HB 1366

Department of Legislative Services

Maryland General Assembly
2025 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1366 (Delegate Ruff, *et al.*)
Health and Government Operations

Health Insurance - Testing for Ovarian and Cervical Cancers - 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 coverage for cervical smear or Pap test for an insured or enrollee. A carrier must also cover "surveillance tests" (an annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound, or a pelvic examination) for ovarian cancer for an insured or enrollee that (1) has at least one first-degree relative with ovarian cancer or a cluster of relatives with breast or nonpolyposis colorectal cancer or (2) has tested positive for the *BRCA1* or *BRCA2* gene mutation. A carrier may not impose a copayment, coinsurance, or deductible on the coverage, with the exception of a deductible for a high-deductible health plan (HDHP). **The bill takes effect January 1, 2026, 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 2026 only from the $125 rate and form filing fee; review of additional filings can be handled with existing budgeted resources. Any impact on expenditures for the State Employee and Retiree Health and Welfare Benefits Program is anticipated to be minimal.

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 (known as an MRI), computed tomography (known as a 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.

Additional Comments: 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 individual and small group ACA plans.

Additional Information

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

Designated Cross File: None.

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

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km/ljm

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