MARYLAND HEALTH CARE COMMISSION

Required Under Section 15-1502 of the Insurance Article

Study of Mandated Health Insurance Services: A Comparative Evaluation

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MARYLAND HEALTH CARE COMMISSION

Mandated Services and the Affordable Care Act

The Affordable Care Act (ACA) requires each state to pay, for every policy purchased through the health benefits exchange, the additional premium associated with any state-mandated benefit that is not included in the essential health benefits (EHB) package. The ACA specifies broad categories of covered services that must be included in the essential health benefits but gives the Secretary of Health and Human Services (HHS) broad discretion to define the package through rulemaking.

To assist with the process, HHS asked the Institute of Medicine (IOM) to recommend a process for establishing the initial EHB package that will be available beginning in 2014, as well as a process for updating the package to account for gaps in access to coverage, advances in science, and the impact of any benefit changes on cost. The IOM issued its report in October 2011, with the following recommendations for adopting the initial EHB package[1]:

1. ***Identify the typical small group health plan***. The IOM recommends that the starting point for the initial EHB package be a benefit design (including cost sharing and benefit limitations) that is typically available in the small group market. The IOM indicated that state-mandated benefits should be subject to the same evidence-based review and cost analysis as other benefits considered for the EHB package.
2. ***Modify the typical small employer package to reflect ACA's requirements***. In addition, the report recommends a set of criteria[2] for HHS to use to define the EHB package.
3. ***Adjust the preliminary EHB package so that it does not exceed a target cost.*** The report recommends that the initial EHB package be adjusted so that the expected national average premium for a silver-level plan is actuarially equivalent to the average premium that would have been paid by small employers in 2014 for a typical benefit design, with the goal to achieve access to affordable coverage and to help HHS choose between competing benefit options to include in the EHB package. The report suggests that HHS address this trade-off through a public deliberation process.
4. ***Propose the EHB package in regulations***. The report urges HHS to be as specific as possible with regard to benefits that are included in and excluded from the EHB package and to provide more detail than is provided by the ten required categories.
5. ***Allows states that are administering their own Exchanges to define their own EHB package***, as long as the package is actuarially equivalent to the national package and is developed utilizing a public deliberation process.

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[1] Covington & Burling LLP. "ACA Advisory #85: IOM Releases Recommendations on Essential Health Benefits Package." October 19, 2011. http://www.cov.com/files/Uploads/Documents/Advisory%20on%20IOM%20Report%20(10-19-2011).pdf

[2] http://www.iom.edu/~/media/Files/Report%20Files/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost/EHB_insert.pdf

With regard to the process for updating the EHB package, the IOM report included the following recommendations:

1. Develop a framework by January 1, 2013 for obtaining and analyzing data necessary for updating the EHB package. This information to be gathered includes changes related to providers, patients, consumers, and health plans.
2. Follow a 3-step process for updating the EHB package: set goals for updating the EHB package; propose a method for using costs to frame modifications to the EHB package; and develop a strategy to address increases in health care spending.
3. Establish an advisory group to assist in updating the EHB package. This National Benefits Advisory Council should be established to advise HHS on a research plan and data requirements for updating the EHB package; make annual recommendations regarding any changes to the EHB package; and advise HHS on utilizing the public deliberation process when updating the EHB package.

The IOM report recommends that HHS establish the initial EHB package by May 1, 2012.

On December 16th, HHS released guidance on its approach to defining essential health benefits. HHS proposes to allow states considerable flexibility in 2014 and 2015. States can choose one of the following four benchmark plan types as the reference plan:

- One of the three largest small group plans in the state by enrollment
- One of the three largest state employee health benefit plans by enrollment
- One of the three largest federal employee health benefit plan options by enrollment
- The largest insured commercial non-Medicaid HMO operating in the state.

States that decide not to select a benchmark health plan must use the HHS default benchmark plan, which will be the small group plan with the largest enrollment in the state.

Maryland mandates that apply to the benchmark plan will apply under essential health benefits in 2014 and 2015. During a conference call among states and HHS on December 22nd, HHS clarified that only those mandates currently in law will be included in the essential health benefits. Any new mandate enacted during the 2012 legislative session, regardless of its effective date, would not be part of the essential health benefits. However, since HHS is accepting comments from states on this particular clarification, as well as other provisions in the December 16th guidance, HHS may make additional changes that could affect what is offered in 2014 and 2015.

Maryland has a substantial number of mandated services. This latest Comparative Evaluation report on all mandated services estimates the full cost of current mandated services as a percentage of premium as follows:

- The State employee health plan: 17.9%
- A typical group plan: 18.8%
- An individual plan: 19.6%
- The CSHBP offered in the small group market: 22%[3]

Mercer's report also provides comparative data on Maryland's mandates to those in our neighboring states; however, we currently do not have information to compare Maryland to the rest of the nation.

The Administration and the General Assembly will need to determine which of the four benchmark plans provided in the December 16th guidance best serves the needs of Maryland in 2014 and 2015 and reevaluate any current mandated health services that are inconsistent with the option of choice. Since 1998, the Maryland Health Care Commission has been responsible for evaluating and reporting the medical, social, and financial impact of mandates that are proposed but are not passed in the prior session, or where a review of a potential mandate is requested by a Legislator. The Commission's success in delivering comprehensive mandate evaluations is a testament to the diverse knowledge and skills of staff and its appointed Commissioners, as well as that of its consulting actuaries, Mercer/Oliver Wyman. All remain ready to support the essential health benefits/mandate evaluation process.

[3] The 22% estimate reflects the full cost of current mandates as a percentage of premium for the CSHBP without riders. This estimate will differ from percentages shown in other reports that reflect coverages under the CSHBP with riders.

Study of Mandated Health Insurance Services: A Comparative Evaluation

Report Prepared by Mercer

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Introduction

The Maryland Health Care Commission (MHCC) engaged Mercer and its sibling company Oliver Wyman Actuarial Consulting, Inc. (collectively referenced as "Mercer" in this report) to re-valuate the costs of existing mandated services in Maryland and its surrounding states. Mercer completed a similar report for MHCC, published in January 2008. Maryland statute (Insurance Article § 15-1502, Annotated Code of Maryland) requires this analysis every four years.

This report contains four sections. The first section evaluates the full cost of each existing mandated health insurance service as a percentage of the State's average annual wage and of premiums for the individual, group, Comprehensive Standard Health Benefit Plan (CSHBP) for small employers, and State employee health insurance markets. The second section assesses the degree to which existing mandated health insurance services are covered in self-funded plans (voluntary compliance). The third section applies the voluntary compliance from the second section to estimate the mandates' marginal cost as a percentage of group premium. The last section compares the mandated health insurance services required in Maryland with those required in Delaware, the District of Columbia, Pennsylvania, and Virginia.

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

- List of benefit mandates with current descriptions (provided by MHCC)
- Health plan surveys (conducted by Mercer) regarding current practices of self-funded clients
- Surveys of Mercer's top eight self-funded clients in Maryland regarding their voluntary coverage of mandates
- Mercer proprietary databases, which include financial information on indemnity and managed care plans (regularly updated databases include data purchased from other sources, emerging experience for multiple health plans, and several comprehensive surveys)
- Statistics on premiums and members for individual, CSHBP, and large group markets (provided by MHCC)
- Statistics on premiums for the State employee health insurance plan (made publicly available by Maryland's Department of Budget and Management)
- Public sources, including Internet searches
- Mandate-specific research by Mercer's consultants

John Welch of Mercer, and Karen Bender FCA, ASA, MAAA and Randall Fitzpatrick, ASA, MAAA of Oliver Wyman were the individuals who conducted the surveys and provided the analyses for the contents of this paper.

While surveys are an important tool in evaluating the prevalence and costs of mandates, they introduce a source of variation. For example, while we surveyed the same health plans in the current study that we queried for the 2008 report, their client base of self-funded employers may have changed substantially over the past four years, resulting in differences attributable to a change in the mix of benefit plans, as opposed to employers' increasing or decreasing their own benefit plans. The same is true for the survey of Mercer's top eight self-funded clients in Maryland. The clients in the most recent survey are not identical to those utilized in the previous

study. Therefore, at least some of the changes between this study and the previous report must be considered in this light.

Mercer relied on the survey participants to provide accurate information. While we reviewed the information for reasonableness and consistency and followed up with the participants to verify results, we did not perform independent audits to verify its accuracy. Significant errors or omissions in the information could affect our conclusions. We should note that there were variations in the results from the previous report.

Mercer independently generated the full costs of each mandate. These costs are based on our best estimate for a large, stable population. The actual cost experienced by any specific plan and/or insurer may vary significantly from our estimate for many reasons, such as differences in physician reimbursement levels, differences in mixes of risks and underlying demographics of members, differences in how care is delivered and the degree to which care is managed (such as a closed network HMO compared with a broad network PPO), the degree of individual choice among benefit plans, and random fluctuations. The results should be considered within this context.

Passage of the Patient Protection and Affordable Care Act (PPACA) has had – and will continue to have – a significant impact on the prevalence of mandated benefits. This is the first four-year mandate report completed since the passage of PPACA. We have followed the format we used in previous studies and have identified costs for state-specific mandates as written. While we continue to show the comparison of costs for Maryland mandated benefits to mandated benefits in other states, some of these differences should no longer be pertinent, as PPACA has already required inclusion of many preventive benefits[1] and will require the implementation of women's preventive health benefits in August 2012. This includes the following eight categories of women's preventive services:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- Sexually transmitted infection counseling
- HIV screening and counseling
- FDA-approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies and counseling, and
- Domestic violence screening and counseling.

[1] Effective September 23, 2010 PPACA required the following benefit changes for non-grandfathered policies: elimination of lifetime dollar maximum; phase-in of elimination of annual dollar maximum; coverage of certain preventive procedures with no cost sharing; designated rules for access to primary care physician; emergency services and cost sharing limitations; internal and external claims appeals procedures and notices; dependent coverage to age 26; no pre-existing condition limitations for children under age 19; minimum loss ratio requirements.

Introduction

With the passage of the Mental Health Parity Act, we would have anticipated the marginal costs associated with mental health and substance abuse mandates to decrease. However, the marginal cost for mental illness and substance abuse as covered under Section 15–802 continues to be one of the most expensive mandates.

In 2014, Health and Human Services (HHS) will adopt an Essential Health Benefit plan (EHB). There is a financial impact on the state of Maryland if a particular mandate is not included in the EHB, and Maryland elects to retain the benefit and require carriers to offer. Federal premium subsidies and tax credits will be based only on the EHB, and will not include any credits or subsidies for additional benefits. PPACA requires that the states fund any additional costs associated with benefits that exceed the EHB.

