LEWIS & ELLIS
Actuaries and Consultants

6600 Chase Oaks Blvd, Suite 150
Plano, TX 75023-2383

972-850-0850
lewisellis.com

A Comprehensive Analysis of Maryland's Mandated Health Insurance Services

Required Under Insurance Article § 15-1502

March 13, 2024

PREPARED FOR THE MARYLAND HEALTH CARE COMMISSION

Randolph S. Sergent, Esq.
Chairman

Ben Steffen
Executive Director

PREPARED BY:
TRACI HUGHES, FSA, MAAA
DAVE DILLON, FSA, MAAA

MARYLAND Health Care Commission

Randolph S. Sergent, Esq., Chairman
Vice President and Deputy General Counsel
CareFirst BlueCross BlueShield

Arun Bhandari, M.D.
Chesapeake Oncology Hematology Associates, PA

Hassanatu Blake, PhD, MPH, MBA
Director, Health Equity & Social Justice
National Association of County & City Health Officials

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Founder
Immune Deficiency Foundation

Kenneth Buczynski, M.D.
Founder of Wellspring Family Medicine

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Physician in Chief of the Mid-Atlantic Permanente Medical Group

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Director of Talent Development
Brightview Senior Living

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Education Division Director
COLA, Inc.

Joan L. Gelrud, RN, MSN, FACHE, CPHQ
Court Appointed Special Advocate for Children Removed for Abuse and Neglect

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Director, Health Equity Initiatives
The Patient Advocate Foundation

Mark T. Jensen, Esq.
Partner
Bowie & Jensen, LLC

Awawu Ojikutu, CRNP
Nurse Practitioner
AIM Behavioral Health Services

Jovonni Spinner, Ph.D, MPH, CHES
CEO/Founder
Beacon Public Health

Marcus L. Wang, Esq.
Director, Department of Economic and Workforce Development, Baltimore County

Karrie M. Wood
Business Development Market Executive
Shore United Bank

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Highlights

The following is a brief outline of the highlights from the full report on the comprehensive, comparative review, and actuarial analysis of state mandated health insurance benefits and services (mandates) in Maryland and its surrounding states:

- There are 68 mandates outlined in detail within the full report, with 56 of them applying to all markets.

- A detailed comparison of the mandates to the essential health benefits (EHBs) and EHB-benchmark plan is outlined in the full report. In summary, 57 of the 68 Maryland mandates are covered by the EHB-benchmark plan.

- The total full cost of the mandates was estimated to be 17.3% of premium, or $101.21 per member per month (PMPM), on average across all markets. The top ten most costly mandates accounted for approximately 13.5% of the 17.3% of premium cost. Further details regarding the factors contributing to the higher costs of these top ten mandates are included in the full report. While the overall full cost of the top ten most expensive mandates as a percentage of premium is significant, the marginal cost of these mandates is estimated to be only 0.1% of premium.

- The total marginal cost, or the full cost minus the benefit cost that would remain even if the mandate were repealed, was estimated to be 0.8% of premium, or $5.03 PMPM, on average across all markets.

- Most self-insured plans are regulated by the Employee Retirement Income Security Act of 1974 (ERISA) and not required to comply with state mandates. The Maryland data on voluntary self-insured compliance was broad and imprecise, so L&E categorized the compliance levels into specific ranges detailed in the full report. In summary, 60 out of 68 mandates had an estimated self-funded market compliance rate of “half” or more.

- In comparison to neighboring jurisdictions (Delaware, the District of Columbia, Pennsylvania, and Virginia) Maryland's mandates demonstrate a similar overall value. Whether contemplating reducing mandates to align more closely with surrounding states, adding mandates to achieve parity with surrounding states, or a combination of both approaches, Maryland's current mandate full cost value remains within a range of 4 percentage points.

Executive Summary

INTRODUCTION

The Maryland Health Care Commission (MHCC) engaged Lewis & Ellis, LLC (L&E) to assist with conducting a comprehensive, comparative review, and actuarial analysis of state mandated health insurance benefits and services (mandates) in Maryland and its surrounding states. This analysis is required every four years by Insurance Article §15-1502 of the Annotated Code of Maryland.

The mandates included within the analysis are within the Annotated Code of Maryland, *Insurance Article Title 15, Subtitle 8, Required Health Insurance Benefits.* There are 68 mandates outlined in detail within the full report, with 56 of them applying to all markets. Seven mandates have been amended and nine mandates have been added since the prior comprehensive mandate analysis was performed.

COMPARISON OF MANDATES TO ESSENTIAL HEALTH BENEFITS

The Affordable Care Act (ACA) was signed into law in 2010 with the majority of its small group and individual market policies becoming effective in 2014. Per the ACA, all individual and small group insurance plans are mandated to include coverage for 10 essential health benefits (EHBs). The U.S. Department of Health and Human Services (HHS) regulations (45 CFR §156.110 through §156.115) further defines compliance with the EHB provision as a health plan that provides benefits that are, among other things, substantially equal to a state's selected EHB-benchmark plan. For both the individual and small group markets, Maryland's EHB-benchmark plan is the 2017 Small Group CareFirst BlueChoice HMO/HRA $1500 Plan. A detailed comparison of the mandates to the EHB-benchmark plan is outlined in the full report. In summary, 57 of the 68 Maryland mandates are covered by the EHB-benchmark plan.

FULL COST ANALYSIS

L&E conducted a comprehensive assessment of the full cost of each mandate, presented in the full report as a percentage of premium and as a percentage of the State's average annual wage. This full cost evaluation was conducted for each designated market, including Individual, Small Group, Large Group, and the State Employee Health Benefit Plan (SEHBP or "State Plan"). The primary data sources employed were the responses obtained from L&E's insurance carrier survey. The primary data utilized from the insurance carrier survey was data from 2022.

Total 2022 Premiums by Market were:

Market	PMPM
Individual	$402.97
Small Group	$495.95
Large Group	$553.15
Fully Insured Subtotal	*$524.49*
SEHBP	$901.71
Grand Total	**$596.93**

As a percent of premium, the total full cost of the mandates by market were estimated to be:

Market	% of Premium	PMPM
Individual	28.7%	$115.65
Small Group	16.1%	$79.94
Large Group	15.7%	$86.92
Fully Insured Subtotal	*17.5%*	*$89.55*
SEHBP	16.7%	$150.29
Grand Total	**17.3%**	**$101.21**

The top ten highest full cost mandates, on average across all markets, were –

- 15-802: Mental Health & Substance Abuse Treatment
- 15-812: Hospital Coverage for Mothers and Newborns - Minimum Coverage
- 15-817: Child Wellness Services
- 15-835: Habilitative Services for Minors
- 15-853: Lymphedema Treatment
- 15-814: Cancer Screening - Mammograms
- 15-837: Cancer Screening - Colorectal
- 15-846: Cancer Coverage - Cost Sharing for Oral Chemotherapy
- 15-822.1: Prescription Drugs - Limit Cost Sharing for Insulin
- 15-808: Home Health Care

The top ten mandates account for an estimated 13.5% of premium while all mandates account for an estimated 17.3% of premium, on average across all markets.

The following reasons are attributed to their inclusion among the most expensive mandates –

- Mental health & substance abuse treatment is the highest cost mandate. The surge in the demand and the severity of these services, fueled by the COVID-19 pandemic and the persistent opioid crises, play significant roles in driving up the costs associated with this mandate.
- A few mandates encompass expansive service categories utilized for various purposes, including mental health & substance abuse treatment, habilitative services, and home health care.
- A few mandates cover commonly utilized preventive care services: child wellness services and cancer screenings (mammograms and colorectal).
- Hospitalization for childbirth is a widely utilized service, given the birth rate of 11 per 1,000 in the United States. Moreover, it comes with a significant cost, averaging around $15,000.
- Lymphedema, particularly secondary lymphedema, is the most common cause of disease and affects approximately 1 in 1,000 Americans. Furthermore, the treatment for lymphedema comes with a considerable cost, averaging around $15,000.
- Oral chemotherapy is a viable treatment option for nearly all cancer types, including some of the most common: breast cancer, prostate cancer, and colorectal cancer. Additionally, oral chemotherapy entails significant costs, averaging around $50,000.

- ❖ Insulin is highly utilized as a primary treatment for diabetes, which is prevalent in approximately 9% of the United States population. Approximately 12% of those diagnosed with diabetes start using insulin within a year of diagnosis. Insulin has a material annual cost of approximately $6,000.

L&E notes that while the overall full cost of the top ten most expensive mandates as a percentage of premium is significant, the marginal cost of these mandates is estimated to be only 0.1% of premium.

MARGINAL COST ANALYSIS

While a mandate's full cost is important in analyzing its impact, it is essential to recognize that a significant portion of the full costs would be present in health insurance coverage even without a mandate. There are two primary reasons costs might exist independently of a mandate:

1. A carrier covers the service. This can be defined by a carrier:
   - ➢ Covering the benefit or service before the mandate was effective,
   - ➢ Covering the benefit or service in a market in which it is not mandated, or
   - ➢ Covering the benefit or service in another state in which it is not mandated.
2. The benefit is required to be covered by the ACA and/or the State's EHB-Benchmark plan.

Marginal cost is defined as the full cost minus the benefit cost that would remain even if the mandate were repealed. This approach produces the residual cost induced by the mandate.

The marginal cost, expressed as a percent of premium for each market, is estimated to be:

Market	% of Premium	PMPM
Individual	0.3%	$0.99
Small Group	0.2%	$0.73
Large Group	1.0%	$5.59
Fully Insured Subtotal	*0.8%*	*$4.22*
SEHBP	0.9%	$8.46
Grand Total	**0.8%**	**$5.03**

MANDATES IN THE SELF-FUNDED MARKET

Most self-insured plans are regulated by the Employee Retirement Income Security Act of 1974 (ERISA). As a result, most self-insured plans are not required to comply with state mandates. The Maryland data on voluntary self-insured compliance was broad and imprecise, so L&E categorized the compliance levels into specific ranges.

- "Almost All": 90-100% compliance rate
- "Most": 61-89% compliance rate
- "Half": 40-60% compliance rate
- "Some": 11-39% compliance rate
- "Very Little": 0-10% compliance rate

In summary, 60 out of 68 mandates had a self-funded market compliance rate of "half" or more.

COMPARISON OF MANDATES TO SURROUNDING STATES

Additionally, L&E conducted a comparative analysis of mandated health insurance benefits and services between Maryland and the following neighboring jurisdictions: Delaware, the District of Columbia, Pennsylvania, and Virginia. A detailed comparison is included in the full report.

In summary, in comparison to neighboring states, Maryland's mandates demonstrate a similar overall value. Whether contemplating reducing mandates to align more closely with surrounding states, adding mandates to achieve parity with surrounding states, or a combination of both approaches, Maryland's current mandate full cost value remains within a range of 4 percentage points.

Introduction

The Maryland Health Care Commission (MHCC) engaged Lewis & Ellis, LLC (L&E) to assist with conducting a comprehensive, comparative review, and actuarial analysis of state mandated health insurance benefits and services (mandates) in Maryland and its surrounding states. This analysis is required every four years by Insurance Article §15-1502 of the Annotated Code of Maryland.

As part of this analysis, L&E was asked to do the following tasks:

- Indicate how the coverage required by each mandate may overlap with the Essential Health Benefits (EHBs) provision of the Affordable Care Act (ACA).
- Develop an assessment of the full cost of each mandate as a percentage of premium and as a percentage of Maryland's average annual wage.
- Develop an assessment of the marginal cost of each mandate as a percentage of premium.
- Assess the degree to which mandated services are voluntarily covered under self-funded plans.
- Provide a comparison of mandated services in Maryland versus those required in surrounding states (Delaware, D.C., Pennsylvania, Virginia).

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

- Maryland published reports[1,2,3,4] and discussions with MHCC regarding mandates and their applicability to various markets.
- Insurance carrier surveys, conducted by L&E, sent to Aetna, CareFirst, Cigna, Kaiser, and United Healthcare.
- Codes and/or statutes of surrounding states.
- Mandate cost impact analysis reports available from other states.
- Other publicly available research.

Maryland Health Benefit Mandates

L&E began by determining the mandates that should be included within the analysis and report by reviewing the Annotated Code of Maryland, *Insurance Article Title 15, Subtitle 8, Required Health Insurance Benefits.*

Table 1 includes a statute citation, an indication of whether the mandate was added or amended since the prior comprehensive mandate analysis (2019), and the health insurance markets

[1] https://insurance.maryland.gov/Consumer/Documents/publicnew/mandatedbenefits.pdf

[2] Annotated Code of Maryland, Insurance Article §15-801 through §15-860 and §31-116

[3] https://insurance.maryland.gov/Insurer/Pages/FormFilingChecklists.aspx

[4] Maryland Insurance Administration Bulletins 15-33 and 23-5

(individual, small group, and large group) in which each mandate applies.[5] The State Employee Health Benefit Plan (SEHBP or "State Plan") is self-insured but is a public/non-ERISA (Employee Retirement Income Security Act of 1974) plan and is therefore subject to state mandates.

TABLE 1 - APPLICATION OF MARYLAND MANDATES TO THE INDIVIDUAL, SMALL GROUP, AND LARGE GROUP FULLY INSURED HEALTH INSURANCE MARKETS

Citation	Added or Amended Since 2019	Mandate Description	Individual	Small Group	Large Group/ SEHBP
15-801		Alzheimer's Disease Treatment & Care	**N/A**	**Offered**	**Offered**
15-802	Amended	Mental Health & Substance Abuse Treatment	**Yes**	**Yes**	**Yes**
15-803		Blood Products	**Yes**	**Yes**	**Yes**
15-804		Prescription Drugs - Off-Label Use	**Yes**	**Yes**	**Yes**
15-805		Prescription Drugs - Mail Order Cost Sharing & Reimbursement	**Yes**	**Yes**	**Yes**
15-806		Prescription Drugs - Choice of Pharmacy	**Yes**	**Yes**	**Yes**
15-807		Medical Foods & Modified Food Products	**Yes**	**Yes**	**Yes**
15-808		Home Health Care	**Yes**	**Yes**	**Yes**
15-809		Hospice Care Services	**Offered**	**Offered**	**Offered**
15-810	Amended	In Vitro Fertilization (IVF) Infertility Benefits	**Yes**	**Partial (1)**	**Yes**
15-810.1		Fertility Preservation Procedures for Iatrogenic Infertility	**N/A**	**N/A**	**Yes**
15-811		Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage	**Yes**	**Yes**	**Yes**
15-812		Hospital Coverage for Mothers and Newborns - Minimum Coverage	**Yes**	**Yes**	**Yes**
15-813		Benefits for Disabilities Caused by Pregnancy or Childbirth	**N/A**	**Offered**	**Offered**
15-814		Cancer Screening - Mammograms	**Yes**	**Yes**	**Yes**
15-814.1	Added	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	**Yes**	**Yes**	**Yes**
15-815		Reconstructive Breast Surgery	**Yes**	**Yes**	**Yes**
15-816		Direct Access to Gynecological Care	**Yes**	**Yes**	**Yes**
15-817		Child Wellness Services	**Yes**	**Yes**	**Yes**
15-818		Cleft Lip/Cleft Palate Treatment	**Yes**	**Yes**	**Yes**
15-819		Utilization Review Denial Alternative Coverage and Second Opinions	**Yes**	**Yes**	**Yes**
15-820		Orthopedic Braces	**Yes**	**Yes**	**Yes**
15-821		Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	**Yes**	**Yes**	**Yes**
15-822		Diabetic Equipment, Supplies, and Self-Management Training	**Yes**	**Yes**	**Yes**
15-822.1	Added	Prescription Drugs - Cost Sharing for Insulin	**Yes**	**Yes**	**Yes**
15-823		Osteoporosis Prevention and Treatment	**Yes**	**Yes**	**Yes**
15-824		Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	**Yes**	**Yes**	**Yes**
15-825	Amended	Cancer Screening - Prostate	**Yes**	**Yes**	**Yes**
15-826/826.1		Contraceptive Drugs or Devices	**Yes**	**Yes**	**Yes**
15-826.2		Male Sterilization Cost Sharing	**Yes**	**Yes**	**Yes**
15-826.3		Fertility Awareness-Based Methods	**N/A**	**N/A**	**Yes**
15-827		Clinical Trials	**Yes**	**Yes**	**Yes**

[5] If a mandate applies to the Individual Market, it also applies to the Student Health Market per: https://www.cms.gov/CCIIO/Resources/Training-Resources/Downloads/Student-Health-Plan-Checklist.pdf.

Citation	Added or Amended Since 2019	Mandate Description	Individual	Small Group	Large Group/ SEHBP
15-828		General Anesthesia for Pediatric Dental Care	**Yes**	**Yes**	**Yes**
15-829		Chlamydia & Human Papillomavirus Screening	**Yes**	**Yes**	**Yes**
15-830	Amended	Referrals to Specialists	**Yes**	**Yes**	**Yes**
15-831	Amended	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	**Yes**	**Yes**	**Yes**
15-832		Surgical Removal of Testicle	**Yes**	**Yes**	**Yes**
15-832.1		Hospitalization Coverage Following Mastectomy	**Yes**	**Yes**	**Yes**
15-833		Extension of Benefits	**Yes**	**Yes**	**Yes**
15-834		Prostheses Following Mastectomy	**Yes**	**Yes**	**Yes**
15-835		Habilitative Services for Minors	**Yes**	**Yes**	**Yes**
15-836		Hair Prosthesis	**Yes**	**N/A**	**Yes**
15-837		Cancer Screening - Colorectal	**Yes**	**Yes**	**Yes**
15-838		Hearing Aids for Minors	**Yes**	**Yes**	**Yes**
15-839		Morbid Obesity Treatment	**Yes**	**Yes**	**Yes**
15-840		Medically Necessary Residential Crisis Services	**Yes**	**Yes**	**Yes**
15-841		Smoking Cessation Treatment	**Yes**	**Yes**	**Yes**
15-842		Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	**Yes**	**Yes**	**Yes**
15-843		Amino Acid-Based Elemental Formula	**Yes**	**Yes**	**Yes**
15-844		Prosthetic Devices	**Yes**	**Yes**	**Yes**
15-845		Prescription Drugs - Eye Drop Refills	**Yes**	**Yes**	**Yes**
15-846		Cancer Coverage - Cost Sharing for Oral Chemotherapy	**Yes**	**Yes**	**Yes**
15-847/847.1	Amended	Prescription Drugs - Specialty Drug Cost Sharing Limit	**Yes**	**Yes**	**Yes**
15-848		Ostomy Equipment and Supplies	**N/A**	**N/A**	**Yes**
15-849		Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	**Yes**	**Yes**	**Yes**
15-850		Prior Authorizations for Opioid Antagonist	**Yes**	**Yes**	**Yes**
15-851		Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	**Yes**	**Yes**	**Yes**
15-852		Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	**Yes**	**Yes**	**Yes**
15-853		Lymphedema Treatment	**N/A**	**N/A**	**Yes**
15-854	Added	Prior Authorizations for Drugs Used to Treat Chronic Conditions	**Yes**	**Yes**	**Yes**
15-855	Added	Pediatric Autoimmune Neuropsychiatric Disorders	**N/A**	**N/A**	**Yes**
15-856[6]	Added	COVID-19 Tests Coverage	**N/A**	**N/A**	**N/A**
15-857	Added	Coverage of Abortion Care Services	**Yes**	**Yes**	**Yes**
15-858	Added	Prior Authorizations for Prescription Drug HIV Prevention	**Yes**	**Yes**	**Yes**
15-859	Added	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	**Yes**	**Yes**	**Yes**
15-860	Added	Biomarker Testing	**N/A**	**N/A**	**Yes**
(1) 15-810 does not apply except for the requirements outlined in subsection (b) **if** IVF benefits are covered					
"Offered" indicates mandated benefits that only must be offered and not covered					

[6] 15-856 mandated COVID-19 testing coverage as required by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The CARES Act set forth requirements for COVID-19 testing coverage during the Public Health Emergency (PHE). The PHE ended in May 2023, therefore COVID-19 testing coverage requirements have expired.

