HB 1451

Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1451 (Delegate McComas, *et al.*)
Health

Public Health - Women's Health Care Data - Report

This bill requires the Maryland Department of Health (MDH) to collect and compile data annually regarding the costs of prenatal care, birth, postpartum care, pregnancy care, abortion services, and menopausal care, as specified, to (1) better understand the financial impact of these services; (2) inform public policy decisions related to maternal and reproductive health care; (3) evaluate whether public and private funds for women's health care are used effectively; (4) perform cost analyses to identify gaps or emerging needs; and (5) promote transparency and accountability in health care spending. MDH is not required to collect or report data that would violate federal or State privacy laws. The bill may not be construed to authorize or require the collection or disclosure of individually identifiable patient information or any other data that may compromise patient privacy or confidentiality. By December 1, 2026, and annually thereafter, MDH must submit a comprehensive report and analysis to the General Assembly and make the report publicly available on its website. **The bill takes effect June 1, 2026.**

Fiscal Summary

State Effect: No effect in FY 2026. MDH general fund expenditures increase by $298,000 in FY 2027 for personnel. Future years reflect ongoing costs and elimination of one part-time contractual position at the end of FY 2027. Revenues are not affected.

(in dollars)	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
Revenues	$0	$0	$0	$0	$0
GF Expenditure	298,000	223,800	234,100	244,700	255,400
Net Effect	($298,000)	($223,800)	($234,100)	($244,700)	($255,400)

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

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary:

Data Collection and Privacy

MDH must collect and compile data annually regarding the costs of:

- delivery, including (1) standard delivery costs; (2) costs of complications, including emergency interventions; and (3) neonatal care, if applicable;
- postpartum care, including (1) follow-up medical visits and (2) costs associated with addressing postpartum mental health conditions, including postpartum depression;
- pregnancy care, including (1) routine obstetric and gynecological visits; (2) prenatal vitamins and supplements; (3) diagnostic and monitoring services, including ultrasounds and genetic testing; and (4) perinatal mental health conditions, including perinatal depression;
- abortion, including (1) procedural costs; (2) costs associated with complications or follow-up care; (3) prescription costs for abortion pills, including costs associated with abortion pill reversals; (4) costs of abortion care training programs; and (5) post-abortive mental health symptoms, including anxiety, depression, or trauma-related indicators; and
- menopause-related health care, including (1) utilization and associated costs of hormonal and nonhormonal therapies; (2) availability and accessibility of educational and communications resources for patients and health care providers; and (3) mental health conditions related to perimenopause, menopause, and postmenopause, including diagnosis, treatment, and long-term management.

Abortion data must include only aggregated budget and expenditure data and may not include procedure-level details or any other information prohibited from disclosure under State law.

MDH must also track Maryland Medicaid funds used for chemical or surgical abortion procedures, including (1) the total expenditure allocated for chemical abortions, including associated prescription costs and (2) the total expenditure for surgical abortions, including pre- and postoperative care.

MDH must develop and implement a standardized reporting system, including forms and worksheets, with instructions, for the collection of revenues, charges, prices, and utilization data related to women's health care services for budgetary analysis and expenditure monitoring. Uniform reporting requirements must allow MDH to identify statewide and

regional trends in the cost, price, availability, and utilization of women's medical, surgical, reproductive, diagnostic, prenatal, postpartum, menopausal, and other health care services.

Each licensed hospital, health care provider, and any other entity that provides delivery, postpartum care, pregnancy care, abortion services, or menopause-related health care must use the MDH-developed reporting system to report applicable data. These entities must (1) comply with MDH's data submission requirements and (2) anonymize and de-identify patient data as necessary to comply with federal and State privacy laws.

Data collected under the bill must be limited to the information necessary to assess the costs of services for each category of care. MDH and any reporting entity may not collect or report personal health information or identifiable patient data.

Annual Report

The annual report must include, for the immediately preceding fiscal year: (1) aggregated cost data for delivery, abortion, postpartum care, pregnancy care, and menopause-related health care; (2) comparative data by region within the State; (3) analysis of trends in the costs of each category of care over time; and (4) recommendations, if any, for improving cost efficiency. The report may not include any personally identifiable information and must comply with all federal and State privacy laws.

Current Law: For more information on the status of abortion laws on the State and federal levels, please see **Appendix – Legal Developments Regarding Abortion**.

State Expenditures: Under the bill, MDH must (1) develop a standardized system to collect consistent data from each licensed hospital, health care provider, and any other entity; (2) collect and compile data annually regarding the cost of birth, postpartum care, pregnancy care, abortion, and menopause-related health care, as specified; (3) track Maryland Medicaid funds used for chemical or surgical abortion procedures; (4) evaluate whether public and private funds for women's health care are used effectively; (5) perform cost analyses to identify gaps or emerging needs related to women's health care; and (6) submit (and post on the MDH website) a comprehensive report by December 1, 2026, and annually thereafter. Given the scope of the bill, MDH requires additional resources.

Thus, MDH general fund expenditures increase by $298,011 in fiscal 2027. This estimate reflects the cost of hiring (1) one permanent full-time database specialist to develop the standardized reporting system and instructions for data submission, provide technical support, and maintain the system; (2) one permanent full-time epidemiologist to extract, clean, and analyze data sets and perform cost analyses and evaluations; and (3) one six-month contractual health policy analyst to provide stakeholder engagement on the new data collection process and prepare the first annual report. All positions are

assumed to be hired effective July 1, 2026, to ensure completion of the report by December 1, 2026. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Positions	2.5
Salaries and Fringe Benefits	$228,075
Operating Expenses	69,937
Total FY 2027 State Expenditures	**$298,011**

Future year expenditures reflect full salaries for the permanent positions with annual increases and employee turnover as well as annual increases in ongoing operating expenses. The contractual position is assumed to terminate December 31, 2026, following submission of the first annual report.