Full Cost of Current Mandates

According to Section 15–1502 of the Maryland Insurance Article, the full cost of each existing mandated health insurance service must be assessed as a percentage of the State's average annual wage and as a percentage of premiums for the individual, group, CSHBP, and State employee health insurance markets. This requirement applies to the 45 mandates defined in Sections 15–801 through 15–844 of the Insurance Article. It should be noted that the CSHBP is exempt from mandates unless the Commission adopts the mandate for the CSHBP[2].

The following table summarizes the full cost of the current mandates as a percentage of premiums for each of the specified markets.

[2] IVF, hair prostheses, smoking cessation, and amino acid elemental formula are not covered under the CSHBP.

Full Cost of Current Mandates

Mandate	Section	Full Cost			
		Percentage of Premium			
		Group	CSHBP	Individual	State Employee
Alzheimer's	15-801	0.0%	0.0%	0.0%	0.0%
Mental illness; drug & alcohol abuse	15-802	4.7%	5.9%	4.9%	4.5%
Blood products	15-803	0.3%	0.4%	0.3%	0.3%
Off-label use of drugs	15-804	0.0%	0.0%	0.0%	0.0%
Pharmaceutical products	15-805	0.0%	0.0%	0.0%	0.0%
Choice of pharmacy	15-806*	0.0%	0.0%	0.0%	0.0%
Medical foods & modified food products	15-807	0.0%	0.0%	0.0%	0.0%
Home health care	15-808	0.1%	0.1%	0.1%	0.1%
Hospice care	15-809	0.0%	0.0%	0.0%	0.0%
In vitro fertilization	15-810	1.4%	0.0%	1.5%	1.3%
Hospitalization benefits for childbirth	15-811	4.0%	5.1%	4.2%	3.8%
Length of stay for mothers of newborn	15-812	0.5%	0.7%	0.6%	0.5%
Disability due to pregnancy or childbirth	15-813	0.0%	0.0%	0.0%	0.0%
Mammograms	15-814	0.6%	0.8%	0.7%	0.6%
Reconstructive breast surgery	15-815	0.2%	0.2%	0.2%	0.2%
Routine gynecological care	15-816	0.6%	0.8%	0.7%	0.6%
Child wellness	15-817	1.7%	2.1%	1.7%	1.6%
Treatment of cleft lip & cleft palate	15-818	0.0%	0.0%	0.0%	0.0%
OP services & second opinions	15-819	0.0%	0.0%	0.0%	0.0%
Orthopedic braces	15-820**	0.0%	0.4%	0.0%	0.0%
Diagnostic & surgical procedures for bones of face, head, & neck	15-821	0.1%	0.2%	0.1%	0.1%
Diabetes equipment, supplies, & self-management training	15-822	1.0%	1.3%	1.1%	1.0%
Osteoporosis treatment	15-823	0.1%	0.2%	0.2%	0.1%
Maintenance drugs	15-824	0.0%	0.0%	0.0%	0.0%
Detection of prostate cancer	15-825	0.7%	0.9%	0.7%	0.7%
Contraceptives	15-826	0.6%	0.8%	0.7%	0.6%
Clinical trials under specific conditions	15-827	0.1%	0.1%	0.1%	0.1%
General anesthesia for dental care under specified conditions	15-828	0.1%	0.1%	0.1%	0.1%
Chlamydia screening	15-829	0.0%	0.1%	0.0%	0.0%
Referrals to specialists	15-830	0.0%	0.0%	0.0%	0.0%
Prescription drugs & devices	15-831	0.0%	0.0%	0.0%	0.0%
Removal of testicle	15-832	0.0%	0.0%	0.0%	0.0%
Length of stay for mastectomies	15-832-1	0.0%	0.0%	0.0%	0.0%
Extension of benefits	15-833	0.3%	0.3%	0.3%	0.3%
Prosthesis following mastectomy	15-834	0.0%	0.0%	0.0%	0.0%
Habilitative services for children	15-835	0.1%	0.1%	0.1%	0.1%
Wigs for hair loss due to chemotherapy	15-836	0.0%	0.0%	0.0%	0.0%
Colorectal cancer screening	15-837	0.6%	0.8%	0.7%	0.6%
Hearing aids for a minor child	15-838	0.0%	0.0%	0.0%	0.0%
Treatment of morbid obesity	15-839	0.3%	0.4%	0.4%	0.3%
Residential crisis services	15-840	0.0%	0.0%	0.0%	0.0%
Smoking cessation	15-841	0.1%	0.0%	0.1%	0.1%
Prescription drug cost-share limit	15-842	0.0%	0.0%	0.0%	0.0%
Coverage for amino-acid based elemental formula	15-843	0.1%	0.0%	0.1%	0.1%
Benefits for prosthetic devices	15-844	0.1%	0.1%	0.1%	0.1%
Total		**18.8%**	**22.0%**	**19.6%**	**17.9%**

* *Value excluded because mandate applies only to non-profit plans*

** *Applies only to CSHBP & non-profit plans*

The table on the previous page shows that the mandates' full cost represents 18.8% of a typical group premium and 17.9% of the State employee plan premium. The mandates' full cost

represents 22.0% of premium for the CSHBP and 19.6% of premium for the individual market. The cost differences for the individual and CSHBP group market compared with the typical group market reflect the richness in the underlying benefit plans and, in the case of the individual market, the allowance of medical underwriting. The cost-sharing requirements for the CSHBP and individual market are significantly greater than the cost-sharing requirements for the large group markets. Thus, the full cost of the mandates as a percentage of premiums is higher for the CSHBP and individual market than it is for the other two markets.

Within the table on the previous page we have highlighted those mandates that have already been required or are scheduled to be covered as a result of PPACA with one exception: we believe that maternity benefits will be part of any ultimate EHB, even though they have not yet been scheduled to be covered. .

In the 2008 study, the full cost of the mandates represented 15.4% of a typical group premium and 15.8% of the State employee plan premium. The full costs of the mandates were 17.5% of premium for the CSHBP and 18.6% of premium for the individual market. The increase in cost from our previous study is due mostly to the increase in cost for preventative services.

On a full cost basis, the mandates with the largest increases in cost are:

- Hospitalization benefits for childbirth and length of stay for mothers of newborn (§15–811 and §15–812): 0.5% to 1.1%
- Mammograms (§15–814): 0.3% to 0.4%
- Routine gynecological care (§15–816): 0.6% to 0.8%
- Child wellness (§15–817): 0.2% to 0.4%
- Diabetes equipment, supplies, & self-management training (§15–822): 0.5% to 0.6%
- Detection of prostate cancer (§15–825): 0.4% to 0.5%
- Colorectal cancer screening (§15–837): 0.4% to 0.5%

Since the previous report, Maryland has passed three new mandates: length of stay coverage associated with removal of testicle (§15-832); coverage for amino-acid based elemental formula (§15-843); and benefits for prosthetic devices (§15-844). These new mandates collectively have a nominal impact on premium across all markets.

On a full cost basis, the most expensive mandates are:

- Mental illness and substance abuse as covered under Section 15–802, with a cost ranging from 4.5% of premium to 5.9% of premium, depending on the market
- Hospitalization benefits for childbirth and length of stay for mothers of newborn under Sections 15–811 and 15–812, with a full cost ranging from 4.3% of premium to 5.8% of premium, depending on the market[3]

[3] Please note that the cumulative costs for these two mandates may differ from the sum of the costs for each mandate shown on the previous chart due to rounding.

Full Cost of Current Mandates

For purposes of this report, habilitative services for children (§15-835) are defined as physical therapy, occupational therapy, and speech therapy for children with congenital or genetic birth defects, including cerebral palsy, autism, Down syndrome, mental retardation, hydroencephalocele, spina bifida, and some other conditions.

When expressing the mandates' cost as a percentage of the average annual wage, we did not segregate the wage by type of contract; therefore, we used the same wage base for all types of contracts. The average annual wage in 2010 was $51,740, according to statistics from the Maryland Department of Labor, Licensing and Regulation (DLLR).

The full cost of the current mandates as a percentage of average annual wages is summarized in the following table.

Full Cost of Current Mandates

Mandate	Section	Full Cost			
		Percentage of wage			
		Group	CSHBP	Individual	State
Alzheimer's	15-801	0.0%	0.0%	0.0%	0.0%
Mental illness; drug & alcohol abuse	15-802	0.5%	0.3%	0.2%	0.6%
Blood products	15-803	0.1%	0.0%	0.0%	0.1%
Off-label use of drugs	15-804	0.0%	0.0%	0.0%	0.0%
Pharmaceutical products	15-805	0.0%	0.0%	0.0%	0.0%
Choice of pharmacy	15-806*	0.0%	0.0%	0.0%	0.0%
Medical foods & modified food products	15-807	0.0%	0.0%	0.0%	0.0%
Home health care	15-808	0.0%	0.0%	0.0%	0.0%
Hospice care	15-809	0.0%	0.0%	0.0%	0.0%
In vitro fertilization	15-810	0.2%	0.0%	0.1%	0.3%
Hospitalization benefits for childbirth	15-811	0.7%	0.5%	0.3%	0.9%
Length of stay for mothers of newborn	15-812	0.0%	0.0%	0.0%	0.0%
Disability due to pregnancy or childbirth	15-813	0.0%	0.0%	0.0%	0.0%
Mammograms	15-814	0.1%	0.1%	0.1%	0.1%
Reconstructive breast surgery	15-815	0.0%	0.0%	0.0%	0.0%
Routine gynecological care	15-816	0.1%	0.1%	0.0%	0.1%
Child wellness	15-817	0.3%	0.2%	0.1%	0.4%
Treatment of cleft lip & cleft palate	15-818	0.0%	0.0%	0.0%	0.0%
OP services & second opinions	15-819	0.0%	0.0%	0.0%	0.0%
Orthopedic braces	15-820**	0.0%	0.0%	0.0%	0.0%
Diagnostic & surgical procedures for bones of face, head, & neck	15-821	0.0%	0.0%	0.0%	0.0%
Diabetes equipment, supplies, & self-management training	15-822	0.2%	0.1%	0.1%	0.2%
Osteoporosis treatment	15-823	0.0%	0.0%	0.0%	0.0%
Maintenance drugs	15-824	0.0%	0.0%	0.0%	0.0%
Detection of prostate cancer	15-825	0.1%	0.1%	0.1%	0.2%
Contraceptives	15-826	0.0%	0.0%	0.0%	0.0%
Clinical trials under specific conditions	15-827	0.0%	0.0%	0.0%	0.0%
General anesthesia for dental care under specified conditions	15-828	0.0%	0.0%	0.0%	0.0%
Chlamydia screening	15-829	0.0%	0.0%	0.0%	0.0%
Referrals to specialists	15-830	0.0%	0.0%	0.0%	0.0%
Prescription drugs & devices	15-831	0.0%	0.0%	0.0%	0.0%
Removal of testicle	15-832	0.0%	0.0%	0.0%	0.0%
Length of stay for mastectomies	15-832-1	0.0%	0.0%	0.0%	0.0%
Extension of benefits	15-833	0.0%	0.0%	0.0%	0.1%
Prosthesis following mastectomy	15-834	0.0%	0.0%	0.0%	0.0%
Habilitative services for children	15-835	0.0%	0.0%	0.0%	0.0%
Wigs for hair loss due to chemotherapy	15-836	0.0%	0.0%	0.0%	0.0%
Colorectal cancer screening	15-837	0.1%	0.1%	0.1%	0.2%
Hearing aids for a minor child	15-838	0.0%	0.0%	0.0%	0.0%
Treatment of morbid obesity	15-839	0.1%	0.0%	0.0%	0.1%
Residential crisis services	15-840	0.0%	0.0%	0.0%	0.0%
Smoking cessation	15-841	0.0%	0.0%	0.0%	0.0%
Prescription drug cost-share limit	15-842	0.0%	0.0%	0.0%	0.0%
Coverage for amino-acid based elemental formula	15-843	0.0%	0.0%	0.0%	0.0%
Benefits for prosthetic devices	15-844	0.0%	0.0%	0.0%	0.0%
Total		**2.6%**	**1.8%**	**1.3%**	**3.5%**