As shown in Table 1, most mandates are applicable to all insured markets. Seven mandates have been amended and nine mandates have been added since the prior comprehensive mandate analysis was performed.

Comparison of Mandates to Essential Health Benefits

The Affordable Care Act (ACA) was signed into law in 2010 with the majority of its small group and individual market policies becoming effective in 2014. Per the ACA, all individual and small group insurance plans are mandated to include coverage for 10 essential health benefits. The EHB requirement does not extend to self-insured group health plans, health plans in the large group market, or grandfathered health plans. Per the EHB requirement, all ACA-regulated individual and small group plans must cover[7]:

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital)
2. Emergency services
3. Hospitalization (like surgery and overnight stays)
4. Pregnancy, maternity, and newborn care (both before and after birth, including birth control and breastfeeding)
5. Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)

The U.S. Department of Health and Human Services (HHS) regulations (45 CFR §156.110 through §156.115) further defines compliance with the EHB provision as a health plan that provides benefits that are, among other things, substantially equal to a state's selected EHB-benchmark plan.

To promote flexibility, in 2018 each state was allowed three options in selecting an EHB-benchmark plan for 2020 and beyond (45 CFR §156.111). The options included[8]:

1. Selecting the EHB-benchmark plan that another state used for the 2017 plan year.
2. Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year.

[7] "What Marketplace Health Insurance Plans Cover." Health Insurance Marketplace, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/

[8] "Information on Essential Health Benefits (EHB) Benchmark Plans." Centers for Medicare and Medicaid Services, www.cms.gov/marketplace/resources/data/essential-health-benefits.

3. Otherwise selecting a revised set of benefits for the state's EHB-benchmark plan.

Additionally, a state's benchmark plan cannot exceed the generosity of the most generous among a set of comparison plans as defined in 45 CFR §156.111(b)(ii). Under these provisions, a state can change its EHB-benchmark plan in any given year. To do so, a state must notify HHS of the new EHB-benchmark plan selection by the first Wednesday in May of the year that is two years before the effective date. If this notification deadline is not met, the EHB-benchmark remains unchanged.

Maryland law does not permit the state to change the benchmark plan unless the HHS secretary requires a state to select a new benchmark plan [MD Ins Code §31-116(c)]. Therefore, Maryland is unable to take advantage of flexibility option #1 stated above without a state law change. However, states can direct issuers to comply with changes to the state's EHB-benchmark plan. Two examples in Maryland include the issuance of Maryland Insurance Administration's Bulletins 15-33 and 23-5.

For both the individual and small group markets, Maryland's EHB-benchmark plan is the 2017 Small Group CareFirst BlueChoice HMO/HRA $1500 Plan[9,10].

Table 2 lists each mandate and specifies whether the mandated coverage is included within the EHB-benchmark plan. In total, 57 of the 68 mandates are covered by the EHB-benchmark plan.

TABLE 2 - INCLUSION OF MARYLAND MANDATES IN MARYLAND'S EHB-BENCHMARK PLAN FOR THE INDIVIDUAL AND SMALL GROUP FULLY INSURED MARKETS

Citation	Mandated Benefit Description	Covered by EHB-Benchmark Plan
15-801	Alzheimer's Disease Treatment & Care	**No**
15-802	Mental Health & Substance Abuse Treatment	**Yes**
15-803	Blood Products	**Yes**
15-804	Prescription Drugs - Off-Label Use	**Yes**
15-805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	**Yes**
15-806	Prescription Drugs - Choice of Pharmacy	**Yes**
15-807	Medical Foods & Modified Food Products	**Yes**
15-808	Home Health Care	**Yes**
15-809	Hospice Care Services	**Yes**
15-810	In Vitro Fertilization (IVF) Infertility Benefits	**Yes (1)**
15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility	**No**
15-811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage	**Yes**
15-812	Hospital Coverage for Mothers and Newborns - Minimum Coverage	**Yes**
15-813	Benefits for Disabilities Caused by Pregnancy or Childbirth	**No**
15-814	Cancer Screening - Mammograms	**Yes**
15-814.1	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	**No**
15-815	Reconstructive Breast Surgery	**Yes**

[9] https://www.cms.gov/marketplace/resources/data/essential-health-benefits#Maryland

[10] MIA Bulletin 15-33, https://insurance.maryland.gov/Insurer/Documents/bulletins/15-33_2017-ACA-Rate-Form-Filing-Deadlines-and-Substitution-Rules.pdf

Citation	Mandated Benefit Description	Covered by EHB-Benchmark Plan
15-816	Direct Access to Gynecological Care	**Yes**
15-817	Child Wellness Services	**Yes**
15-818	Cleft Lip/Cleft Palate Treatment	**Yes**
15-819	Utilization Review Denial Alternative Coverage and Second Opinions	**Yes**
15-820	Orthopedic Braces	**Yes**
15-821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	**Yes**
15-822	Diabetic Equipment, Supplies, and Self-Management Training	**Yes**
15-822.1	Prescription Drugs - Cost Sharing for Insulin	**No**
15-823	Osteoporosis Prevention and Treatment	**Yes**
15-824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	**Yes**
15-825	Cancer Screening - Prostate	**Yes**
15-826/826.1	Contraceptive Drugs or Devices	**Yes**
15-826.2	Male Sterilization Cost Sharing	**No**
15-826.3	Fertility Awareness-Based Methods	**Yes**
15-827	Clinical Trials	**Yes**
15-828	General Anesthesia for Pediatric Dental Care	**Yes**
15-829	Chlamydia & Human Papillomavirus Screening	**Yes**
15-830	Referrals to Specialists	**Yes**
15-831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	**Yes**
15-832	Surgical Removal of Testicle	**Yes**
15-832.1	Hospitalization Coverage Following Mastectomy	**Yes**
15-833	Extension of Benefits	**Yes**
15-834	Prostheses Following Mastectomy	**Yes**
15-835	Habilitative Services for Minors	**Yes**
15-836	Hair Prosthesis	**Yes (2)**
15-837	Cancer Screening - Colorectal	**Yes**
15-838	Hearing Aids for Minors	**Yes**
15-839	Morbid Obesity Treatment	**Yes**
15-840	Medically Necessary Residential Crisis Services	**Yes**
15-841	Smoking Cessation Treatment	**Yes**
15-842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	**Yes**
15-843	Amino Acid-Based Elemental Formula	**Yes**
15-844	Prosthetic Devices	**Yes**
15-845	Prescription Drugs - Eye Drop Refills	**Yes**
15-846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	**Yes**
15-847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	**Yes (2)**
15-848	Ostomy Equipment and Supplies	**Yes**
15-849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	**Yes**
15-850	Prior Authorizations for Opioid Antagonist	**Yes**
15-851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	**Yes**
15-852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	**No**
15-853	Lymphedema Treatment	**Yes**
15-854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	**No**
15-855	Pediatric Autoimmune Neuropsychiatric Disorders	**Yes**
15-856	COVID-19 Tests Coverage	**No**
15-857	Coverage of Abortion Care Services	**No**
15-858	Prior Authorizations for Prescription Drug HIV Prevention	**Yes**
15-859	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	**No**
15-860	Biomarker Testing	**Yes**
(1) Individual market only per MIA Bulletin 15-33		
(2) Covered per MIA Bulletin(s) 15-33 and/or 23-5		

Mandate Cost Analysis

FULL COST ANALYSIS

After establishing the mandates for the analysis and comparing them to the EHB-Benchmark plan, L&E conducted a comprehensive assessment of the full cost of each mandate, presented both as a percentage of premium and as a percentage of the State's average annual wage.

This full cost evaluation was conducted for each designated market, including Individual, Small Group, Large Group, and the SEHBP. The primary data sources employed were the responses obtained from L&E's insurance carrier survey. The primary data utilized from the insurance carrier survey was data from 2022.

Tables 3A, 3B, and 4 outline and summarize the full cost expressed as a percentage of premium.

Total 2022 Premiums by Market were[11]:

Market	PMPM
Individual	$402.97
Small Group	$495.95
Large Group	$553.15
Fully Insured Subtotal	*$524.49*
SEHBP	$901.71
Grand Total	**$596.93**

As a percent of premium, the total mandate cost by market is:

Market	% of Premium	PMPM
Individual	28.7%	$115.65
Small Group	16.1%	$79.94
Large Group	15.7%	$86.92
Fully Insured Subtotal	*17.5%*	*$89.55*
SEHBP	16.7%	$150.29
Grand Total	**17.3%**	**$101.21**

In 2019, Maryland introduced a 1332 Waiver Reinsurance Program for the individual market which decreased premium PMPM in the individual market. This contributes to a cost PMPM impact as a percentage of premium that is higher for the individual market compared to the other markets.

[11] Based on 2022 Maryland Supplemental Health Care Exhibits.

TABLE 3A - FULL COST OF CURRENT MANDATES AS A PERCENTAGE OF ANNUAL PREMIUM BY MARKET

Citation	Mandate Description	Individual	Small Group	Large Group	SEHBP
15-801	Alzheimer's Disease Treatment & Care	0.00%	0.00%	0.00%	0.00%
15-802[12]	Mental Health & Substance Abuse Treatment	15.76%	6.97%	3.62%	8.22%
15-803	Blood Products	0.30%	0.12%	0.09%	0.09%
15-804	Prescription Drugs - Off-Label Use	0.00%	0.00%	0.00%	0.00%
15-805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	0.00%	0.00%	0.00%	0.00%
15-806	Prescription Drugs - Choice of Pharmacy	0.00%	0.00%	0.11%	0.07%
15-807	Medical Foods & Modified Food Products	0.05%	0.03%	0.02%	0.03%
15-808	Home Health Care	0.47%	0.25%	0.22%	0.34%
15-809	Hospice Care Services	0.00%	0.00%	0.00%	0.00%
15-810	In Vitro Fertilization (IVF) Infertility Benefits	0.63%	0.00%	0.18%	0.26%
15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility	N/A	N/A	0.00%	0.00%
15-811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage	0.26%	0.25%	0.14%	0.09%
15-812	Hospital Coverage for Mothers and Newborns - Minimum Coverage	2.37%	2.24%	1.18%	0.72%
15-813	Benefits for Disabilities Caused by Pregnancy or Childbirth	0.00%	0.00%	0.00%	0.00%
15-814	Cancer Screening - Mammograms	0.93%	0.63%	0.98%	0.54%
15-814.1	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	0.06%	0.03%	0.03%	0.06%
15-815	Reconstructive Breast Surgery	0.37%	0.29%	0.22%	0.27%
15-816	Direct Access to Gynecological Care	0.12%	0.08%	0.26%	0.05%
15-817	Child Wellness Services	0.66%	0.82%	1.55%	0.28%
15-818	Cleft Lip/Cleft Palate Treatment	0.02%	0.02%	0.01%	0.01%
15-819	Utilization Review Denial Alternative Coverage and Second Opinions	0.07%	0.07%	0.04%	0.00%
15-820	Orthopedic Braces	0.06%	0.05%	0.03%	0.08%
15-821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	0.09%	0.05%	0.05%	0.06%
15-822	Diabetic Equipment, Supplies, and Self-Management Training	0.23%	0.16%	0.09%	0.29%
15-822.1	Prescription Drugs - Cost Sharing for Insulin	0.48%	0.28%	0.19%	0.44%
15-823	Osteoporosis Prevention and Treatment	0.02%	0.01%	0.05%	0.02%
15-824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	0.03%	0.03%	0.02%	0.01%
15-825	Cancer Screening - Prostate	0.02%	0.01%	0.06%	0.02%

[12]Regarding the higher impact of 15-802 in the individual market compared to the other market – In addition to the effect of the reinsurance program on the individual market, anti-selection can also contribute to higher costs in the individual market. Anti-selection occurs when an individual enrolls in health insurance knowing that they will need to utilize services in an above-average manner. Conversely, in group markets, an individual is more likely to elect health insurance as a collective part of their employee benefit package even if they don't utilize the services in an above-average manner. Overall, the data provided for 15-802 showed approximately 6.0% cost as a percentage of premium in total for all markets, which is consistent with other publicly available sources found. (Link)

Citation	Mandate Description	Individual	Small Group	Large Group	SEHBP
15-826/826.1	Contraceptive Drugs or Devices	0.14%	0.11%	0.26%	0.08%
15-826.2	Male Sterilization Cost Sharing	0.15%	0.09%	0.06%	0.10%
15-826.3	Fertility Awareness-Based Methods	N/A	N/A	0.32%	0.46%
15-827	Clinical Trials	0.00%	0.00%	0.35%	0.21%
15-828	General Anesthesia for Pediatric Dental Care	0.02%	0.02%	0.05%	0.01%
15-829	Chlamydia & Human Papillomavirus Screening	0.15%	0.12%	0.07%	0.11%
15-830	Referrals to Specialists	0.00%	0.00%	0.00%	0.00%
15-831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	0.31%	0.35%	0.31%	0.06%
15-832	Surgical Removal of Testicle	0.00%	0.00%	0.01%	0.00%
15-832.1	Hospitalization Coverage Following Mastectomy	0.03%	0.05%	0.04%	0.02%
15-833	Extension of Benefits	0.19%	0.18%	0.16%	0.10%
15-834	Prostheses Following Mastectomy	0.03%	0.03%	0.01%	0.01%
15-835	Habilitative Services for Minors	2.20%	1.02%	0.78%	1.25%
15-836	Hair Prosthesis	0.00%	N/A	0.00%	0.00%
15-837	Cancer Screening - Colorectal	1.16%	0.74%	0.69%	0.59%
15-838	Hearing Aids for Minors	0.03%	0.03%	0.35%	0.23%
15-839	Morbid Obesity Treatment	0.10%	0.06%	0.05%	0.08%
15-840	Medically Necessary Residential Crisis Services	0.03%	0.03%	0.02%	0.01%
15-841	Smoking Cessation Treatment	0.00%	0.00%	0.00%	0.00%
15-842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	0.00%	0.00%	0.00%	0.00%
15-843	Amino Acid-Based Elemental Formula	0.00%	0.00%	0.05%	0.00%
15-844	Prosthetic Devices	0.08%	0.04%	0.03%	0.05%
15-845	Prescription Drugs - Eye Drop Refills	0.00%	0.00%	0.02%	0.01%
15-846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	0.64%	0.61%	0.82%	0.15%
15-847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	0.08%	0.07%	0.06%	0.04%
15-848	Ostomy Equipment and Supplies	N/A	N/A	0.00%	0.00%
15-849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	0.01%	0.01%	0.01%	0.00%
15-850	Prior Authorizations for Opioid Antagonist	0.00%	0.00%	0.00%	0.00%
15-851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	0.00%	0.00%	0.00%	0.00%
15-852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	0.00%	0.00%	0.00%	0.00%
15-853	Lymphedema Treatment	N/A	N/A	1.48%	0.66%
15-854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	0.00%	0.00%	0.19%	0.01%
15-855	Pediatric Autoimmune Neuropsychiatric Disorders	N/A	N/A	0.05%	0.09%
15-856	COVID-19 Tests Coverage	N/A	N/A	N/A	N/A
15-857	Coverage of Abortion Care Services	0.04%	0.03%	0.02%	0.03%
15-858	Prior Authorizations for Prescription Drug HIV Prevention	0.14%	0.03%	0.02%	0.00%
15-859	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	0.18%	0.11%	0.10%	0.14%

Citation	Mandate Description	Individual	Small Group	Large Group	SEHBP
15-860	Biomarker Testing	N/A	N/A	0.17%	0.20%
Total		28.70%	16.12%	15.71%	16.67%

TABLE 3B - FULL COST OF CURRENT MANDATES AS A PERCENTAGE OF ANNUAL PREMIUM BY MARKET TOTALS

Citation	Mandate Description	Fully Insured Subtotal	Grand Total
15-801	Alzheimer's Disease Treatment & Care	0.00%	0.00%
15-802	Mental Health & Substance Abuse Treatment	5.73%	6.21%
15-803	Blood Products	0.12%	0.12%
15-804	Prescription Drugs - Off-Label Use	0.00%	0.00%
15-805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	0.00%	0.00%
15-806	Prescription Drugs - Choice of Pharmacy	0.08%	0.08%
15-807	Medical Foods & Modified Food Products	0.02%	0.02%
15-808	Home Health Care	0.26%	0.27%
15-809	Hospice Care Services	0.00%	0.00%
15-810	In Vitro Fertilization (IVF) Infertility Benefits	0.21%	0.22%
15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility	0.00%	0.00%
15-811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage	0.17%	0.16%
15-812	Hospital Coverage for Mothers and Newborns - Minimum Coverage	1.50%	1.35%
15-813	Benefits for Disabilities Caused by Pregnancy or Childbirth	0.00%	0.00%
15-814	Cancer Screening - Mammograms	0.91%	0.84%
15-814.1	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	0.04%	0.04%
15-815	Reconstructive Breast Surgery	0.25%	0.26%
15-816	Direct Access to Gynecological Care	0.21%	0.18%
15-817	Child Wellness Services	1.32%	1.12%
15-818	Cleft Lip/Cleft Palate Treatment	0.01%	0.01%
15-819	Utilization Review Denial Alternative Coverage and Second Opinions	0.05%	0.04%
15-820	Orthopedic Braces	0.03%	0.04%
15-821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	0.06%	0.06%
15-822	Diabetic Equipment, Supplies, and Self-Management Training	0.12%	0.15%
15-822.1	Prescription Drugs - Cost Sharing for Insulin	0.25%	0.28%
15-823	Osteoporosis Prevention and Treatment	0.04%	0.04%
15-824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	0.02%	0.02%
15-825	Cancer Screening - Prostate	0.05%	0.04%
15-826/826.1	Contraceptive Drugs or Devices	0.22%	0.20%
15-826.2	Male Sterilization Cost Sharing	0.08%	0.08%

