial premium/Medicaid cost attributable to mandated benefits	$0.0287	$0.0293	$0.0142	$0.0219	$0.0417	$0.0256	$0.0035
Enrollee out-of-pocket expenses attributable to mandated benefits	$0.0124	$0.0103	$0.0046	$0.0082	$0.0018	$0.0070	$0.0000
Total Cost of Care for Mandated Benefits	**$0.0411**	**$0.0396**	**$0.0189**	**$0.0301**	**$0.0434**	**$0.0326**	**$0.0035**
Post-Mandate							
Commercial premium/Medicaid cost attributable to mandated benefits	$0.1082	$0.2247	$0.0300	$0.0961	$0.2634	$0.1276	$0.0056
Enrollee out-of-pocket expenses attributable to mandated benefits	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000
Total Cost of Care for Mandated Benefits	**$0.1082**	**$0.2247**	**$0.0300**	**$0.0961**	**$0.2634**	**$0.1276**	**$0.0056**
Financial Impact of Mandate							
Change in commercial premium/Medicaid cost	$0.0795	$0.1955	$0.0158	$0.0742	$0.2217	$0.1020	$0.0021
Change in enrollee out-of-pocket expenses	-$0.0124	-$0.0103	-$0.0046	-$0.0082	-$0.0018	-$0.0070	$0.0000
Total Mandate Impact	**$0.0671**	**$0.1851**	**$0.0111**	**$0.0659**	**$0.2200**	**$0.0950**	**$0.0021**

Appendix C2: HB 1366 Baseline and post-mandate PMPM

COMMERCIAL PREMIUM, MEDICAID COST, AND ENROLLEE OUT-OF-POCKET PMPM

HB 1366	Individual	Small Group	Fully Insured Large Group	Total Fully Insured Commercial	State Health Plan	Total Commercial	Medicaid
Total enrollees subject to state mandates	281,000	200,000	441,000	922,000	214,000	1,136,000	1,498,000
Baseline							
Commercial premium/Medicaid cost attributable to mandated benefits	$0.1097	$0.0855	$0.1000	$0.2953	$0.0822	$0.3774	$0.0111
Enrollee out-of-pocket expenses attributable to mandated benefits	$0.0031	$0.0030	$0.0035	$0.0096	$0.0007	$0.0103	$0.0000
Total Cost of Care for Mandated Benefits	**$0.1127**	**$0.0885**	**$0.1036**	**$0.3048**	**$0.0829**	**$0.3878**	**$0.0111**
Post-Mandate							
Commercial premium/Medicaid cost attributable to mandated benefits	$0.1290	$0.1313	$0.1085	$0.3688	$0.1628	$0.5316	$0.0134
Enrollee out-of-pocket expenses attributable to mandated benefits	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000
Total Cost of Care for Mandated Benefits	**$0.1290**	**$0.1313**	**$0.1085**	**$0.3688**	**$0.1628**	**$0.5316**	**$0.0134**
Financial Impact of Mandate							
Change in commercial premium/Medicaid cost	$0.0193	$0.0458	$0.0084	$0.0199	$0.0806	$0.0313	$0.0023
Change in enrollee out-of-pocket expenses	-$0.0031	-$0.0030	-$0.0035	-$0.0033	-$0.0007	-$0.0028	$0.0000
Total Mandate Impact	**$0.0163**	**$0.0428**	**$0.0049**	**$0.0166**	**$0.0798**	**$0.0285**	**$0.0023**

Appendix C3: SB 518 and HB 1366 Baseline and post-mandate PMPM

COMMERCIAL PREMIUM, MEDICAID COST, AND ENROLLEE OUT-OF-POCKET PMPM

SB 518 and HB 1366	Individual	Small Group	Fully Insured Large Group	Total Fully Insured Commercial	State Health Plan	Total Commercial	Medicaid
Total enrollees subject to state mandates	281,000	200,000	441,000	922,000	214,000	1,136,000	1,498,000
Baseline							
Commercial premium/Medicaid cost attributable to mandated benefits	$0.1335	$0.1105	$0.1112	$0.3552	$0.1152	$0.4705	$0.0142
Enrollee out-of-pocket expenses attributable to mandated benefits	$0.0137	$0.0117	$0.0068	$0.0323	$0.0021	$0.0343	$0.0000
Total Cost of Care for Mandated Benefits	**$0.1473**	**$0.1222**	**$0.1180**	**$0.3875**	**$0.1173**	**$0.5048**	**$0.0142**
Post-Mandate							
Commercial premium/Medicaid cost attributable to mandated benefits	$0.2206	$0.3230	$0.1313	$0.6749	$0.3729	$1.0478	$0.0184
Enrollee out-of-pocket expenses attributable to mandated benefits	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000
Total Cost of Care for Mandated Benefits	**$0.2206**	**$0.3230**	**$0.1313**	**$0.6749**	**$0.3729**	**$1.0478**	**$0.0184**
Financial Impact of Mandate							
Change in commercial premium/Medicaid cost	$0.0871	$0.2125	$0.0201	$0.0822	$0.2577	$0.1153	$0.0042
Change in enrollee out-of-pocket expenses	-$0.0137	-$0.0117	-$0.0068	-$0.0100	-$0.0021	-$0.0085	$0.0000
Total Mandate Impact	**$0.0733**	**$0.2008**	**$0.0133**	**$0.0723**	**$0.2556**	**$0.1068**	**$0.0042**