** Value excluded because mandate applies only to non-profit plans*

*** Applies only to CSHBP & non-profit plans*

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The full cost of the mandates as a percentage of wages is 2.6% for group, 3.5% for the State employee plan, 1.8% for the CSHBP, and 1.3% for individual markets. In the 2008 report, the

full cost of the mandates as a percentage of wages was 2.3% for group, 2.5% for the State employee plan, 1.5% for the CSHBP, and 1.2% for individual markets. The change is partly due to a change in the assumption of the number of members per contract among lines of business. When the 2008 report was completed, the information available was at an aggregate level. As such, it was assumed that all lines of business had the same number of members per contract. As a result of additional reporting requirements due to federal reforms, more detailed information is now available for each market segment. Therefore, in this updated report, we were able to use actual members per contract for each market segment. In addition, the differences in costs for the individual market and the CSHBP group market compared with the typical group market reflect the richness in the underlying benefit plans and, in the case of the individual market, the allowance of medical underwriting.

Voluntary Compliance in the Self-Funded Market

Another requirement under Section 15–1502 of the Maryland Insurance Article is to assess the degree to which existing mandated services are covered by self-funded plans. Through ERISA, employers who self-fund their health benefit plan are exempt from state-specific mandate requirements. This section examines whether there are mandates that self-funded plans typically exclude. To address this question, Mercer developed a survey to compare the benefits of an insured plan with self-funded benefits offered by large employers. The survey addressed self-funded plans' voluntary compliance with the Maryland mandates.

To get a reliable sample, we surveyed the primary carriers that administer the health benefits for self-funded plans in Maryland. These included Aetna, CareFirst, Cigna, Coventry, Kaiser, and United HealthCare. The survey defined Maryland's health insurance mandates and asked the health plan administrators to report the rate of voluntary compliance and the typical level of benefits. While the administrators were not legally required to respond to the survey, they replied to almost all of the questions. We followed up on any missing or incomplete responses.

We also surveyed the benefit plans of eight of Mercer's largest Maryland-based clients with self-funded plans. These eight employers cover roughly 174,000 people, or approximately 9% of the self-insured market in Maryland. We found some significant differences between the voluntary compliance responses provided by the carriers and the benefit plans of Mercer's eight largest Maryland based clients with self-funded plans, which indicates that there is variability in the coverage provided within the self-funded market. The mandate for which we observed the most variability was mental health and substance abuse benefits (Section 15–802). Carriers replied that only 80% of the self-funded members had coverage comparable to the current mandate. All of Mercer's self-funded plan clients offer mental health and substance abuse benefits at least as rich as the Maryland mandate. This shows there is variation in the level of coverage for these benefits.

The response for coverage for in vitro fertilization (IVF) (§15-810) was also materially different between the Mercer self-funded clients and the carrier self-funded plans. Just under half (44%) of Mercer's self-funded clients offer IVF coverage comparable to the current Maryland mandate; however, the surveyed carriers stated that voluntary compliance is 9%.

Our third source of benefit information was Mercer's 2010 National Survey of Employer-Sponsored Health Plans. This survey contains data from 1,767 employers on the scope of coverage but does not focus on Maryland's health insurance mandates. This survey did allow for a secondary reasonability check of the administrators' answers on some health benefits.

We used the following rankings of voluntary compliance by mandate:

- *All comply (100%)* – All surveyed employers with self-funded plans provide benefits that comply fully with the mandate requirement
- *Almost all comply (At least 90%)* – A small percentage of surveyed employers with self-funded plans do not comply fully with the mandate requirement

Voluntary Compliance in the Self-Funded Market

- *Most comply (61% to 89%)* – Significantly more than half – but not all – of the surveyed employers with self-funded plans provide benefits that comply fully with the mandate requirement
- *Half comply (40% to 60%)* – About 50% of surveyed employers with self-funded plans provide benefits that comply fully with the mandate requirement
- *Some comply (Less than 40%)* – Significantly less than half of surveyed employers with self-funded plans provide benefits that comply fully with the mandate requirement
- *No compliance (0%)* – No employers with self-funded plans provide benefits that comply fully with the mandate requirement

The following chart shows the compliance rate by mandate:

Subsection	Mandate Description	Compliance Rate
15-801	Benefits for Alzheimer's disease and care of elderly individuals	Most
15-802	Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse	Most
15-803	Payments for blood products	Almost All
15-804	Coverage for off-label use of drugs	Most
15-805	Reimbursement for pharmaceutical products	Half
15-806	Choice of pharmacy for filling prescriptions	Most
15-807	Coverage for medical foods and modified food products	Most
15-808	Benefits for home health care	Almost All
15-809	Benefits for hospice care	Almost All
15-810	Benefits for in vitro fertilization (IVF)	Some
15-811	Hospitalization benefits for childbirth	Almost All
15-812	Inpatient hospitalization coverage for mothers and newborn children	Almost All
15-813	Benefits for disability caused by pregnancy or childbirth	Most
15-814	Coverage for mammograms	Almost All
15-815	Coverage for reconstructive breast surgery	Almost All
15-816	Benefits for routine gynecological care	Almost All
15-817	Coverage for child wellness services	Almost All
15-818	Benefits for treatment of cleft lip and cleft palate	Most
15-819	Coverage for outpatient services and second opinions	Almost All
15-820	Benefits for prosthetic devices and orthopedic braces	Almost All
15-821	Diagnostic and surgical procedures for bones of face, neck, and head	Almost All
15-822	Coverage for diabetes equipment, supplies, and self-management training	Most
15-823	Coverage for osteoporosis prevention and treatment	Almost All
15-824	Coverage for maintenance drugs	Most
15-825	Coverage for detection of prostate cancer	Most
15-826	Coverage for contraceptive drugs and devices	Most
15-827	Coverage for patient cost for clinical trials	Almost All
15-828	Coverage for general anesthesia for dental care under specified conditions	Almost All
15-829	Coverage for detection of chlamydia	Most

Voluntary Compliance in the Self-Funded Market

Subsection	Mandate Description	Compliance Rate
15-830	Referrals to specialists	Almost All
15-831	Coverage for prescription drugs and devices	Most
15-832	Coverage for removal of testicle	Most
15-832.1	Coverage for mastectomies	Almost All
15-833	Extension of benefits	Most
15-834	Coverage for prosthesis following mastectomy	Almost All
15-835	Coverage for habilitative services for children under 19 years of age	Half
15-836	Hair prosthesis	Half
15-837	Colorectal cancer screening coverage	Most
15-838	Hearing aid coverage for a minor child	Half
15-839	Coverage for treatment of morbid obesity	Most
15-840	Coverage for medically necessary residential crisis services	Most
15-841	Coverage for nicotine replacement therapy	Some
15-842	Prescription drug cost-share limit	Most
15-843	Coverage for amino-acid based elemental formula	Some
15-844	Benefits for prosthetic devices	Most

The voluntary compliance rate shows the difference between the responsibility of mandates put on employers with insured plans and the responsibility of mandates taken on voluntarily by self-funded plans. Overall, self-funded plans voluntarily cover 81% of the cost of mandated services, down from 86% in the previous survey. Part of this decrease may be due to a change in the mix of self-funded clients reflected in the health plan responses.

Marginal Cost of Current Mandates

The cost of mandated health insurance services could be defined either as the full cost of the service or as the marginal or additional cost of the mandate. The marginal cost equals the full cost of the service minus the value of the services that would be covered without the mandate. For example, the full cost for requiring coverage of hospitalization for maternity equals the assumed number of maternity cases times the hospital cost per case. The vast majority of contracts would include coverage of maternity cases that satisfy the mandate requirements even without the mandate; therefore, the marginal cost equals the assumed number of cases that would not be covered without the mandate times the hospital cost per case. This section shows estimates for the marginal cost of each existing mandate in Maryland.

In the previous section, we looked at the voluntary compliance rate for self-funded plans. We assume that, in the absence of mandates, (1) insurance contract holders would request coverage at the level provided by self-funded plans and (2) carriers would be willing to offer that level of coverage. In a competitive work environment, coverage in self-funded plans becomes the de facto coverage in other markets (with or without mandates): fully insured employers must provide similar benefits, as they compete for the same workers. Under this assumption, the marginal cost of the mandate equals the portion of mandated coverage not covered by self-funded plans.

The following table shows the marginal cost of each of the 45 existing mandated services as a percentage of premiums.

