MARYLAND Health Care Commission

Marcia Boyle, MS, Acting Chair
Douglas Jacobs, MD, MPH, Executive Director

December 19, 2025

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

The Honorable Bonnie Cullison,
Vice Chair
House Health and Government Operations
Committee
240 Taylor House Office Building
Annapolis, MD 21401

Re: SB 508/HB 381, (2025) Maryland Medical Assistance Program and Health Insurance – Required Coverage for Aesthetic Services and Restorative Care for Victims of Domestic Violence (Healing Our Scars Act)

Dear Chair Beidle and Vice-Chair Cullison:

The Maryland Health Care Commission (MHCC or Commission) is submitting this mandate study in accordance with the letter from Chair Beidle and Senate Finance on Senate Bill (SB) 508 /House Bill (HB) 381 - ***Maryland Medical Assistance Program and Health Insurance – Required Coverage for Aesthetic Services and Restorative Care for Victims of Domestic Violence (Healing Our Scars Act).*** The legislation would have required Medicaid, insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for victims of domestic violence (DV) for certain medically necessary aesthetic services and restorative care. DV and intimate partner violence (IPV) are nuanced topics with many differing definitions.

The bill defines "victim of domestic violence" as "an individual who has received deliberate, severe, and demonstrable physical injury, or is in fear of imminent deliberate, severe, and demonstrable physical injury from a current or former spouse, or a current or former cohabitant." Varying but similar definitions of DV, including intimate partner violence (IPV), appear throughout the available literature.

• The U.S. Department of Justice Office of Violence Against Women (OVW) defines DV as a "pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner."

• The Centers for Disease Control and Prevention (CDC) defines IPV as "physical or sexual violence, stalking, and/or psychological aggression by a current or former dating partner or spouse."

Although these definitions are broader than those used in the legislation, they are incorporated throughout the report to help ensure all relevant information is captured for a thorough analysis. This report uses DV and IPV interchangeably, often presented as DV/IPV to incorporate the nuances of both terms.

Maryland insurers report covering medically necessary care regardless of cause of injury to improve functionality; however, there remains a gap related to aesthetic care. BerryDunn developed actuarial estimates for the fiscal impact of the proposed mandate requiring coverage for certain medically necessary aesthetic services for victims/survivors of DV/IPV, with medical necessity determined by the treating physician rather than the insurer. There were several limitations to the information available for this mandate study, including the inability to identify claims for injuries caused by DV/IPV, the lack of insurance coverage for aesthetic services, and the lack of available studies on residual injuries sustained by DV/IPV victims in Maryland.

In addition, there were factors BerryDunn considered but could not quantify, such as the extent of underreporting of DV/IPV and potential pent-up demand for aesthetic treatments to treat residual injuries caused by DV/IPV. As a result of these limitations, the bill's impact estimates and ranges were developed based on a set of assumptions informed by a review of available literature. Having more unknown factors than usual adds more uncertainty, warranting wider ranges than typical. The modeling indicates that the mandate would result in increases in health insurance costs across all market segments. The details of those findings are in the report.

We appreciate your consideration. If you have any questions, please do not hesitate to contact me at douglas.jacobs@maryland.gov or Ms. Tracey DeShields, Director of Policy Development and External Affairs at tracey.deshields2@maryland.gov.

Sincerely,

Douglas Jacobs, MD, MPH
Executive Director

cc:
Senate Finance Committee Members
Health and Government Operations Committee Members
Marcia Boyle, Acting MHCC Chair
Maryland Health Care Commissioners
The Honorable Meena Seshamani, Secretary, Maryland Department of Health (MDH)
Perrie Briskin, Deputy Secretary, Maryland Medicaid Administration, MDH
Michael Huber, Deputy Chief of Staff, Governor's Office (on behalf of Governor Moore)
Hannah Dier, Deputy Legislative Office, Governor's Legislative Office
Jason Heo, Governor's Office
Sophie Bergmann, Governor's Office
Sarah Albert, Department of Legislative Services (5 hard copies)
Lisa Simpson, Committee Counsel, House Health and Government Operations,
Nathan McCurdy, Committee Counsel, Senate Finance
Kenneth Yeates-Trotman, Director, Center for Analysis and Information Systems, MHCC
Jason Caplan, Chief of Special Projects, Center for Analysis and Information Systems, MHCC
Meghan Lynch, Director, Governmental Affairs, MDH
Tracey DeShields, Director of Policy Development and External Affairs, MHCC

BerryDunn

Maryland Health Care Commission

Maryland Medical Assistance Program and Health Insurance – Required Coverage for Aesthetic Services and Restorative Care for Victims of Domestic Violence (Healing Our Scars Act) – House Bill 381 and Senate Bill 508

MARYLAND Health Care Commission

Submitted By:
Berry, Dunn, McNeil & Parker, LLC
2211 Congress Street, Portland, ME 04102
207.541.2200

Lisa Kennedy
Principal | Berry, Dunn, McNeil & Parker, LLC
LKennedy@berrydunn.com

Valerie Hamilton
Principal | Berry, Dunn, McNeil & Parker, LLC
VHamilton@berrydunn.com

Submitted On: November 25, 2025

Content Notice:

This document includes sensitive content regarding domestic and intimate partner violence. The content of this document may be difficult for some readers and discretion is advised.

Table of Contents

Highlights

House Bill 381/Senate Bill 508 Required Coverage for Aesthetic Services and Restorative Care for Victims of Domestic Violence (Healing Our Scars Act)

The Maryland Health Care Commission (MHCC) is required to evaluate the medical, social, and financial impact of proposed mandated health insurance services that failed to pass during the preceding legislative session. House Bill 381 and companion Senate Bill 508 would have required the Maryland Medical Assistance Program (Medicaid) and Maryland's state-regulated commercial insurers to provide coverage to victims of domestic violence (DV) for certain medically necessary aesthetic[i] services and restorative[ii] care. DV and intimate partner violence (IPV) is a nuanced topic with many differing definitions. Please see Section 1.1 for more context. For brevity, DV/IPV is used in the highlights page.

Social Evaluation

- DV/IPV, including physical DV/IPV, can affect anyone, yet historically underserved groups experience higher rates of DV/IPV; DV/IPV-related injuries may not heal properly and/or can alter victims'/survivors' physical appearance.
- DV/IPV and DV/IPV-related healthcare utilization is widely underreported due to low screening rates, varying coding practices among healthcare providers, and disclosure barriers and/or preferences among victims/survivors.
- Research on physical DV/IPV leading to residual (permanent mark or scar) injuries is limited; one study suggests that nearly 60% of victims/survivors have a permanent mark or scar as a result of DV/IPV.
- Illinois was the only additional state found to have similar legislation.

Medical Evaluation

- There are a wide range of treatments that may be indicated for victims/survivors of DV/IPV depending on the type of injuries.
- Physical DV/IPV is linked to negative health effects including physical injuries, increased health risks, pain, and mental health conditions. Visible scars, especially on the face, negatively impact overall well-being.
- All experts interviewed noted that scar treatment would support psychological healing for victims/survivors.

Financial Evaluation

Maryland insurers report covering medically necessary care regardless of cause of injury to improve functionality; however, there remains a gap related to aesthetic care. BerryDunn developed actuarial estimates for the fiscal impact of the proposed mandate requiring coverage for certain medically necessary aesthetic services for victims/survivors of DV/IPV, with medical necessity determined by the treating physician rather than the insurer. There were several limitations to information available for this mandate study including the inability to identify claims for injuries caused by DV/IPV, the lack of insurance coverage for aesthetic services, and the lack of available studies on residual injuries sustained by DV/IPV victims in Maryland. In addition, there were factors BerryDunn considered but could not quantify, such as the extent of underreporting of DV/IPV and potential pent-

[i] Insurers typically define aesthetic services as cosmetic. Aesthetic is used throughout the report.
[ii] Insurers typically define restorative procedures as reconstructive. Restorative is used throughout the report.

up demand for aesthetic treatments to treat residual injuries caused by DV/IPV. As a result of these limitations, the bill's impact estimates and ranges were developed based on a set of assumptions informed by a review of available literature. Having more unknown factors than usual adds more uncertainty, warranting wider ranges than typical.