Citation	Mandate Description	Fully Insured Subtotal	Grand Total
15-826.3	Fertility Awareness-Based Methods	**0.23%**	**0.27%**
15-827	Clinical Trials	**0.25%**	**0.24%**
15-828	General Anesthesia for Pediatric Dental Care	**0.04%**	**0.04%**
15-829	Chlamydia & Human Papillomavirus Screening	**0.09%**	**0.09%**
15-830	Referrals to Specialists	**0.00%**	**0.00%**
15-831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	**0.32%**	**0.27%**
15-832	Surgical Removal of Testicle	**0.01%**	**0.01%**
15-832.1	Hospitalization Coverage Following Mastectomy	**0.04%**	**0.03%**
15-833	Extension of Benefits	**0.17%**	**0.15%**
15-834	Prostheses Following Mastectomy	**0.02%**	**0.01%**
15-835	Habilitative Services for Minors	**1.00%**	**1.05%**
15-836	Hair Prosthesis	**0.00%**	**0.00%**
15-837	Cancer Screening - Colorectal	**0.76%**	**0.73%**
15-838	Hearing Aids for Minors	**0.26%**	**0.25%**
15-839	Morbid Obesity Treatment	**0.06%**	**0.06%**
15-840	Medically Necessary Residential Crisis Services	**0.02%**	**0.02%**
15-841	Smoking Cessation Treatment	**0.00%**	**0.00%**
15-842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	**0.00%**	**0.00%**
15-843	Amino Acid-Based Elemental Formula	**0.03%**	**0.03%**
15-844	Prosthetic Devices	**0.04%**	**0.04%**
15-845	Prescription Drugs - Eye Drop Refills	**0.01%**	**0.01%**
15-846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	**0.76%**	**0.65%**
15-847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	**0.07%**	**0.06%**
15-848	Ostomy Equipment and Supplies	**0.00%**	**0.00%**
15-849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	**0.01%**	**0.01%**
15-850	Prior Authorizations for Opioid Antagonist	**0.00%**	**0.00%**
15-851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	**0.00%**	**0.00%**
15-852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	**0.00%**	**0.00%**
15-853	Lymphedema Treatment	**1.05%**	**0.97%**
15-854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	**0.13%**	**0.11%**
15-855	Pediatric Autoimmune Neuropsychiatric Disorders	**0.04%**	**0.05%**
15-856	COVID-19 Tests Coverage	**0.00%**	**0.00%**
15-857	Coverage of Abortion Care Services	**0.03%**	**0.03%**
15-858	Prior Authorizations for Prescription Drug HIV Prevention	**0.04%**	**0.03%**
15-859	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	**0.12%**	**0.12%**
15-860	Biomarker Testing	**0.12%**	**0.14%**

Citation	Mandate Description	Fully Insured Subtotal	Grand Total
Total		**17.47%**	**17.32%**

TABLE 4 – TOP TEN HIGHEST COST MANDATES BY MARKET

Market	Top Ten Highest Cost Mandates	Total Cost of Top Ten (% of Premium)
Individual	• Mental Health & Substance Abuse Treatment • Hospital Coverage for Mothers and Newborns - Minimum Coverage • Habilitative Services for Minors • Cancer Screening - Colorectal • Cancer Screening - Mammograms • Child Wellness Services • Cancer Coverage - Cost Sharing for Oral Chemotherapy • In Vitro Fertilization (IVF) Infertility Benefits • Prescription Drugs - Cost Sharing for Insulin • Home Health Care	**25.29%**
Small Group	• Mental Health & Substance Abuse Treatment • Hospital Coverage for Mothers and Newborns - Minimum Coverage • Habilitative Services for Minors • Child Wellness Services • Cancer Screening - Colorectal • Cancer Screening - Mammograms • Cancer Coverage - Cost Sharing for Oral Chemotherapy • Prescription Drugs - Coverage of Certain Non-Formulary Drugs • Reconstructive Breast Surgery • Prescription Drugs - Cost Sharing for Insulin	**13.95%**
Large Group	• Mental Health & Substance Abuse Treatment • Child Wellness Services • Lymphedema Treatment • Hospital Coverage for Mothers and Newborns - Minimum Coverage • Cancer Screening - Mammograms • Cancer Coverage - Cost Sharing for Oral Chemotherapy • Habilitative Services for Minors • Cancer Screening - Colorectal • Hearing Aids for Minors • Clinical Trials	**11.80%**
Fully Insured Markets	• Mental Health & Substance Abuse Treatment • Hospital Coverage for Mothers and Newborns - Minimum Coverage • Child Wellness Services • Lymphedema Treatment • Hearing Aids for Minors • Cancer Screening - Mammograms • Cancer Coverage - Cost Sharing for Oral Chemotherapy • Cancer Screening - Colorectal • Prescription Drugs - Coverage of Certain Non-Formulary Drugs • Hearing Aids for Minors	**13.63%**

Market	Top Ten Highest Cost Mandates	Total Cost of Top Ten (% of Premium)
SEHBP	• Mental Health & Substance Abuse Treatment • Habilitative Services for Minors • Hospital Coverage for Mothers and Newborns - Minimum Coverage • Lymphedema Treatment • Cancer Screening - Colorectal • Cancer Screening - Mammograms • Fertility Awareness-Based Methods • Prescription Drugs - Cost Sharing for Insulin • Home Health Care • Diabetic Equipment, Supplies, and Self-Management Training	**13.50%**
All Markets	• Mental Health & Substance Abuse Treatment • Hospital Coverage for Mothers and Newborns - Minimum Coverage • Child Wellness Services • Habilitative Services for Minors • Lymphedema Treatment • Cancer Screening - Mammograms • Cancer Screening - Colorectal • Cancer Coverage - Cost Sharing for Oral Chemotherapy • Prescription Drugs - Cost Sharing for Insulin • Home Health Care	**13.48%**

Regarding the top ten highest cost mandates on average across all markets, the following reasons are attributed to their inclusion among the most expensive mandates –

- ❖ Mental health & substance abuse treatment is the highest cost mandate. The surge in demand and the severity of these services, fueled by the COVID-19 pandemic and the persistent opioid crises, play significant roles in driving up the costs associated with this mandate[13,14,15].
- ❖ A few mandates encompass expansive service categories utilized for various purposes, including mental health & substance abuse treatment, habilitative services, and home health care.
- ❖ A few mandates cover commonly utilized preventive care services: child wellness services and cancer screenings (mammograms and colorectal).
- ❖ Hospitalization for childbirth is a widely utilized service, given the birth rate of 11 per 1,000 in the United States[16]. Moreover, it comes with a significant cost, averaging around $15,000[17].
- ❖ Lymphedema, particularly secondary lymphedema, is the most common cause of disease and affects approximately 1 in 1000 Americans[18]. Furthermore, the treatment for lymphedema comes with a considerable cost, averaging around $15,000[19].

[13] https://www.rand.org/news/press/2023/08/25/index1.html

[14] https://www.nyu.edu/about/news-publications/news/2022/april/covid-19-drug-use.html

[15] https://www.cdc.gov/opioids/basics/epidemic.html

[16] https://www.cdc.gov/nchs/fastats/births.htm

[17] https://www.uwhealth.org/news/how-much-does-it-really-cost-have-baby

[18]https://www.ncbi.nlm.nih.gov/books/NBK537239/#:~:text=Primary%20lymphedema%20is%20rare%2C%20affecting,approximately%201%20in%201000%20Americans.

[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8208383/

- Oral chemotherapy is a viable treatment option for nearly all cancer types, including some of the most common: breast cancer, prostate cancer, and colorectal cancer. Additionally, oral chemotherapy entails significant costs, averaging around $50,000[20].
- Insulin is highly utilized as a primary treatment for diabetes, which is prevalent in approximately 9% of the United States population[21]. Approximately 12% of those diagnosed with diabetes start using insulin within a year of diagnosis. Insulin has a material annual cost of approximately $6,000[22].

L&E highlights that while the overall full cost of the top ten most expensive mandates as a percentage of premium is significant, the marginal cost of these mandates, as detailed in the following subsection, is estimated to be only 0.1%.

Table 5A and 5B show the full cost expressed as a percentage of Maryland's average annual wage.

In 2021, Maryland's average annual wage was $71,500[23]. L&E trended this forward to 2023 using a 5-year average wage increase of 4.2%. This produced an estimated average annual wage of $77,669 for 2023.

TABLE 5A - FULL COST OF CURRENT MANDATES AS A PERCENTAGE OF MARYLAND AVERAGE ANNUAL WAGE BY MARKET

Citation	Mandate Description	Individual	Small Group	Large Group	SEHBP
15-801	Alzheimer's Disease Treatment & Care	0.00%	0.00%	0.00%	0.00%
15-802	Mental Health & Substance Abuse Treatment	1.25%	0.59%	0.45%	0.94%
15-803	Blood Products	0.02%	0.01%	0.01%	0.01%
15-804	Prescription Drugs - Off-Label Use	0.00%	0.00%	0.00%	0.00%
15-805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	0.00%	0.00%	0.00%	0.00%
15-806	Prescription Drugs - Choice of Pharmacy	0.00%	0.00%	0.01%	0.00%
15-807	Medical Foods & Modified Food Products	0.00%	0.00%	0.00%	0.00%
15-808	Home Health Care	0.04%	0.02%	0.03%	0.04%
15-809	Hospice Care Services	0.00%	0.00%	0.00%	0.00%
15-810	In Vitro Fertilization (IVF) Infertility Benefits	0.05%	0.00%	0.02%	0.03%
15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility	N/A	N/A	0.00%	0.00%
15-811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage	0.02%	0.02%	0.02%	0.01%
15-812	Hospital Coverage for Mothers and Newborns - Minimum Coverage	0.19%	0.19%	0.15%	0.05%

[20] https://www.valueinhealthjournal.com/article/S1098-3015(13)00719-5/fulltext

[21] https://www.cdc.gov/diabetes/data/statistics-report/index.html#:~:text=1.7%20million%20adults%20aged%2020,a%20year%20of%20their%20diagnosis.

[22]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7646207/#:~:text=Cost%20projections%20were%20based%20on,18%25%20from%20%2449%20to%20%2458.

[23] https://msa.maryland.gov/msa/mdmanual/01glance/economy/html/wages.html#wages

Citation	Mandate Description	Individual	Small Group	Large Group	SEHBP
15-813	Benefits for Disabilities Caused by Pregnancy or Childbirth	0.00%	0.00%	0.00%	0.00%
15-814	Cancer Screening - Mammograms	0.07%	0.05%	0.12%	0.06%
15-814.1	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	0.00%	0.00%	0.00%	0.01%
15-815	Reconstructive Breast Surgery	0.03%	0.03%	0.03%	0.03%
15-816	Direct Access to Gynecological Care	0.01%	0.01%	0.03%	0.05%
15-817	Child Wellness Services	0.05%	0.07%	0.19%	0.03%
15-818	Cleft Lip/Cleft Palate Treatment	0.02%	0.02%	0.01%	0.01%
15-819	Utilization Review Denial Alternative Coverage and Second Opinions	0.01%	0.01%	0.00%	0.00%
15-820	Orthopedic Braces	0.00%	0.00%	0.00%	0.01%
15-821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	0.01%	0.00%	0.01%	0.01%
15-822	Diabetic Equipment, Supplies, and Self-Management Training	0.02%	0.01%	0.01%	0.03%
15-822.1	Prescription Drugs - Cost Sharing for Insulin	0.04%	0.02%	0.02%	0.03%
15-823	Osteoporosis Prevention and Treatment	0.00%	0.00%	0.01%	0.00%
15-824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	0.03%	0.03%	0.02%	0.01%
15-825	Cancer Screening - Prostate	0.00%	0.00%	0.01%	0.00%
15-826/826.1	Contraceptive Drugs or Devices	0.01%	0.01%	0.03%	0.01%
15-826.2	Male Sterilization Cost Sharing	0.01%	0.01%	0.01%	0.01%
15-826.3	Fertility Awareness-Based Methods	N/A	N/A	0.07%	0.06%
15-827	Clinical Trials	0.00%	0.00%	0.04%	0.02%
15-828	General Anesthesia for Pediatric Dental Care	0.02%	0.02%	0.05%	0.01%
15-829	Chlamydia & Human Papillomavirus Screening	0.01%	0.01%	0.01%	0.01%
15-830	Referrals to Specialists	0.00%	0.00%	0.00%	0.00%
15-831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	0.02%	0.03%	0.04%	0.00%
15-832	Surgical Removal of Testicle	0.00%	0.00%	0.01%	0.00%
15-832.1	Hospitalization Coverage Following Mastectomy	0.03%	0.05%	0.04%	0.02%
15-833	Extension of Benefits	0.01%	0.02%	0.02%	0.01%
15-834	Prostheses Following Mastectomy	0.03%	0.03%	0.01%	0.01%
15-835	Habilitative Services for Minors	0.17%	0.09%	0.10%	0.14%
15-836	Hair Prosthesis	0.00%	N/A	0.00%	0.00%
15-837	Cancer Screening - Colorectal	0.09%	0.06%	0.09%	0.07%
15-838	Hearing Aids for Minors	0.00%	0.00%	0.04%	0.03%
15-839	Morbid Obesity Treatment	0.01%	0.00%	0.01%	0.01%
15-840	Medically Necessary Residential Crisis Services	0.03%	0.03%	0.02%	0.01%
15-841	Smoking Cessation Treatment	0.00%	0.00%	0.00%	0.00%
15-842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	0.00%	0.00%	0.00%	0.00%
15-843	Amino Acid-Based Elemental Formula	0.00%	0.00%	0.05%	0.00%
15-844	Prosthetic Devices	0.01%	0.00%	0.00%	0.01%
15-845	Prescription Drugs - Eye Drop Refills	0.00%	0.00%	0.02%	0.01%

Citation	Mandate Description	Individual	Small Group	Large Group	SEHBP
15-846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	0.05%	0.05%	0.10%	0.01%
15-847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	0.01%	0.01%	0.01%	0.00%
15-848	Ostomy Equipment and Supplies	N/A	N/A	0.00%	0.00%
15-849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	0.01%	0.01%	0.01%	0.00%
15-850	Prior Authorizations for Opioid Antagonist	0.00%	0.00%	0.00%	0.00%
15-851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	0.00%	0.00%	0.00%	0.00%
15-852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	0.00%	0.00%	0.00%	0.00%
15-853	Lymphedema Treatment	N/A	N/A	0.19%	0.08%
15-854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	0.00%	0.00%	0.02%	0.00%
15-855	Pediatric Autoimmune Neuropsychiatric Disorders	N/A	N/A	0.01%	0.01%
15-856	COVID-19 Tests Coverage	N/A	N/A	N/A	N/A
15-857	Coverage of Abortion Care Services	0.04%	0.03%	0.02%	0.03%
15-858	Prior Authorizations for Prescription Drug HIV Prevention	0.01%	0.00%	0.00%	0.00%
15-859	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	0.01%	0.01%	0.01%	0.02%
15-860	Biomarker Testing	N/A	N/A	0.02%	0.02%
Total		2.48%	1.56%	2.22%	1.98%

TABLE 5B - FULL COST OF CURRENT MANDATES AS A PERCENTAGE OF MARYLAND AVERAGE ANNUAL WAGE BY MARKET TOTALS

Citation	Mandate Description	Fully Insured Subtotal	Grand Total
15-801	Alzheimer's Disease Treatment & Care	0.00%	0.00%
15-802	Mental Health & Substance Abuse Treatment	0.58%	0.65%
15-803	Blood Products	0.01%	0.01%
15-804	Prescription Drugs - Off-Label Use	0.00%	0.00%
15-805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	0.00%	0.00%
15-806	Prescription Drugs - Choice of Pharmacy	0.01%	0.01%
15-807	Medical Foods & Modified Food Products	0.00%	0.00%
15-808	Home Health Care	0.03%	0.03%
15-809	Hospice Care Services	0.00%	0.00%
15-810	In Vitro Fertilization (IVF) Infertility Benefits	0.02%	0.02%
15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility	0.00%	0.00%
15-811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage	0.02%	0.02%
15-812	Hospital Coverage for Mothers and Newborns - Minimum Coverage	0.16%	0.14%
15-813	Benefits for Disabilities Caused by Pregnancy or Childbirth	0.00%	0.00%

Citation	Mandate Description	Fully Insured Subtotal	Grand Total
15-814	Cancer Screening - Mammograms	**0.11%**	**0.10%**
15-814.1	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	**0.00%**	**0.00%**
15-815	Reconstructive Breast Surgery	**0.03%**	**0.03%**
15-816	Direct Access to Gynecological Care	**0.03%**	**0.03%**
15-817	Child Wellness Services	**0.16%**	**0.13%**
15-818	Cleft Lip/Cleft Palate Treatment	**0.01%**	**0.01%**
15-819	Utilization Review Denial Alternative Coverage and Second Opinions	**0.00%**	**0.00%**
15-820	Orthopedic Braces	**0.00%**	**0.00%**
15-821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	**0.01%**	**0.01%**
15-822	Diabetic Equipment, Supplies, and Self-Management Training	**0.01%**	**0.02%**
15-822.1	Prescription Drugs - Cost Sharing for Insulin	**0.03%**	**0.03%**
15-823	Osteoporosis Prevention and Treatment	**0.01%**	**0.00%**
15-824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	**0.02%**	**0.02%**
15-825	Cancer Screening - Prostate	**0.01%**	**0.01%**
15-826/826.1	Contraceptive Drugs or Devices	**0.03%**	**0.02%**
15-826.2	Male Sterilization Cost Sharing	**0.01%**	**0.01%**
15-826.3	Fertility Awareness-Based Methods	**0.05%**	**0.05%**
15-827	Clinical Trials	**0.03%**	**0.03%**
15-828	General Anesthesia for Pediatric Dental Care	**0.04%**	**0.04%**
15-829	Chlamydia & Human Papillomavirus Screening	**0.01%**	**0.01%**
15-830	Referrals to Specialists	**0.00%**	**0.00%**
15-831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	**0.04%**	**0.03%**
15-832	Surgical Removal of Testicle	**0.01%**	**0.01%**
15-832.1	Hospitalization Coverage Following Mastectomy	**0.04%**	**0.03%**
15-833	Extension of Benefits	**0.02%**	**0.02%**
15-834	Prostheses Following Mastectomy	**0.02%**	**0.01%**
15-835	Habilitative Services for Minors	**0.11%**	**0.11%**
15-836	Hair Prosthesis	**0.00%**	**0.00%**
15-837	Cancer Screening - Colorectal	**0.08%**	**0.08%**
15-838	Hearing Aids for Minors	**0.03%**	**0.03%**
15-839	Morbid Obesity Treatment	**0.01%**	**0.01%**
15-840	Medically Necessary Residential Crisis Services	**0.02%**	**0.02%**
15-841	Smoking Cessation Treatment	**0.00%**	**0.00%**
15-842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	**0.00%**	**0.00%**
15-843	Amino Acid-Based Elemental Formula	**0.03%**	**0.03%**
15-844	Prosthetic Devices	**0.00%**	**0.00%**
15-845	Prescription Drugs - Eye Drop Refills	**0.01%**	**0.01%**

Citation	Mandate Description	Fully Insured Subtotal	Grand Total
15-846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	**0.09%**	**0.07%**
15-847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	**0.01%**	**0.01%**
15-848	Ostomy Equipment and Supplies	**0.00%**	**0.00%**
15-849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	**0.01%**	**0.01%**
15-850	Prior Authorizations for Opioid Antagonist	**0.00%**	**0.00%**
15-851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	**0.00%**	**0.00%**
15-852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	**0.00%**	**0.00%**
15-853	Lymphedema Treatment	**0.13%**	**0.12%**
15-854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	**0.02%**	**0.01%**
15-855	Pediatric Autoimmune Neuropsychiatric Disorders	**0.00%**	**0.01%**
15-856	COVID-19 Tests Coverage	**0.00%**	**0.00%**
15-857	Coverage of Abortion Care Services	**0.03%**	**0.03%**
15-858	Prior Authorizations for Prescription Drug HIV Prevention	**0.00%**	**0.00%**
15-859	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	**0.01%**	**0.01%**
15-860	Biomarker Testing	**0.02%**	**0.02%**
Total		**2.15%**	**2.12%**

MARGINAL COST ANALYSIS

While a mandate's full cost is important in analyzing its impact, it is essential to recognize that a significant portion of the full costs would be present in health insurance coverage even without a mandate. There are two primary reasons costs might exist independently of a mandate:

1. A carrier covers the service. This can be defined by a carrier:
   - ❖ Covering the benefit or service before the mandate was effective,
   - ❖ Covering the benefit or service in a market in which it is not mandated, or
   - ❖ Covering the benefit or service in another state in which it is not mandated.
2. The benefit is required to be covered by the ACA and/or the State's EHB-Benchmark plan.