Marginal Cost of Current Mandates

Mandate	Section	Expected Portion of Cost Covered Without a Mandate	Marginal Cost			
			Percentage of Premium			
			Group	CSHBP	Individual	State
Alzheimer's	15-801	81%	0.0%	0.0%	0.0%	0.0%
Mental illness; drug & alcohol abuse	15-802	78%	1.0%	1.3%	1.1%	1.0%
Blood products	15-803	97%	0.0%	0.0%	0.0%	0.0%
Off-label use of drugs	15-804	63%	0.0%	0.0%	0.0%	0.0%
Pharmaceutical products	15-805	52%	0.0%	0.0%	0.0%	0.0%
Choice of pharmacy	15-806*	87%	0.0%	0.0%	0.0%	0.0%
Medical foods & modified food products	15-807	69%	0.0%	0.0%	0.0%	0.0%
Home health care	15-808	99%	0.0%	0.0%	0.0%	0.0%
Hospice care	15-809	99%	0.0%	0.0%	0.0%	0.0%
In vitro fertilization	15-810	9%	1.3%	0.0%	1.3%	1.2%
Hospitalization benefits for childbirth	15-811	99%	0.0%	0.1%	0.0%	0.0%
Length of stay for mothers of newborn	15-812	99%	0.0%	0.0%	0.0%	0.0%
Disability due to pregnancy or childbirth	15-813	61%	0.0%	0.0%	0.0%	0.0%
Mammograms	15-814	98%	0.0%	0.0%	0.0%	0.0%
Reconstructive breast surgery	15-815	98%	0.0%	0.0%	0.0%	0.0%
Routine gynecological care	15-816	99%	0.0%	0.0%	0.0%	0.0%
Child wellness	15-817	99%	0.0%	0.0%	0.0%	0.0%
Treatment of cleft lip & cleft palate	15-818	65%	0.0%	0.0%	0.0%	0.0%
OP services & second opinions	15-819	99%	0.0%	0.0%	0.0%	0.0%
Orthopedic braces	15-820**	95%	0.0%	0.0%	0.0%	0.0%
Diagnostic & surgical procedures for bones of face, head, &	15-821	94%	0.0%	0.0%	0.0%	0.0%
Diabetes equipment, supplies, & self-management training	15-822	87%	0.1%	0.2%	0.1%	0.1%
Osteoporosis treatment	15-823	96%	0.0%	0.0%	0.0%	0.0%
Maintenance drugs	15-824	77%	0.0%	0.0%	0.0%	0.0%
Detection of prostate cancer	15-825	78%	0.2%	0.2%	0.2%	0.2%
Contraceptives	15-826	83%	0.1%	0.1%	0.1%	0.1%
Clinical trials under specific conditions	15-827	92%	0.0%	0.0%	0.0%	0.0%
General anesthesia for dental care under specified conditions	15-828	94%	0.0%	0.0%	0.0%	0.0%
Chlamydia screening	15-829	71%	0.0%	0.0%	0.0%	0.0%
Referrals to specialists	15-830	98%	0.0%	0.0%	0.0%	0.0%
Prescription drugs & devices	15-831	72%	0.0%	0.0%	0.0%	0.0%
Removal of testicle	15-832	71%	0.0%	0.0%	0.0%	0.0%
Length of stay for mastectomies	15-832-1	97%	0.0%	0.0%	0.0%	0.0%
Extension of benefits	15-833	75%	0.1%	0.1%	0.1%	0.1%
Prosthesis following mastectomy	15-834	99%	0.0%	0.0%	0.0%	0.0%
Habilitative services for children	15-835	40%	0.0%	0.0%	0.0%	0.0%
Wigs for hair loss due to chemotherapy	15-836	56%	0.0%	0.0%	0.0%	0.0%
Colorectal cancer screening	15-837	63%	0.2%	0.3%	0.2%	0.2%
Hearing aids for a minor child	15-838	44%	0.0%	0.0%	0.0%	0.0%
Treatment of morbid obesity	15-839	61%	0.1%	0.2%	0.1%	0.1%
Residential crisis services	15-840	89%	0.0%	0.0%	0.0%	0.0%
Smoking cessation	15-841	30%	0.1%	0.0%	0.1%	0.1%
Prescription drug cost-share limit	15-842	64%	0.0%	0.0%	0.0%	0.0%
Coverage for amino-acid based elemental formula	15-843	19%	0.1%	0.0%	0.1%	0.1%
Benefits for prosthetic devices	15-844	71%	0.0%	0.0%	0.0%	0.0%
Total		**81%**	**3.5%**	**2.7%**	**3.6%**	**3.3%**

** Value excluded because mandate applies only to non-profit plans*

*** Applies only to CSHBP & non-profit plans*

On a marginal cost basis, the most expensive mandate is coverage for IVF, (§15–810), with a marginal cost equal to 1.2% to 1.3% of premium.

The next most expensive mandate on a marginal cost basis involves coverage for mental illness and substance abuse, (§15–802), with a marginal cost equal to 1.0% to 1.3% of premium. The

actual cost will vary by plan and will depend on how plans manage mental health benefits. Some plans carve out these services to a specialty vendor, who manages the benefits and may be able to realize lower marginal costs.

These two mandates were the most costly on a marginal basis in the 2008 report as well.

Comparison with Other States

Section 15–1502 of the Maryland Insurance Article requires a comparison of mandated services required by Maryland with those required in Delaware, the District of Columbia, Pennsylvania, and Virginia, including the:

- Number of mandated health insurance services
- Type of mandated health insurance services
- Level and extent of coverage for each mandated health insurance service
- Financial impact of different levels of coverage for each mandated health insurance service

This report focuses on benefit requirements included under Subtitle 8 of Title 15 of Maryland's Insurance Article. Mercer compared these mandates to mandates required in the following states using the corresponding sources:

State	Insurance Code
Maryland	Maryland Code Annotated
Delaware	Delaware Code
District of Columbia	District of Columbia Code
Pennsylvania	Pennsylvania Unconsolidated Statutes
Virginia	Virginia Code Annotated & Virginia Administrative Code

While two states may have mandates that address the same health services, they may have significantly different mandates. A short description of each state's mandate is included in Exhibit 1. For the 45 Maryland mandates covered in this report, the following table summarizes how many are mandated in some form by Delaware, the District of Columbia, Pennsylvania, and Virginia.

State	Number of Maryland Mandated Benefits Required in Neighboring States 2011	Number of Maryland Mandated Benefits Required in Neighboring States 2007
Delaware	20	16
District of Columbia	12	12
Maryland	45	42
Pennsylvania	16	15
Virginia	22	23

Comparison with Other States

This would indicate that, given the number of benefits mandated, Maryland has the highest burden; however, this does not take into account the relative cost of the mandates.

To understand the difference in the financial burden, we looked at the estimated financial impact if Maryland matched the mandates specific to each of the other four states. The following table shows the estimated full and marginal costs for each state.

Comparison with Other States

MD Mandate	Value Relative to MD Mandate				Premium Impact to Revise Mandate to Match Other State							
					Full Cost				Marginal Cost			
	DE	DC	PA	VA	DE	DC	PA	VA	DE	DC	PA	VA
15-801	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-802	110%	100%	80%	60%	0.5%	0.0%	-0.9%	-1.9%	0.1%	0.0%	-0.2%	-0.4%
15-803	0%	0%	0%	100%	-0.3%	-0.3%	-0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
15-804	0%	0%	0%	25%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-805	100%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-806	100%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-807	100%	0%	100%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-808	0%	0%	10%	0%	-0.1%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%
15-809	0%	0%	0%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-810	0%	0%	0%	0%	-1.4%	-1.4%	-1.4%	-1.4%	-1.3%	-1.3%	-1.3%	-1.3%
15-811	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-812	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-813	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-814	100%	110%	100%	100%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-815	95%	120%	95%	50%	0.0%	0.0%	0.0%	-0.1%	0.0%	0.0%	0.0%	0.0%
15-816	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-817	40%	0%	40%	60%	-1.0%	-1.7%	-1.0%	-0.7%	0.0%	0.0%	0.0%	0.0%
15-818	0%	0%	100%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-819	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-820	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-821	0%	0%	0%	100%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
15-822	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-823	0%	0%	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%
15-824	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-825	75%	100%	0%	90%	-0.2%	0.0%	-0.7%	-0.1%	0.0%	0.0%	-0.2%	0.0%
15-826	100%	0%	0%	100%	0.0%	-0.6%	-0.6%	0.0%	0.0%	-0.1%	-0.1%	0.0%
15-827	100%	0%	0%	70%	0.0%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
15-828	0%	0%	0%	85%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
15-829	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-830	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-831	0%	0%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-832	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-832-1	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-833	0%	0%	0%	0%	-0.3%	-0.3%	-0.3%	-0.3%	-0.1%	-0.1%	-0.1%	-0.1%
15-834	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-835	0%	50%	0%	50%	-0.1%	0.0%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
15-836	110%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-837	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-838	90%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-839	0%	0%	0%	100%	-0.3%	-0.3%	-0.3%	0.0%	-0.1%	-0.1%	-0.1%	0.0%
15-840	0%	0%	50%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-841	0%	0%	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%
15-842	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-843	0%	0%	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%
15-844	100%	0%	0%	0%	0.0%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%
Total	**80%**	**70%**	**65%**	**73%**	**-3.8%**	**-5.6%**	**-6.6%**	**-5.1%**	**-1.6%**	**-1.9%**	**-2.2%**	**-2.0%**

Comparison with Other States

When applying the differences, there are both increases and reductions in the level of the mandates. Overall, the value of the reductions exceeds the value of the increases in each state.

On a full cost basis, most of the reductions to premiums come from the following mandates:

- Mental illness and substance abuse (§15–802) in PA and VA (0.9% – 1.9%)
- Blood products (§15–803) in DE, DC, and PA (0.3%)
- In vitro fertilization (§15–810) in DE, DC, PA, and VA (1.4%)
- Child wellness services (§15–817) in DE, DC, PA, and VA (0.7% – 1.7%)
- Contraceptives (§15–826) in DC and PA (0.6%)
- Extension of benefits (§15–833) in DE, DC, PA, and VA (0.3%)
- Treatment of morbid obesity (§15–839) in DE, DC, and PA (0.3%)

On a full cost basis for the 45 Maryland mandates, the other states have a lower financial burden. Based on a percent of premium, the difference ranges from 3.8% of premium lower in Delaware to 6.6% lower in Pennsylvania. The 2008 study reported differences ranging from 3.6% lower in Delaware to 6.2% lower in Pennsylvania.

PPACA requires (or will require) coverage for child wellness services and contraceptives (August 2012), which removes any gross cost savings attributable to these specific mandates.

Also, on a marginal cost basis for the 45 Maryland mandates, the other states have a lower financial burden, but the picture differs significantly. Based on a percent of premium, the difference ranges from 1.6% of premium lower in Delaware to 2.2% lower in Pennsylvania. The marginal cost differences in the current report are slightly greater than those in the previous report, which ranged from 1.4% lower in Delaware and Virginia to 1.8% lower in Pennsylvania.

On a marginal cost basis, the majority of the reductions to premiums come from the following mandates:

- Mental illness and substance abuse (§15–802) in PA and VA (0.2% – 0.4%)
- IVF (§15–810) in DE, DC, PA, and VA (1.3%)

IVF stands out, with a 1.3% of premium difference under the marginal cost basis. While all these mandates were passed with the intention of improving access to medically necessary care, many self-funded plans do not view IVF as medically necessary; therefore, the marginal cost is almost as high as the full cost.