The modeling indicates that the mandate would result in increases in health insurance costs[iii] across all market segments. For fully insured health plans, the projected premium increase is $0.02 (or 0.00%) to $0.15 (or 0.03%) per member per month (PMPM). For the self-insured State of Maryland employee health benefit plans (State Health Plan), the projected premium equivalent increase is $0.02 (0.00%) to $0.15 (0.03%) PMPM. While this mandate does not apply to self-insured plans under the Employee Retirement Income Security Act of 1974 (ERISA), these plans may elect to follow the coverage requirements to help ensure consistent benefits for members, however self-insured impacts, other than impacts for the State Health Plans, are not included in the scope for these estimates. The projected Medicaid program cost increase is $0.07 (0.02%) to $0.47 (0.11%) PMPM. Table 1 below summarizes the projected incremental cost of the proposed mandate by market segment.

Table 1: Aesthetic Services Projected Incremental Cost Summary by Market Segment

Range of Estimates	Low	Middle	High
Fully Insured Individual			
% of Fully Insured Individual Market Population Receiving Aesthetic Services	0.01%	0.02%	0.02%
Fully Insured Individual Premium PMPM Increase	$0.02	$0.06	$0.15
Fully Insured Individual Premium PMPM % Increase	0.00%	0.01%	0.03%
Fully Insured Individual Premium Increase	$73,528	$214,457	$514,697
Fully Insured Small Group			
% of Fully Insured Small Group Population Receiving Aesthetic Services	0.01%	0.02%	0.02%
Fully Insured Small Group Premium PMPM Increase	$0.02	$0.06	$0.15
Fully Insured Small Group Premium PMPM % Increase	0.00%	0.01%	0.02%
Fully Insured Small Group Premium Increase	$49,601	$144,669	$347,205
Fully Insured Large Group			
% of Fully Insured Large Group Population Receiving Aesthetic Services	0.01%	0.02%	0.02%
Fully Insured Large Group Premium PMPM Increase	$0.02	$0.06	$0.14
Fully Insured Large Group Premium PMPM % Increase	0.00%	0.01%	0.02%
Fully Insured Large Group Premium Increase	$105,272	$307,043	$736,904
Totally Fully Insured Commercial (Individual, Small Group, Large Group)			
% of Total Fully Insured Population Receiving Aesthetic Services	0.01%	0.02%	0.02%
Total Fully Insured Premium PMPM Increase	$0.02	$0.06	$0.15
Total Fully Insured Premium PMPM % Increase	0.00%	0.01%	0.03%
Total Fully Insured Premium Increase	$228,401	$666,169	$1,598,806
Self-Insured State Health Plans			
% of Self-Insured State Health Plan Population Receiving Aesthetic Services	0.01%	0.02%	0.02%
Self-Insured State Health Plan Premium Equivalent PMPM Increase	$0.02	$0.06	$0.15
Self-Insured State Health Plan Premium Equivalent PMPM % Increase	0.00%	0.01%	0.02%
Self-Insured State Health Plan Premium Equivalent Increase	$51,321	$149,686	$359,246
Medicaid			
% of Medicaid Population Receiving Aesthetic Services	0.06%	0.06%	0.08%
Medicaid Program Cost PMPM Increase	$0.07	$0.20	$0.47
Medicaid Program Cost PMPM % Increase	0.02%	0.05%	0.11%
Medicaid Program Cost Increase	$1,336,840	$3,899,116	$9,357,878

[iii] The term "health insurance costs" is used to describe premiums in the fully insured market, premium equivalents in the self-insured market, and program costs for Medicaid. Health insurance cost components vary by market segment but refer to projected funding to cover any fee-for service claims, non-claim benefit expenses, capitation, administrative expenses, fixed fees, assessments, taxes, contribution to reserve/profit margin, cost of capital, and risk and contingency margin. Member cost-sharing (e.g., deductible, copay, and coinsurance) is not included in health insurance costs.

1.0 Executive Summary

1.1 Background

Insurance Article §15-1501, Annotated Code of Maryland, requires the Maryland Health Care Commission (MHCC) to evaluate the medical, social, and financial impact of proposed mandated health insurance services that failed to pass during the preceding legislative session.[1] This report addresses House Bill (HB) 381[2] and companion Senate Bill (SB) 508[3] (collectively referred to as the bill), introduced in the 2025 legislative session. The bill would have required Medicaid and other state-regulated health insurers[iv] to provide coverage to victims of DV/IPV for certain medically necessary aesthetic services and restorative care. Restorative procedures improve the functionality of a part of the body, while aesthetic procedures are performed to improve an individual's appearance and sense of self.[4] Some procedures can be categorized as both restorative or aesthetic, depending on the circumstances (e.g., rhinoplasty).[4]

The bill defines "victim of domestic violence," as "an individual who has received deliberate, severe, and demonstrable physical injury, or is in fear of imminent deliberate, severe, and demonstrable physical injury from a current or former spouse, or a current or former cohabitant."[v,2,3,5]

Varying but similar definitions of DV, including intimate partner violence (IPV), appear throughout the available literature.

- The U.S. Department of Justice Office of Violence Against Women (OVW) defines DV as a "pattern of abusive behavior[vi] in any relationship that is used by one partner to gain or maintain power and control over another intimate partner."[vii,6]
- The Centers for Disease Control and Prevention (CDC) defines IPV as "physical or sexual violence, stalking, and/or psychological aggression by a current or former dating partner or spouse."[7]

Although these definitions are broader than those used in the legislation, they are incorporated throughout the report to help ensure all relevant information is captured for a thorough analysis. This report uses DV and IPV interchangeably, often presented as DV/IPV to incorporate the nuances of both terms. Table 2 below summarizes the definitions incorporated into the report.

[iv] Insurers include commercial health insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations.
[v] "Cohabitant" refers to "a person who has had a sexual relationship with the respondent and resided with the respondent in the home for a period of at least 90 days within 1 year before filing of the petition."
[vi] Abusive behavior includes "any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten blame, hurt, injure, or wound someone."
[vii] This definition of intimate partner includes partners who are married, living together, dating, or share a child, as compared to the "cohabitant" definition included in the proposed legislation.

Table 2: Summary of Definitions for Domestic Violence, Intimate Partner Violence, and Related Terms

Term	Definition
Cohabitant	"A person who has had a sexual relationship with the respondent and resided with the respondent in the home for a period of at least 90 days within 1 year before filing of the petition."[2,35]
Domestic Violence	"A pattern of abusive behavior ["physical, sexual, emotional, economic, or psychological"] in any relationship that is used by one partner to gain or maintain power and control over another intimate partner."[6]
DV/IPV	An individual's experience of abusive behaviors (physical, emotional, psychological) from a former or current romantic partner.[viii]
Intimate Partner	Individuals who are "married, living together, dating, or share a child."[6]
Intimate Partner Violence	"Intimate partner violence refers to any physical or sexual violence, stalking, and/or psychological aggression by a current or former dating partner or spouse."[7] IPV does not require sexual intimacy.
Victim of Domestic Violence	"An individual who has received deliberate, severe, and demonstrable physical injury, or is in fear of imminent deliberate, severe, and demonstrable physical injury from a current or former spouse, or a current or former cohabitant."[2,3]

The term "victim" is typically used in legal definitions and emphasizes a person's experience of harm—whether mental, physical, financial, social, emotional, or spiritual—resulting from a crime.[8] The term "survivor" emphasizes the strength and resilience of a person who has experienced trauma.[8] This report uses both terms, presented as "victim/survivor," to acknowledge the value of each term and to honor the preferences of individuals who have experienced domestic violence.[9]

For this study, the analysis is limited to physical components of DV/IPV. Emotional, mental, and sexual forms of violence are not included, and the estimates reflect injuries and related outcomes linked to physical harm only. Dental services are excluded from the bill and this study's cost analysis.

1.2 Social Evaluation

Physical DV/IPV affects over 40% adults in the U.S. and often results in injuries.[7] Victims/survivors of DV/IPV experience varying degrees of physical DV/IPV severity, injuries, and long-term effects such as mental health conditions and physical scars. Women and men have similar rates of DV/IPV; however, women experience higher rates of injuries compared to men and are more likely to need medical care as a result.[7] Additionally, historically underserved individuals, including individuals who are Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning (LGBTQ+), non-white,[10] low-income,[11] and/or immigrants[12] experience higher rates of DV/IPV. Research suggests higher rates of healthcare utilization among individuals who have experienced DV, but does not specify if the utilization is causally

[viii] BerryDunn combined DV/IPV for this study to align bill and literature definitions.

linked to DV.[13] While DV/IPV is a well-established public health issue, ascertaining DV/IPV prevalence and related healthcare utilization is challenging; screening rates are low, providers utilize varying coding practices, and victims/survivors may not disclose their experiences.

