SB 551

Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
Third Reader

Senate Bill 551 (Senator Charles)

Finance Health

Health Insurance - Ovarian Cancer Prevention With Salpingectomy - Required Coverage and Prohibited Cost Sharing

This bill requires certain insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers) to provide salpingectomy coverage (the surgical removal of fallopian tubes) for ovarian cancer prevention. A carrier may not impose a copayment, coinsurance, or deductible on the coverage, except for a deductible for a high-deductible health plan (HDHP). **The bill takes effect January 1, 2027, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) in FY 2027 only from the $125 rate and form filing fee; review of filings can be handled with existing resources. State Employee and Retiree Health and Welfare Benefits Program expenditures increase by at least $25,000 in FY 2027 (and at least $50,000 annually thereafter) to provide the required coverage without cost sharing.

(in dollars)	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
SF Revenue	-	$0	$0	$0	$0
GF/SF/FF Exp.	$25,000	$50,000	$50,000	$50,000	$50,000
Net Effect	($25,000)	($50,000)	($50,000)	($50,000)	($50,000)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: To the extent the bill increases the cost of health insurance premiums, expenditures may increase for local jurisdictions that purchase fully insured plans. Revenues are not affected.

Small Business Effect: None.

Analysis

Current Law: Under Maryland law, there are more than 50 mandated health insurance benefits that certain carriers must provide. With respect to cancer screenings, certain carriers must cover the following screenings or testing for breast, colorectal, lung, and prostate cancer:

- **Breast cancer screenings** in accordance with the latest screening guidelines issued by the American Cancer Society (ACS). Currently, (1) women ages 40 to 44 may get annual breast cancer screenings with mammograms, and (2) starting at age 45, women should have annual mammograms. Carriers must also provide coverage for digital tomosynthesis if an enrollee's treating physician determines it is medically appropriate and necessary. A deductible may not be imposed for covered digital tomosynthesis or mammograms.
- **Colorectal screening** in accordance with the latest guidelines issued by ACS. Coverage may be subject to a copayment or coinsurance requirement provided it is no greater than that imposed for similar coverages.
- **Recommended follow-up diagnostic imaging to assist in the diagnosis of lung cancer** for individuals for whom lung cancer screening is recommended by the U.S. Preventative Services Task Force. Coverage must include diagnostic ultrasound, magnetic resonance imaging, computed tomography (CT), and image-guided biopsy. A carrier may not impose a copayment, coinsurance, or deductible on the coverage that is greater than that for breast cancer screening and diagnosis (with the exception for an HDHP deductible requirement).
- Expenses incurred in conducting a digital rectal exam and a prostate-specific antigen (more commonly known as PSA) blood test for men between 40 and 75 years of age who are at high risk for **prostate cancer**. Carriers may not apply a deductible, copayment, or coinsurance to coverage for preventive care screening services for prostate cancer.

The federal Patient Protection and Affordable Care Act (ACA) requires nongrandfathered health plans to cover 10 essential health benefits (EHBs), including preventive and wellness services and chronic disease management. The ACA requires most private health insurance plans and Medicaid ACA expansion programs to cover many recommended preventive services without any patient cost sharing, including the following cancer-related screening tests: mammograms; preventive medications and genetic counseling for breast cancer; colonoscopies for colon cancer screening; pap smears for detection of cervical cancer; CT tests to screen for lung cancer; and behavioral counseling on skin cancer.

Under § 31-116 of the Maryland Insurance Article, EHBs must be included in the State benchmark plan and, not withstanding any other benefits mandated by State law, must

be the benefits required in (1) all individual health benefit plans and health benefit plans offered to small employers (except for grandfathered health plans) offered outside the Maryland Health Benefit Exchange (MHBE) and (2) all qualified health plans offered in MHBE.

For additional information on mandated health insurance benefits in Maryland, please see the **Appendix – Mandated Health Insurance Benefits**.

State Expenditures: The State Employee and Retiree Health and Welfare Benefits Program is largely self-insured for its medical contracts and, as such, except for the one fully insured integrated health model medical plan (Kaiser), is exempt from most State health insurance mandates. However, the program generally provides coverage as otherwise required under State law.

The program currently covers salpingectomy for ovarian cancer prevention. However, current coverage includes cost sharing. The Department of Budget and Management (DBM) advises that to provide such coverage without cost sharing, expenditures increase by at least $50,000 and as much as $250,000 annually, depending on the number of preventive salpingectomy procedures performed. Thus, DBM expenditures (general, special, and federal funds) increase by at least $25,000 in fiscal 2027, to reflect the bill's January 1, 2027 effective date, and by at least $50,000 (and as much as $250,000) in future years.