Next we look at the financial impact of adopting each mandate with the most generous coverage and least generous coverage in the four surrounding states[4], either all mandates or none of the mandates currently covered in the four surrounding states. The impact is summarized in the following table:

[4] Least generous = Minimum "Value Relative to MD" across all four states in the table on the previous page
Most generous = Maximum "Value Relative to MD" across all four states in the table on the previous page

Comparison with Other States

MD Mandate	Value Relative to MD Mandate		Premium Impact to Revise Mandate to Match			
			Full Cost		Marginal Cost	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
15-801	0%	0%	0.0%	0.0%	0.0%	0.0%
15-802	60%	110%	-1.9%	0.5%	-0.4%	0.1%
15-803	0%	100%	-0.3%	0.0%	0.0%	0.0%
15-804	0%	25%	0.0%	0.0%	0.0%	0.0%
15-805	0%	100%	0.0%	0.0%	0.0%	0.0%
15-806	0%	100%	0.0%	0.0%	0.0%	0.0%
15-807	0%	100%	0.0%	0.0%	0.0%	0.0%
15-808	0%	10%	-0.1%	-0.1%	0.0%	0.0%
15-809	0%	100%	0.0%	0.0%	0.0%	0.0%
15-810	0%	0%	-1.4%	-1.4%	-1.3%	-1.3%
15-811	100%	100%	0.0%	0.0%	0.0%	0.0%
15-812	100%	100%	0.0%	0.0%	0.0%	0.0%
15-813	0%	0%	0.0%	0.0%	0.0%	0.0%
15-814	100%	110%	0.0%	0.1%	0.0%	0.0%
15-815	50%	120%	-0.1%	0.0%	0.0%	0.0%
15-816	100%	100%	0.0%	0.0%	0.0%	0.0%
15-817	0%	60%	-1.7%	-0.7%	0.0%	0.0%
15-818	0%	100%	0.0%	0.0%	0.0%	0.0%
15-819	0%	0%	0.0%	0.0%	0.0%	0.0%
15-820	0%	0%	0.0%	0.0%	0.0%	0.0%
15-821	0%	100%	-0.1%	0.0%	0.0%	0.0%
15-822	100%	100%	0.0%	0.0%	0.0%	0.0%
15-823	0%	0%	-0.1%	-0.1%	0.0%	0.0%
15-824	0%	0%	0.0%	0.0%	0.0%	0.0%
15-825	0%	100%	-0.7%	0.0%	-0.2%	0.0%
15-826	0%	100%	-0.6%	0.0%	-0.1%	0.0%
15-827	0%	100%	-0.1%	0.0%	0.0%	0.0%
15-828	0%	85%	-0.1%	0.0%	0.0%	0.0%
15-829	0%	0%	0.0%	0.0%	0.0%	0.0%
15-830	100%	100%	0.0%	0.0%	0.0%	0.0%
15-831	0%	100%	0.0%	0.0%	0.0%	0.0%
15-832	0%	0%	0.0%	0.0%	0.0%	0.0%
15-832-1	0%	0%	0.0%	0.0%	0.0%	0.0%
15-833	0%	0%	-0.3%	-0.3%	-0.1%	-0.1%
15-834	100%	100%	0.0%	0.0%	0.0%	0.0%
15-835	0%	50%	-0.1%	0.0%	0.0%	0.0%
15-836	0%	110%	0.0%	0.0%	0.0%	0.0%
15-837	100%	100%	0.0%	0.0%	0.0%	0.0%
15-838	0%	90%	0.0%	0.0%	0.0%	0.0%
15-839	0%	100%	-0.3%	0.0%	-0.1%	0.0%
15-840	0%	50%	0.0%	0.0%	0.0%	0.0%
15-841	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%
15-842	0%	0%	0.0%	0.0%	0.0%	0.0%
15-843	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%
15-844	0%	100%	-0.1%	0.0%	0.0%	0.0%
Total			**-8.4%**	**-2.3%**	**-2.5%**	**-1.4%**

Comparison with Other States

This table shows that by going to the lowest level (which may be *no* mandate) for each of the 45 benefits, the full cost under a typical group plan for Maryland would be reduced by 8.4% of premium, resulting in the mandates' full cost decreasing from 18.8% of premium to 10.4% of premium. Similarly, the current mandates' marginal cost would be reduced by 2.5% of premium, resulting in the mandates' marginal cost decreasing from 3.5% of premium to 1.0% of premium.

The following mandates have a full cost of 0.5% of premium or higher in Maryland when the minimum level covered in another state is considered:

- Mental illness and substance abuse
- In vitro fertilization
- Child wellness services
- Detection of prostate cancer
- Contraceptives

As indicated previously, PPACA requires coverage for child wellness benefits and screening for prostate cancer. Beginning August 2012, it will also require contraceptive coverage. So implementing coverage for these services comparable to the leanest coverage required in the surrounding states would not yield any savings for three out of the five mandates whose cost exceed the percent of premium on either a full cost or marginal basis.

By going to the richest level of coverage required for each of the 45 Maryland mandates, the full cost would be reduced by 2.3% of premium[5]. The resulting full cost under a typical group plan would be 16.5% of premium instead of the current 18.8%. Similarly, the marginal cost of current mandates would be reduced by 1.4% of premium and drop to 2.1% of premium instead of the current 3.5% under a typical group plan. This does *not* include benefit mandates required outside of Maryland if a similar mandate is not required in Maryland.

When looking at the lowest level, note that none of the surrounding states in this study have mandates similar to the following 14 Maryland mandates:

[5] Please note that going to the richest mandate required in other states may result in a particular mandate not being covered.

Comparison with Other States

Maryland Mandate	Cost as a Percentage of Premium	
	Full	Marginal
15-801: Alzheimer's disease & care of elderly individuals	0.0%	0.0%
15-810: In vitro fertilization	1.4%	1.3%
15-813: Disability caused by pregnancy or childbirth	0.0%	0.0%
15-819: Outpatient services & second opinions	0.0%	0.0%
15-820: Orthopedic braces	0.0%	0.0%
15-823: Osteoporosis prevention & treatment	0.1%	0.0%
15-824: Maintenance prescription drugs	0.0%	0.0%
15-829: Chlamydia screening	0.0%	0.0%
15-832: Removal of testicle	0.0%	0.0%
15-832-1: Length of stay for mastectomies	0.0%	0.0%
15-833: Extension of benefits	0.3%	0.1%
15-841: Smoking cessation	0.1%	0.1%
15-842: Prescription drug cost-share limit	0.0%	0.0%
15-843: Coverage for amino-acid based elemental formula	0.1%	0.1%
Total	**2.1%**	**1.5%**

The following benefits are not required by Maryland, but are mandated in nearby states:

Delaware:

Mandate	Description	Statutory Citation
Ovarian Cancer	Ovarian cancer screening (CA-125) subsequent to treatment must be covered for enrollees residing or having their principal place of employment in Delaware.	18-3555
Hemophilia	Coverage for treatment of congenital defects, including hemophilia.	
Pap smears	Mandatory annual benefit for Pap smears for all females age 18 and over.	18-3561; 18-3552
Dental services for children with a severe disability	Mandated 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, payment must 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 non-network practitioner accepting payment under this section may not balance bill the insured. Allows for contract or policy provisions involving deductibles, coinsurance, maximum dollar limitations or coordination of benefits, if applied using in-network standards.	18 s 3571C

Comparison with Other States

District of Columbia:

Mandate	Description	Statutory Citation
AIDS	Coverage required; insurer may not limit coverage or impose a deductible or coinsurance provision related to the care of AIDS or related diseases unless it applies to all covered diseases.	31-1603
Pap smears	Mandatory coverage for Pap smear annually and when medically necessary. Coverage may not be subject to an annual deductible or coinsurance.	35-2402

Pennsylvania:

Mandate	Description	Statutory Citation
Autism	Requires coverage for the diagnosis and treatment for autism spectrum disorders and for the treatment of autism spectrum disorders for covered individuals under 21. Subject to a maximum benefit of $36,000 (adjusted yearly), but no limits on the number of visits to an autism service provider for treatment of autism spectrum disorders. Cost sharing and any other general exclusions or limitations apply in the same way as other covered medical services.	40 P.S. s 764h
Pap smears	Required coverage for an annual gynecological examination and routine Pap smears.	40 P.S. s 1574

Virginia:

Mandate	Description	Statutory Citation
AIDS	Insurers may not exclude or limit coverage or treatment of HIV infection or AIDS or related complications.	38.2-3401; 14 VAC 5-180-60
Autism	Requires coverage for diagnosis and treatment of autism spectrum disorders (ASDs) for children ages two to seven; must include behavioral, therapeutic, pharmacy, psychiatric and psychological care, but plans can limit annual benefits for applied behavior analysis to $35,000. No limit on number of ASD treatment visits; deductibles, or other cost-sharing requirements must be the same as for other covered health conditions.	38.2-3418.17
Hemophilia	Coverage required for the treatment of hemophilia and other congenital bleeding disorders; must include home treatment coverage.	38.2-3418.3
Hospital stay for hysterectomy	Mandatory coverage for hysterectomy with a 23 hour post-op stay.	38.2-3418.9
Lymphedema	Mandatory coverage for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema.	38.2-3418.14
Pap smears	Coverage required for annual Pap smears.	38.2-3418.1:2

Comparison with Other States

Adding these additional mandates to the Maryland mandates covered in other states, the neighboring states come somewhat closer to the 45 mandates required in Maryland. The following table summarizes the number of mandates in each state.

State	Total Number of Mandated Benefits
Delaware	24
District of Columbia	14
Maryland	45
Pennsylvania	18
Virginia	28

Eight of the mandates required by one or more neighboring states are not required in Maryland. If Maryland adopted these additional mandates, the full cost of the mandates would increase by up to 2.4% of premium. Mercer's survey of carriers in the Maryland market shows that, with the exception of autism and dental treatment for disabled children, health plans in Maryland already comply with these mandates. As a result, there is no marginal cost associated with these six mandates, and the marginal costs for autism and dental treatment would be 0.07%, combined. The potential full cost of these eight additional mandates in their respective states is summarized in the following table.

Mandate Not Required in Maryland	Premium Impact to Add Mandate to Match Other					
	Full Cost				Full Cost	
	DE	DC	PA	VA	Minimum	Maximum
AIDS treatment	-	1.0%	-	1.0%	0.0%	1.0%
Lymphedema treatment	-	-	-	0.0%	0.0%	0.0%
Hemophilia treatment	0.8%	-	-	0.8%	0.0%	0.8%
Hysterectomy post-op stay	-	-	-	0.1%	0.0%	0.1%
Ovarian cancer screening	0.0%	-	-	-	0.0%	0.0%
Pap smears/gynecological exams	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Autism	-	-	0.3%	0.2%	0.0%	0.3%
Dental treatment for disabled children	0.1%	-	-	-	0.0%	0.1%
Total	**1.0%**	**1.2%**	**0.5%**	**2.3%**	**0.2%**	**2.5%**

PPACA currently requires coverage for Pap smears and gynecological exams. Although Maryland has no specific mandate for these services, all non-grandfathered plans have provided this benefit since September 2010. This would lower the minimum full cost to 0.0% and the maximum full cost to 2.3%.