Under the Affordable Care Act (ACA), insurers cannot discriminate against individuals who have experienced DV by prohibiting coverage or charging these individuals higher premiums.[14] Currently, the ACA does not require specific coverage for DV-related aesthetic services. While the ACA requires states to utilize a benchmark plan for State-regulated coverage, Maryland's current plan does not require coverage for aesthetic services.[15] Insurers in Maryland generally provide coverage for medically necessary restorative services regardless of the cause of decreased functionality. Aesthetic procedures are usually excluded from coverage, unless they meet restorative standards. In most cases, services require prior authorization, and providers may need to provide supporting documentation.

Illinois is the only other state with similar legislation, and the law does not specify a population (i.e., victims of DV) or type of physical trauma.[16]

1.3 Medical Evaluation

The head and neck area is the most common site of DV-related injury.[17] Broadly, visible scars, especially on the face, are correlated with worse mental health and overall well-being. Victims/survivors report experiencing lingering physical impacts after healing from previous injuries (e.g., pain, itchiness) as well as adverse mental health effects (e.g., stigma, anxiety, depression).[18,19,20,21] Historically underserved groups face additional barriers to physical and psychological healing, influenced by a lack of access to medical care, historic and structural injustices, cost of care, and ongoing inequities.[22]

Currently, there are no clinical guidelines that address coverage for DV/IPV-related restorative or aesthetic care. The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends a trauma-informed approach to care.[ix,22] Providers recognize the mental and emotional impact of scars. All experts interviewed indicated that scar treatment would facilitate psychological healing for victims/survivors.

1.4 Financial Evaluation

BerryDunn conducted a financial evaluation to estimate the potential fiscal impact of mandating insurance coverage of certain aesthetic and restorative services for victims/survivors of DV/IPV under the proposed legislation. One of the biggest challenges BerryDunn faced when estimating the financial impact of this bill was the lack of comprehensive data and research on DV/IPV and associated residual injuries in Maryland. This resulted in considering more unknown factors than usual when developing actuarial assumptions and ranges, which increases uncertainty. The actuarial estimates and ranges in this report are not intended to address every possible outcome, but instead reflect a reasonable range for the purposes of this analysis.

This analysis relied on data from Maryland's All Payer Claims Database (APCD), the Medical Care Data Base (MCDB). The MCDB includes enrollment, provider, and claims data for Maryland residents

[ix] More details on trauma-informed care can be found in section 4.5.

across private insurance (excluding self-insured plans governed by ERISA since 2015), Medicaid fee-for-service (FFS), and Medicaid Managed Care Organizations (MCOs).[23] Data from the MCDB was supplemented by:

- Insurer responses to the survey administered by MHCC in conjunction with BerryDunn.
- Input from medical and policy experts.
- Data points from reviewed published literature to contextualize and support the analysis.
- Maryland State Employee Health Benefit Plan (State Health Plan) information.
- Maryland Medicaid financial monitoring reports.

The number of adults projected to receive aesthetic services (users) per year was developed from estimates for the number of adults who have experienced IPV in a year, sustained injuries resulting in scarring, and would choose to seek aesthetic services if coverage were mandated.[x] The cost per user was estimated from literature review. The projected number of aesthetic service users multiplied by the estimated cost per user yields the estimated incremental claim cost due to the mandate. Retention[xi] factors were applied to the incremental claim cost estimates to calculate the projected impact to insurance costs. The modeling indicates that the proposed mandate would increase insurance costs across market segments: $0.02 (or 0.00%) to $0.15 (or 0.03%) PMPM for fully insured plans, $0.02 (or 0.00%) to $0.15 (or 0.02%) PMPM for the State Health Plan, and $0.07 (0.02%) to $0.47 (0.11%) PMPM for Medicaid.

These results suggest that while the mandate would expand access to medically necessary aesthetic services for DV/IPV victims/survivors, the analysis produced a wider range of potential cost outcomes, reflecting uncertainty in the cost and utilization of these services should the mandate pass. These estimates are subject to a range of considerations and limitations, including uncertainty in DV/IPV reporting rates; the number of DV/IPV-related injuries resulting in scarring; the proportion of victims/survivors with scarring who would seek aesthetic services under the mandate; variation in treatment options and associated service costs; and limitations in available claims data. As a result, actual costs could be higher or lower depending on future reporting, utilization patterns, and coverage policies.

[x] Dental services are excluded from the proposed legislation and accordingly have been excluded from the cost analysis of this report.
[xi] Depending on the market segment, retention can include administrative expenses, fees, assessments, taxes, contribution to reserve/profit margin, cost of capital, and risk and contingency margin.

Content notice: This section includes detailed descriptions of physical violence and related injuries. Reader discretion is advised

2.0 Social Evaluation

Background

Physical DV/IPV is the use of physical force with or without a weapon. Individuals may experience and sustain injuries from being slapped, pushed, shoved, kicked, burned, choked, scratched, and/or use of weapons such as knives, guns, or other objects. Resulting injuries include but are not limited to scratches, bruises, cuts, black eyes, broken bones or teeth, back or neck injury, injuries to ligaments, muscles, or tendons, injuries related to being knocked out or choked, and head injuries such as traumatic brain injury (TBI).[7,24]

Physical DV/IPV is linked to many adverse health outcomes[xii] for victims/survivors, such as physical injuries, chronic pain, and mental health conditions.[24,25] Outcomes and experiences vary depending on the abuse experienced by individual victims/survivors.[24,25] The scope of this report includes the effects of physical DV/IPV, specifically physical violence which resulted in alterations to appearance that can be treated via restorative or aesthetic care that would not be covered in the absence of this bill. Notably, many studies on this topic contain small sample sizes that influence their generalizability to larger populations.

2.1 Prevalence of DV/IPV and Related Injuries

Identifying DV/IPV prevalence as well as residual injury prevalence and injury incidence, and consequent healthcare utilization, remains a challenge. DV/IPV, along with other violent crimes, is largely underreported. The U.S. Department of Justice estimates that in 2023, less than half (47.2%) of IPV was reported to the police, likely due to unique IPV relationship dynamics (e.g., fear, control) suppressing reporting.[26] Rates of DV/IPV are underreported due to disclosure barriers[xiii,27] victim/survivor preferences,[28] varying provider coding practices, and lack of standardized DV/IPV definitions, screening, and reporting requirements.[29] Additionally, many providers may be unaware that an individual's injuries are related to DV/IPV, and both individuals and providers might be uncomfortable discussing injuries.[30] This report uses the best available estimates of DV/IPV rates and related injuries, though gaps remain.[xiv]

[xii] Adverse health effects include but are not limited to complications associated with TBI (headaches, memory loss, tinnitus (ear ringing), seizures, vision and hearing problems), increased risk of carotid artery dissection or stroke after strangulation, chronic pain, physical injuries (broken bones, cuts, burns), mental health impacts (depression, anxiety, posttraumatic stress disorder), gastrointestinal problems, increased risk of suicide, and increased risk of death.

[xiii] Barriers for victims/survivors to disclose abuse include, but are not limited to: fear of potential negative consequences as a result of reporting, fear of judgement or being discredited when disclosing, fear of abuser, confidentiality concerns, lack of trust in providers, feelings of shame or low self-esteem, lack of awareness or denial that the individual was experiencing abuse, and other individual decisions to disclose.

[xiv] More details on data gaps are discussed in section 2.3.