Additional Comments: A 2023 systematic review published in *JAMA Surgery* noted that salpingectomy has been associated with ovarian cancer risk reduction of approximately 80%. Studies demonstrated that salpingectomy was safe and cost-effective and, with widespread implementation, has the potential to reduce ovarian cancer mortality in the United States by an estimated 15%.

MIA advises that the bill does not apply to the nongrandfathered individual and small employer markets. Should the bill be amended to apply to all markets, the State would be required to defray the cost of the new mandate to the extent it applies to the individual and small group ACA plans.

The Maryland Health Care Commission (MHCC) conducted a study to estimate the cost impact of covering salpingectomy for ovarian cancer prevention without cost sharing. MHCC estimates that such coverage will add about $0.05 per member per month (PMPM) or about $0.60 per member per year to fully insured and privately insured health care premiums, or an increase of 0.007%. The estimated impact on the State Employee and Retiree Health and Welfare Benefits Program is $0.003 PMPM or 0.002%. The study assumed that the prohibition on cost sharing would apply to females aged 45 and older and include those who are high risk for cancer who have tested positive for BRCA 1 and 2

(BReast CAncer genes 1 and 2). However, the Department of Legislative Services notes that the bill requires coverage for salpingectomy for ovarian cancer prevention and does not specify any age or risk factors to qualify for the procedure. Thus, the study may underestimate the potential cost to cover the procedure as specified in the bill.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: HB 633 (Delegate Hill, *et al.*) - Health.

Information Source(s): *JAMA Surgery;* Maryland Department of Health; Department of Budget and Management; Maryland Insurance Administration; Department of Legislative Services

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Appendix – Mandated Health Insurance Benefits

Overview

Fully insured, large group plans and certain individual plans must cover Maryland's mandated health insurance benefits. These mandates do not apply to most individual or small group plans, public health insurance, or plans issued outside of Maryland. However, individual and small group plans and plans sold through the Maryland Health Benefit Exchange (MHBE) must cover federal essential health benefits (EHBs). Thus, the type of plan an individual is enrolled in generally determines which benefits must be provided.

Most Marylanders Are Insured by Employment-based Coverage

Maryland residents generally obtain health insurance from one of three sources: (1) employment-based coverage; (2) private coverage in the individual market; or (3) public health insurance provided by the State and/or federal government (*i.e.*, Medicaid, the Maryland Children's Health Program (MCHP), Medicare, and military-related coverage). In calendar 2023 (the most recent data available), more than one-half (53.9%) of the State's population had employment-based coverage, more than one-third (34.1%) were covered by public health insurance programs, and 5.7% purchased coverage in the individual market. The remaining 6.5% of Marylanders were uninsured.

State Regulation of Insurance Applies Only to Certain Plans

Employment-based coverage is either fully insured or self-insured. A fully insured plan is a traditional model for health insurance under which an employer pays a fixed premium to an insurer and the insurer assumes all financial risk and responsibility for paying claims. Fully insured plans are most common among small to mid-sized businesses as they offer more predictable costs and less administrative burden. In a self-insured plan, the employer assumes all financial risk and pays claims directly, usually through a third-party administrator. Self-insured plans are more common among larger employers with the resources to assume the financial risk.

The federal Employee Retirement Income Security Act preempts states' ability to require private employers to offer health insurance coverage and exempts self-insured plans from state insurance regulation. As a result, only fully insured plans are regulated by state insurance regulators. Thus, in Maryland, self-insured plans are not regulated by the Maryland Insurance Administration (MIA) and are not subject to Maryland law.

In calendar 2024, 2.58 million Maryland residents younger than age 65 were insured through commercial health benefit plans, of which 890,245 were covered by a fully insured plan and 1.69 million were covered by a self-insured plan. Thus, only about one-third (34.5%) of those covered through commercial plans were in fully insured plans subject to State regulation. Overall, only 17.4% of the State's nonelderly population was covered by a plan subject to State regulation.

Mandated Benefits Apply Only to Large Group and Grandfathered Plans

Maryland law requires insurers, health maintenance organizations, and nonprofit health service plans to cover more than 50 specific benefits. These "mandated benefits" apply to expense-incurred contracts that provide "hospital, medical, and surgical benefits," which include non-major medical products and federally excepted benefits (benefits outside of primary medical coverage that are not subject to certain federal requirements). These include fully insured, large group plans (≥50 employees), individual grandfathered plans in effect on or before March 23, 2010, when the federal Patient Protection and Affordable Care Act (ACA) was enacted, and limited or specialty plans such as fixed-indemnity plans. Maryland's State Employee and Retiree Health and Welfare Benefits Program is predominately self-insured and thus largely exempt from mandated benefits. However, the program generally provides coverage for these benefits as otherwise required under State law.