When combining the mandates required in Maryland and these eight additional mandates, the difference in the full cost of mandates between Maryland and its neighboring states decreases.

Comparison with Other States

The marginal cost difference remains the same, for all practical purposes. The following table shows the cost differences expressed as a percentage of a typical group premium.

Mandate	Premium Impact to Revise Mandate to Match Other State*							
	Full Cost				Marginal Cost			
	DE	DC	PA	VA	DE	DC	PA	VA
Required in MD	-3.8%	-5.6%	-6.6%	-5.1%	-1.6%	-1.9%	-2.2%	-2.0%
Not required in MD	1.0%	1.2%	0.5%	2.3%	0.0%	0.0%	0.0%	0.0%
Total	**-2.8%**	**-4.4%**	**-6.1%**	**-2.8%**	**-1.6%**	**-1.9%**	**-2.2%**	**-2.0%**

**Total may not equal sum of individual parts due to rounding*

After including these eight additional mandates, on a full cost basis for all mandates, the other states still have a smaller financial burden. The difference ranges from 2.8% of premium lower in Delaware and Virginia to 6.1% lower in Pennsylvania. The range in the 2008 report was 2.6% of premium lower in the District of Columbia to 5.9% lower in Pennsylvania.

Also, on a marginal cost basis for all mandates, the other states still have a lower financial burden, but the difference is much smaller than under the full cost basis. The difference ranges from 1.6% of premium lower in Delaware to 2.2% lower in Pennsylvania. This compares to analogous statistics in the 2008 report of 1.4% lower in Delaware and Virginia to 1.8% lower in Pennsylvania.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
801	Benefits for Alzheimer's disease and care of elderly individuals	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.				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
802	Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse	Mandatory coverage on the same terms as physical illness; minimum 60 days partial hospitalization; 80% coverage for first 5 visits; 65% coverage of 6-30 visits; 50% coverage for visits beyond 30. Lifetime limits same as physical illness.	18-3343: Mandatory coverage for drug and alcohol dependencies. Terms of the coverage cannot place a greater financial burden on an insured than for covered services of any other illness or disease.	31-3102; 31-3103: Alcohol/ Substance Abuse – Minimum yearly inpatient coverage of 28 days, plus 12 days for detoxification; 30 days minimum outpatient visits.	40 P.S. 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.	38.2-3412.1: Large employers follow MHPAEA; For others: Alcohol/ Substance Abuse – Minimum yearly inpatient coverage of 20 days for adults and 25 days for children; 20 days minimum outpatient visits.
			18-3576: follows MHPAEA; 18-3578: Mandatory coverage for serious mental illnesses. Terms of the coverage cannot place a greater financial burden on an insured than for covered services of any other illness or disease.	35-2302; 35-2304; 35-2305: 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. 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.	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.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
803	Payments for 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	Coverage for off-label use of drugs	Requires coverage for approved off-label drugs.				38.2-3407.5; 38.2-3407.6.1: Mandatory coverage of off-label cancer drugs and excess dosages of drugs to relieve cancer pain.
805	Reimbursement for pharmaceutical products	Subject policies cannot establish varied reimbursement based on the type of prescriber and cannot vary copayments based on community pharmacy vs. mail order.	18 s 7303: Insurers and HMOs cannot impose on a beneficiary any co-payment or condition that is not equally imposed with all contracting pharmacy providers the beneficiary may use. Nor can they require an enrollee to obtain prescription drugs exclusively through a mail-order pharmacy.			

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
806	Choice of pharmacy for filling prescriptions	The non-profit health service plan shall allow the member to fill prescriptions at the pharmacy of choice.	18 s 7303: Enrollees must be able to select the pharmacy of their choice as long as the pharmacy agrees to participate in the plan according to its terms.			
807	Coverage for medical foods and modified food products	Mandatory coverage of medically necessary, low protein modified medical food products.	18 s 3571: must include coverage for medical formulas and foods and low protein modified formulas and modified food products for the treatment of inherited metabolic diseases, if such products are prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases, and administered under the direction of a physician.		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.	

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
808	Benefits for home health care	Mandatory home health care coverage for enrollees who would have otherwise required institutionalization up to 40 visits per year for up to 4 hours per visit.			40 P.S. s 764d: Mandatory coverage for a medically necessary home health care visit within 48 hours after a mastectomy. 40 P.S. s 1583: Mandatory visit within 48 hours after discharge for childbirth when discharge occurs prior to 48-96 guidelines.	
809	Benefits for hospice care	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.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
810	Benefits for in vitro fertilization (IVF)	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 have a history of infertility of at least 2 years or have become infertile from endometriosis, exposure to DES, blockage or removal of fallopian tubes, or abnormal male factors. Carriers may limit coverage of these benefits to 3 IVF attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
811	Hospitalization benefits for childbirth	Every insurance policy that provides benefits for normal pregnancy must provide hospitalization benefits to the same extent as that provided for any covered illness.	See section 812.	See section 812.	See section 812.	See section 812.
812	Inpatient hospitalization coverage for mothers and newborn children	If pregnancy is covered, hospitalization for childbirth and postpartum stay of 48 to 96 hours must also be covered.	18-3577: Follows federal law; 18-3553: Services by a licensed certified nurse midwife must be covered.	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, post delivery stay must be covered for 48-96 hours.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
813	Benefits for disability caused by pregnancy or childbirth	Insurers must offer to groups purchasing a temporary disability policy the option of extending these benefits to temporary disabilities caused by pregnancy or childbirth				
814	Coverage for mammograms	All hospital and major medical insurance policies must include coverage for a baseline mammogram for women who are 35 to 39, a biannual mammogram for women who are 40 to 49, and an annual mammogram for women who are at least 50.	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 an annual or coinsurance deductible.	40 P.S. 764c: Required coverage for all costs associated with a mammogram every year for women age 40 or older or 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.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
815	Coverage for reconstructive breast surgery	Requires carriers to provide coverage for reconstructive breast surgery resulting from a mastectomy to reestablish symmetry between the two breasts.	18-3563: Mandatory benefits for reconstructive surgery following mastectomies, including surgery 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.	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. Coverage may be limited to six years following the date of the mastectomy.	38.2-3418.4: Reconstructive surgery coverage is required for breast surgery.
816	Benefits for 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, who is not her primary care physician; requires an ob/gyn to confer with a primary care physician.	18 s 3556: Carrier must provide direct access to ob/gyn.	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.	40 P.S. s 991.2111: Managed care organizations must provide direct access to obstetrical and gynecological services without prior approval from a primary care provider.	38.2-3407.11: Carrier must provide direct access to ob/gyn.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
817	Coverage for child wellness services	Insurers must include child wellness services in a family policy. Minimally, this must include coverage for immunizations, PKU test, screening tests (tuberculosis, anemia, lead toxicity, hearing & vision), universal hearing screening of newborns, a physical exam, developmental assessment & parental anticipatory guidance services at each visit, and lab tests. Insurers may impose copayments but no deductible.	18-3554 & 18-3558: Childhood immunizations must be covered to age 18. Mandatory coverage for lead screening tests for children at age 1, with additional tests to age 6 for those at high risk. 18 s 3571D: Covered children eligible to receive developmental screenings at ages 9 months, 18 months, and 30 months. 18 s 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, including the imposition of co-payment, coinsurance, deductible, or any dollar limit or other cost-sharing provisions otherwise applicable under the policy.		40 P.S. 3503: Immunizations must be covered.	38.2-3411.1; 38.2-3411.3; : Immunizations must be covered. Well child care to age 6 must be covered and exempt from deductibles and coinsurance.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
818	Benefits for treatment of cleft lip and cleft palate	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.	
819	Coverage for outpatient services 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	Benefits for orthopedic braces	Individual and group contracts written by a non-profit health service plan must provide benefits for orthopedic braces.				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
821	Diagnostic and surgical procedures for bones of face, neck, and head	Health insurers must cover face, neck, and head bone and joint conditions if other skeletal bones and joints are covered, and if the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.				38.2-3418.2: Head / neck bone disorders, including face and jaw, must be covered.
822	Coverage for diabetes 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.	18-3560: If prescription drugs are covered, equipment and supplies for the treatment of diabetes must also be covered.	31-3002: Requires health benefit plans to provide coverage for the equipment, supplies, and other outpatient self-management training and education, including medical nutrition therapy.	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.	38.2-3418.10: Coverage required for equipment, supplies, and self-management training.
823	Coverage for osteoporosis prevention and treatment	Carrier shall include coverage for qualified individuals for bone mass measurement when requested by a health care provider.				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
824	Coverage 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	Coverage for detection of prostate cancer	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.		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.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
826	Coverage for contraceptive drugs and devices	Mandatory coverage for any FDA-approved, prescription contraceptive drug or device and related services. Exempts religious organizations.	18-3559: Mandatory coverage for FDA-approved prescription contraceptive drugs, devices and outpatient contraceptive services; exempts religious employers.			38.2-3407.5:1: If prescription drugs are covered, all FDA-approved prescription contraceptives must be covered.
827	Coverage for patient cost for clinical trials	Mandatory coverage for routine costs to an enrollee in a clinical trial for a life-threatening condition or prevention and early detection of cancer.	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.			38.2-3418.8: Mandatory coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer.
828	Coverage for general anesthesia for dental care under specified conditions	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.				38.2-3418.12: Mandatory coverage of anesthesia for dental procedures for children.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
829	Coverage for detection of chlamydia	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.				
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.	18 s 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.	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.	40 P.S. 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.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
831	Non-formulary drugs or devices	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. 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.
832	Coverage for 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.				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
832.1	Inpatient hospitalization coverage following mastectomy	Requires carriers to cover at least 1 home visit within 24 hrs. after discharge (& an add'l home visit if prescribed) for a patient who had <48 hrs. of inpatient hospitalization after a mastectomy.				