National DV/IPV Prevalence

The Centers for Disease Control and Prevention (CDC) administers the National Intimate Partner and Sexual Violence Survey (NISVS). The most recent report, released in 2022, draws on 2016/2017 survey data. According to the NISVS, nationally 42% of women (52 million) and 42.3% of men (49.9 million) will experience physical violence by an intimate partner in their lifetime.[xv,7]

Although rates of physical violence are similar among men and women, women report higher rates of IPV-related injuries and require medical care more often.[xvi] Using data from the NISVS, about 35.3% of U.S. adult women (44 million) reported ever experiencing IPV-related injuries, with 1.3% of women (1.7 million) reporting sustaining an injury within the year prior to the survey. Over 21% of men (24.9 million) reported ever experiencing IPV-related injuries, with 0.8% (927,000) reporting sustaining an injury within the year prior to the survey.[7]

KFF (formerly Kaiser Family Foundation) reported that in 2024, nationally, an estimated 19% of women ages 18 – 64 years old have experienced IPV, and nearly half (9%) of these women have sustained an IPV-related physical injury.[xvii,31] Researchers found an increase in physical IPV, including severity of IPV-related injuries, during the COVID-19 pandemic.[32,33,34]

DV/IPV Prevalence in Maryland

In Maryland, an estimated 38% of women and 35% of men will experience IPV in their lifetime.[35] In 2023, assault was the highest reported domestic crime in Maryland, with one in five domestic assaults classified as aggravated (involving a weapon and/or resulting in severe bodily injury). The Maryland Department of State Police categorizes aggravated assault injuries as “apparent broken bones, loss of teeth, possible internal injury, severe laceration, or loss of consciousness.” [36]

DV/IPV Prevalence Among Historically Underserved Groups

A 2020 study and NISVS survey found an increased prevalence of IPV among individuals who identify as part of the LGBTQ+ community,[10,37,38] especially individuals who identify as non-binary. [xviii,39] One study found that bisexual individuals (21.6%) and gay men (18.5%) reported the highest rates of IPV, respectively.[38]

The NISVS 2016/2017 Report on Victimization by Sexual Identity found that bisexual women have greater lifetime prevalence of any physical violence and severe physical violence compared to lesbian and heterosexual women.[35] The NISVS study found that heterosexual men have greater lifetime

[xv] Data is based on the most recent 2016/2017 National Intimate Partner and Sexual Violence Survey, which did not include information for other sexes or gender identities. Some data on IPV by sexual identity can be found in the NISVS 2016/2017 Report on Victimization by Sexual Identity.
[xvi] In the year before the NISVS survey, 5.7 million women reported experiencing sexual violence, physical violence, and/or stalking by an intimate partner, with at least one impact. One in three women were injured (1.6 million) and one in eight women (739,000) needed medical care as a result. Comparatively, of 3.3 million men surveyed, one in five men (927,000) reported injuries and one in 23 men (336,000) reported needing medical care as a result of IPV.
[xvii] Physical injuries among women surveyed include those as a result of being pushed, hit, slapped, kicked, choked, or other related injuries.
[xviii] Non-binary means a person who does not identify solely as a man or woman; many non-binary individuals also identify as transgender (gender expression and identity that differs from the sex assigned at birth).

prevalence of any physical violence and gay men have increased prevalence of severe physical violence compared to heterosexual and bisexual men.[35]

KFF reported that nationally, LGBTQ+ individuals experience higher rates of IPV-related physical violence compared to non-LGBTQ+ identifying women.[31] Researchers estimate that transgender individuals are nearly 1.7 times more likely to experience IPV than cisgender individuals and are more than twice as likely to experience physical IPV.[40]

The NISVS survey found that nationally, women who identify as multiracial have the highest rates of IPV (all types of violence) among women (63.8%), followed by American Indian/Alaska Native (AI/AN) (57.7%), Black (53.6%), White (48.4%), Hispanic (42.1%), and Asian/Pacific Islander (API) (27.2%) women.[7] Additionally, Black men experience the highest rates of IPV (57.6%), followed by multiracial (51.5%), AI/AN (51.1%), White (44.0%), Hispanic (40.3%), and API (24.8%) men.[7] Some studies find that immigrant populations are more likely to experience IPV than those born in the U.S.,[12] depending on survey type used and the immigrant population(s) included in the study.[41]

Common DV/IPV Injuries

Approximately 50% – 80% of DV/IPV injuries occur in the head and neck region, and can result in bruises, and facial and oral trauma, including facial or tooth fractures,[42,43,44] and TBI.[45] Among individuals with facial injuries attributable to IPV, nearly 60% experienced facial fractures.[46] Many studies document nose, lower jaw, cheek, and eye socket fractures as the most common facial fractures related to IPV.[46,47] Isolated facial fractures (bones) were more common than isolated soft tissue (muscle, ligament, blood vessels) injuries. However, all individuals who experienced facial fractures also had associated soft tissue injuries.[46] Back and upper body injuries are also common, along with hand and foot injuries.[43] Table 3 below summarizes lifetime physical injuries among men and women as a result of IPV.

Table 3: Reported Lifetime Physical Injuries Among Men and Women, Percent and Estimated Number of Victims/Survivors (2016/2017 NISVS)[7 7]

	Men		Women	
Injury Type	Percent	Estimated Affected Individuals	Percent	Estimated Affected Individuals
Minor bruises or scratches	15.4%	18.2 million	25.9%	32.4 million
Cuts, major bruises, or black eyes	6.4%	7.5 million	15.8%	19.7 million
Injuries to ligaments, muscles, or tendons	0.9%	1 million	3.7%	4.6 million
Broken bones or teeth	0.7%	799,000	3.7%	4.6 million
Back or neck injury	0.7%	799,000	3.3%	4.1 million
Injuries related to being knocked out or choked	0.6%	691,000	3.4%	4.3 million
Head injury	0.8%	928,000	3.6%	4.3 million

Common Types of Scars

Scarring results from many DV/IPV injuries. Scars are typically initially pink or red (immature) and accompanied by erythema (skin redness as a result of inflammation) and can take weeks, months, or years to transition into mature scars, marked by the absence of erythema.[48] Hypertrophic scars[xix] and keloids[xx] are common mature scars that can happen as a result of increased collagen production after experiencing burns, surgery, and physical trauma.[49] Individuals with increased melanin may be more prone to keloid scars.[50]

Residual Injury Prevalence

A recent study found, via survey, that over half of women who have experienced DV had an aesthetic concern from a DV/IPV injury, including scars (45.5%), and impacts to the teeth, lips, and jaw (27.3%).[51] Another study found that nearly 60% of victims/survivors who experienced IPV had at least one residual injury (permanent mark or scar), over 30% had one to three residual injuries, almost 20% had four to 10 residual injuries, and over 5% had more than 10 residual injuries.[52]

2.2 Coverage of Services

Federal Coverage of Services

The ACA prevents health insurers from denying enrollment or charging more based on "health status-related factors" for individuals and dependents. These factors include health status, medical conditions or diagnoses, previously submitted claims, previous healthcare utilization, medical history, genetic information, evidence of insurability (explicitly cites DV), disability, and other factors deemed necessary by the Secretary of Health and Human Services (HHS).[14] Most of these factors could affect individuals seeking DV/IPV-related treatment. Under the ACA, states must select benchmark plans which include coverage for services from each of the 10 essential health benefits.[53] Maryland's current benchmark plan does not cover aesthetic procedures.[15]

Insurance Coverage for DV/IPV Screening and Screening Rates

In June 2025, the United States Preventive Services Task Force (USPSTF) issued a "B" [xxi,54] grade for screening reproductive age women, including pregnant and postpartum people, for IPV.[37] Although the ACA requires non-legacy health plans to cover screening and treatments that receive and "A" or "B" grade from the USPSTF without cost sharing,[55] IPV screening is not widely implemented by providers.[56]

[xix] Hypertrophic scars are raised, thick scars that do not extend beyond the original site of injury, most common on limbs. Hypertrophic scars can be treated and are unlikely to reoccur.
[xx] Keloids are raised, thick scars that can grow indefinitely, beyond the original injury site. Keloids are more common in the upper body and face area and may not go away, even after treatment.
[xxi] The USPSTF assigns letter grades to services to signify level of endorsement, based on the quantity and quality (strength) of available evidence (studies). The USPSTF issues an "A" grade, the highest grade, for recommended services and the expected net benefit greatly outweighs any potential harms. A "B" grade means the USPSTF recommends the service, and the expected net benefit is moderate to substantial.

Existing Coverage of Services in Maryland

Based on insurers' responses to a survey administered by the MHCC in conjunction with BerryDunn, restorative services could be covered when the procedures are deemed medically necessary by the insurer, e.g., to restore function or to correct abnormalities. While there are no exclusions specific to DV, most insurers reported that they do not consistently track or identify DV-related claims, but some utilize diagnosis codes related to trauma or DV in combination with procedure codes. Coverage determinations are guided by insurer defined medical necessity criteria, with aesthetic procedures excluded unless they meet restorative standards. In most cases, services require prior authorization, and providers may need to submit supporting documentation. Some insurers note that the absence of specific procedure codes in the proposed mandate makes it difficult to assess utilization or denials. Coverage of the proposed services among self-funded employer groups varies by plan design and is determined by each employer.