To pinpoint the cost attributable to the benefit being mandated, a marginal cost analysis is performed. Marginal cost is defined as the full cost minus the benefit cost that would remain even if the mandate were repealed. This approach produces the residual cost induced by the mandate.

Tables 6A and 6B present the marginal cost estimates for each Maryland mandate as a percent of premium for each market. The marginal cost equal to one minus the 'Expected Portion of Cost Covered Without Mandate' multiplied by the full cost of the mandate as a percentage of premium (refer to Table 3). An example of the marginal cost calculation is provided below. The primary data sources employed were the responses obtained from insurance carrier surveys. The primary data utilized from the insurance carrier survey was data from 2022.

MARGINAL COST CALCULATION EXAMPLE: 15-822.1, INDIVIDUAL MARKET

Full Cost Impact as a Percentage of Premium (A)	0.48%
Expected Portion of Cost Covered Without Mandate (B)	70%
(C) = 1 - (B)	30%
Marginal Cost Impact as a Percentage of Premium (D) = (A) * (C)	0.14%

The marginal cost, expressed as a percent of premium for each market, is:

Market	% of Premium	PMPM
Individual	0.3%	$0.99
Small Group	0.2%	$0.73
Large Group	1.0%	$5.59
Fully Insured Subtotal	*0.8%*	*$4.22*
SEHBP	0.9%	$8.46
Grand Total	**0.8%**	**$5.03**

TABLE 6A - MARGINAL COST OF CURRENT MANDATES AS A PERCENTAGE OF PREMIUM BY MARKET

Citation	Mandate Description	Expected Portion of Cost Covered Without Mandate	Individual	Small Group	Large Group	SEHBP
15-801	Alzheimer's Disease Treatment & Care	**N/A**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
15-802	Mental Health & Substance Abuse Treatment	**100%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
15-803	Blood Products	**90%**	**0.00%**	**0.00%**	**0.01%**	**0.01%**
15-804	Prescription Drugs - Off-Label Use	**80%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
15-805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	**60%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
15-806	Prescription Drugs - Choice of Pharmacy	**80%**	**0.00%**	**0.00%**	**0.02%**	**0.01%**
15-807	Medical Foods & Modified Food Products	**90%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
15-808	Home Health Care	**100%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
15-809	Hospice Care Services	**N/A**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
15-810	In Vitro Fertilization (IVF) Infertility Benefits	**30%**	**0.00%**	**0.00%**	**0.13%**	**0.18%**
15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility	**60%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
15-811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage	**100%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
15-812	Hospital Coverage for Mothers and Newborns - Minimum Coverage	**100%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**

Citation	Mandate Description	Expected Portion of Cost Covered Without Mandate	Individual	Small Group	Large Group	SEHBP
15-813	Benefits for Disabilities Caused by Pregnancy or Childbirth	N/A	0.00%	0.00%	0.00%	0.00%
15-814	Cancer Screening - Mammograms	100%	0.00%	0.00%	0.00%	0.00%
15-814.1	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	70%	0.02%	0.01%	0.01%	0.02%
15-815	Reconstructive Breast Surgery	100%	0.00%	0.00%	0.00%	0.00%
15-816	Direct Access to Gynecological Care	100%	0.00%	0.00%	0.00%	0.00%
15-817	Child Wellness Services	100%	0.00%	0.00%	0.00%	0.00%
15-818	Cleft Lip/Cleft Palate Treatment	80%	0.00%	0.00%	0.00%	0.00%
15-819	Utilization Review Denial Alternative Coverage and Second Opinions	100%	0.00%	0.00%	0.00%	0.00%
15-820	Orthopedic Braces	100%	0.00%	0.00%	0.00%	0.00%
15-821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	60%	0.00%	0.00%	0.02%	0.02%
15-822	Diabetic Equipment, Supplies, and Self-Management Training	90%	0.00%	0.00%	0.01%	0.01%
15-822.1	Prescription Drugs - Cost Sharing for Insulin	70%	0.14%	0.09%	0.06%	0.13%
15-823	Osteoporosis Prevention and Treatment	100%	0.00%	0.00%	0.00%	0.00%
15-824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	100%	0.00%	0.00%	0.00%	0.00%
15-825	Cancer Screening - Prostate	100%	0.00%	0.00%	0.00%	0.00%
15-826/826.1	Contraceptive Drugs or Devices	100%	0.00%	0.00%	0.00%	0.00%
15-826.2	Male Sterilization Cost Sharing	90%	0.02%	0.01%	0.01%	0.01%
15-826.3	Fertility Awareness-Based Methods	80%	0.00%	0.00%	0.06%	0.09%
15-827	Clinical Trials	100%	0.00%	0.00%	0.00%	0.00%
15-828	General Anesthesia for Pediatric Dental Care	80%	0.00%	0.00%	0.01%	0.00%
15-829	Chlamydia & Human Papillomavirus Screening	100%	0.00%	0.00%	0.00%	0.00%
15-830	Referrals to Specialists	100%	0.00%	0.00%	0.00%	0.00%
15-831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	70%	0.00%	0.00%	0.09%	0.02%
15-832	Surgical Removal of Testicle	100%	0.00%	0.00%	0.00%	0.00%
15-832.1	Hospitalization Coverage Following Mastectomy	100%	0.00%	0.00%	0.00%	0.00%
15-833	Extension of Benefits	60%	0.00%	0.00%	0.06%	0.04%
15-834	Prostheses Following Mastectomy	100%	0.00%	0.00%	0.00%	0.00%
15-835	Habilitative Services for Minors	100%	0.00%	0.00%	0.00%	0.00%
15-836	Hair Prosthesis	50%	0.00%	0.00%	0.00%	0.00%
15-837	Cancer Screening - Colorectal	100%	0.00%	0.00%	0.00%	0.00%
15-838	Hearing Aids for Minors	30%	0.00%	0.00%	0.25%	0.16%
15-839	Morbid Obesity Treatment	10%	0.00%	0.00%	0.04%	0.08%

Citation	Mandate Description	Expected Portion of Cost Covered Without Mandate	Individual	Small Group	Large Group	SEHBP
15-840	Medically Necessary Residential Crisis Services	100%	0.00%	0.00%	0.00%	0.00%
15-841	Smoking Cessation Treatment	100%	0.00%	0.00%	0.00%	0.00%
15-842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	100%	0.00%	0.00%	0.00%	0.00%
15-843	Amino Acid-Based Elemental Formula	80%	0.00%	0.00%	0.01%	0.00%
15-844	Prosthetic Devices	100%	0.00%	0.00%	0.00%	0.00%
15-845	Prescription Drugs - Eye Drop Refills	100%	0.00%	0.00%	0.00%	0.00%
15-846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	100%	0.00%	0.00%	0.00%	0.00%
15-847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	0%	0.00%	0.00%	0.06%	0.04%
15-848	Ostomy Equipment and Supplies	100%	0.00%	0.00%	0.00%	0.00%
15-849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	90%	0.00%	0.00%	0.00%	0.00%
15-850	Prior Authorizations for Opioid Antagonist	100%	0.00%	0.00%	0.00%	0.00%
15-851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	90%	0.00%	0.00%	0.00%	0.00%
15-852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	50%	0.00%	0.00%	0.00%	0.00%
15-853	Lymphedema Treatment	100%	0.00%	0.00%	0.00%	0.00%
15-854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	70%	0.00%	0.00%	0.06%	0.00%
15-855	Pediatric Autoimmune Neuropsychiatric Disorders	90%	0.00%	0.00%	0.01%	0.01%
15-856	COVID-19 Tests Coverage	80%	0.00%	0.00%	0.00%	0.00%
15-857	Coverage of Abortion Care Services	60%	0.01%	0.01%	0.01%	0.01%
15-858	Prior Authorizations for Prescription Drug HIV Prevention	90%	0.00%	0.00%	0.00%	0.00%
15-859	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	70%	0.05%	0.03%	0.03%	0.04%
15-860	Biomarker Testing	80%	0.00%	0.00%	0.03%	0.04%
Total			0.25%	0.15%	1.01%	0.94%

TABLE 6B - MARGINAL COST OF CURRENT MANDATES AS A PERCENTAGE OF PREMIUM BY MARKET TOTALS

Citation	Mandate Description	Fully Insured Subtotal	Grand Total
15-801	Alzheimer's Disease Treatment & Care	0.00%	0.00%
15-802	Mental Health & Substance Abuse Treatment	0.00%	0.00%
15-803	Blood Products	0.01%	0.01%
15-804	Prescription Drugs - Off-Label Use	0.00%	0.00%
15-805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	0.00%	0.00%

Citation	Mandate Description	Fully Insured Subtotal	Grand Total
15-806	Prescription Drugs - Choice of Pharmacy	**0.02%**	**0.02%**
15-807	Medical Foods & Modified Food Products	**0.00%**	**0.00%**
15-808	Home Health Care	**0.00%**	**0.00%**
15-809	Hospice Care Services	**0.00%**	**0.00%**
15-810	In Vitro Fertilization (IVF) Infertility Benefits	**0.09%**	**0.11%**
15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility	**0.00%**	**0.00%**
15-811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage	**0.00%**	**0.00%**
15-812	Hospital Coverage for Mothers and Newborns - Minimum Coverage	**0.00%**	**0.00%**
15-813	Benefits for Disabilities Caused by Pregnancy or Childbirth	**0.00%**	**0.00%**
15-814	Cancer Screening - Mammograms	**0.00%**	**0.00%**
15-814.1	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	**0.01%**	**0.01%**
15-815	Reconstructive Breast Surgery	**0.00%**	**0.00%**
15-816	Direct Access to Gynecological Care	**0.00%**	**0.00%**
15-817	Child Wellness Services	**0.00%**	**0.00%**
15-818	Cleft Lip/Cleft Palate Treatment	**0.00%**	**0.00%**
15-819	Utilization Review Denial Alternative Coverage and Second Opinions	**0.00%**	**0.00%**
15-820	Orthopedic Braces	**0.00%**	**0.00%**
15-821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	**0.01%**	**0.02%**
15-822	Diabetic Equipment, Supplies, and Self-Management Training	**0.01%**	**0.01%**
15-822.1	Prescription Drugs - Cost Sharing for Insulin	**0.07%**	**0.08%**
15-823	Osteoporosis Prevention and Treatment	**0.00%**	**0.00%**
15-824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	**0.00%**	**0.00%**
15-825	Cancer Screening - Prostate	**0.00%**	**0.00%**
15-826/826.1	Contraceptive Drugs or Devices	**0.00%**	**0.00%**
15-826.2	Male Sterilization Cost Sharing	**0.01%**	**0.01%**
15-826.3	Fertility Awareness-Based Methods	**0.05%**	**0.05%**
15-827	Clinical Trials	**0.00%**	**0.00%**
15-828	General Anesthesia for Pediatric Dental Care	**0.01%**	**0.01%**
15-829	Chlamydia & Human Papillomavirus Screening	**0.00%**	**0.00%**
15-830	Referrals to Specialists	**0.00%**	**0.00%**
15-831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	**0.07%**	**0.06%**
15-832	Surgical Removal of Testicle	**0.00%**	**0.00%**

Citation	Mandate Description	Fully Insured Subtotal	Grand Total
15-832.1	Hospitalization Coverage Following Mastectomy	0.00%	0.00%
15-833	Extension of Benefits	0.05%	0.04%
15-834	Prostheses Following Mastectomy	0.00%	0.00%
15-835	Habilitative Services for Minors	0.00%	0.00%
15-836	Hair Prosthesis	0.00%	0.00%
15-837	Cancer Screening - Colorectal	0.00%	0.00%
15-838	Hearing Aids for Minors	0.17%	0.17%
15-839	Morbid Obesity Treatment	0.03%	0.04%
15-840	Medically Necessary Residential Crisis Services	0.00%	0.00%
15-841	Smoking Cessation Treatment	0.00%	0.00%
15-842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	0.00%	0.00%
15-843	Amino Acid-Based Elemental Formula	0.01%	0.01%
15-844	Prosthetic Devices	0.00%	0.00%
15-845	Prescription Drugs - Eye Drop Refills	0.00%	0.00%
15-846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	0.00%	0.00%
15-847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	0.05%	0.04%
15-848	Ostomy Equipment and Supplies	0.00%	0.00%
15-849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	0.00%	0.00%
15-850	Prior Authorizations for Opioid Antagonist	0.00%	0.00%
15-851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	0.00%	0.00%
15-852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	0.00%	0.00%
15-853	Lymphedema Treatment	0.00%	0.00%
15-854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	0.04%	0.03%
15-855	Pediatric Autoimmune Neuropsychiatric Disorders	0.00%	0.00%
15-856	COVID-19 Tests Coverage	0.00%	0.00%
15-857	Coverage of Abortion Care Services	0.01%	0.01%
15-858	Prior Authorizations for Prescription Drug HIV Prevention	0.00%	0.00%
15-859	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	0.03%	0.04%
15-860	Biomarker Testing	0.02%	0.03%
Total		0.77%	0.81%

Mandates in the Self-Funded Market

As required by Insurance Article §15-1502(a)(2)(ii) of the Annotated Code of Maryland, L&E assessed the level of voluntary-compliance by self-insured plans for each mandate. Most self-

insured plans are regulated by the Employee Retirement Income Security Act of 1974 (ERISA). As a result, most self-insured plans are not required to comply with state mandates. The primary data sources employed for estimating the voluntary self-insured compliance level were the responses obtained from insurance carrier surveys. The primary data utilized from the insurance carrier survey was data from 2022.

The Maryland data on voluntary self-insured compliance was broad and imprecise, so L&E categorized the compliance levels into specific ranges.

- "Almost All": 90-100% compliance rate
- "Most": 61-89% compliance rate
- "Half": 40-60% compliance rate
- "Some": 11-39% compliance rate
- "Very Little": 0-10% compliance rate

Table 7 shows the compliance level by mandate.

TABLE 7 - VOLUNTARY COMPLIANCE IN THE SELF-INSURED MARKET

Citation	Mandate Description	Compliance Level
15-801	Alzheimer's Disease Treatment & Care	**N/A**
15-802	Mental Health & Substance Abuse Treatment	**Almost All**
15-803	Blood Products	**Almost All**
15-804	Prescription Drugs - Off-Label Use	**Most**
15-805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	**Half**
15-806	Prescription Drugs - Choice of Pharmacy	**Most**
15-807	Medical Foods & Modified Food Products	**Almost All**
15-808	Home Health Care	**Almost All**
15-809	Hospice Care Services	**N/A**
15-810	In Vitro Fertilization (IVF) Infertility Benefits	**Some**
15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility	**Half**
15-811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage	**Almost All**
15-812	Hospital Coverage for Mothers and Newborns - Minimum Coverage	**Almost All**
15-813	Benefits for Disabilities Caused by Pregnancy or Childbirth	**N/A**
15-814	Cancer Screening - Mammograms	**Almost All**
15-814.1	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	**Most**
15-815	Reconstructive Breast Surgery	**Almost All**
15-816	Direct Access to Gynecological Care	**Almost All**
15-817	Child Wellness Services	**Almost All**
15-818	Cleft Lip/Cleft Palate Treatment	**Most**
15-819	Utilization Review Denial Alternative Coverage and Second Opinions	**Almost All**
15-820	Orthopedic Braces	**Almost All**
15-821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	**Half**
15-822	Diabetic Equipment, Supplies, and Self-Management Training	**Almost All**

Citation	Mandate Description	Compliance Level
15-822.1	Prescription Drugs - Cost Sharing for Insulin	**Most**
15-823	Osteoporosis Prevention and Treatment	**Almost All**
15-824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	**Almost All**
15-825	Cancer Screening - Prostate	**Almost All**
15-826/826.1	Contraceptive Drugs or Devices	**Almost All**
15-826.2	Male Sterilization Cost Sharing	**Almost All**
15-826.3	Fertility Awareness-Based Methods	**Most**
15-827	Clinical Trials	**Almost All**
15-828	General Anesthesia for Pediatric Dental Care	**Most**
15-829	Chlamydia & Human Papillomavirus Screening	**Almost All**
15-830	Referrals to Specialists	**Almost All**
15-831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	**Most**
15-832	Surgical Removal of Testicle	**Almost All**
15-832.1	Hospitalization Coverage Following Mastectomy	**Almost All**
15-833	Extension of Benefits	**Half**
15-834	Prostheses Following Mastectomy	**Almost All**
15-835	Habilitative Services for Minors	**Almost All**
15-836	Hair Prosthesis	**Half**
15-837	Cancer Screening - Colorectal	**Almost All**
15-838	Hearing Aids for Minors	**Some**
15-839	Morbid Obesity Treatment	**Very Little**
15-840	Medically Necessary Residential Crisis Services	**Almost All**
15-841	Smoking Cessation Treatment	**Almost All**
15-842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	**Almost All**
15-843	Amino Acid-Based Elemental Formula	**Most**
15-844	Prosthetic Devices	**Almost All**
15-845	Prescription Drugs - Eye Drop Refills	**Almost All**
15-846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	**Almost All**
15-847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	**Very Little**
15-848	Ostomy Equipment and Supplies	**Almost All**
15-849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	**Almost All**
15-850	Prior Authorizations for Opioid Antagonist	**Almost All**
15-851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	**Almost All**
15-852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	**Half**
15-853	Lymphedema Treatment	**Almost All**
15-854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	**Most**
15-855	Pediatric Autoimmune Neuropsychiatric Disorders	**Almost All**
15-856	COVID-19 Tests Coverage	**Most**
15-857	Coverage of Abortion Care Services	**Half**
15-858	Prior Authorizations for Prescription Drug HIV Prevention	**Almost All**
15-859	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	**Most**

Citation	Mandate Description	Compliance Level
15-860	Biomarker Testing	**Most**

In summary, 60 out of 68 mandates had a self-funded market compliance rate of "half" or more.

Comparison of Mandates to Surrounding States

Additionally, L&E conducted a comparative analysis of mandated health insurance benefit and services between Maryland and the following neighboring jurisdictions: Delaware, the District of Columbia, Pennsylvania, and Virginia.[24]

The comparison includes the following:

- The number of mandates.
- The type of mandates.
- The level and extent of coverage for each mandated health insurance service.
- The financial impact of different levels of coverage for each mandated health insurance service.

The primary sources used for the mandate comparison are provided in Table 8.

TABLE 8 - PRIMARY SOURCES USED FOR THE COMPARISON OF STATE MANDATES

State	Primary Source(s)
Maryland	Code of Maryland, Insurance Article, Title 15, Subtitle 8
Delaware	Delaware Code, Title 18, Chapters 33 & 35
District of Columbia	District of Columbia Code, Titles 31 & 44
Pennsylvania	Pennsylvania Statutes, Title 40
Virginia	Code of Virgina, Title 38.2, Chapter 34

For each service that is mandated in Maryland, L&E determined if a similar service was mandated in any of the surrounding states or required under Federal EHB requirements (ex. preventive screenings).

Table 9 summarizes:

- The total number of health benefit mandates in each jurisdiction.
- The number of mandates that overlap with Maryland; and
- The number of mandates that do not overlap with Maryland.

[24] As required by Md. Code, Insurance Article § 15–1502(a)(2)(iii).

TABLE 9 - HEALTH BENEFIT MANDATES COMPARISON TO SURROUNDING STATES

State	Health Benefit Mandate Total Count	Health Benefit Mandates Overlapping with Maryland	Health Benefit Mandates Not Overlapping with Maryland
Maryland	68	N/A	N/A
District of Columbia (D.C.)	23	20	3
Delaware	39	28	11
Pennsylvania	23	19	4
Virginia	42	33	9

For each state and service, L&E determined if the mandate was more or less generous than Maryland's mandate. L&E then estimated the relative value for each mandate. This comparison is reported in Table 10.