This estimate does not include any health insurance costs that could be incurred for specified contractual employees under the State's implementation of the federal Patient Protection and Affordable Care Act.

To the extent additional contractual support is needed in future years, general fund expenditures increase by an additional amount.

Additional Information

Recent Prior Introductions: Similar legislation has been introduced within the last three years. See SB 965 and HB 1357 of 2025.

Designated Cross File: SB 485 (Senator Carozza, *et al.*) - Finance.

Information Source(s): Maryland Department of Health; Department of Legislative Services

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sj/jc

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Appendix – Legal Developments Regarding Abortion

Status of Federal Abortion Law

In June 2022, the U.S. Supreme Court overturned precedent regarding abortion access in *Dobbs v. Jackson Women's Health Organization*. Before this decision, abortions prior to viability were constitutionally protected based on *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*. The petitioners in *Dobbs* sought to overturn the invalidation of Mississippi's Gestational Age Act, which prohibited abortions after 15 weeks gestation except for medical emergencies or severe fetal abnormalities. The U.S. Supreme Court upheld the Mississippi law by overturning *Roe* and *Casey*, holding that there is no constitutionally protected right to an abortion as it is not a right explicitly granted by the Constitution or a right "deeply rooted" in the country's history and tradition. The *Dobbs* decision leaves states to decide how to regulate abortion access, resulting in a patchwork of state laws with varying degrees of access to abortion care.

Maryland Abortion Law

Roe and *Casey* were codified in Maryland law before the *Dobbs* decision, thereby limiting its impact in the State. Section 20-209 of the Health-General Article prohibits the State from interfering with an abortion conducted (1) before viability or (2) at any point, if the procedure is necessary to protect the health or life of the woman or in cases of fetal defect, deformity, or abnormality. The Maryland Department of Health (MDH) may also adopt regulations consistent with established clinical practice if they are necessary and the least intrusive method to protect the life and health of the woman.

Chapter 56 of 2022 expanded beyond physicians the types of health care providers who may provide abortions to include nurse practitioners, nurse-midwives, licensed certified midwives, physician assistants, and other qualified licensed health care providers. The Act also established the Abortion Care Clinical Training Program to (1) ensure there are enough health care professionals to provide abortion services in the State and (2) require health insurers and Maryland Medicaid to cover abortion services without a deductible, coinsurance, copayment, or other cost-sharing requirement. Chapters 248 and 249 of 2023 require certain health insurers that provide labor and delivery coverage to also cover abortion care services, with limited exceptions.

Chapters 244 and 245 of 2023 proposed a constitutional amendment to (1) establish an individual's fundamental right to reproductive freedom, including but not limited to the ability to make and effectuate decisions to prevent, continue, or end one's own pregnancy and (2) prohibit the State from directly or indirectly denying, burdening, or abridging the

right unless justified by a compelling State interest achieved by the least restrictive means. In November 2024, Maryland voters approved this constitutional amendment through a ballot referendum.

Chapters 435 and 436 of 2025 established the Public Health Abortion Grant Program. The program was intended to transfer excess funds from carriers' segregated accounts, which are required under the federal Patient Protection and Affordable Care Act (ACA), to a separate fund under MDH to provide grants to improve access to abortion care clinical services for individuals without sufficient resources. Uncodified language in the Acts specified that the bills must terminate if the federal Centers for Medicare and Medicaid Services (CMS) advised that the bills violate the ACA. On December 9. 2025, CMS issued new guidance about the use of carriers' segregated funds. CMS subsequently notified the Maryland Insurance Administration that, in accordance with the guidance, the Acts exceed the permissible uses of the segregated funds under Section 1303 of the ACA. Therefore, the Acts must terminate.

Maryland Shield Laws

Chapters 248 and 249 generally prohibit the disclosure of mifepristone data or the diagnosis, procedure, medication, or related codes for abortion care and other sensitive health services (including reproductive health services other than abortion care) by a health information exchange, electronic health network, or health care provider. The Acts also define "legally protected health care" to mean all reproductive health services, medications, and supplies related to the provision of abortion care and other sensitive health services as determined by the Secretary of Health based on the recommendation of the Protected Health Care Commission.

Chapters 246 and 247 of 2023 generally (1) establish additional protections for information related to "legally protected health care" when that information is sought by another state; (2) prohibit a health occupations board from taking specified disciplinary actions related to the provision of legally protected health care; (3) prohibit a medical professional liability insurer from taking "adverse actions" against a practitioner related to the practice of legally protected health care; and (4) prohibit specified State entities, agents, and employees from participating in any interstate investigation seeking to impose specified liabilities or sanctions against a person for activity related to legally protected health care (with limited exception). Data related to legally protected health care is also generally protected from other states.

State Actions Following the Dobbs Decision

As of December 2025, 41 states have some type of abortion ban or gestational limit in place with limited exceptions. Thirteen states (Alabama, Arkansas, Idaho, Indiana, Kentucky,

Louisiana, Mississippi, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia) have implemented total abortion bans. Twenty-eight states have abortion restrictions based on gestational duration, including seven states that ban abortion at or before 18 weeks gestation and 21 states that ban abortion at some point after 18 weeks. All 41 states have an exception for a threat to the mother's life; 22 states have exceptions for a threat to the physical health of the mother; and 13 states have exceptions for a threat to the general health of the mother. Several states also have limited exceptions for rape (9 states), incest (8 states), or lethal fetal anomalies (13 states).