Medicaid currently covers plan determined medically necessary restorative surgery and procedures but does not cover aesthetic services or associated anesthesia.[57]

Dental coverage varies by plan and is subject to varying annual coverage maximums. Medicaid adult dental benefits do not include cosmetic procedures.[58] A financial evaluation of requiring coverage of dental services for injuries caused by DV/IPV was excluded from this study.

2.3 Public Demand and Treatment Utilization

DV/IPV Disclosure

A 2022 qualitative systematic review and a 2020 qualitative meta-analysis, which included research outside the U.S., found that women did not disclose DV/IPV to healthcare providers primarily because of safety concerns (for themselves and/or children) and fear that disclosing DV/IPV would negatively affect the patient-provider relationship.[59,60] Researchers found that the disclosure process could be a facilitator or a barrier to victims/survivors talking about their experiences.[59] Women felt more comfortable disclosing DV/IPV when they felt emotionally safe and supported; women were more likely to disclose if they had sufficient time and privacy with the provider and the provider validated the individual's DV/IPV experiences. Victims/survivors also preferred continuity of care from the same provider over time.[60] Additionally, women felt more comfortable discussing their experiences if the provider was caring, empathetic, and kind, used active listening, emphasized confidentiality, helped connect victims/survivors to advocacy agencies, social supports, safety planning, and used shared decision-making/empowerment, culturally appropriate, and disability sensitive care, as appropriate.[59,60]

While validated screening tools for DV/IPV exist and can help clinicians identify DV/IPV, [37]these tools are not always implemented, and when they are, the results fall short of providing a full view into the extent of individuals' injuries or related impacts. Prevalence and utilization cannot yet be fully understood in part due to a lack of a universal DV/IPV definition and resulting related injuries.

DV/IPV Healthcare Utilization

Healthcare utilization for DV/IPV survivors is higher across multiple settings, including emergency, outpatient, and primary care services, particularly for women who have experienced physical abuse.[13]

Researchers found that women who have experienced IPV are more likely to utilize the emergency department (ED) (54% more likely) and hospital outpatient settings (16% more likely),[61] as well as have increased utilization of "primary care, pharmacy, specialty, laboratory, and radiology" compared to women who have not reported experiencing IPV.[13] IPV healthcare utilization rates have been correlated with ongoing IPV; and, healthcare utilization overall remained higher among women who ever experienced IPV, compared to women who have not.[13,61] Some researchers estimate that 80% of mental health costs related to IPV are attributable to physical assaults.[13]

Some victims/survivors do not seek medical care immediately; individuals may have experienced years of physical injury(ies) before seeking care, resulting in wounds that did not heal properly.[17] The American Academy of Facial Plastic and Reconstructive Surgery offers treatment to individuals who have experienced DV through the Face-to-Face (FTF) program. In the FTF program, plastic surgeons provide free or low-cost care to victims/survivors, primarily for scar revisions. Individuals must meet eligibility criteria[xxii,62] to receive treatment, and the program does not cover anesthesia or surgery for scar revision.[xxiii] A 2022 study found that before the COVID-19 pandemic, the average time from the initial injury to applying for treatment through the FTF program was 9.26 years. Between 2017 and 2021, of the 114 DV-related injuries addressed in the FTF program, individuals sought aesthetic and/or restorative care for scarring (43%), a broken nose (39%), ear injuries (6%), jaw fractures (4%), eye socket fractures (4%), and cheekbone fractures (4%). This study estimated that while IPV prevalence increased during the pandemic, victims/survivors may not seek aesthetic and/or restorative care for 10 years.[17]

This report was unable to evaluate alternative treatments to the proposed mandated benefits as they are specific to the type of injury, underreported, and indistinguishable from other sources of injury.

Motivations for and Barriers to Accessing Aesthetic Surgery

A 2018 study found that, generally, the most common reasons individuals pursue aesthetic procedures is due to general unhappiness, irritation of the area, and pain, (51.4%) as well as the ability to afford the treatment (59.5%). The study found that insurance covering a procedure, or access to insurance, was the least common factor in pursuing treatment (8.1% of respondents).[63] In a recent study with a small sample size, nearly 75% of women surveyed who experienced DV-related injuries did not pursue aesthetic and/or restorative care due to financial barriers.[51]

2.4 Access and Disparities

Currently, prevalence and research on intersectionality, the overlapping of identities and experiences, including overlapping experiences of historic discrimination (e.g., race/ethnicity, socioeconomic status, [dis]ability, gender, sexuality, immigration status)[64] and DV/IPV remains limited.[65,66] Individual needs

[xxii] FTF eligibility criteria for victims/survivors to receive care include: being a victim/survivor of DV from a spouse, intimate partner, caregiver, sibling, or parent; being out of the abusive relationship for a minimum of 12 months before applying for care; having contact with a DV advocate, social worker, case manager, counselor, or therapist at least twice along with a letter of support from the referring individual/organization; a complete application; signed consent form; participation in a phone call to verify application; potential contact with the referring individual/organization to confirm involvement.
[xxiii] Per expert interview.

and healing experiences may also be influenced by cultural and societal norms,[66] in addition to adequate access to medical treatment. Historical trauma, trauma that impacts culture and has lingering effects for many generations (e.g., historical events of oppression and/or violence), can also exacerbate individual experiences of trauma. Additionally, historically underserved groups have an increased mistrust in the healthcare system due to historic injustices which may result in decreased utilization of needed care.[22]

DV/IPV can impact anyone, yet individuals who are low-income, live in rural areas,[11] and/or are a person of color,[7] experience higher rates of DV/IPV. One study found that historically underserved women with lower incomes are at increased risk for IPV, depression, and pain.[67] Immigration status is a risk factor for DV/IPV because of cultural differences (e.g., patriarchal culture, stereotypical gender roles), limited English proficiency, dependency on spouses, fear of deportation, lack of awareness of legal or advocacy support, social isolation, and lack of or disruption to social support systems.[68]

2.5 State Comparisons and Key Considerations

As of January 1, 2025, certain commercial insurers in Illinois and Illinois Medicaid are required to cover "medically necessary reconstructive services"[16]; reconstructive services include treatments that restore an individual's physical appearance after experiencing traumatic damage or injury. As a result of this mandate, many Illinois insurers have implemented prior authorization requirements for cosmetic services. Since Illinois recently enacted this mandate, data on cost and utilization was not yet available at the time this report was prepared.

The Illinois legislation is broader than the proposed bill in Maryland; it does not only apply to victims/survivors of DV/IPV nor define which types of trauma apply. To qualify for care, the bill proposed in Maryland might inadvertently require victims/survivors to disclose DV/IPV experiences as the source of their injuries. Additionally, among Maryland insurers surveyed, one noted a preference to broaden the population included in the bill rather than focus on victims/survivors of domestic violence due to difficulties tracking claims.

3.0 Medical Evaluation

3.1 Medical Efficacy of Treatments[xxiv]

Common Scar Treatments

Common scar treatments available include chemical treatments, dermabrasion,[xxv] surgical scar revision,[69] corticosteroids, chemotherapy,[xxvi,70] silicone gel sheets, cryotherapy (extreme cold), radiation therapy,[xxvii] tissue fillers, and laser treatment.[71]

Effects of Alteration to Appearance and Treatment Utilization

SAMHSA denotes that psychological trauma results from "an event, series of events, or a set of circumstances an individual experiences as physically or emotionally harmful or threatening, which may have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." Psychological trauma impacts individuals differently; individuals who experienced the same exact event can have differing trauma responses and impacts.[22]

Women who have experienced IPV report physical, emotional, and social pain because of abuse.[67,72] Many women report exhaustion, fatigue, and impaired functionality, even years after the last interaction with their abuser. Women reported that lingering chronic pain due to DV/IPV could be retraumatizing and overwhelming, often interfering with daily activities.[67] Psychological stress negatively impacts wound and scar healing and can lead to weaker skin tissue.[69] Additionally, injuries sustained by individuals of color are disproportionately overlooked in part due to increased melanin.[73]