When the value of the Maryland mandate is approximately equal to the surrounding state's mandate, the relative value is reported as 100%. Conversely, 0% indicates that the state does not have a mandate similar to Maryland's. When the value of the surrounding state's mandate is less than Maryland's value, the relative value is between 0% and 100%. When the value of the surrounding state's mandate is greater than Maryland's, the relative value is greater than 100%.

Several mandated benefits and/or services are federally required by the ACA. For these mandates, states may not have enacted a state-specific mandate because the federal requirement already enforces compliance. Therefore, for these mandates, even if another state does not have a state-specific mandate, the estimated relative value is 100%.

TABLE 10 - SURROUNDING STATE MANDATES RELATIVE VALUE TO MARYLAND MANDATE

Citation	Mandate Description	DC	DE	PA	VA
15-801	Alzheimer's Disease Treatment & Care	**0%**	**0%**	**0%**	**0%**
15-802	Mental Health & Substance Abuse Treatment	**100%**	**100%**	**100%**	**100%**
15-803	Blood Products	**0%**	**0%**	**0%**	**100%**
15-804	Prescription Drugs - Off-Label Use	**0%**	**0%**	**0%**	**0%**
15-805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	**0%**	**100%**	**50%**	**0%**
15-806	Prescription Drugs - Choice of Pharmacy	**0%**	**100%**	**0%**	**100%**
15-807	Medical Foods & Modified Food Products	**100%**	**100%**	**100%**	**100%**
15-808	Home Health Care	**0%**	**0%**	**0%**	**0%**
15-809	Hospice Care Services	**0%**	**0%**	**0%**	**100%**
15-810	In Vitro Fertilization (IVF) Infertility Benefits	**100%**	**0%**	**0%**	**0%**
15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility	**100%**	**0%**	**0%**	**0%**
15-811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage*	**100%**	**100%**	**100%**	**100%**
15-812	Hospital Coverage for Mothers and Newborns - Minimum Coverage*	**100%**	**100%**	**100%**	**100%**
15-813	Benefits for Disabilities Caused by Pregnancy or Childbirth	**0%**	**0%**	**0%**	**100%**
15-814	Cancer Screening - Mammograms*	**100%**	**100%**	**100%**	**100%**

Citation	Mandate Description	DC	DE	PA	VA
15-814.1	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	0%	70%	100%	0%
15-815	Reconstructive Breast Surgery	100%	100%	100%	100%
15-816	Direct Access to Gynecological Care	100%	100%	100%	100%
15-817	Child Wellness Services*	100%	100%	100%	100%
15-818	Cleft Lip/Cleft Palate Treatment	0%	0%	100%	100%
15-819	Utilization Review Denial Alternative Coverage and Second Opinions	0%	0%	0%	0%
15-820	Orthopedic Braces	0%	100%	0%	0%
15-821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	0%	0%	0%	100%
15-822	Diabetic Equipment, Supplies, and Self-Management Training	95%	120%	95%	95%
15-822.1	Prescription Drugs - Cost Sharing for Insulin	0%	30%	0%	60%
15-823	Osteoporosis Prevention and Treatment	0%	0%	0%	0%
15-824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	0%	0%	0%	0%
15-825	Cancer Screening - Prostate	100%	100%	0%	100%
15-826/826.1	Contraceptive Drugs or Devices*	100%	100%	100%	100%
15-826.2	Male Sterilization Cost Sharing	0%	0%	0%	0%
15-826.3	Fertility Awareness-Based Methods	0%	0%	0%	0%
15-827	Clinical Trials	100%	100%	0%	100%
15-828	General Anesthesia for Pediatric Dental Care	0%	100%	100%	75%
15-829	Chlamydia & Human Papillomavirus Screening*	100%	100%	100%	100%
15-830	Referrals to Specialists	100%	100%	100%	100%
15-831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	0%	0%	70%	100%
15-832	Surgical Removal of Testicle	0%	0%	0%	0%
15-832.1	Hospitalization Coverage Following Mastectomy	0%	0%	50%	100%
15-833	Extension of Benefits	0%	0%	0%	0%
15-834	Prostheses Following Mastectomy	100%	100%	100%	100%
15-835	Habilitative Services for Minors*	100%	100%	100%	100%
15-836	Hair Prosthesis	0%	140%	0%	0%
15-837	Cancer Screening – Colorectal*	100%	100%	100%	100%
15-838	Hearing Aids for Minors	0%	90%	0%	105%
15-839	Morbid Obesity Treatment	0%	0%	0%	100%
15-840	Medically Necessary Residential Crisis Services	100%	100%	100%	100%
15-841	Smoking Cessation Treatment*	100%	100%	100%	100%
15-842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	0%	100%	0%	100%
15-843	Amino Acid-Based Elemental Formula	100%	0%	100%	100%
15-844	Prosthetic Devices	0%	100%	0%	100%
15-845	Prescription Drugs - Eye Drop Refills	0%	0%	0%	0%
15-846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	100%	100%	100%	100%
15-847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	0%	100%	0%	0%
15-848	Ostomy Equipment and Supplies	0%	0%	0%	0%

Citation	Mandate Description	DC	DE	PA	VA
15-849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	0%	0%	0%	0%
15-850	Prior Authorizations for Opioid Antagonist	0%	0%	0%	0%
15-851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	0%	0%	0%	0%
15-852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	0%	0%	0%	0%
15-853	Lymphedema Treatment	100%	100%	100%	100%
15-854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	0%	0%	0%	0%
15-855	Pediatric Autoimmune Neuropsychiatric Disorders	0%	100%	0%	0%
15-856	COVID-19 Tests Coverage	0%	0%	0%	0%
15-857	Coverage of Abortion Care Services	0%	0%	0%	0%
15-858	Prior Authorizations for Prescription Drug HIV Prevention	0%	0%	0%	0%
15-859	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	0%	0%	0%	0%
15-860	Biomarker Testing	0%	0%	0%	0%
*Coverage required federally by the ACA; therefore, relative value is 100% regardless of specific state mandate.					

A more descriptive comparison by mandate is provided in Appendix A.

Table 11 outlines the full cost impact by state, as a percentage of premium, to modify the value of the Maryland mandate to the value of the comparison state's mandate. For example, if the comparison state does not have a mandate and Maryland were to remove its mandate in order to meet the value of the comparison state's mandate, then there would be a decrease to Maryland's mandate-induced cost impact. So, in this example, the table below would show a negative value.

Several mandated benefits and/or services are federally required by the ACA. For these mandates, states may not have enacted a state-specific mandate because the federal requirement already enforces compliance. Therefore, for these mandates, even if another state does not have a state-specific mandate, the estimated cost impact is 0.0%.

TABLE 11 – FULL COST IMPACT AS A PERCENTAGE OF PREMIUM TO MODIFY THE VALUE OF THE MARYLAND MANDATE TO THE VALUE OF THE COMPARISON STATE'S MANDATE

Citation	Mandate Description	DC	DE	PA	VA
15-801	Alzheimer's Disease Treatment & Care	0.00%	0.00%	0.00%	0.00%
15-802	Mental Health & Substance Abuse Treatment	0.00%	0.00%	0.00%	0.00%
15-803	Blood Products	-0.12%	-0.12%	-0.12%	0.00%
15-804	Prescription Drugs - Off-Label Use	0.00%	0.00%	0.00%	0.00%
15-805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	0.00%	0.00%	0.00%	0.00%
15-806	Prescription Drugs - Choice of Pharmacy	-0.08%	0.00%	-0.08%	0.00%
15-807	Medical Foods & Modified Food Products	0.00%	0.00%	0.00%	0.00%
15-808	Home Health Care	-0.27%	-0.27%	-0.27%	-0.27%
15-809	Hospice Care Services	0.00%	0.00%	0.00%	0.00%
15-810	In Vitro Fertilization (IVF) Infertility Benefits	0.00%	-0.22%	-0.22%	-0.22%

Citation	Mandate Description	DC	DE	PA	VA
15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility	0.00%	0.00%	0.00%	0.00%
15-811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage*	0.00%	0.00%	0.00%	0.00%
15-812	Hospital Coverage for Mothers and Newborns - Minimum Coverage*	0.00%	0.00%	0.00%	0.00%
15-813	Benefits for Disabilities Caused by Pregnancy or Childbirth	0.00%	0.00%	0.00%	0.00%
15-814	Cancer Screening – Mammograms*	0.00%	0.00%	0.00%	0.00%
15-814.1	Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	-0.04%	-0.01%	0.00%	-0.04%
15-815	Reconstructive Breast Surgery	0.00%	0.00%	0.00%	0.00%
15-816	Direct Access to Gynecological Care	0.00%	0.00%	0.00%	0.00%
15-817	Child Wellness Services*	0.00%	0.00%	0.00%	0.00%
15-818	Cleft Lip/Cleft Palate Treatment	-0.01%	-0.01%	0.00%	0.00%
15-819	Utilization Review Denial Alternative Coverage and Second Opinions	-0.04%	-0.04%	-0.04%	-0.04%
15-820	Orthopedic Braces	-0.04%	0.00%	-0.04%	-0.04%
15-821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	-0.06%	-0.06%	-0.06%	0.00%
15-822	Diabetic Equipment, Supplies, and Self-Management Training	-0.01%	0.03%	-0.01%	-0.01%
15-822.1	Prescription Drugs - Cost Sharing for Insulin	-0.28%	-0.20%	-0.28%	-0.11%
15-823	Osteoporosis Prevention and Treatment	-0.04%	-0.04%	-0.04%	-0.04%
15-824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	-0.02%	-0.02%	-0.02%	-0.02%
15-825	Cancer Screening - Prostate	0.00%	0.00%	-0.04%	0.00%
15-826/826.1	Contraceptive Drugs or Devices*	0.00%	0.00%	0.00%	0.00%
15-826.2	Male Sterilization Cost Sharing	-0.08%	-0.08%	-0.08%	-0.08%
15-826.3	Fertility Awareness-Based Methods	-0.27%	-0.27%	-0.27%	-0.27%
15-827	Clinical Trials	0.00%	0.00%	-0.24%	0.00%
15-828	General Anesthesia for Pediatric Dental Care	-0.04%	0.00%	0.00%	-0.01%
15-829	Chlamydia & Human Papillomavirus Screening*	0.00%	0.00%	0.00%	0.00%
15-830	Referrals to Specialists	0.00%	0.00%	0.00%	0.00%
15-831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	-0.27%	-0.27%	-0.08%	0.00%
15-832	Surgical Removal of Testicle	-0.01%	-0.01%	-0.01%	-0.01%
15-832.1	Hospitalization Coverage Following Mastectomy	-0.03%	-0.03%	-0.02%	0.00%
15-833	Extension of Benefits	-0.15%	-0.15%	-0.15%	-0.15%
15-834	Prostheses Following Mastectomy	0.00%	0.00%	0.00%	0.00%
15-835	Habilitative Services for Minors*	0.00%	0.00%	0.00%	0.00%
15-836	Hair Prosthesis	0.00%	0.00%	0.00%	0.00%
15-837	Cancer Screening – Colorectal*	0.00%	0.00%	0.00%	0.00%
15-838	Hearing Aids for Minors	-0.25%	-0.03%	-0.25%	0.01%
15-839	Morbid Obesity Treatment	-0.06%	-0.06%	-0.06%	0.00%
15-840	Medically Necessary Residential Crisis Services	0.00%	0.00%	0.00%	0.00%
15-841	Smoking Cessation Treatment*	0.00%	0.00%	0.00%	0.00%

Citation	Mandate Description	DC	DE	PA	VA
15-842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	0.00%	0.00%	0.00%	0.00%
15-843	Amino Acid-Based Elemental Formula	0.00%	-0.03%	0.00%	0.00%
15-844	Prosthetic Devices	-0.04%	0.00%	-0.04%	0.00%
15-845	Prescription Drugs - Eye Drop Refills	-0.01%	-0.01%	-0.01%	-0.01%
15-846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	0.00%	0.00%	0.00%	0.00%
15-847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	-0.06%	0.00%	-0.06%	-0.06%
15-848	Ostomy Equipment and Supplies	0.00%	0.00%	0.00%	0.00%
15-849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	-0.01%	-0.01%	-0.01%	-0.01%
15-850	Prior Authorizations for Opioid Antagonist	0.00%	0.00%	0.00%	0.00%
15-851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	0.00%	0.00%	0.00%	0.00%
15-852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	0.00%	0.00%	0.00%	0.00%
15-853	Lymphedema Treatment	0.00%	0.00%	0.00%	0.00%
15-854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	-0.11%	-0.11%	-0.11%	-0.11%
15-855	Pediatric Autoimmune Neuropsychiatric Disorders	-0.05%	0.00%	-0.05%	-0.05%
15-856	COVID-19 Tests Coverage	0.00%	0.00%	0.00%	0.00%
15-857	Coverage of Abortion Care Services	-0.03%	-0.03%	-0.03%	-0.03%
15-858	Prior Authorizations for Prescription Drug HIV Prevention	-0.03%	-0.03%	-0.03%	-0.03%
15-859	Coverage for Diagnostic & Supplemental Lung Cancer Imaging	-0.12%	-0.12%	-0.12%	-0.12%
15-860	Biomarker Testing	-0.14%	-0.14%	-0.14%	-0.14%
Total		-2.77%	-2.33%	-2.98%	-1.86%
*Coverage required federally by the ACA, therefore there is no cost impact regardless of the presence of a state mandate.					

In summary, if the lesser benefit level of each mandate required in the surrounding states were mandated in Maryland the full cost of mandates would be reduced by less than 4%.

However, it is important to note that several benefits and/or services that are not mandated in surrounding states are covered by Maryland's EHB-Benchmark plan. In these cases, even if Maryland removed or reduced its mandate, the individual and small group market plans would still have to comply with EHB-benchmark plan requirements. Therefore, the marginal cost decrease would be lower than the full cost decrease presented in Table 11.

Table 12 shows mandates present in neighboring jurisdictions but absent in Maryland. The cost, expressed as a percentage of the premium, to incorporate each mandate in Maryland is also summarized. "N/A" indicates that the state does not have the type of mandate listed. A more detailed description of these mandates is provided in Appendix B.

TABLE 12 – FULL COST OF SURROUNDING STATES' MANDATES AS A PERCENTAGE OF ANNUAL PREMIUM

Citation	Mandate Description	DC	DE	PA	VA
DC: § 31-2803	Emergency Department HIV Screening	**0.00%**	**N/A**	**N/A**	**N/A**
DC: § 31-3834	Hormone Replacement Therapy Coverage	**0.20%**	**N/A**	**N/A**	**N/A**
DC: § 31-3862 DE: 18 § 3370, 3571R VA: § 38.2-3418.16	Telehealth Reimbursement	**0.00%**	**0.00%**	**N/A**	**0.00%**
DE: 18 § 3336, 3553	Midwife Services Reimbursement	**N/A**	**0.00%**	**N/A**	**N/A**
DE: 18 § 3338, 3555	Coverage of Ovarian Cancer Monitoring Test	**N/A**	**0.00%**	**N/A**	**N/A**
DE: 18 § 3338B, 3555B VA: § 38.2-3407.5, 3407.6:1	Utilization Review of FDA-Approved Drugs for Treatment of Cancer	**N/A**	**0.02%**	**N/A**	**0.00%**
DE: 18 § 3344C, 3560B	Cost Sharing for Insulin Pumps	**N/A**	**0.07%**	**N/A**	**N/A**
DE: 18 § 3345, 3561 PA: 40 § 1574 VA: § 38.2-3418.1:2	Coverage for Annual Pap Smear/Gynecological Exam	**N/A**	**0.30%**	**0.30%**	**0.30%**
DE: 18 § 3349A, 3565A VA: § 38.2-3407.9	Reimbursement Parity for Emergency Medical Vehicle Transportation	**N/A**	**0.00%**	**N/A**	**0.00%**
DE: 18 § 3365, 3571G	School-Based Health Centers	**N/A**	**0.00%**	**N/A**	**N/A**
DE: 18 § 3366, 3570A PA: 40 § 764h VA: § 38.2-3418.17	Autism Spectrum Disorder Coverage	**N/A**	**0.36%**	**0.36%**	**0.36%**
DE: 18 § 3370D, 3571Y	Coverage for Epinephrine Autoinjectors	**N/A**	**0.00%**	**N/A**	**N/A**
DE: 18 § 3370E, 3571Z	Coverage for Annual Behavioral Health Well Check	**N/A**	**0.10%**	**N/A**	**N/A**
PA: 40 § 764b	Reimbursement Parity for Cancer Therapy	**N/A**	**N/A**	**0.00%**	**N/A**
PA: 40 § 764d.1	Coverage for BRCA-Related Genetic Counseling and Genetic Testing	**N/A**	**N/A**	**0.05%**	**N/A**
VA: § 38.2-3407.9:02	Prohibits Denial FDA-Approved Drugs Based on Certain Criteria	**N/A**	**N/A**	**N/A**	**0.00%**
VA: § 38.2-3407.11:5	Prior Authorization of Interhospital Transfer of Newborn or Mother	**N/A**	**N/A**	**N/A**	**0.00%**
VA: § 38.2-3418.19	Prohibits Denial of Organ, Eye, or Tissue Transplant for Certain Criteria	**N/A**	**N/A**	**N/A**	**0.00%**
VA: § 38.2-3418.9	Minimum Hospital Stay for Hysterectomy	**N/A**	**N/A**	**N/A**	**0.09%**
Total		**0.20%**	**0.90%**	**0.72%**	**0.74%**

If Maryland adopted these additional mandates, the full cost of mandates would be estimated to increase by less than 2%. The marginal cost increase would likely be lower than the full cost increase presented in Table 12.

Based on the results outlined in Tables 11 and 12, for example, if Maryland were to "mirror" its mandates to match DC's mandates then Maryland's full cost of mandates would be estimated to decrease by 2.6%[25].

[25] [(1-.0277) * (1+.0020)] – 1 = 2.58%, where 2.77% is the DC total from Table 11 and 0.20% is the DC total from Table 12.

Conclusion

The full cost of the 68 health insurance service mandates in Maryland amounts to approximately 17.3% of the premium when averaged across all markets. However, most of these mandates are covered by Maryland's EHB-benchmark plan and/or are typically covered outside of the coverage induced by the mandate. Therefore, the marginal cost attributed to the mandates is much less, averaging approximately 0.8% of the premium across all markets. Additionally, 60 of the 68 mandates have a self-funded market compliance rate of "half" or more.

In comparison to neighboring states, Maryland's mandates demonstrate a similar overall value. Whether contemplating reducing mandates to align more closely with surrounding states, adding mandates to achieve parity with surrounding states, or a combination of both approaches, Maryland's current mandate full cost value remains within a range of 4 percentage points.

