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FISCAL AND POLICY NOTE
First Reader

House Bill 1117
Health

(Delegate Lopez, *et al.*)

Elopement Response Devices - Insurance and Maryland Medical Assistance
Program Coverage and Provision Under State Programs

This bill requires certain insurers, nonprofit health service plans, and health maintenance organizations (collectively carriers), as well as Medicaid, to provide coverage for an “approved elopement response device” and associated supports for an eligible individual (or recipient) when ordered or prescribed by a qualified licensed provider and documented in a “qualifying plan.” Certain State programs must consider such a device to be a medical device, durable medical equipment (DME), or assistive technology (AT). By December 1, 2027, and annually thereafter for two more years, the Maryland Department of Health (MDH) must report to specified committees of the General Assembly on implementation of Medicaid coverage under the bill. **The bill generally takes effect July 1, 2026; insurance provisions take effect January 1, 2027, and apply 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 increase in special fund revenues for the Maryland Insurance Administration (MIA) in FY 2027 only from the \$125 rate and form filing fee; any additional workload on MIA can be handled with existing resources. Medicaid expenditures increase by an indeterminate but significant amount (50% general funds, 50% federal funds) beginning in FY 2027, as discussed below. Federal fund revenues increase accordingly. State Employee and Retiree Health and Welfare Benefits Program (State plan) expenditures (general, special, and federal funds) increase, as discussed below, **This bill increases the cost of an entitlement program beginning in FY 2027.**

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

Small Business Effect: None.

Analysis

Bill Summary: “Approved elopement response device” means a medical device or assistive technology approved by MDH for the prevention of, or response to, elopement. This includes door or window sensors, wearable or portable location-enabled devices, and related alerting technology.

“Elopement” means behavior in which an individual with a cognitive, developmental, or neurological condition leaves or attempts to leave a safe and supervised area without the ability to recognize or avoid risk or the ability to return safely without assistance. “Elopement” includes wandering that creates the risk of harm, injury, or death.

“Qualifying plan” means an Individualized Education Program (IEP), a behavioral health plan, an Individualized Family Service Plan (IFSP), or any other clinical and educational plan that documents a history or risk of elopement.

State Programs

If a State program provides funding or reimbursement for, or the direct provision of, medical equipment or medical-related supplies to older adults or individuals with disabilities, the program must consider an approved elopement response device to be a medical device, DME, or AT. This requirement applies regardless of when the State program was established.

Health Insurance Coverage

An eligible individual for an approved elopement response device is an individual who has been diagnosed with Alzheimer’s disease or a related dementia and meets medical necessity criteria established by MDH.

Medicaid

An eligible recipient of an approved elopement response device is a Medicaid recipient who (1) is younger than 21 and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; (2) is eligible for coverage through a home- and community-based services (HCBS) waiver; or (3) has been diagnosed with

Alzheimer's disease or a related dementia and meets medical necessity criteria established by MDH.

Medicaid coverage may be provided under the State Plan, including as DME or a comparable benefit category; as an EPSDT services when medically necessary for eligible recipients younger than age 21; or as AT or specialized medical equipment for purposes of an HCBS waiver.

MDH must (1) establish reasonable prior authorization and replacement and maintenance requirements, as specified; (2) require informed consent from the recipient (or their parent or guardian, as specified) for any location-enabled device; (3) adopt privacy safeguards and data minimization standards for approved elopement response devices; (4) in consultation with the Maryland State Department of Education, issue guidance to enable school-based billing or cost allocation when federally allowable; (5) by October 1, 2026, submit any necessary State Plan amendments or waiver amendments necessary to carry out the bill; and (6) maximize federal financial participation.

The use of an approved elopement response device or failure to use such a device may not be a condition of eligibility for Medicaid services or benefits. An approved elopement response device may not be determined to be ineligible for coverage or funding solely on the basis that the device incorporates global positioning system technology, wireless communication, or consumer-available components.

MDH may establish pilots or phased implementation. MDH may implement the bill through regulations, provider bulletins, or guidance prior to final adoption of regulations.

By December 1, 2027, and annually thereafter through December 1, 2029, MDH must report to specified committees of the General Assembly on implementation status, utilization of approved devices, costs, and outcomes.

Current Law:

Mandated Health Insurance Benefits

Under Maryland law, there are more than 50 mandated health insurance benefits that specified carriers must provide to their enrollees. The federal Patient Protection and Affordable Care Act (ACA) requires nongrandfathered health plans to cover 10 essential health benefits (EHBs).

Under § 31-116 of the Maryland Insurance Article, EHBs must be included in the State benchmark plan and, notwithstanding 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**.