Direct studies of restorative and/or aesthetic care for victims of DV/IPV are limited. Therefore, this study incorporates evidence of impacts of physical traumatic injuries[xxviii,74] more broadly, regardless of the cause, since the literature, experts, and insurers noted that physical treatment options would not differ based on injury cause. Broadly, individuals seek aesthetic procedures to improve psychological and emotional well-being, including increasing confidence.[63] While psychological outcomes are not currently factored in medically necessary criteria,[63] there is strong evidence to show that timely facial fracture management, septoplasty,[xxix,75] closed nasal reduction,[xxx,76] restorative dental care,[xxxi,77] and scar-

[xxiv] Since insurers already cover medically necessary restorative care, the medical and social efficacy focuses on aesthetic procedures.
[xxv] Dermabrasion is a procedure that removes the top layer of skin.
[xxvi] Chemotherapeutic agents, in combination with surgical excision, can be effective treatment for certain scars.
[xxvii] Although radiation therapy after excision is the most effective treatment for keloids, results vary, sometimes leading to complications.
[xxviii] Traumatic injuries are sudden injures endured as a result of violence or accident (e.g., sports injuries, injuries as a result of a car accident, DV/IPV).
[xxix] Septoplasty is a minor surgical procedure that straightens the septum. A septoplasty is often performed for a patient with a deviated septum.
[xxx] Closed nasal reduction is a non-surgical procedure that repositions displaced nasal bones. Closed nasal reduction can be performed alone or in conjunction with septoplasty.
[xxxi] Restorative dental focuses on improving functionality via repairing or replacing teeth. Restorative dental procedures can also provide cosmetic benefits. Common treatments include crowns (tooth shaped cap), implants (a small post to replace a tooth root, followed by a crown), and dentures (removable device that replaces several teeth.

focused interventions all result in significantly improved psychological outcomes for patients.[21,78,79,80] Research on treatment of DV/IPV-related residual injuries and its impact on mental health outcomes is currently limited.[52]

In addition to the physical impacts of traumatic scarring individuals report negative impacts to their "psychological, social, physical, and sexual well-being."[18] Studies[xxxii] consistently report that individuals with scarring from an injury, especially to the face, report worse mental health and decreased quality of life.[18,19,20,21] Traumatic injuries (e.g., facial scars and burns), including those from DV/IPV are correlated with increased stigma, anxiety, depression, post-traumatic stress disorder (PTSD), psychological distress, poor body image, and low self-esteem.[19,20,81] Visible scars as a result of traumatic injuries can also result in individuals re-living the incident that led to the injury and consequent scar(s),[82] especially for individuals with facial scars.[81] Evidence is mixed on whether the type of physical trauma (e.g., car accident versus domestic violence) impacts psychological outcomes, with some studies reporting no differences and other studies concluding that injuries associated with assault have a greater psychological impact.[21,46] Financial analysis of the psychological impact of DV/IPV is beyond the scope of this analysis.

3.2 Medical Community Recognition

Professional Guidelines

Major professional and public health bodies emphasize the importance of proactive identification and prevention of IPV. In addition to the USPSTF, the American Medical Association (AMA),[83] Women's Preventive Services Initiative,[84] and American College of Obstetricians and Gynecologists[85] recommend routine screening for IPV across clinical settings. While many of these organizations support interventions, referrals and appropriate follow-up care, to date, no guidelines exist for DV/IPV-related restorative or aesthetic care.

Provider Screening and Documentation Patterns

Researchers estimate that between 9% – 40% of clinicians routinely screen for IPV.[56] Clinicians are reluctant to screen for DV/IPV due to a lack of clinician time, privacy, and training (fear of offending individuals, feeling uncomfortable screening, not knowing how to respond to a positive screen).[56,86] While dental care was excluded from this review, dental providers can identify and/or treat DV/IPV injuries such as cuts in or around the mouth, a loose tooth, tooth dislocation, and tooth loss[45]; however, most dental providers lack the necessary training, education, and confidence to address DV.[42,45]

Among experts interviewed, many noted that DV/IPV screening rates remain low and inconsistent and that individuals, even if screened, may not disclose experiencing DV/IPV. Experts also noted that utilization of diagnosis codes varies depending on provider preference. Some providers might not use diagnosis codes to document DV/IPV and might be reluctant to include cause of injury in an individual's electronic health record (EHR).[87] A 2021 study found that in a hospital in Boston, IPV-related upper body injuries were most commonly reported during ED triage, and 17% of patients disclosed IPV as the cause of injury; however, over one-third of these cases were undocumented in individual's EHR.[46]

[xxxii] Studies on the psychological impact of scars are limited in the United States. To complete a thorough analysis, this section includes insights from international studies.

When DV/IPV-related injuries are identified, referrals for restorative or aesthetic care depend heavily on provider familiarity with available programs and the patient's ability to afford treatment. Thus, while medically necessary restorative services are available through certain clinical and volunteer programs, utilization among DV/IPV survivors is low relative to need, reflecting systemic gaps in physician awareness, screening, and coordinated follow-up care.

Provider Recognition of Treatment Efficacy

All experts interviewed noted mental and emotional impacts of scars for victims/survivors. One expert emphasized that scars, especially obvious scars, which are likely to occur on the head, face, and neck, complicate healing and any support to facilitate physical and emotional healing would benefit victims/survivors. All experts expressed that scar treatment would support psychological healing.

Trauma-Informed Care

SAMHSA promotes implementation of trauma-informed care – the realization of the impact of trauma and paths to recovery, recognition of the signs and symptoms of trauma, integration of trauma-informed principles into all levels of an organization, and prevention of re-traumatizing individuals – in programs, organizations, and systems. Healthcare organizations/staff can implement trauma-informed care for victims/survivors by utilizing six key principles[22]:

- Safety: Ensuring physical and psychological safety
- Trustworthiness and transparency: Building and maintaining trust
- Peer support: Providing opportunities for self-help and peer support
- Collaboration and mutuality: Minimizing power imbalances among staff and individuals seeking services
- Empowerment, voice and choice: Highlighting victim/survivor's strengths and prioritizing individual empowerment in decision-making
- Cultural, historical, and gender issues: Providing racially, ethnically, and culturally appropriate care and access to gender responsive services.

Victims/survivors' recovery from DV/IPV is often multi-faceted, non-linear, and individual.[88] Not all victims/survivors seek or need the same treatment in their path to recovery. Researchers note that prioritizing opportunities for victims/survivors to feel empowered and improve self-trust can help facilitate recovery.[89]

4.0 Financial Evaluation

BerryDunn conducted a financial evaluation to estimate the potential fiscal impact of mandating insurance coverage of certain aesthetic services for victims/survivors of DV/IPV under the proposed legislation. There were several limitations of the information available for this study, and factors BerryDunn considered but could not quantify. Some of these limitations and considerations are listed below; additional discussion is in Section 4.3:

- BerryDunn was unable to identify claims for injuries caused by DV/IPV in the MCDB, so the assumed number of DV/IPV survivors seeking aesthetic treatment for scars relied on a series of assumptions based on available literature.
- Since aesthetic services have not been covered by insurance, treatment costs and utilization of aesthetic services could not be used as a baseline.
- Literature suggests DV/IPV cases are underreported, and it is difficult to predict the impact this mandate would have on the number of people reporting DV/IPV.
- The pent-up demand for aesthetic services to treat existing residual injuries related to DV/IPV is unknown.
- Historical enrollment in the market segments is impacted by the Medicaid continuous coverage during the COVID-19 Public Health Emergency, and subsequent unwinding of continuous coverage.

The analysis focused on the incremental, or marginal, costs associated with expanding coverage, recognizing that insurers generally cover medically necessary services but that aesthetic services for this population are not currently covered absent the mandate.[xxxiii] The evaluation incorporated estimates of the population likely to seek these services under the mandate, drawing on published data on DV/IPV, scarring prevalence, and DV/IPV reporting patterns. These estimates were applied to Maryland's adult population to project the number of new users who would receive coverage. Costs were estimated primarily from literature and retention factors to project insurance cost PMPM impacts. This approach provides an assumption-based estimate of the range of costs that health insurers and public programs may experience if the mandate is implemented.