Appendix A

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
801	Alzheimer's Disease Treatment & Care	Health insurers must offer the option of including benefits for the expenses arising from the care of victims of Alzheimer's disease and the care of the elderly to all group purchasers.				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
802	Mental Health & Substance Abuse Treatment	Coverage shall be provided for at least the following benefits for the diagnosis and treatment of a mental illness, emotional disorder, drug use disorder, or alcohol use disorder: (1) inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient and residential treatment center benefits; (2) partial hospitalization benefits for a minimum of 60 days for at least 4 hours per day; and (3) outpatient and intensive outpatient benefits, including all office visits, diagnostic evaluation, opioid treatment services, medication evaluation and management, and psychological and neuropsychological testing for diagnostic purposes. The benefits required under this section must be comparable as written and in operation to, and applied no more stringently than the benefits for physical illnesses covered under the health benefit plan. The ASAM criteria for shall be used for all medical necessity and utilization management determinations for substance use disorder benefits.	18-3343, 18-3576, 18-3578: Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans issued in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following: 1. Inpatient coverage for the diagnosis and treatment. 2. Unlimited medically necessary treatment for drug and alcohol dependencies as required by the MHPAEA and determined by the use of the full set of ASAM criteria, in all of the following: A. Treatment provided in residential setting. B. Intensive Outpatient Programs. C. Inpatient withdrawal management. No carrier may issue any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan.	31-3102; 31-3103, 31-3104: Alcohol/ Substance Abuse – Minimum yearly inpatient coverage of 28 days, plus 12 days for detoxification; 30 days minimum outpatient visits. Mental Health – Mandatory coverage of 45 days inpatient. Outpatient coverage must be at least 75% for the first 40 visits during the year; 60% after that. Lifetime maximum of the greater of $80,000 or 1/3 the lifetime max for physical illness.	40 P.S. 908-2; 908-3; 908-4; 908-5: Alcohol/ Substance Abuse – Mandatory coverage of 7 days per inpatient admission, 30 days non-hospital residential treatment coverage, and 30 days minimum outpatient visits. 40 P.S. 764g: Mental Health – Mandatory coverage of 30 days inpatient coverage and 60 days minimum outpatient visits. Lifetime maximum cannot be less than lifetime coverage for physical illness.	38.2-3412.1: Alcohol/ Substance Abuse – Minimum yearly inpatient coverage of 20 days for adults and 25 days for children; 20 days minimum outpatient visits. Mental Health – Minimum yearly inpatient coverage of 20 days for adults and 25 days for children; 20 days minimum outpatient visits. Lifetime maximum cannot be more restrictive than that for physical illness; coinsurance cannot exceed 50% for outpatient visits.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
803	Blood Products	Health insurers may not exclude payments for blood products except whole blood or concentrated red blood cells.				38.2-3418.3: Blood products for home treatment of hemophilia must be covered.
804	Prescription Drugs - Off-Label Use	Carriers may not exclude coverage of a drug for an off-label use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature.				
805	Prescription Drugs - Mail Order Cost Sharing & Reimbursement	Subject policies cannot establish varied reimbursement based on the type of prescriber and cannot vary copayments based on community pharmacy vs. mail order.	18-7303: No insurer shall impose on a beneficiary any co-payment or condition that is not equally imposed with all contracting pharmacy providers the beneficiary may utilize. No insurer shall require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy.		40 P.S. 764l: Carriers shall not impose on a covered individual utilizing a retail pharmacy a copayment, deductible, fee, limitation on benefits or other condition or requirement not otherwise imposed on the covered individual when using a mail order pharmacy.	
806	Prescription Drugs - Choice of Pharmacy	A nonprofit health service plan that provides pharmaceutical services shall allow a subscriber, member, or beneficiary to fill prescriptions at the pharmacy of the subscriber's, member's, or beneficiary's choice.	18-7303: Any person in the State may select the pharmacy of the person's choice as long as the pharmacy has agreed to participate in the plan according to the terms offered by the insurer.			38.2-3407.7: No contracts shall prohibit any person receiving pharmacy benefits, including specialty pharmacy benefits, furnished thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
807	Medical Foods & Modified Food Products	Mandatory coverage of medically necessary and low protein modified medical food products for the treatment of inherited metabolic diseases.	18-3571, 18-3355: must include coverage for medical formulas and foods and low protein modified formulas and modified food products for the treatment of inherited metabolic diseases.	31-3871: Requires coverage for the cost of medically necessary food ordered as necessary by a provider for the following diseases or conditions: (1) Inflammatory bowel disease, including Crohn's disease, ulcerative colitis, and indeterminate colitis; (2) Gastroesophageal reflux disease that is nonresponsive to standard medical therapies; (3) Immunoglobulin E- and non-Immunoglobulin E-mediated allergies; (4) Food protein-induced enterocolitis syndrome; (5) Eosinophilic disorders; (6) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract, including short bowel syndrome and chronic intestinal pseudo-obstruction; (7) Malabsorption due to liver or pancreatic disease; (8) Inherited metabolic disorders; and (9) Any other diseases or conditions as determined by the Mayor through rulemaking. Cost sharing may be required but may not be greater than cost sharing for similar coverages.	40 P.S. 3904: Mandatory coverage for the cost of medically necessary nutritional supplements and formulas in the treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.	38.2-3418.18: Requires coverage for medically necessary formula and enteral nutrition products on the same terms and subject to the same conditions imposed on other medicines covered under the policy, contract, or plan.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
808	Home Health Care	Carriers shall provide benefits for the expenses of home health care that is provided by a person licensed under the Health Occupations Article if institutionalization of the individual would have been required if home health care was not provided. Carriers may limit the number of home health care visits, but not to fewer than 40 visits per year for up to 4 hours per visit.				
809	Hospice Care Services	Health insurers must offer individuals and groups benefits for hospice care services.				38.2-3418.11: Coverage mandatory for hospice services, including psychological, psychosocial, and other health services.
810	In Vitro Fertilization (IVF) Infertility Benefits	Carriers that provide pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from IVF procedures. The benefits shall be provided to the same extent as benefits provided for other pregnancy-related procedures. The patient or the patient's spouse must meet certain infertility requirements outlined in the mandate. Carriers may limit coverage of these benefits to 3 IVF attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.		31-3834.06 [Effective 1/1/2025]: Requires coverage for the diagnosis and treatment of infertility, including in vitro fertilization and standard fertility preservation services for at least 3 complete oocyte retrievals and unlimited embryo transfers from those oocyte retrievals, as well as any medically necessary ovulation enhancing drugs for at least 3 cycles of ovulation-enhancing medication.		

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
810.1	Fertility Preservation Procedures for Iatrogenic Infertility	Requires coverage for standard fertility preservation procedures: (1) performed on a policyholder or subscriber or on the covered dependent of a policyholder or subscriber; and (2) that are medically necessary to preserve fertility for a policyholder or subscriber or for the covered dependent of a policyholder or subscriber due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility.		31-3834.06 [Effective 1/1/2025]: Requires coverage for the diagnosis and treatment of infertility, including in vitro fertilization and standard fertility preservation services for at least 3 complete oocyte retrievals and unlimited embryo transfers from those oocyte retrievals, as well as any medically necessary ovulation enhancing drugs for at least 3 cycles of ovulation-enhancing medication.		
811	Hospital Coverage for Mothers and Newborns - Medically Necessary Coverage	Every insurance policy that provides benefits for normal pregnancy must provide hospitalization benefits to the same extent as that provided for any covered illness. Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, the insurer or nonprofit health service plan shall pay the cost of additional hospitalization for the newborn for up to 4 days.				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
812	Hospital Coverage for Mothers and Newborns - Minimum Coverage	If inpatient hospitalization is covered, hospitalization for childbirth and postpartum stay of 48 to 96 hours must also be covered. If the mother requests a shorter hospital stay, the carrier must provide coverage for one home visit by a registered nurse within 24 hours after discharge from the hospital, and if prescribed by the attending provider, an additional home visit.		31-3802.01: Plans that provide maternity coverage must cover inpatient postpartum stay of a minimum of 48 hours after a vaginal delivery, and 96 hours after a Cesarean delivery.	40 P.S. 1583; 3002: If maternity care is covered, post delivery inpatient care must be covered for 48-96 hours. Must also cover services by a licensed certified nurse midwife. Mandatory coverage for one home health care visit within 48 hours after discharge for childbirth when discharge occurs prior to 48-96 hour guidelines.	38.2-3414.1; 38.2-3418: Maternity coverage not required except in the case of rape or incest, but must be an employer option. If it is covered, benefits for inpatient care and a home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists.
813	Benefits for Disabilities Caused by Pregnancy or Childbirth	Health insurers must offer group purchasers the option of including temporary disability benefits for temporary disability caused or contributed to by pregnancy or childbirth.				38.2-3407.11:4: Contracts that provide coverage for short-term disability arising out of childbirth shall provide coverage for a payable benefit of at least 12 weeks immediately following childbirth for such a disability.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
814	Cancer Screening - Mammograms	Coverage required for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society, including coverage for digital tomosynthesis that, under accepted standards in the practice of medicine, the treating physician determines is medically appropriate and necessary for an enrollee or insured. A deductible may not be applied to this coverage. A copayment or coinsurance requirement for digital tomosynthesis that is greater than a copayment or coinsurance requirement for other breast cancer screenings may not be imposed.	18-3552: Mandatory coverage for one mammogram for women age 35 or older, every 1 to 2 years for women age 40 to 50, every year for women age 50 and over and for any woman who is at high risk for breast cancer.	31-2902: Mandated baseline and annual mammogram for women. Coverage may not be subject to any cost sharing 31-3834.02: Requires coverage for adjuvant breast cancer screening, including magnetic resonance imaging, ultrasound screening, or molecular breast imaging of the breast, if: (i) A mammogram demonstrates a Class C or Class D breast density classification; or (ii) A woman is believed to be at an increased risk for cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications of an increased risk for cancer as determined by a woman's physician or advanced practice registered nurse	40 P.S. 764c: Required coverage for all costs associated with a mammogram every year for women age 40 or older and one supplemental breast screening each year when medically necessary.	38.2-3418.1: Coverage required includes one mammogram for women ages 35-39, one every other year for those 40-49, and one annually for women 50 and older.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
814.1	[Effective 1/1/2024] Cancer Screening - Cost Sharing for Diagnostic and Supplemental Mammograms	Carriers may not impose a copayment, coinsurance, or deductible requirement on coverage for diagnostic breast examinations or supplemental breast examinations.	18-3370F, 18-3552A: All individual, group, and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, extended, or modified in this State shall provide coverage for diagnostic breast examinations and supplemental breast screening examinations. The terms of such coverage, including cost-sharing requirements, shall be no less favorable than the cost-sharing requirements applicable to screening mammography for breast cancer.		40 P.S. 764c: Required coverage for all costs associated with a mammogram every year for women age 40 or older and one supplemental breast screening each year when medically necessary.	
815	Reconstructive Breast Surgery	Requires carriers to provide coverage for reconstructive breast including coverage reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast	18-3563, 18-3347: Contracts that provide coverage for medical and surgical benefits with respect to a mastectomy must provide coverage that covers all states of reconstruction and reconstruction of the other breast to produce a symmetrical appearance and prostheses.	31-3832: If mastectomies are covered, reconstructive surgery, including surgery of the healthy breast to produce a symmetrical appearance and prosthetic devices, must also be covered. Cost sharing may be required but may not be greater than cost sharing for similar coverages.	40 P.S. 764d: If mastectomies are covered, coverage is also required for prosthetic devices and breast reconstruction, including surgery of the healthy breast to achieve symmetry.	38.2-3418.4: Reconstructive surgery coverage is required for breast surgery, including reconstruction of the other breast to produce a symmetrical appearance and prostheses. Cost sharing may be required but may not be greater than cost sharing for similar coverages.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
816	Routine Gynecological Care	Requires carriers to permit a woman to have direct access to gynecological care from an in- network obstetrician/ gynecologist or other non-physician, including a certified nurse midwife, without first requiring the woman to visit a primary care provider; or classify an obstetrician/gynecologist as a primary care provider.	18-3556, 18-3342: Requires carriers to permit female insureds to designate a participating, in-network, obstetrician-gynecologist as the enrollee's primary care provider if the obstetrician-gynecologist meets certain requirements outlined in the mandate. If the female insured designates a primary care provider that is not an obstetrician-gynecologist then the carrier must permit a woman to have direct access to gynecological care from an in- network obstetrician/ gynecologist or other non-physician, including a certified nurse midwife, without first requiring the woman to visit a primary care provider.	44-302.03: Health plans must permit women direct access for gynecological care to a gynecologist or advance practice registered nurse without referral by a primary care provider; or classify an obstetrician/gynecologist as a primary care provider.	40 P.S. 991.2111: Carriers must allow direct access to obstetrical and gynecological services without prior approval from a primary care provider.	38.2-3407.11: Carriers must allow direct access to obstetrical and gynecological services without prior approval from a primary care provider.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
817	Child Wellness Services	Requires coverage of certain preventative services, including well child visits, immunizations and screening tests for hearing, vision, tuberculosis, anemia and lead toxicity. For newborns, coverage of hereditary and metabolic screening also included. Insurers may impose copayments but no deductible.	18-3337, 18-3554: Mandatory coverage for lead screening tests for children. 18-3360, 18-3571D: Covered children eligible to receive developmental screenings at ages 9 months, 18 months, and 30 months. 18-3352, 18-3568: Mandated coverage for hearing loss screening tests of newborns and infants provided by a hospital before discharge. Benefits must be consistent with reimbursement of other medical expenses under the policy. 18-3363, 18-3558: Carriers must cover immunizations for routine use in children with no cost sharing		40 P.S. 3503: Child immunizations must be covered.	38.2-3411.1; 38.2-3411.3; 3411.4: Immunizations must be covered. Well child care to age 6 must be covered and exempt from deductibles and coinsurance.
818	Cleft Lip/Cleft Palate Treatment	Every hospital or major medical insurance policy must include benefits for inpatient or outpatient expenses arising from the management of cleft lip, cleft palate, or both.			40 P.S. 772: Mandatory coverage for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.	38.2-3411: Requires coverage for inpatient and outpatient dental, oral surgical, and orthodontic services that are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia. Cost sharing may be required but may not be greater than cost sharing for similar coverages.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
819	Utilization Review Denial Alternative Coverage and Second Opinions	Health insurers must cover a second opinion when required by a utilization review program, and must provide outpatient coverage for a service for which a hospital admission is denied.				
820	Orthopedic Braces	Individual and group contracts written by a non-profit health service plan that provides hospital benefits must provide benefits for orthopedic braces.	18-3362, 18-3571E: Carriers that provide medical coverage that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage, shall provide reimbursement for orthotic and prosthetic devices at least equal to federal reimbursements rates provided for under federal laws for health insurance for the aged and disabled. Prior authorization may be required. Repair and replacement shall also be covered subject to cost sharing.			

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
821	Diagnostic and Surgical Procedures for Bones or Joints of the Face, Neck, or Head	Health insurers may not exclude or deny coverage for the same diagnostic or surgical procedure involving a bone or joint of the face, neck, or head if, under the accepted standards of the profession of the health care provider rendering the service, the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.				38.2-3418.2: Contract that provide coverage for diagnostic and surgical treatment involving any bone or joint of the skeletal structure shall not exclude coverage for such diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw or impose limits that are more restrictive than limits on coverage applicable to such treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
822	Diabetic Equipment, Supplies, and Self-Management Training	Mandatory coverage for all medically necessary diabetes equipment, supplies, and outpatient self- management training and educational services, including medical nutrition therapy. Cost sharing may not be imposed on diabetes test strips.	18-3344,18-3560: If prescription drugs are covered, equipment and supplies for the treatment of diabetes must also be covered. Benefits shall be provided to the same extent as for any other sickness under the contract. 18-3344D, 18-3560C: A contract that provides coverage for any diabetes equipment or supplies must cap the total amount that a covered individual is required to pay for diabetes equipment and supplies at no more than $35 per month for each enrolled individual, regardless of the amount or types of diabetes equipment or supplies needed to fill the individual's prescriptions.	31-3002: Requires coverage for the equipment, supplies, and other outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional.	40 P.S. 764e: Mandatory coverage for all medically necessary diabetes equipment, supplies, and outpatient self-management training and educational services, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional.	38.2-3418.10: Requires coverage for the equipment, supplies, and other outpatient self- management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
822.1	[Effective 1/1/2023] Prescription Drugs - Cost Sharing for Insulin	Carriers must limit the amount a covered individual is required to pay in copayments or coinsurance for a covered prescription insulin drug to not more than $30 for a 30-day supply, regardless of the amount or type of insulin needed to fill the covered individual's prescription.	18-3560A, 18-3344B: Contracts that provide coverage for prescription insulin drugs must (1) Cap the total amount that a covered individual is required to pay for covered prescription insulin drugs at no more than $100 per month for each enrolled individual, regardless of the amount or types of insulin needed to fill the covered individual's prescriptions. The $100 per month cap includes deductible payments and cost-sharing amounts charged once a deductible is met. (2) Include at least 1 formulation of each of the following types of prescription insulin drugs on the lowest tier of the drug formulary developed and maintained by the carrier: a. Rapid-acting. b. Short-acting. b. Intermediate-acting. c. Long-acting. (3) For purposes of paragraph (b)(2) of this section, the "lowest tier of the drug formulary" means either of the following: a. If the prescription insulin drug is a generic drug, the lowest tier for generic drugs. b. If the prescription insulin drug is a brand-name drug, the lowest tier for brand-name drugs.			38.2-3407.15:5: Carriers shall set the cost-sharing payment that a covered person is required to pay for a covered prescription insulin drug at an amount that does not exceed $50 per 30-day supply of the prescription insulin drug, regardless of the amount or type of insulin needed to fill the covered person's prescription.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
823	Osteoporosis Prevention and Treatment	Carrier shall include coverage for qualified individuals for reimbursement for bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a health care provider for the qualified individual, for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional				
824	Prescription Drugs - Allowance of 90-Day Supply for Maintenance Drugs	Carrier shall allow the insured to receive up to a 90-day supply of a prescribed maintenance drug in a single dispensing, except for new prescriptions or changes in prescriptions. If carrier increases copayment, it shall proportionally increase the dispensing fee.				
825	Cancer Screening - Prostate	Mandatory coverage for prostate screening for men who are between 40 and 75 years of age or who are at high risk for prostate cancer.	18-3552: Mandatory coverage for prostate cancer screening for enrollees age 50 or above.	31-2952: Mandatory coverage for prostate cancer screening benefits that comply with American Cancer Society guidelines. Cost sharing may be required but may not be greater than cost sharing for similar coverages.		38.2-3418.7: Coverage required for annual PSA test for men age 50 and older and those age 40 and older at high risk.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
826/826.1	Contraceptive Drugs or Devices	Mandatory coverage for any FDA- approved, prescription contraceptive drug or device and related services, without prior authorization and without requiring a prescription. Exempts religious organizations. Cost sharing must not be different than for any other prescription.	18-3342A, 18-3559: Mandatory coverage for FDA- approved prescription contraceptive drugs, devices and outpatient contraceptive services; exempts religious employers.	31-3834.01: Contracts that offer prescription drug coverage must provide coverage for a supply of contraceptives intended to last over the course of a 12-month period, that shall be dispensed all at once or over the course of the 12 months at the patient's election, including for over-the-counter contraceptives and contraceptives obtained from a licensed pharmacist. 31-3834.03: Requires coverage for all contraceptive drugs, devices, products and services approved by the U.S. Food and Drug Administration ("FDA"), including emergency contraception.		38.2-3407.5:1, 38.2-3407.5:2: If prescription drugs are covered, all FDA-approved prescription contraceptives must be covered. Coverage must be for up to a 12-month supply dispensed at one time for hormonal contraceptives. Cost sharing may be required but may not be greater than cost sharing for similar coverages.
826.2	Male Sterilization Cost Sharing	Requires coverage for male sterilization with no cost sharing.				
826.3	Fertility Awareness-Based Methods	Requires coverage for instruction by a licensed health care provider on fertility awareness-based methods, which can be used to identify times of fertility and infertility by an individual to avoid pregnancy, with no cost sharing.				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
827	Clinical Trials	Mandatory coverage for patient costs to an enrollee in a clinical trial for a life-threatening condition or prevention and early detection of cancer.	18-3351, 18-3567: Mandatory coverage for routine patient care costs for covered items and services for enrollees engaging in clinical trials for treatment of life threatening diseases. 18-3351B, 18-3567B: Prohibits denial of coverage for treatment that is experimental or investigational.	31-2993.02: Carriers may not limit or deny coverage, or impose additional conditions on the payment for the coverage, of routine patient care costs of items, drugs, and services furnished to a qualified individual in connection with participation in an approved clinical trial. A health insurer shall not be required to pay for costs of items, services, or drugs that are customarily provided by the sponsors of an approved clinical trial.		38.2-3418.8: Mandatory coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
828	General Anesthesia for Pediatric Dental Care	Mandatory coverage for general anesthesia and associated hospital charges for dental care for children aged 7 or younger, the developmentally disabled, and where medically necessary. Prior authorization may be required. Does not apply to dental care rendered for TMJ	18-3358, 18-3571C: Carries must authorize payment to a licensed practitioner for dental services to a child with a severe disability irrespective of lack of contractual or network status. Unless otherwise negotiated with the practitioner in advance, such payment shall be in an amount at least equal to the insurer's reasonable and customary compensation for the same or similar services in the same geographical area. A nonnetwork practitioner accepting payment under this section may not balance bill the insured. Nothing in this section shall prevent the application of contract or policy provisions involving deductibles, coinsurance, maximum dollar limitations or coordination of benefits, provided that such limits shall be applied using in-network standards.		40 P.S. 3510.3: Mandatory coverage for general anesthesia and associated hospital charges for dental care for children aged 7 or younger, the developmentally disabled, and where medically necessary. Cost sharing may be required but may not be greater than cost sharing for similar coverages. Does not apply to dental care rendered for TMJ	38.2-3418.12: Mandatory coverage of anesthesia for dental procedures for children aged 5 or younger, the developmentally disabled, and where medically necessary