Maryland Assistive Technology Program

The Maryland Assistive Technology Program in the Maryland Department of Disabilities (MDOD) is intended to (1) increase access to AT devices and AT services for individuals with disabilities; (2) support the State's efforts to improve the provision of AT to individuals with disabilities of all ages, including underrepresented populations, through comprehensive statewide programs of technology-related assistance; (3) ensure statewide access to AT lending libraries that allow individuals with disabilities and those supporting individuals with disabilities to learn about, try, and borrow AT devices through short-term loans; and (4) implement activities required by federal grants, including funding authorized under the federal 21st Century Assistive Technology Act.

MDOD's Assistive Technology Loan Program helps Maryland residents with disabilities and their families qualify for low-interest loans to buy equipment that will help them live, work, and learn more independently, including elopement response devices.

State Fiscal Effect:

Medicaid

Under the bill, MDH must cover the cost of approved elopement response devices for Medicaid recipients who (1) are younger than age 21 and eligible for EPSDT services; (2) are eligible for an HCBS waiver; or (3) have Alzheimer's disease or a related dementia and meet medical necessity criteria established by MDH. By October 1, 2026, MDH must submit any State Plan or waiver amendments necessary to implement the bill.

MDH estimates that more than 46,000 Medicaid recipients would be eligible for an approved elopement response device under the bill, including individuals younger than 21 with an autism diagnosis, individuals with an Alzheimer's or related dementia diagnosis, and individuals with a specific diagnosis indicating that they are prone to wandering. MDH notes that participants enrolled in HCBS waivers are already eligible to receive elopement response devices under their existing AT benefit. However, as related devices must be directly tied to an activity of daily living, utilization is currently limited. Excluding those participants and estimating usage at 80% among non-waiver individuals and 15% among waiver individuals, MDH estimates that roughly 17,391 participants may be newly eligible for elopement response devices.

Elopement response devices require both the device itself and a fee to ensure continued monitoring. In fiscal 2025, the average per person cost associated with elopement-related devices was \$848 (including \$252 for a wearable device, \$496 for annual monitoring costs, and \$100 for a window/door device). To the extent that 17,391 individuals are ordered or prescribed an approved elopement response device by a qualified licensed provider, Medicaid expenditures increase by a significant amount (50% general funds, 50% federal funds) beginning in fiscal 2027. Actual expenditures depend on the number of individuals that require a device and the type(s) of device(s) chosen for them. Furthermore, the bill does authorize MDH to establish pilots or phased implementation of the required coverage, which could impact annual costs.

For illustrative purposes only, to provide a window/door device for all 17,391 individuals, expenditures increase by \$1.7 million (50% general funds, 50% federal funds). To provide a wearable device for all 17,391 individuals, expenditures increase by \$4.4 million (50% general funds, 50% federal funds) on an initial basis, and then on a recurring basis to replace devices as necessary (estimated at approximately once every two to five years). To provide monitoring of wearable devices for 17,391 individuals for one year, expenditures increase by \$8.6 million (50% general funds, 50% federal funds); this cost is ongoing for all recipients with wearable devices.

State Employee and Retiree Health and Welfare Benefits Program

The State plan is largely self-insured for its medical contracts and, as such, with the exception of the one fully insured integrated health model medical plan (Kaiser), is not subject to this mandate. However, the State plan generally provides coverage for mandated health insurance benefits.

Under the bill, carriers must provide coverage for an approved elopement response device and associated supports for an individual with Alzheimer's or a related dementia that meets medical necessity criteria established by MDH when the device is ordered or prescribed by a qualified licensed provider and documented in a qualifying plan.

Assuming the State plan provides the coverage, costs increase beginning in fiscal 2027. *For illustrative purposes only*, for every 100 individuals that take advantage of the benefit, State expenditures (general, federal, and special funds) increase by approximately \$75,000 to purchase a wearable device and provide a full year of monitoring. (Thus, if 1,000 individuals are covered, expenditures increase by approximately \$750,000.) As under Medicaid, some of these costs are assumed to be one-time-only, some are recurring every two to five years (for replacement devices), and monitoring costs are ongoing. Actual costs depend on how many individuals seek the benefit, how many are deemed eligible for coverage, and the type(s) of device(s) chosen for them.

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 the individual and small group ACA plans.

Additional Information

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

Designated Cross File: None.

Information Source(s): Office of the Attorney General; Department of Budget and Management; Maryland Department of Disabilities; Maryland Department of Health; Maryland Insurance Administration; Legislative Services; 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