4.1 Methodology

To estimate the potential fiscal impact of the proposed mandate requiring coverage of certain aesthetic services for victims/survivors conducted a multi-step modeling process. First, insurer responses to the survey were reviewed, which indicated that services deemed medically necessary by each insurer absent the mandate are generally already covered; most restorative care was categorized as medically necessary by insurers. Therefore, this analysis defines the marginal cost of the mandate as the cost of those aesthetic services sought by victims/survivors of DV/IPV and determined to be medically necessary by a licensed physician, that may not be considered medically necessary by insurers.

The analysis required a review of the financial implications of mandating coverage across market segments. The Medicaid, individual, and fully insured small and large employer group populations were identified in the MCDB using market segment codes. The State Health Plan population, identified via employer identification number (EIN), was assumed to be only those that were classified as self-insured.[90,91] BerryDunn assumed the State Health Plan would voluntarily adopt these mandated benefits, so the same impact assumptions as the fully insured population were applied.[xxxiv]

[xxxiii] Dental services are excluded from the proposed legislation and accordingly have been excluded from the cost analysis of this report.
[xxxiv] This assumption is commonly used in actuarial reviews to estimate the broader cost impacts of state insurance mandates on self-insured public employee coverage.

BerryDunn developed an estimate of the population that would seek aesthetic services that are not currently covered by insurance. First, BerryDunn calculated the percentage of the total adult population who seeks medical care due to DV/IPV each year. This calculation was based on published prevalence rates of DV/IPV, the percentage of DV/IPV victims/survivors reporting injury within the last year,[7] and the ratio of those who sought care to those reporting injuries.[92] This was further adjusted by the percentage of DV/IPV incidents that occur between cohabitants,[36] consistent with the language of the bill. In addition to stratification by market segment, population estimates were stratified by gender, recognizing that the incidence of DV/IPV-related injuries differ between men and women.[xxxv,7] Some research suggests that individuals with a lower socioeconomic status (SES), including Medicaid enrollees, are more likely to experience DV/IPV.[93,94,95] Using these studies, BerryDunn assumed that Medicaid enrollees are 4.5 times more likely to be victims/survivors of DV/IPV and stratified our prevalence assumptions by Medicaid/non-Medicaid populations from the overall DV/IPV prevalence.

BerryDunn then used published estimates of the proportion of DV/IPV victims/survivors who report permanent marks or scars as a proxy for those who might seek aesthetic services.[5252] Table 4 presents the key assumptions used by BerryDunn to estimate the eligible populations—defined as the percentage of adults who experienced DV/IPV, sought medically necessary care, and sustained residual injuries. [52] Table 4 presents the key assumptions used by BerryDunn to estimate the eligible populations—defined as the percentage of adults who experienced DV/IPV, sought medically necessary care, and sustained residual injuries.

Table 4: Eligible Population Assumptions

Assumption	Market Segment	Female	Male
Percentage of adult population with an IPV/DV-related injury within a year	Non-Medicaid	0.5%	0.3%
	Medicaid	2.2%	1.4%
	All	1.3%	0.8%
Percentage of IPV/DV incidents occurring between cohabitants	All	63.6%	63.6%
Percentage of individuals with an IPV/DV-related injury who sought any medical care	All	37.5%	21.7%
Percentage of individuals with residual injury	All	56%	56%

The percentages above, in Table 4, were applied to the in-scope insured adult females and males to estimate the eligible population to receive aesthetic services under the mandate. A 2025 study reported that 31.8% of the IPV/DV victims were likely or extremely likely to seek aesthetic treatment for residual injuries in the future. In the same study, 72.7% of the DV/IPV survivors indicated that financial barriers were a concern for seeking plastic surgery.[51] BerryDunn developed a range of uptake assumptions,

[xxxv] This estimation was based on data limited to men and women gender identities.

including low (30%), middle (50%), and high (70%) scenarios. The range of uptake assumptions were then applied to the eligible population to estimate the number of IPV/DV victims who are likely to seek aesthetic services, that would be newly covered by insurance under the mandate.

The next step in the analysis was to estimate the cost of aesthetic services per DV/IPV user. Since aesthetic procedures are generally not covered absent the mandate, and procedure codes for aesthetic services do not identify whether the services are related to DV/IPV injuries, claim data was not available, so BerryDunn conducted a literature review to estimate the average cost per user for aesthetic procedures.[96,97,98] Given the limited literature on the utilization mix of surgical versus non-surgical aesthetic procedures, BerryDunn developed low, middle, and high scenarios, varying service utilization mix assumptions to derive a range of cost per user estimates. The resulting ranges are $2,000 for the low scenario, $3,500 for the middle, and $6,000 for the high.

The cost per user estimates were then applied to the projected number of new DV/IPV victim users to calculate the marginal cost of the mandate. The incremental claim cost PMPMs were calculated by dividing the marginal cost by 2024 membership. Retention assumptions were then applied to the marginal claim costs PMPM to derive the corresponding insurance cost PMPM impacts for each market segment.[99,100]

To derive the percentage increase in insurance costs PMPM under mandated coverage, premium PMPMs for the fully insured individual, small group, and large group segments were taken from the carrier survey responses. For total fully insured, the average premium PMPM reflects a weighted average using the carrier survey responses' reported enrollees for fully insured individual, small group, and large group. The premium equivalent PMPM for the State Health Plan was derived using the Maryland State Health Plan benefits information[101] and subscriber relationships from the MCDB. A Maryland Department of Health financial monitoring report[102] included an average program cost for Medicaid MCOs, which make up 88% of Medicaid in Maryland. For simplicity the program cost for Medicaid FFS was assumed to be the same as for Medicaid MCOs.

4.2 Results

Using 2024 as the base year, BerryDunn's modeling indicates that the proposed mandate would increase insurance costs PMPM across market segments. For fully insured plans and the State Health Plan, the estimated increase to insurance costs ranges from $0.02 to $0.15 PMPM, representing percentage increases of 0.00% to 0.03%. For Medicaid, which includes FFS and MCOs, the projected increase is $0.07 (0.02%) to $0.47 (0.11%) PMPM. Table 5 below shows the results in detail.

Table 5: Aesthetic Services Projected Cost Summary by Market Segment

Range of Estimates by Market Segment	Low	Middle	High
Individual			
% of Individual Market Population Receiving Aesthetic Services	0.01%	0.02%	0.02%
Individual Premium PMPM Increase	$0.02	$0.06	$0.15
Individual Premium PMPM % Increase	0.00%	0.01%	0.03%
Individual Premium Increase	$73,528	$214,457	$514,697
Fully Insured Small Group			
% of Fully Insured Small Group Population Receiving Aesthetic Services	0.01%	0.02%	0.02%
Fully Insured Small Group Premium PMPM Increase	$0.02	$0.06	$0.15
Fully Insured Small Group Premium PMPM % Increase	0.00%	0.01%	0.02%
Fully Insured Small Group Premium Increase	$49,601	$144,669	$347,205
Fully Insured Large Group			
% of Fully Insured Large Group Population Receiving Aesthetic Services	0.01%	0.02%	0.02%
Fully Insured Large Group Premium PMPM Increase	$0.02	$0.06	$0.14
Fully Insured Large Group Premium PMPM % Increase	0.00%	0.01%	0.02%
Fully Insured Large Group Premium Increase	$105,272	$307,043	$736,904
Totally Fully Insured Commercial (Individual, Small Group, Large Group)			
% of Total Fully Insured Population Receiving Aesthetic Services	0.01%	0.02%	0.02%
Total Fully Insured Premium PMPM Increase	$0.02	$0.06	$0.15
Total Fully Insured Premium PMPM % Increase	0.00%	0.01%	0.03%
Total Fully Insured Premium Increase	$228,401	$666,169	$1,598,806
State Health Plan			
% of State Health Plan Population Receiving Aesthetic Services	0.01%	0.02%	0.02%
State Health Plan Premium Equivalent PMPM Increase	$0.02	$0.06	$0.15
State Health Plan Premium Equivalent PMPM % Increase	0.00%	0.01%	0.02%
State Health Plan Premium Equivalent Increase	$51,321	$149,686	$359,246
Medicaid			
% of Medicaid Population Receiving Aesthetic Services	0.06%	0.06%	0.08%
Medicaid Program Cost PMPM Increase	$0.07	$0.20	$0.47
Medicaid Program Cost PMPM % Increase	0.02%	0.05%	0.11%
Medicaid Program Cost Increase	$1,336,840	$3,899,116	$9,357,878

4.3 Considerations and Limitations

When evaluating the potential financial impact of mandating coverage for certain aesthetic services for victims/survivors of DV/IPV, several considerations and limitations should be noted. The analysis relies on a series of assumptions to estimate the proportion of the insured population that would seek these services under the mandate, given that claims data in the MCDB do not indicate whether a service is related to DV/IPV. Many of these assumptions, such as rates of DV/IPV, reporting of injuries, and the proportion of victims/survivors who would seek aesthetic services, are based on published estimates or proxies and carry inherent uncertainties due to the limited availability of robust data in the literature. Additional uncertainty arises from potential variations in how the mandate may be implemented and interpreted by insurers and providers.