Exhibit 1 – Comparison of State Mandates

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, the plan must continue coverage for ▪ up to 12 months for – treatment begun before termination related to disability – a claim in progress – hospital confinement ▪ up to 30 days for already ordered glasses or contact lenses ▪ up to 60 days or the end of the billing quarter for orthodontia ▪ up to 90 days for – an accident that occurs while the individual is covered – a course of treatment begun before termination.				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
834	Coverage for prostheses	Requires carriers to provide coverage for a prosthesis prescribed by a physician for a member who has undergone a mastectomy & has not had breast reconstruction.	18 s 3563: If mastectomy is covered, breast prostheses must be covered.	31-3832: If mastectomy is covered, breast prostheses must be covered.	40 P.S. 764d: Required coverage for breast prosthesis after mastectomy.	38.2-3418.6: Plan must cover medically necessary prostheses related to a mastectomy.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
835	Coverage for habilitative services for children under 19 years of age	Requires carriers to provide coverage of habilitative services for children under the age of 19 years with a congenital or genetic birth defect, including autism & cerebral palsy; carriers may do so through a managed care system. Carriers must provide notice annually to members about the required coverage. Carriers are not required to reimburse for habilitative services delivered through early intervention or school services. A carrier's denial of payment for services because a defect is not congenital or genetic is considered an adverse decision.		31-3271: Requires carriers to provide coverage for autism as a congenital birth defect, including habilitative services.		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.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
836	Hair prosthesis	Requires carriers to provide one hair prosthesis at a cost not to exceed $350 for a member whose hair loss results from chemotherapy or radiation treatment for cancer.	18 s 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 co-insurance provisions consistent with those established for other benefits under the plan of coverage. Written notice must be delivered to the insured, participant, policyholder, subscriber, and beneficiary at enrollment and annually.			

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
837	Colorectal cancer screening coverage	As of July 1, 2001, carriers shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society (ACS).	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. 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: Coverage required for risk groups established by the American College of Gastroenterology.
838	Hearing aid coverage for a minor child	As of October 1, 2001, 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 s 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.			

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
839	Coverage for treatment of morbid obesity	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/				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.
840	Coverage for 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.			40 P.S. s 908-4: Must cover alcoholism or drug addiction residential treatment program.	

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
841	Coverage for nicotine replacement therapy	Carriers shall provide coverage for nicotine replacement therapy, 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.				
842	Member prescription drug cost share cannot exceed the retail price of prescription drug	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.				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
843	Coverage for amino acid-based elemental formula	Effective October 1, 2008, 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.				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
844	Benefits for prosthetic devices	Effective October 1, 2009, 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 s 3571E: Health insurance plans issued or renewed on or after January 1, 2012, must provide reimbursement for orthotic and prosthetic devices at least equal to federal reimbursement rates provided for under Social Security. Coverage may require prior authorization in the same manner it is required for any other covered benefit. Must also cover the repair and replacement of orthotic or prosthetic devices subject to co-payments and deductibles, unless necessitated by misuse or loss.			

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
801	Benefits for Alzheimer's disease and care of elderly individuals		X	X		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.	Not specifically addressed as covered or excluded; could be covered by .03 A (28): "Any other service approved by a carrier's case management program"

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**

§ 15-802 **MENTAL HEALTH PARITY:** *All policies providing coverage for health care may not discriminate against any person with a mental illness, emotional disorder, or drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions that apply under the contract or policy for treatment of physical illness, or require payment of a deductible separate from the deductible payable for services related to physical illnesses.* *Inpatient Services* – coverage is at least equal to coverage for inpatient services for physical illness. *Partial Hospitalization* – For individual contracts, a minimum of at least 60 days of partial hospitalization under the same terms and conditions that apply to the benefits available under the policy or contract for physical illness. For large employer contracts, the greater of the benefit payable for partial hospitalization for physical illness under the contract or 60 days. *Outpatient Services* – For individual contracts, coverage for expenses arising from services to treat mental illness, emotional disorders, or drug or alcohol abuse, including psychological or neuropsychological testing for diagnostic purposes, at a rate, after the applicable deductible is not less than 80% for the first 5 visits in any calendar year or benefit period of not more than 12 months; 65% coverage for 6-30 visits; 50% coverage for 31st visit and any visits after the 31st. For large employer contracts, benefits for outpatient services to treat mental illness, emotional disorders, or drug or alcohol abuse, including psychological or neuropsychological testing for diagnostic purposes, must cover under the same terms and conditions that apply to similar benefits available under the contract for physical illness. *Medication Management* – Coverage for office visits to a physician or health care provider for medication management are covered under the same terms and conditions under the policy for physical illness. *New Methadone Maintenance Treatment* – a copayment that is greater than 50% of the daily cost for methadone maintenance treatment may not be charged.	**.03 A (4):** Inpatient mental health and substance abuse services provided through a carrier's managed care system, including residential crisis services, up to a maximum of 60 days per covered person per year in a hospital or related institution **.03 A (5):** "Outpatient mental health and substance abuse services provided through a carrier's managed care system" **.03 A (7):** "Detoxification in a hospital or related institution" **.03 C:** "All mental health and substance abuse services described in § A (4) and (5) of this regulation shall be delivered through a carrier's managed care system" **.05 A:** "General Cost-Sharing Arrangement for Outpatient Mental Health and Substance Abuse Services." Except for out-of-network services of this regulation, "...the carrier shall pay for each service 70 percent of allowable charges"

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
803	Payments for blood products	X 19-706(r)	X	X	X	Health insurers may not exclude payments for blood products	Covered; .03 A (24): "All cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin"
804	Coverage for off-label use of drugs	X 19-706(i)	X	X	X	Requires coverage for approved off-label drugs	
805	Reimbursement for pharmaceutical products		X	X	X	Subject policies cannot establish varied reimbursement based on the type of prescriber and cannot vary copayments based on community pharmacy vs. mail order	
806	Choice of pharmacy for filling prescriptions		X			The non-profit health service plan shall allow the member to fill prescriptions at the pharmacy of choice	

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
807	Coverage for medical foods and modified food products	X 19-705.5	X	X	X	All insurers shall include under family member coverage, coverage for medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical foods or low protein modified food products are: (1) prescribed as medically necessary for therapeutic treatment of inherited metabolic diseases; and, (2) administered under the direction of a physician	Covered; .03 A (21): "Medical food for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders"
808	Benefits for home health care		X	X	X	Health insurance policies that provide coverage for inpatient hospital care on an expense-incurred basis must provide coverage for home health care. The minimum benefit is 40 visits in any calendar year.	Covered; .03 A (11): "Home health care services…as an alternative to otherwise covered services in a hospital or related institution;…"
809	Benefits for hospice care services		X	X	X	Health insurers must offer individuals and groups benefits for hospice care services	Covered; .03 A (12): "Hospice care services"

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
810	Benefits for in vitro fertilization (IVF)	X 19-706 (oo)	X	X	X	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 have a history of infertility of at least 2 years or have become infertile from endometriosis, exposure to DES, blockage or removal of fallopian tubes, or abnormal male factors. Carriers may limit coverage of these benefits to 3 IVF attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.	Excluded; .06 B (11): "In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures"
811	Hospitalization benefits for childbirth	X 19-703 (g)	X	X	X	Every insurance policy that provides hospitalization benefits for normal pregnancy must provide hospitalization benefits for childbirth to the same extent as that provided for any covered illness.	Covered; .03 A (25): "Pregnancy and maternity services, including abortion;" §15-811 adopted as mandate

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
812	Inpatient hospitalization coverage for mothers and newborn children	X 19-706(i)	X	X	X	Requires carriers to provide inpatient hospitalization coverage for a mother and newborn child for a minimum of 48 hours after an uncomplicated vaginal delivery and 96 hours after an uncomplicated caesarean section; authorizes a home visit by an experienced registered nurse if the mother requests a shorter hospital stay and an additional home visit if prescribed by the provider; authorizes coverage for up to four additional days for a newborn when the mother continues to be hospitalized; and prohibits sanctions against a provider who advocates a longer stay	Covered; Required by §19-1305.4; effective 7/1/96; §15-812 adopted as mandate
813	Benefits for disability caused by pregnancy on childbirth			X		Insurers must offer to groups purchasing a temporary disability policy the option of extending these benefits to temporary disabilities caused by pregnancy or childbirth	Disability caused by pregnancy/childbirth: Not addressed.
814	Coverage for breast cancer screenings	X	X	X	X	Carriers must provide coverage for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society; carriers may not impose a deductible	Covered; .03 A (10): "Mammography services for persons ages 40 to 49 once every other calendar year, and for ages 50 and above once per calendar year"

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
815	Coverage for reconstructive breast surgery	X 19-706 (d)(2)	X	X	X	Requires carriers to provide coverage for reconstructive breast surgery, including surgery on a non-diseased breast to establish symmetry with the diseased breast; & coverage for physical complications resulting from mastectomy	Covered; .03 A (30): "Breast reconstructive surgery as specified in Insurance Article, § 15-815, Annotated Code of Maryland, and breast prosthesis"
816	Benefits for routine gynecological care	X 19-706 (l)	X	X	X	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, who is not her primary care physician; requires an obstetrician/ gynecologist to confer with a primary care physician	§15-816 adopted as mandate
817	Coverage for child wellness services		X	X	X	Insurers must include child wellness services in a family policy. Minimally, this must include coverage for immunizations, PKU test, screening tests (tuberculosis, anemia, lead toxicity, hearing & vision), universal hearing screening of newborns; a physical exam, developmental assessment & parental anticipatory guidance services at each visit; and lab tests. Insurers may impose copayments but no deductible	Covered; in accordance with the schedule in the U.S. Preventive Services Task Force Guidelines

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
818	Benefits for treatment of cleft lip and cleft palate	X 19-706 (bb)	X	X	X	Carriers must include benefits for inpatient or outpatient expenses arising from the management of cleft lip, cleft palate, or both	Covered; .03 A (23): "...habilitative services for children 0 to 19 years old for the treatment of congenital or genetic birth defects"
819	Coverage for outpatient services and second opinions		X	X	X	Health insurers must provide reimbursement for a second opinion when denied hospital admission by a utilization review program and when required by a utilization review program and outpatient coverage for a service for which an admission is denied	No specific references.
820	Benefits for orthopedic braces		X			Individual and group contracts written by a non-profit health service plan must provide benefits for orthopedic braces	Covered; .03 A (13): "Durable medical equipment, including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses"

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
821	Diagnostic and surgical procedures for bones of face, neck, and head		X	X	X	Health insurers that provide coverage for a diagnostic or surgical procedure involving a bone or joint of the skeletal structure may not exclude or deny coverage for the same diagnostic or surgical procedure involving a bone or joint of the face, neck, or head if the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.	Covered; .06 B (43): "TMJ treatment and treatment for CPS" are excluded, EXCEPT "for surgical services for TMJ and CPS, if medically necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury"
822	Coverage for diabetes equipment, supplies, and self-management training	X 19-706(x)	X	X	X	Carriers shall provide coverage for all medically appropriate and necessary diabetes equipment, diabetes supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy for insulin users, non-insulin users, or elevated blood glucose levels induced by pregnancy	Provides coverage for all medically necessary supplies and equipment; includes 6 nutritional visits. Does not include other educational services.
823	Coverage for osteoporosis prevention and treatment	X 19-706(p)	X	X	X	Carrier shall include coverage for qualified individuals for bone mass measurement when requested by a health care provider	Covered under terms of "medical necessity" as of July 1, 1998; §15-823 adopted as mandate
824	Coverage for maintenance drugs	X 19-706(q)	X	X	X	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, they shall proportionally increase the dispensing fee.	Covered