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
829	Chlamydia & Human Papillomavirus Screening	Coverage shall be provided for an annual routine chlamydia screening test for women who are under the age of 20 if they are sexually active and at least 20 if they have multiple risk factors, and for men who have multiple risk factors. Coverage shall be provided for human papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists. Cost sharing may be required but may not be greater than cost sharing for similar coverages.				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
830	Referrals to Specialists	Plans that don't allow direct access to health care specialists must establish and implement a procedure by which insureds can obtain a standing referral to a health care specialist, including an ob/gyn, under certain circumstances.	18-3564, 18-3348: Plans that don't allow direct access to health care specialists must establish and implement a procedure by which insureds can obtain a standing referral to a health care specialist under certain circumstances.	44-302.01: Plans must permit a member with a chronic disabling or life-threatening condition to have direct access to a specialist qualified to treat the condition, subject to initial referral and a treatment plan approved by the primary care provider; or classify a classify a health care specialist as a primary care provider. 44-302.02: Carriers shall permit a member to receive medically necessary or appropriate specialty care for more than one visit without having to obtain the insurer's approval for subsequent visits authorized by a primary care provider.	40 P.S. 991.2111: Managed care plans must adopt procedures by which an enrollee with a life-threatening, degenerative, or disabling disease or condition may receive a standing referral to a specialist with clinical expertise in treating the disease or condition.	38.2-3407.11:1: Health plans must permit any covered individual to obtain a standing referral to a specialist if determined by the primary care physician to be appropriate or if the individual is a cancer patient.
831	Prescription Drugs - Coverage of Certain Non-Formulary Drugs	Health plans that limit prescription coverage to a formulary must establish & implement a procedure for an enrollee to obtain a drug or device that isn't on the plan's formulary when there is no equivalent drug or device in the formulary or when an equivalent drug is ineffective or has caused an adverse reaction.			40 P.S. 991.2136: Plans using a drug formulary must have a written policy that includes an exception process by which a health care provider may prescribe and obtain coverage for the enrollee for specific drugs and medications not included in the formulary when the formulary's equivalent has been ineffective in the treatment of the enrollee's disease or if the drug causes adverse reactions.	38.2-3407.9:01: Plans must establish a process to allow an enrollee to obtain, without additional cost-sharing, non-formulary prescription drugs if the formulary drug is determined by the plan and the prescribing physician to be an inappropriate therapy for the enrollee's medical condition.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
832	Surgical Removal of Testicle	Requires carriers to cover at least 1 home visit within 24 hrs. after discharge for a patient who has <48 hrs. of inpatient hospitalization after the surgical removal of a testicle, or who undergoes procedure on an outpatient basis. An additional home visit must be covered if prescribed by the patient's attending physician				
832.1	Hospitalization Coverage Following Mastectomy	Coverage for a minimum 48-hour inpatient hospital stay following a mastectomy. The patient may request a shorter length of stay. A carrier must provide a patient that receives less than a 48 hour stay, or who undergoes a mastectomy on an outpatient basis, one home visit scheduled to occur within 24 hours after discharge and an additional home visit if prescribed.			40 P.S. § 764d: Mastectomy coverage must include coverage for a home health care visit that the treating physician determines is necessary within forty-eight hours after discharge when the discharge occurs within forty-eight hours following admission for the mastectomy.	38.2-3418.6: Requires coverage providing a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified radical mastectomy and not less than twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
833	Extension of Benefits	If an individual's coverage terminates, except for termination due to non-payment or fraud, the plan must continue coverage for up to 12 months for (1) treatment begun before termination related to disability (2) a claim in progress (3) hospital confinement. The plan must continue coverage for (1) up to 30 days for already ordered glasses or contact lenses (2) up to 60 days or the end of the billing quarter for orthodontia (3) up to 90 days for dental care that begun before the termination and requires two or more dental visits (4) up to 90 days for an accident that occurs while the individual is covered. Premium may not be charged for these types of benefit extensions.				
834	Prostheses Following Mastectomy	Requires carriers to provide coverage for a prosthesis that has been prescribed by a physician for an enrollee or insured who has undergone a mastectomy and has not had breast reconstruction.	18-3563, 18-3347: Contracts that provide coverage for medical and surgical benefits with respect to a mastectomy must provide coverage that covers all states of reconstruction and reconstruction of the other breast to produce a symmetrical appearance and prostheses.	31-3832: If mastectomies are covered, reconstructive surgery, including surgery of the healthy breast to produce a symmetrical appearance and prosthetic devices, must also be covered. Cost sharing may be required but may not be greater than cost sharing for similar coverages.	40 P.S. 764d: If mastectomies are covered, coverage is also required for prosthetic devices and breast reconstruction, including surgery of the healthy breast to achieve symmetry.	38.2-3418.4: Reconstructive surgery coverage is required for breast surgery, including reconstruction of the other breast to produce a symmetrical appearance and prostheses. Cost sharing may be required but may not be greater than cost sharing for similar coverages.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
835	Habilitative Services for Minors	Requires carriers to provide coverage of habilitative services for insureds and enrollees who are children until at least the end of the month in which the insured or enrollee turns 19 years old.		31-3272: Requires carriers to provide coverage of habilitative services for children under the age of 21 years. Cost sharing may be required but may not be greater than cost sharing for similar coverages.		38.2-3418.5: Requires coverage for speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices for disabled dependents from birth to age three (early intervention services) up to $5,000 per insured per year. Dollar limits, deductibles, and co-insurance same as for other conditions.
836	Hair Prosthesis	Requires carriers to provide one hair prosthesis at a cost not to exceed $350 when prescribed by a provider (As revised in MD MIA Bulletin 23-5)	18-3356, 18-3571B: If prostheses are covered, coverage is mandated for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. Coverage is subject to the same limitations and guidelines as other prostheses. Coverage for alopecia areata must not exceed $500 per year, and may be subject to annual deductibles and coinsurance provisions consistent with those established for other benefits under the plan of coverage.			

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
837	Cancer Screening - Colorectal	Carriers shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society (ACS). Cost sharing may be required but may not be greater than cost sharing for similar coverages.	18-3346, 18-3562: Mandatory coverage for colorectal cancer screening for persons 50 years of age or older and those at high risk for colon cancer.	31-2931: Mandatory coverage for colorectal cancer screening for policyholders residing in the District in accordance with the American Cancer Society guidelines.	40 P.S. 764i: Must provide coverage for colorectal cancer screening for covered individuals in accordance with American Cancer Society guidelines for colorectal cancer screening published as of January 1, 2008, and consistent with approved medical standards and practices.	38.2-3418.7:1: Coverage required for risk groups established by the American College of Gastroenterology. Cost sharing may be required but may not be greater than cost sharing for similar coverages.
838	Hearing Aids for Minors	Carriers shall provide coverage for hearing aids for a minor child covered under a policy if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. Carriers may limit the benefit to $1,400 per hearing aid for each hearing-impaired ear every 36 months.	18-3357, 18-3571A: Mandated hearing aid coverage of up to $1,000 per individual hearing aid, per ear, every 3 years, for children less than 24 years of age, covered as a dependent by the policy holder. The insured may choose a hearing aid exceeding $1,000 and pay the difference in cost.			38.2-3418.21: Requires coverage for hearing aids and related services for children 18 years of age or younger under any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth. The coverage shall include payment of the cost of one hearing aid per hearing-impaired ear every 24 months, up to $1,500 per hearing aid. The insured may choose a higher-priced hearing aid and may pay the difference in cost above $1,500
839	Morbid Obesity Treatment	Carriers must provide coverage for the treatment of morbid obesity through gastric bypass surgery or another surgical method that is recognized by the NIH as effective for the long-term reversal of morbid obesity. Benefits should be provided to the same extent as for other medically necessary surgical procedures.				38.2-3418.13: Mandatory morbid obesity coverage for those 100 lbs. over their recommended weight, or with a specified body mass index in conjunction with obesity-related illnesses. Cost sharing may be required but may not be greater than cost sharing for similar coverages.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
840	Medically Necessary Residential Crisis Services	Carriers must provide coverage for medically necessary residential crisis services that are intensive mental health & support services, provided to someone with a mental illness at risk of a psychiatric crisis; designed to prevent, shorten, or provide an alternative to an inpatient admission; provided on a short-term basis; and provided by licensed entities.	18-3343, 18-3576, 18-3578: Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans issued in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following: 1. Inpatient coverage for the diagnosis and treatment. 2. Unlimited medically necessary treatment for drug and alcohol dependencies as required by the MHPAEA and determined by the use of the full set of ASAM criteria, in all of the following: A. Treatment provided in residential setting. B. Intensive Outpatient Programs. C. Inpatient withdrawal management. No carrier may issue any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan.	31-3102; 31-3103, 31-3104: Covered benefits for drug abuse, alcohol abuse, and mental illness in insurance policies and contracts shall be limited to inpatient, residential, and outpatient services certified as necessary by a physician, psychologist, advanced practice registered nurse, or social worker.	40 P.S. 908-4: Must cover alcoholism or drug addiction residential treatment program. Treatment may be subject to a lifetime limit, for any covered individual, of ninety (90) days.	38.2-3412.1: Required mental health and substance use coverage includes residential crises services.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
841	Smoking Cessation Treatment	Carriers shall provide coverage for two 90-day courses of nicotine replacement therapy each year, defined as a product that: (1) is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and (2) is obtained under a prescription written by an authorized prescriber. Cost sharing may be required but may not be greater than cost sharing for similar coverages.				
842	Prescription Drugs - Prohibits Cost Sharing Greater Than Retail Price	Carriers that provide prescription drug coverage may not impose a copayment or coinsurance requirement for a covered drug or device that exceeds the retail price of the prescription drug or device.	18-3350A, 18-3350B, 18-3566A: (c) A carrier subject to this section may not impose a copayment or coinsurance requirement for a covered prescription drug that exceeds the lesser of one of the following: (1) The applicable copayment or coinsurance that would apply for the prescription drug in the absence of this section. (2) The amount an individual would pay for the prescription drug if the individual were paying the usual and customary price. (3) The contract price for the prescription drug.			38.2-3407.15:4: Carriers may not impose a copayment for a covered prescription drug in an amount that exceeds the least of - 1. The applicable copayment for the prescription drug that would be payable in the absence of this section; or 2. The cash price the enrollee would pay for the prescription drug if the enrollee purchased the prescription drug without using the enrollee's health plan.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
843	Amino Acid-Based Elemental Formula	Carriers shall include under family member coverage if medically necessary, coverage for amino acid-based elemental formula, regardless of delivery method, for the diagnosis & treatment of Immunoglobulin E & non-Immunoglobulin E mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders, as evidenced by a biopsy; & impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, & motility of the gastrointestinal tract. Carriers may use a private review agent to review medical necessity determination.		31-3871: Requires coverage for the cost of medically necessary food ordered as necessary by a provider for the following diseases or conditions: (1) Inflammatory bowel disease, including Crohn's disease, ulcerative colitis, and indeterminate colitis; (2) Gastroesophageal reflux disease that is nonresponsive to standard medical therapies; (3) Immunoglobulin E- and non-Immunoglobulin E-mediated allergies; (4) Food protein-induced enterocolitis syndrome; (5) Eosinophilic disorders; (6) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract, including short bowel syndrome and chronic intestinal pseudo-obstruction; (7) Malabsorption due to liver or pancreatic disease; (8) Inherited metabolic disorders; and (9) Any other diseases or conditions as determined by the Mayor through rulemaking. Cost sharing may be required but may not be greater than cost sharing for similar coverages.	40 P.S. 3904: Carriers shall provide that the health insurance benefits applicable under the policy include coverage for infants and children for the usual and customary cost of amino acid-based elemental medical formula ordered by a physician as medically necessary and administered orally or enterally for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short-bowel syndrome. An amino acid-based elemental formula covered under this section is a formula made of 100% free amino acids as the protein source.	38.2-3418.18: Requires coverage for medically necessary formula and enteral nutrition products on the same terms and subject to the same conditions imposed on other medicines covered under the policy, contract, or plan.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
844	Prosthetic Devices	Carriers shall provide coverage for prosthetic devices; components of prosthetic devices; & repairs to prosthetic devices. Cost sharing cannot be higher than cost sharing for primary care benefits. Carriers may not impose a separate annual or lifetime dollar maximum. Medical necessity requirements may not be more restrictive than those established under the Medicare Coverage Database.	18-3362, 18-3571E: Carriers that provide medical coverage that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage, shall provide reimbursement for orthotic and prosthetic devices at least equal to federal reimbursements rates provided for under federal laws for health insurance for the aged and disabled. Prior authorization may be required. Repair and replacement shall also be covered subject to cost sharing.			38.2-3418.15, 38.2-3418.15.1: Requires coverage for medically necessary prosthetic devices and their repair, fitting, replacement, and component

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
845	Prescription Drugs - Eye Drop Refills	Carriers shall provide coverage for a refill of prescription eye drops: (1) in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid Services; and (2) if: (i) the prescribing health care practitioner indicates on the original prescription that additional quantities of the prescription eye drops are needed; (ii) the refill requested by the insured does not exceed the number of additional quantities indicated on the original prescription by the prescribing health care practitioner; and (iii) the prescription eye drops prescribed by the health care practitioner are a covered benefit under the policy or contract of the insured.				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
846	Cancer Coverage - Cost Sharing for Oral Chemotherapy	Carriers: (1) may not impose dollar limits, copayments, deductibles, or coinsurance requirements on coverage for orally administered cancer chemotherapy that are less favorable to an insured or enrollee than the dollar limits, copayments, deductibles, or coinsurance requirements that apply to coverage for cancer chemotherapy that is administered intravenously or by injection. (2) may not reclassify cancer chemotherapy or increase a copayment, deductible, coinsurance requirement, or other out-of-pocket expense imposed on cancer chemotherapy to achieve compliance with this section.	18-3338A, 18-3555A: Contracts that provide coverage for prescription drugs and anticancer medication must provide coverage for a prescirbed, orally administered anticancer medication used to kill or slow the growth of cancerous cells. The cost sharing applied must be the lower of (1) anticaner medication under the prescription drug benefit; or (2) Intravenous or injected anticancer medications	31-2995.02: Contracts that provide coverage for prescription drugs, shall provide health insurance coverage for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells and the person receiving such prescribed medication shall have the option of having it dispensed at any appropriately licensed pharmacy. Cost sharing may be required but may not be greater than cost sharing for similar coverages.	40 P.S. 764b.1: A policy shall not provide coverage or impose cost sharing for a prescribed, orally administered chemotherapy medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected chemotherapy.	38.2-3407.18: Contract that include coverage for cancer chemotherapy drugs administered orally and intravenously or by injection shall provide that the criteria for establishing cost sharing applicable to orally administered cancer chemotherapy drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied within the same plan.

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
847/847.1	Prescription Drugs - Specialty Drug Cost Sharing Limit	Carriers may not impose a copayment or coinsurance requirement on a covered specialty drug that exceeds $150 for up to a 30-day supply of the specialty drug as of 2020. Each year this limit will increase by a percentage equal to the percentage change from the preceding year in the medical care component of the March Consumer Price Index for All Urban Consumers, Washington Metropolitan Area, from the U.S. Department of Labor, Bureau of Labor Statistics. Carriers may not impose a copayment or coinsurance requirement on a covered specialty drug that exceeds $150 for up to a 30-day supply for a prescription drug prescribed to treat diabetes, HIV, or AIDS.	18-3364 & 18-3580: A health plan that provides coverage for prescription drugs and utilizes a Specialty drug tier shall ensure that any required copayment or coinsurance applicable to specialty drugs on a specialty tier does not exceed $150 per month for each specialty drug up to a 30-day supply of any single drug.			
848	Ostomy Equipment and Supplies	Requires coverage for all medically appropriate and necessary equipment and supplies used for the treatment of ostomies, including flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts, and catheters used for drainage of urostomies				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
849	Minimum Number of Abuse-Deterrent Opioid Analgesic Drugs on Formulary	A policy or contract that provides coverage for prescription drugs shall provide coverage for: (1) At least two brand name abuse-deterrent opioid analgesic drug products, each containing different analgesic ingredients, on the lowest cost tier for brand name prescription drugs on the entity's formulary for prescription drug coverage; and (2) If available, at least two generic abuse-deterrent opioid analgesic drug products, each containing different analgesic ingredients, on the lowest cost tier for generic drugs on the entity's formulary for prescription drug coverage.				
850	Prior Authorizations for Opioid Antagonist	Contracts that include on its formulary an opioid antagonist may apply a prior authorization requirement for an opioid antagonist only if the entity provides coverage for at least one formulation of the opioid antagonist without a prior authorization requirement.				
851	Prior Authorizations for Drugs Used to Treat Opioid Use Disorder	Carriers may not apply a prior authorization requirement for a prescription drug: (1) when used for treatment of an opioid use disorder; and (2) that contains methadone, buprenorphine, or naltrexone.				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
852	Prescription Drugs - Prorated Daily Cost Sharing for Partial Supply	Carriers shall allow and apply a prorated daily copayment or coinsurance amount for a partial supply of a prescription drug dispensed by an in-network pharmacy if: (1) the prescriber determines dispensing a partial supply of a prescription drug to be in the best interest of the member; (2) the prescription drug is anticipated to be required for more than 3 months; (3) the member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the member's prescription drugs; (4) the prescription drug is not a Schedule II controlled dangerous substance; and (5) the supply and dispensing of the prescription drug meets all prior authorization and utilization management requirements specific to the prescription drug at the time of the synchronized dispensing. Carriers: (1) may not deny payment of benefits to an in-network pharmacy for a covered prescription drug solely on the basis that only a partial supply of the prescription drug was dispensed; and (2) shall allow an in-network pharmacy to override any denial codes indicating that a prescription is being refilled too soon.				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
853	Lymphedema Treatment	Requires coverage for the medically necessary diagnosis, evaluation, and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education.	18-3563 & 18-3347: Requires coverage for lymphedemas resulting from mastectomy reconstructive surgery	31-3832: Requires coverage for lymphedemas resulting from mastectomy reconstructive surgery	40 P.S. 764d: Requires coverage for lymphedemas resulting from mastectomy reconstructive surgery	38.2-3418.14: Requires coverage under this section shall include benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.
854	Prior Authorizations for Drugs Used to Treat Chronic Conditions	If an entity subject to this section requires a prior authorization for a prescription drug, the prior authorization request shall allow a health care provider to indicate whether a prescription drug is to be used to treat a chronic condition. If a health care provider indicates that the prescription drug is to treat a chronic condition, carriers may not request a reauthorization for a repeat prescription for the prescription drug for 1 year or for the standard course of treatment for the chronic condition being treated, whichever is less.				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
855	Pediatric Autoimmune Neuropsychiatric Disorders	Requires coverage for medically necessary diagnosis, evaluation, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy. Cost sharing may be required but may not be greater than cost sharing for similar coverages.	18-3370B, 18-3571T: Requires coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy. If it is determined at any time that this requirement will requires the state to defray the cost, the requirement of the mandate will become inoperative.			
856	COVID-19 Tests Coverage	Requires coverage for COVID-19 tests and related items and services for the administration of COVID-19 tests, including facility fees, health care practitioner fees, and evaluation of the member for purposes of determining the need for the COVID-19 test, with no cost sharing				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
857	[Effective 1/1/2023] Coverage of Abortion Care Services	Requires coverage for: (1) cover abortion care services without: (i) a deductible, coinsurance, copayment, or any other cost-sharing requirement; and (ii) restrictions that are inconsistent with the protected rights under Title 20, Subtitle 2 of the Health - General Article; and (2) provide information to consumers about abortion care coverage using the terminology "abortion care" to describe coverage. Exemption is permitted for religious beliefs and practices				
858	[Effective 1/1/2023] Prior Authorizations for Prescription Drug HIV Prevention	Carriers may not apply a prior authorization requirement for a prescription drug used as postexposure prophylaxis for the prevention of HIV if the prescription drug is prescribed for use in accordance with Centers for Disease Control and Prevention guidelines.				