Appendix D1: SB 518 Baseline and post-mandate cost

COMMERCIAL PREMIUM, MEDICAID COST, AND ENROLLEE OUT-OF-POCKET TOTAL COST

SB 518	Individual	Small Group	Fully Insured Large Group	Total Fully Insured Commercial	State Health Plan	Total Commercial	Medicaid
Total enrollees subject to state mandates	281,000	200,000	441,000	922,000	214,000	1,136,000	1,498,000
Baseline							
Commercial premium/Medicaid cost attributable to mandated benefits	$97,000	$70,000	$75,000	$242,000	$107,000	$349,000	$63,000
Enrollee out-of-pocket expenses attributable to mandated benefits	$42,000	$25,000	$25,000	$92,000	$5,000	$97,000	$0
Total Cost of Care for Mandated Benefits	**$139,000**	**$95,000**	**$100,000**	**$334,000**	**$112,000**	**$446,000**	**$63,000**
Post-Mandate							
Commercial premium/Medicaid cost attributable to mandated benefits	$365,000	$539,000	$159,000	$1,063,000	$676,000	$1,739,000	$101,000
Enrollee out-of-pocket expenses attributable to mandated benefits	$0	$0	$0	$0	$0	$0	$0
Total Cost of Care for Mandated Benefits	**$365,000**	**$539,000**	**$159,000**	**$1,063,000**	**$676,000**	**$1,739,000**	**$101,000**
Financial Impact of Mandate							
Change in commercial premium/Medicaid cost	$268,000	$469,000	$84,000	$821,000	$569,000	$1,390,000	$38,000
Change in enrollee out-of-pocket expenses	-$42,000	-$25,000	-$25,000	-$92,000	-$5,000	-$97,000	$0
Total Mandate Impact	**$226,000**	**$444,000**	**$59,000**	**$729,000**	**$564,000**	**$1,293,000**	**$38,000**

Appendix D2: HB 1366 Baseline and post-mandate cost

COMMERCIAL PREMIUM, MEDICAID COST, AND ENROLLEE OUT-OF-POCKET TOTAL COST

HB 1366	Individual	Small Group	Fully Insured Large Group	Total Fully Insured Commercial	State Health Plan	Total Commercial	Medicaid
Total enrollees subject to state mandates	281,000	200,000	441,000	922,000	214,000	1,136,000	1,498,000
Baseline							
Commercial premium/Medicaid cost attributable to mandated benefits	$370,000	$205,000	$529,000	$1,104,000	$211,000	$1,315,000	$200,000
Enrollee out-of-pocket expenses attributable to mandated benefits	$10,000	$7,000	$19,000	$36,000	$2,000	$38,000	$0
Total Cost of Care for Mandated Benefits	**$380,000**	**$212,000**	**$548,000**	**$1,140,000**	**$213,000**	**$1,353,000**	**$200,000**
Post-Mandate							
Commercial premium/Medicaid cost attributable to mandated benefits	$435,000	$315,000	$574,000	$1,324,000	$418,000	$1,742,000	$242,000
Enrollee out-of-pocket expenses attributable to mandated benefits	$0	$0	$0	$0	$0	$0	$0
Total Cost of Care for Mandated Benefits	**$435,000**	**$315,000**	**$574,000**	**$1,324,000**	**$418,000**	**$1,742,000**	**$242,000**
Financial Impact of Mandate							
Change in commercial premium/Medicaid cost	$65,000	$110,000	$45,000	$220,000	$207,000	$427,000	$42,000
Change in enrollee out-of-pocket expenses	-$10,000	-$7,000	-$19,000	-$36,000	-$2,000	-$38,000	$0
Total Mandate Impact	**$55,000**	**$103,000**	**$26,000**	**$184,000**	**$205,000**	**$389,000**	**$42,000**

Appendix D3: SB 518 and HB 1366 Baseline and post-mandate cost

COMMERCIAL PREMIUM, MEDICAID COST, AND ENROLLEE OUT-OF-POCKET TOTAL COST

SB 518 and HB 1366	Individual	Small Group	Fully Insured Large Group	Total Fully Insured Commercial	State Health Plan	Total Commercial	Medicaid
Total enrollees subject to state mandates	281,000	200,000	441,000	922,000	214,000	1,136,000	1,498,000
Baseline							
Commercial premium/Medicaid cost attributable to mandated benefits	$450,000	$265,000	$589,000	$1,304,000	$296,000	$1,600,000	$255,000
Enrollee out-of-pocket expenses attributable to mandated benefits	$46,000	$28,000	$36,000	$110,000	$5,000	$115,000	$0
Total Cost of Care for Mandated Benefits	**$496,000**	**$293,000**	**$625,000**	**$1,414,000**	**$301,000**	**$1,715,000**	**$255,000**
Post-Mandate							
Commercial premium/Medicaid cost attributable to mandated benefits	$744,000	$775,000	$695,000	$2,214,000	$958,000	$3,172,000	$330,000
Enrollee out-of-pocket expenses attributable to mandated benefits	$0	$0	$0	$0	$0	$0	$0
Total Cost of Care for Mandated Benefits	**$744,000**	**$775,000**	**$695,000**	**$2,214,000**	**$958,000**	**$3,172,000**	**$330,000**
Financial Impact of Mandate							
Change in commercial premium/Medicaid cost	$294,000	$510,000	$106,000	$910,000	$662,000	$1,572,000	$75,000
Change in enrollee out-of-pocket expenses	-$46,000	-$28,000	-$36,000	-$110,000	-$5,000	-$115,000	$0
Total Mandate Impact	**$248,000**	**$482,000**	**$70,000**	**$800,000**	**$657,000**	**$1,457,000**	**$75,000**

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