Mandated benefits *could* apply to individual and small group policies. However, if the benefits go beyond those in the State benchmark plan (a reference plan that defines the minimum benefits that must be offered in the individual and small group markets in Maryland), the State must cover the cost. Thus, mandated benefits are not typically applied to those policies.

Mandated benefits do not apply to Medicaid/MCHP, Medicare, the Federal Employees Health Benefits Program, or military/Veterans Administration coverage. Mandated benefits also do not apply to health benefit plans issued outside of Maryland – such as when a Maryland resident works for an employer based in another state and the plan is issued in that state. In that instance, the plan is subject to the requirements (and mandated benefits) of the state in which it is issued.

Exhibit 1 summarizes mandated benefits for large group and grandfathered plans. For further specifics on mandated benefits, see Title 15, Subtitle 8 of the Insurance Article.

Exhibit 1
Maryland's Mandated Health Insurance Benefits for Large Group and Grandfathered Plans

- Amino-acid elemental formula
- Anesthesia for dental care
- Biomarker testing
- Blood products
- Breast cancer screening
- Breast prosthesis following a mastectomy
- Child well visits and immunizations
- Chlamydia screening
- Cleft lip/palate treatment/management
- Clinical trials
- Colorectal cancer screening
- Contraceptive drugs or devices
- Diabetic equipment or supplies
- Emergency room services
- Fertility awareness-based methods
- Fertility preservation due to medical treatment that may cause infertility
- Gynecological care
- Habilitative services
- Hair prosthesis following cancer
- Hearing aids
- Home health care
- Human papilloma virus screening
- Infertility benefits (including IVF)
- Inpatient hospital services
- Laboratory services
- Lung cancer screening
- Lymphedema diagnosis, evaluation, and treatment
- Male sterilization
- Mastectomies
- Medical foods
- Mental health and substance use treatment
- Morbid obesity surgical treatment
- Osteoporosis prevention and treatment
- Ostomy equipment and supplies
- Physician services
- Pregnancy and maternity benefits
- Prescription benefits
- Preventive services
- Prosthetic devices
- Prostate cancer screening
- Reconstructive breast surgery
- Referrals to specialists
- Second opinions and coverage of outpatient services
- Smoking cessation
- Surgical removal of testicles
- Temporo-Mandibular Joint Syndrome treatment
- X-rays

IVF: in vitro fertilization

Note: Mandated benefits as of January 2025. Coverage of calcium score testing is required beginning January 1, 2026.

Source: Maryland Insurance Administration; Department of Legislative Services

Application of Mandated Benefits in Practice

Legislation is frequently introduced to add new mandated benefits. For example, Senate Bill 518 of 2025 would have required coverage for preventive screenings for ovarian cancer for individuals aged 45 and older. The bill would have applied only to commercial health insurance, specifically fully insured large group plans and individual grandfathered plans. Coverage would not have applied to self-insured plans, nongrandfathered individual or small group plans, plans issued in another state to a Maryland resident, or any public health insurance program (in the same way that current mandated benefits do not apply to these plans).

Essential Health Benefits Apply to Individual and Small Group Plans

The ACA requires nongrandfathered health plans to cover 10 EHBs, which include items and services in the following categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services.

Maryland law requires that EHBs be included in the State benchmark plan and in all qualified health plans offered through MHBE. **Exhibit 2** summarizes the EHBs required as of September 2025. For further specifics, see MIA's *Essential Health Benefits Chart: Individual and Small Group Plans*.

Exhibit 2
Essential Health Benefits for Individual and Small Group Plans

- Allergy serum
- Ambulance service
- Bariatric surgery
- Blood and blood products
- Breast reconstructive surgery/prosthesis
- Cardiac rehabilitation
- Care in office for illness or injury
- Case management
- Chiropractic services
- Controlled clinical trials
- Diabetic treatment/equipment/supplies
- Durable medical equipment
- Emergency services
- Family planning services
- General anesthesia/associated care for dental care for children
- Habilitative services
- Hair prosthesis following cancer
- Hearing aids
- Home health care
- Hospice
- Infertility services (excludes IVF)
- Inpatient hospital services
- Medical food
- Mental health and substance use benefits
- Nutritional services
- Outpatient hospital services
- Outpatient laboratory/diagnostic services
- Outpatient short-term rehabilitation
- Patient centered medical homes
- Pediatric dental
- Pediatric vision
- Pregnancy and maternity
- Prescription drugs
- Preventive services
- Prostate cancer screening
- Pulmonary rehabilitation
- Skilled nursing facility
- Transplants
- Wellness benefits

IVF: in vitro fertilization

Note: Essential health benefits as of September 2025.

Source: Maryland Insurance Administration; Department of Legislative Services