IPV is widely recognized as an underreported condition, with reporting influenced by factors such as stigma, fear of disclosure, provider screening practices, and variation in documentation across care settings. The rate of underreporting of DV/IPV cannot be ascertained, and variations in reporting by

gender, demographics, or coverage type may influence the accuracy of the estimates. Studies on DV/IPV reviewed for this report considered utilization stratified by gender as a binary variable (i.e., men and women); accordingly, BerryDunn adjusted for gender as a binary variable in this analysis.

While the true prevalence of IPV is challenging to quantify accurately across payer types, some prior research indicates that the incidence of IPV may be higher among individuals covered by Medicaid compared to those with private insurance. Surveillance and screening practices may also differ by population, with Medicaid members more likely to interact with systems that conduct regular screening, potentially resulting in higher detection rates rather than true differences in underlying incidence. Noting the limitations of these studies, BerryDunn developed an assumption that Medicaid enrollees are approximately 4.5 times more likely to be DV/IPV victims, based on an average utilization from various studies.[93,94,95] This assumption draws from studies conducted in different settings (e.g., varying states, study periods, and populations). Study limitations, as well as underreporting may affect these studies to varying degrees, so the estimates could deviate from actual figures.

The use of scarring as a proxy for the population that would seek aesthetic services introduces additional uncertainty. People may seek aesthetic services for reasons other than scarring, and not all individuals with scarring will choose to pursue these services. Furthermore, the assumed proportion of individuals with scarring who would seek aesthetic services is difficult to determine precisely due to the lack of literature. It is also difficult to estimate how many scars for which an individual would want to seek treatment. BerryDunn developed a wider-than-typical range of uptake rates for aesthetic services based on a 2025 study of DV victims with residual marks and their attitudes toward plastic surgery. However, attitudes toward surgery do not always correlate with actual utilization of such services. Although the wide range is expected to capture some of the uncertainties, factors such as how the mandate is implemented can drive variance in utilization that deviates from BerryDunn's assumptions.

Cost estimates are also limited by the available data and literature. Because aesthetic services are not currently covered for victims/survivors of DV/IPV, claims data in the MCDB may not reflect the range of services or costs that would be incurred under the mandate. Treatment options and associated costs of aesthetic services can vary widely, and the scenarios for utilization of surgical versus non-surgical aesthetic procedures may not be representative of the actual utilization mix.

The COVID-19 Public Health Emergency Medicaid continuous coverage and subsequent continuous coverage unwinding (MCCU) impacted enrollment and utilization from 2020 to 2024. Medicaid enrollees who had coverage extended (March 2020 to March 2023) and were disenrolled due to the MCCU (April 2023 to June 2024) likely had other insurance coverage that was primary, thus lowering their Medicaid claims. It is unclear how their utilization for aesthetic services will differ. In addition, for simplicity, members eligible for a partial month were counted as eligible for the entire month, which may slightly overestimate the total member months.

Finally, insurance cost and retention levels are uncertain, and actual retention levels may differ from the simplified assumptions used in these insurance cost PMPM estimates. Deviations from these factors could materially affect the projected PMPM cost impacts.

These limitations suggest that while the modeling results provide a useful estimate of the mandate's potential financial impact, actual costs could be higher or lower depending on future utilization patterns,

reporting practices, and coverage decisions. Rising mandate-related costs may constrain some employers, particularly small firms, from offering comprehensive benefits or may lead to increased employee cost sharing. Over the past five years, the average annual premium for family coverage has increased by 24%, reflecting continued upward pressure on employer-sponsored health plan costs.[103] However, mandates can improve access to high-value medical services, which may enhance employee health, treatment outcomes, and productivity, potentially offsetting employer cost pressures over time.

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5.0 Appendix A

Carrier Survey

Maryland Health Care Commission

House Bill (H.B.) 0381 and Senate Bill (S.B.) 508
An Act concerning Maryland Medical Assistance Program and Health Insurance – Required Coverage for Aesthetic Services and Restorative Care for Victims of Domestic Violence (Healing Our Scars Act)
Questions to Insurance Carriers
July 21st, 2025

House bill (H.B.) 0381 and Senate bill (S.B.) 508 are both titled "An Act concerning Maryland Medical Assistance Program and Health Insurance – Required Coverage for Aesthetic Services and Restorative Care for Victims of Domestic Violence (Healing Our Scars Act)" and require the Maryland Medical Assistance Program and other insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations to provide coverage to victims of domestic violence for certain aesthetic services and restorative care. These bills contain identical language and will be collectively referred to as "the bill." As set forth in the bill, the following terms mean:

(1) "Victim of domestic violence," refers to "an individual who has received deliberate, severe, and demonstrable physical injury, or is in fear of imminent deliberate, severe, and demonstrable physical injury from a current or former spouse, or a current or former cohabitant."[2,3]
(2) "Cohabitant" refers to "a person who has had a sexual relationship with the respondent and resided with the respondent in the home for a period of at least 90 days within 1 year before filing of the petition."[2,3]

The Maryland Health Care Commission (MHCC) has engaged BerryDunn to assist with performing a medical and social evaluation of the mandated services and estimating the bill's impact on cost. Our questions relate to existing coverage and the potential responses by your organization if the legislation were to pass. Neither MHCC nor BerryDunn take any position on whether this bill should reach enactment.

We recognize and appreciate the effort you make to complete this survey. Please respond to Dina Nash at BerryDunn (dina.nash@berrydunn.com) by Friday August 22nd, 2025, and please address questions about the survey to Dina, as well. Thank you for your assistance.

Questions:

1) Please tell us to what extent this type of care is already offered or covered by:
    a. Individual market
    b. Small group market
    c. Fully insured group market
    d. Self-insured group market
    e. State employee health plan [State Health Plan]
    f. Medicaid

2) Please complete the following table with how many people are enrolled in the following lines of business as of June 30th, 2025.

Individual Market	Small Group Market	Fully Insured Group Market	Self-insured Group Market	State Employee Health Plan [State Health Plan]	Medicaid

3) Please complete the following table with average monthly premium in the following lines of business as of June 30th, 2025.

Individual Market	Small Group Market	Fully Insured Group Market	Self-insured Group Market	State Employee Health Plan [State Health Plan]	Medicaid

4) Please describe any medical necessity criteria applied to services under the proposed legislation.

5) Please describe any coverage limitations, prior authorization requirements, or utilization management protocols associated with the services included in this proposed legislation. If any limitations vary by age or gender, please include that information as well.

6) Is an increase in utilization observed or expected due to the presence of the proposed legislation? If yes: Please quantify and explain the observed or anticipated impact.

7) As you understand current or soon-to-be-effective federal and Maryland laws and regulations, please describe other requirements related to the subject matter of this proposed legislation, and how you interpret them.

8) Do you anticipate a significant change in utilization of any services as a result of this proposed legislation, if it were to be enacted?

9) Does your organization currently track or identify claims associated with domestic violence, either through diagnosis codes, procedure codes, or internal flags? If so, please describe how these claims are identified and whether that methodology would be used specifically to collect that information in the implementation of the proposed legislation.

10) Please describe the nature and volume of denied claims for members who are victims of domestic violence seeking reconstructive services for 2022, 2023, and 2024 separated by year and by therapy, including related grievances. If possible, please provide the associated diagnosis codes for the denials. If the reason for denials was included, please provide this information.

11) Given your anticipated level of demand, is there an adequate availability of providers who perform aesthetic or reconstructive services? If not, what do you anticipate the impact of provider availability will be on implementation or access under the proposed legislation?

12) What operational, administrative, or data system changes would be necessary for your organization to comply with this proposed legislation if enacted? Please estimate the anticipated implementation timeframe and cost if possible.

13) Please indicate how your cost sharing would change under the proposed legislation.

14) Please provide us with any general comments on the bill.

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