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
825	Coverage for detection of prostate cancer	X 19-706(u)	X	X	X	Coverage shall be provided for a medically recognized diagnostic examination including a digital rectal exam (DRE) and prostate – specific antigen (PSA) test for: 1) men between 40 & 75; 2) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; 3) when used for staging in determining the need for a bone scan in patients with prostate cancer; or 4) when used for male patients who are at high risk for prostate cancer.	As of July 1, 1998 adopts American Cancer Society recommendations: 1) annual DRE for both prostate and colorectal cancer beginning at age 40; 2) annual PSA for African American men and all men age 40 or older with a family history of prostate cancer; and 3) an annual PSA screening for all other men age 50 and older.
826	Coverage for contraceptive drugs and devices	X 19-706(i)	X	X	X	Coverage shall be provided for 1) any contraceptive drug or device that is approved by the U.S. F.D.A. for use as a contraceptive and that is obtained under a prescription written by an authorized prescriber; 2) the insertion or removal, and any medically necessary exam associated with the use of such drug or device. An entity may not impose a different copay or coinsurance for a contraceptive drug or device than is imposed for any other Rx.	Covered, effective July 1, 1999; .03 A (22): "Family planning services, including: (a) Prescription contraceptive drugs or devices; (b) Coverage for the insertion or removal of contraceptive devices; (c) Medically necessary exam associated with the use of contraceptive drugs or devices; and (d) voluntary sterilization"
827	Coverage for patient cost for clinical trials	X 19-706 (aa)	X	X	X	Coverage shall be provided for patient cost to a member in a clinical trial as a result of 1) treatment provided for a life-threatening condition; or 2) prevention, early detection, and treatment studies on cancer.	Covered; .03 A (27): "Controlled clinical trials"

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
828	Coverage for general anesthesia for dental care under specified conditions	X 19-706 (i)	X	X	X	Coverage shall be provided for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to an enrollee or insured under specified conditions.	Covered, effective July 1, 1999; .03 A (32): "General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to the following…"
829	Coverage for detection of chlamydia	X 19-706 (ff)	X	X	X	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; women who are at least 20 if they have multiple risk factors; and men who have multiple risk factors	Covered, effective July 1, 2000; .03 A (33): An annual chlamydia screening test for women who are younger than 20 years old who are sexually active or at least 20 years old who have multiple risk factors and men who have multiple risk factors.
830	Referrals to specialists	X 19-706 (gg)	X	X	X	Requires carriers that do not allow direct access to specialists to establish & implement a procedure by which a member may receive under certain circumstances a standing referral to a participating specialist & under certain circumstances to a non-participating specialist; provides pregnant members with a standing referral to an OB	§15-830 adopted as part of the "Patients' Bill of Rights Act," effective Nov. 1, 1999; standing referral for pregnancy adopted, effective October 1, 2000

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
831	Coverage of prescription drugs and devices	X 19-706 (gg)	X	X	X	Each entity limiting its coverage of Rx drugs or devices to those in a formulary shall establish & implement a procedure for a member to receive a Rx drug or device that is not in the entity's formulary when there is no equivalent Rx drug or device in the entity's formulary, an equivalent Rx drug is ineffective or has caused an adverse reaction	§15-831 adopted as part of the "Patients' Bill of Rights Act," effective Nov. 1, 1999
832	Coverage for removal of testicle	X 19-706 (gg)	X	X	X	Requires carriers to cover at least 1 home visit within 24 hrs. after discharge for a patient who had <48 hrs. of inpatient hospitalization after the surgical removal of a testicle, or who undergoes either procedure on an outpatient basis	§15-832 adopted as part of the "Patients' Bill of Rights Act," effective Nov. 1, 1999
832.1	Inpatient hospitalization coverage following mastectomy	X	X	X	X	Requires carriers to cover at least 1 home visit (& an add'l home visit if prescribed) within 24 hrs. after discharge for a patient who had <48 hrs. of inpatient hospitalization after a mastectomy	§15-832 adopted as part of the "Patients' Bill of Rights Act," effective Nov. 1, 1999
833	Extension of benefits	X 19-706 (hh)	X	X	X	Requires carriers to extend certain benefits under specific circumstances except when coverage is terminated because of specified conditions. Charging of premiums is prohibited when benefits are extended	Law impacted CSHBP; effective Oct. 1, 1999

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
834	Coverage for prostheses	X 19-706 (ii)	X	X	X	Requires carriers to provide coverage for a prosthesis prescribed by a physician for a member who has undergone a mastectomy & has not had breast reconstruction	Covered; .03 A (30): "Breast reconstructive surgery as specified in Insurance Article, § 15-815, Annotated Code of Maryland, and breast prosthesis
835	Coverage for habilitative services for children under 19 years of age	X 19-706 (nn)	X	X	X	Requires carriers to provide coverage of habilitative services for children under the age of 19 years with a congenital or genetic birth defect, including autism & cerebral palsy, and may do so through a managed care system; carriers must provide notice annually to its members about the required coverage; carriers are not required to reimburse for habilitative services delivered through early intervention or school services; carriers denying payment for services because it is not a congenital or genetic birth defect is considered an adverse decision.	Covered; .03 B: "The services described in § A (23) of this regulation shall be delivered through a carrier's managed care system…"
836	Hair prosthesis	X 19-706 (i)	X	X	X	Requires carriers to provide one hair prosthesis at a cost not to exceed $350 for a member whose hair loss results from chemotherapy or radiation treatment for cancer	Excluded; .06 B (39); "Wigs or cranial prosthesis"

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
837	Colorectal cancer screening coverage	X 19-706 (rr)	X	X	X	As of July 1, 2001, carriers shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society (ACS)	As of July 1, 2001, adopted ACS recommendations: colorectal screening covered for men & women ages 50 and older as follows: a) a yearly FOBT w/DRE, plus flexible sigmoidoscopy every 5 years; b) colonoscopy w/DRE every 10 years; or c) a double contrast barium enema w/DRE every 5 years
838	Hearing aid coverage for a minor child	X 19-706 (tt)	X	X	X	As of October 1, 2001, 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	Covered; .03 A (34), effective July 1, 2002: "…hearing aids for persons ages 0 to 18 years of age, up to $1,400 per hearing aid for each hearing-impaired ear every 36 months"

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
839	Coverage for treatment of morbid obesity	X 19-706 (uu)	X	X	X	As of October 1, 2001, carriers shall provide coverage for the surgical treatment of morbid obesity that is recognized by the NIH as effective for the long-term reversal of morbid obesity and consistent with guidelines approved by the NIH. Carriers shall provide coverage for this benefit to the same extent as for other medically necessary surgical procedures under the insured's policy.	Covered, effective July 1, 2009; .03(A)35: The surgical treatment of morbid obesity as specified in Insurance Article, §15-839, Annotated Code of Maryland. A-1. Morbid Obesity. (1) When establishing utilization review criteria for the surgical treatment of morbid obesity, a carrier or a private review agent acting on behalf of a carrier shall adhere to the requirements of COMAR 31.10.33.03. (2) Surgical treatment of morbid obesity shall occur in a facility that is: (a) Designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence; and (b) Designated by the carrier. (3) If a carrier does not make a designation under §A-1(2) of this regulation, the carrier shall provide benefits under the health benefit plan for the surgical treatment of morbid obesity at any facility that is designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence.

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
840	Coverage for medically necessary residential crisis services	X 19-706 (yy)	X	X	X	As of October 1, 2002, carriers shall provide coverage for medically necessary residential crisis services defined as intensive mental health & support services 1) provided to a child or an adult with a mental illness at risk of a psychiatric crisis; 2) designed to prevent or provide an alternative to a psychiatric inpatient admission, or shorten the length of inpatient stay; 3) provided at the residence on a short-term basis; and 4) provided by DHMH-licensed entities.	Covered, effective July 1, 2003; .03A(4): "Inpatient mental health and substance abuse services provided through a carrier's managed care system, including residential crisis services, up to a maximum of 60 days per covered person per year in a hospital, related institution, or entity licensed by DHMH to provide residential crisis services
841	Coverage for smoking cessation treatment	X 19-706 (fff)	X	X	X	Effective October 1, 2005, carriers shall provide coverage for any prescription (not OTC) drug that is approved by the FDA to aid in the cessation of tobacco use; carriers may not impose a different copay or coinsurance for a drug or nicotine replacement therapy than is imposed for any other comparable prescription.	Not mandated under the CSHBP.
842	Copayment or coinsurance for prescription drugs and devices limited	X	X	X	X	Effective October 1, 2007, carriers may not impose a copayment or coinsurance that exceeds the retail price of the prescription drug or device; applies if carrier provides coverage through a PBM	Not mandated under the CSHBP.

Exhibit 2 – Insurance Law Subtitle 8

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
Title 15, Subtitle 8		HMO	Non Profit	Group Ins.	Indiv. Ins.		**COMAR 31.11.06**
843	Coverage for amino acid-based elemental formula	X	X	X	X	Effective October 1, 2008, 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 evidence 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.	Not mandated under the CSHBP.
844	Benefits for prosthetic devices	X	X	X	X	Effective October 1, 2009, 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.	Mandate not adopted under the CSHBP. Prosthetic devices covered in regulation as follow: .03A(13): "Durable medical equipment, including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses"

[i] Updated December 2011

Exhibit 3 – Maryland Insurance Article Section 15–1502

§ 15–1502.

(a) (1) The Commission shall conduct an evaluation of existing mandated health insurance services and make recommendations to the General Assembly regarding decision making criteria for reducing the number of mandates or the extent of coverage.

(2) The evaluation shall include:

(i) an assessment of the full cost of each existing mandated health insurance service as a percentage of the State's average annual wage and of premiums:

(1) under a typical group and individual health benefit plan in the State;

(2) under the State employee health benefit plan; and

(3) under the Comprehensive Standard Health Benefit Plan;

(ii) an assessment of the degree to which existing mandated health insurance services are covered in self-funded plans; and

(iii) a comparison of mandated health insurance services provided by the State with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia.

(3) The comparison described in paragraph (2)(iii) of this subsection shall include:

(i) the number of mandated health insurance services;

(ii) the type of mandated health insurance services;

(iii) the level and extent of coverage for each mandated health insurance service; and

(iv) the financial impact of differences in levels of coverage for each mandated health insurance service.

(4) On or before January 1, 2004, and every 4 years thereafter, the Commission shall submit a report of its findings to the General Assembly, subject to § 2-1246 of the State Government Article.

(b) The General Assembly may consider the information provided under subsection (a) of this section in determining:

(1) whether to enact proposed mandated health insurance services; and

(2) whether to repeal existing mandated health insurance services.