Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1435 (Delegate Spiegel, *et al.*)
Health

Health Insurance - Required Coverage - Hormone-Related Care

This bill requires certain insurers, nonprofit health service plans, and health maintenance organizations (collectively carriers) to provide coverage for "hormone-related care" as specified. By January 1, 2028, and annually thereafter, carriers must report specified information on claims for hormone-related care to the Maryland Insurance Administration (MIA). By July 1, 2028, and annually thereafter, MIA must submit a summary report of this information to the General Assembly. MIA must adopt regulations to carry out the bill. **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 increase in MIA special fund revenues in FY 2027 only from the $125 rate and form filing fee; any additional workload on MIA can be handled with existing budgeted resources. No impact on the State Employee and Retiree Health and Welfare Benefits Program.

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

Small Business Effect: Minimal.

Analysis

Bill Summary: "Hormone-related care" means medically necessary treatment involving the prescription, administration, monitoring, or adjustment of hormone therapies for endocrine, reproductive, metabolic, perimenopausal, menopausal, or other conditions.

"Medically necessary" means care that is consistent with generally accepted standards of medical practice, clinically appropriate for the patient's condition, and not primarily for the convenience of the patient or provider.

A carrier must provide coverage for hormone-related care, including:

- hormone replacement therapy;
- hormone suppression or modulation therapy;
- hormone-modulating medications;
- laboratory testing, diagnostic evaluations, and ongoing monitoring related to hormone therapy; and
- clinical visits for the initiation and continuation of hormone therapy or other hormone-related care.

Coverage may not be denied based on (1) the specific diagnosis for which the hormone-related care is prescribed, including menopausal and perimenopausal symptoms; (2) the patient's age; or (3) prior use or nonuse of hormone-related care.

A carrier may not (1) impose exclusions or limitations on hormone-related care that are more restrictive than those applied to comparable prescription drugs or medical services; (2) require prior authorization, step therapy, or repeated medical necessity reviews that are more burdensome than those applied to comparable treatments; (3) deny coverage solely because the hormone-related care is needed as an ongoing, long-term treatment; or (4) apply higher cost sharing, copayments, or deductibles for hormone-related care than comparable treatments.

A determination of medical necessity for hormone-related care must be based on evidence-based clinical guidelines, the professional judgment of the treating provider, and the individual needs of the patient. A carrier may not substitute its own clinical judgment for that of the treating provider if the provider's determination is consistent with accepted medical standards.

A carrier must ensure that covered individuals have timely access to hormone-related care, including access to in-network providers with appropriate expertise in endocrine, reproductive, perimenopausal, and menopausal care as well as coverage for out-of-network providers if in-network access is unavailable within a reasonable travel area.

By January 1, 2028, and annually thereafter, each carrier must report to MIA on (1) the total number of claims submitted for hormone-related care in the immediately preceding year, including care related to perimenopause and menopause; (2) the total

number of claims denied and the reasons for denying the claims; and (3) the average authorization and processing times.

Current Law: 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, 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**.

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 last three years.

Designated Cross File: None.

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

Fiscal Note History: First Reader - March 12, 2026
caw/ljm

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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