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
859	[Effective 1/1/2024] Coverage for Diagnostic & Supplemental Lung Cancer Imaging	Requires coverage, with no cost sharing, for recommended follow-up diagnostic imaging to assist in the diagnosis of lung cancer for individuals for which lung cancer screening is recommended by the U.S. Preventative Services Task Force, including: diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image-guided biopsy.				
860	[Effective 1/1/2024] Biomarker Testing	Requires coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition that is supported by medical and scientific evidence. Cost sharing may be required but may not be greater than cost sharing for similar coverages.				

Appendix B

DELAWARE		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
18 § 3336, 3553	Midwife Services Reimbursement	(d) Whenever an insurance policy, contract or certificate or health services reimbursement program provides for reimbursement for any health care service which is within those areas of practice for which a midwife may be licensed pursuant to § 122 of Title 16 or pursuant to statute in the state where the service is delivered, or for the cost of birthing facilities, the insured or any other person covered by the policy, contract or certificate, or health services or facilities reimbursement program shall be entitled to reimbursement for such service or use of the facilities performed by a duly licensed certified nurse midwife practicing within those areas for which the certified nurse midwife is licensed in the state where the licensed certified nurse midwife is practicing. Whenever such service is performed by a licensed certified nurse midwife and reimbursed by a professional health services plan corporation, the licensed certified nurse midwife shall be granted such rights of participation, plan admission and registration as may be granted by the professional health services plan corporation, to a physician or osteopath performing such a service. When payment is made for health care services performed by a licensed certified nurse midwife, no payment or reimbursement shall be payable to a physician or osteopath for the services performed by the licensed certified nurse midwife.
18 § 3338, 3555	Coverage of ovarian cancer monitoring test	(a) Every individual health, sickness or accident insurance policy, contract or certificate, which is delivered or issued for delivery in this State by any health insurer, health service corporation or health maintenance organization, and which provide benefits for outpatient services, shall provide to covered persons residing in this State a benefit for CA-125 monitoring of ovarian cancer subsequent to treatment. Such monitoring shall be deemed a covered service, notwithstanding any policy exclusions for services which are considered experimental or investigative; provided however, that nothing contained herein shall be deemed to provide coverage for routine screening.
18 § 3338B, 3555B	Coverage of drugs approved for treatment of certain cancers	No individual policy or contract of health insurance, or certificate issued thereunder, which is delivered, issued for delivery, renewed, modified, altered, or amended in this State by any health insurer, health service corporation or health maintenance organization that directly or indirectly covers the treatment of cancer shall limit or exclude coverage for a drug approved by the United States Food and Drug Administration by mandating that the insured shall first be required to fail to successfully respond to a different drug or drugs or prove a history of failure of such drug or drugs; provided, however that the use of such drug or drugs is consistent with best practices for the treatment of stage 4 advanced, metastatic cancer or, in the case of other cancers, the use of the drug is supported by national clinical guidelines, national standards of care, or peer reviewed medical literature for the treatment of the cancer, or in the case of targeted therapy, the target at issue.

DELAWARE		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
18 § 3344C, 3560B	Cost Sharing for insulin pumps	(b) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for a medically necessary insulin pump at no cost to a covered individual, including deductible payments and cost-sharing amounts charged once a deductible is met. (c) Except as provided under subsection (b) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.
18 § 3345, 3561	Annual pap smear coverage reimbursement	All individual health insurance policies which are delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization or any health services and facilities reimbursement program operated by the State and which provide a benefit for outpatient services shall also provide a benefit for an annual benefit for 1 cervical cancer screening, known as a "pap smear," for all females aged 18 and over.
18 § 3349A, 3565A	Reimbursement Parity for Volunteer Ambulance Services	(b) Every individual health insurance policy, contract, certificate, or plan which is delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization, or managed care organization shall include coverage of not less than the cost of every ambulance run and associated basic life support (BLS) services provided by a volunteer ambulance company, inclusive of an allowance for uncompensated service, whether in the form of: (1) An allowable charge; (2) Through 100% payment; or (3) Any combination of the foregoing.
18 § 3365, 3571G	School-based health centers	(c) Except as noted herein, benefits provided under insurance contracts delivered, issued for delivery, or renewed in this State shall reimburse SBHCs for covered services provided by SBHCs as if those services were provided by a network provider under the relevant contract of insurance. In the absence of an agreement between a carrier and an SBHC on reimbursement, reimbursement for such services shall be at the rate established by the Division of Medicaid and Medical Assistance for those services. Any insurance contract term purporting to exclude otherwise covered services on the basis that they are performed by an SBHC shall be void except as specifically permitted under this chapter.

DELAWARE		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
18 § 3366, 3570A	Autism spectrum disorders coverage	(b) Coverage for applied behavior analysis services under this section by an insurer shall be subject to a maximum benefit of $36,000 per 12-month period per person, but shall not be subject to any limits on the number of visits an individual may make to an autism services provider or that a provider may make to an individual regardless of the locations in which services are provided. After December 31, 2012, the Insurance Commissioner shall, on or before April 1 of each calendar year, publish in the Delaware Register of Regulations an adjustment to the maximum benefit equal to the change in the United States Department of Labor Consumer Price Index for all Urban Consumers (CPI-U) in the preceding year and the published adjusted maximum benefit shall be applicable to all health insurance policies issued or renewed thereafter. Payments made by an insurer on behalf of a covered individual for treatment unrelated to applied behavior analysis shall not be applied toward any maximum benefit established under this subsection.
18 § 3370, 3571R	Telehealth and telemedicine reimbursement	(e) An insurer, health service corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer, health service corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health care services.
18 § 3370D, 3571Y	Coverage for epinephrine autoinjectors	(b) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for medically-necessary epinephrine autoinjectors by including at least 1 formulation of epinephrine autoinjectors on the lowest tier of the drug formulary developed and maintained by the carrier. (c) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility. (d) (1) For individuals who are 18 years of age or under, this section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2021. (2) For individuals who are more than 18 years of age, this section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2024.

DELAWARE		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
18 § 3370E, 3571Z	[Effective 1/1/2024] Annual behavioral health well check	(b) All carriers shall provide coverage of an annual behavioral health well check, which, except as provided in subsection (d) of this section, shall be reimbursed through the following common procedural terminology (CPT) codes at the same rate that such CPT codes are reimbursed for the provision of other medical care, provided that reimbursement may be adjusted for payment of claims that are billed by a non-physician clinician so long as the methodology to determine such adjustments is comparable to and applied no more stringently than the methodology for adjustments made for reimbursement of claims billed by non-physician clinicians for other medical care, in accordance with 45 CFR 146.136 (c)(4)

DISTRICT OF COLUMBIA (D.C.)		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
§ 31-2803	Emergency department HIV screening	(b) A health benefit plan shall reimburse the cost of a voluntary HIV screening test performed on its insured while the insured is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the insured to seek emergency services. (c) The benefits mandated by subsection (b) of this section shall: (1) Include at least one annual emergency department HIV screening test; (2) Reimburse the costs of administering such a test, all laboratory expenses to analyze the test, and the costs of communicating to the patient the results of the test and any applicable follow-up instructions for obtaining health care and supportive services; and (3) Not be subject to any annual or coinsurance deductible or any co-payment other than the co-payment that the insured would have to pay for the applicable hospital emergency department visit.
§ 31-3834	Hormone replacement therapy coverage	An individual or group health plan, and a health insurer offering health care coverage that provides coverage for prescription drugs, shall provide benefits which cover any hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.

DISTRICT OF COLUMBIA (D.C.)		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
§ 31-3862	Private reimbursement	(a) A health insurer offering a health benefits plan in the District may not deny coverage for a healthcare service on the basis that the service is provided through telehealth if the same service would be covered when delivered in person. (b) A health insurer shall reimburse the provider for the diagnosis, consultation, or treatment of the insured when the service is delivered through telehealth. (c) A health insurer shall not be required to: (1) Reimburse a provider for healthcare service delivered through telehealth that is not a covered under the health benefits plan; and (2) Reimburse a provider who is not a covered provider under the health benefits plan. (d) A health insurer may require a deductible, copayment, or coinsurance amount for a healthcare service delivered through teleheath; provided, that the deductible, copayment, or coinsurance amount may not exceed the amount applicable to the same service when it is delivered in person. (e) A health insurer shall not impose any annual or lifetime dollar maximum on coverage for telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services under the health benefits plan.

PENNSYLVANIA		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
40 Pa. Stat. § 764b	Reimbursement parity for cancer therapy	(a) Whenever any individual or group health, sickness or accident insurance policy or subscriber contract or certificate issued by any entity subject to 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations), this act, or the act of July 29, 1977 (P.L. 105, No. 38) , known as the "Fraternal Benefit Society Code," providing hospital or medical/surgical coverage includes within their coverage benefits for cancer chemotherapy and cancer hormone treatments and services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer, the covered individual shall be entitled to benefits for cancer chemotherapy and cancer hormone treatments, whether performed in a physician's office, in an outpatient department of a hospital, in a hospital as a hospital inpatient or in any other medically appropriate treatment setting.
40 Pa. Stat. § 764d.1	Coverage for BRCA-related Genetic Counseling and Genetic Testing	(a) A health insurance policy offered, issued or renewed in this Commonwealth shall provide coverage for BRCA-related genetic counseling and genetic testing provided by an individual licensed, certified or otherwise regulated to provide genetic counseling and genetic testing under the laws of this Commonwealth. The minimum coverage required shall include all costs associated with genetic counseling and, if indicated after genetic counseling, a genetic laboratory test of the BRCA1 and BRCA2 genes for individuals assessed to be at an increased risk, based on a clinical risk assessment tool, of potentially harmful mutations in the BRCA1 or BRCA2 genes due to a personal or family history of breast or ovarian cancer.
40 Pa. Stat. § 764h	Autism spectrum disorders coverage	(a) A health insurance policy or government program covered under this section shall provide to covered individuals or recipients under twenty-one (21) years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders. (b) Coverage provided under this section by an insurer shall be subject to a maximum benefit of thirty-six thousand dollars ($36,000) per year but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders. After December 30, 2011, the Insurance Commissioner shall, on or before April 1 of each calendar year, publish in the Pennsylvania Bulletin an adjustment to the maximum benefit equal to the change in the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U) in the preceding year, and the published adjusted maximum benefit shall be applicable to the following calendar years to health insurance policies issued or renewed in those calendar years. Payments made by an insurer on behalf of a covered individual for treatment of a health condition unrelated to or distinguishable from the individual's autism spectrum disorder shall not be applied toward any maximum benefit established under this subsection.

PENNSYLVANIA		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
40 Pa. Stat. § 1574	Coverage for Annual Gynecological Examination	A health insurance policy which is delivered, issued for delivery, renewed, extended or modified in this Commonwealth by a health care insurer shall provide that the health insurance benefits applicable under the policy include coverage for periodic health maintenance to include: (1) Annual gynecological examination, including a pelvic examination and clinical breast examination. (2) Routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

VIRGINIA		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
§ 38.2-3407.5, 3407.6:1	Utilization Review of FDA-Approved Drugs for Treatment of Cancer	A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits will not be denied for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia. B. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits will not be denied for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

VIRGINIA		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
§ 38.2-3407.9	Reimbursement parity for emergency medical services vehicle transportation services	A. If an accident and sickness insurance policy provides coverage for services provided by an emergency medical services vehicle, any person providing such services to a person covered under such policy shall receive reimbursement for such services directly from the issuer of such policy, when the issuer of such policy is presented with an assignment of benefits by the person providing such services. B. No (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, or (iii) health maintenance organization providing a health care plan for health care services shall establish or promote an emergency medical response and transportation system that encourages or directs access by a person covered under such policy, contract or plan in competition with or in substitution of an emergency 911 system or other state, county or municipal emergency medical system for services provided by an emergency medical services vehicle. An entity subject to this subsection may use transportation outside an emergency 911 system or other state, county or municipal emergency medical system for services that are not services provided by an emergency medical services vehicle.
§ 38.2-3407.9:02	Prohibits Denial FDA-Approved Drugs Based on Certain Criteria	No (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, or (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs shall exclude coverage for any prescription drug solely on the basis of the length of time since the drug obtained FDA approval.

VIRGINIA		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
§ 38.2-3407.11:5	Prior Authorization of Interhospital Transfer of Newborn or Mother	A. Notwithstanding any provision of § 38.2-3407.11 or 38.2-3419 or any other section of this title to the contrary, no insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, corporation providing individual or group accident and sickness subscription contracts, or health maintenance organization providing a health care plan for health care services shall require prior authorization for the interhospital transfer of (i) a newborn infant experiencing a life-threatening emergency condition or (ii) the hospitalized mother of such newborn infant to accompany the infant. B. The requirements of this section shall apply to all policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made thereto.
§ 38.2-3418.1:2	Coverage for Annual Pap Smear	A. Notwithstanding the provisions § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, each corporation providing individual or group accident and sickness subscription contracts and each health maintenance organization providing a health care plan for health care services shall provide coverage under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1996, for annual pap smears, including coverage, on and after July 1, 1999, for annual testing performed by any FDA-approved gynecologic cytology screening technologies. B. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

VIRGINIA		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
§ 38.2-3418.16	Telemedicine Reimbursement	D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact. No insurer, corporation, or health maintenance organization shall require a provider to use proprietary technology or applications in order to be reimbursed for providing telemedicine services. E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services. F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment. G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan. H. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

VIRGINIA		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
§ 38.2-3418.17	Coverage for autism spectrum disorder	A. Notwithstanding the provisions of § 38.2-3419 and any other provision of law, each insurer proposing to issue accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall, as provided in this section, provide coverage for the diagnosis of autism spectrum disorder and the treatment of autism spectrum disorder, in individuals (i) from January 1, 2012, until January 1, 2016, from age two years through age six years; (ii) from January 1, 2016, until January 1, 2020, from age two years through age 10 years; and (iii) from and after January 1, 2020, of any age, subject to the annual maximum benefit limitation set forth in subsection K and to the provisions of subsection G. If an individual who is being treated for autism spectrum disorder becomes older than the applicable maximum age set forth in the preceding sentence and continues to need treatment, this section does not preclude coverage of treatment and services. In addition to the requirements imposed on health insurance issuers by § 38.2-3436, an insurer shall not terminate coverage or refuse to deliver, issue, amend, adjust, or renew coverage of an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder.

VIRGINIA		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
§ 38.2-3418.19	Prohibits Denial of Organ, Eye, or Tissue Transplant for Certain Criteria	A. Notwithstanding the provisions of § 38.2-4319, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services, whose policy, contract, or plan, including any certificate of evidence of coverage issued in connection with such policy, contract, or plan, includes coverage for services related to organ, eye, or tissue transplantation as defined in § 32.1-297.2 shall not: 1. Deny coverage to a covered person solely on the basis of the person's disability; 2. Deny a person eligibility or continued eligibility to enroll in or to renew coverage under the policy, contract, or plan for the purpose of avoiding the requirements of § 32.1-297.2; 3. Penalize a health care provider, reduce or limit the reimbursement of a health care provider, or provide monetary or nonmonetary incentives to a health care provider to induce such health care provider to act in a manner inconsistent with the requirements of § 32.1-297.2; or 4. Reduce or limit coverage for services related to organ, eye, or tissue transplant as defined in § 32.1-297.2 for an eligible individual with a disability as defined in § 32.1-297.2. B. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2021. C. The provisions of this section shall not apply to short-term travel, accident-only, or limited or specified disease policies; contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal government plans; or short-term nonrenewable policies of not more than six months' duration. D. Nothing in this section shall require an insurer to provide coverage for a medically inappropriate organ, eye or tissue transplant.

VIRGINIA		
CITATION	**MANDATE**	**DESCRIPTION OF BENEFIT**
§ 38.2-3418.9	Minimum hospital stay for hysterectomy	A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue an individual or group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care shall provide coverage for laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy as provided in this section. B. Such coverage shall include benefits for a minimum stay in the hospital of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. Nothing in this subsection shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the patient, determines that a shorter period of hospital stay is appropriate. C. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 1999, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[26], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[27], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary
The responsible actuaries are:

- Traci Hughes, FSA, MAAA, Vice President & Principal
- David Dillon, FSA, MAAA, Senior Vice President & Principal

These actuaries are available to provide supplementary information and explanation.

Identification of Actuarial Documents
The date of this document is March 13, 2024. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is November 30, 2023.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Maryland Health Care Commission. The authors of this report are aware that it may be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis, LLC is financially and organizationally independent from the health insurers involved in this analysis. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist Maryland Health Care Commission in conducting a comprehensive, comparative review, and actuarial analysis of state mandated health insurance benefits and services in Maryland and its surrounding states.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the insurers and Maryland Health Care Commission for reasonableness, but the data has not been audited. L&E nor the responsible

[26] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

[27] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

- Several of the assumptions made in this analysis are subject to uncertainty and it is not unexpected that actual results could differ from the calculated estimates.
- L&E is not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.
- The findings of this report are enclosed herein.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report.