

Department of Legislative Services
Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1565 (Delegate Miller, *et al.*)
Health and Appropriations

Public Health - Obesity Management and Treatment Programs (Healthy
Maryland for Every Body)

This bill requires the Secretary of Budget and Management to include an obesity treatment and management program in the State Employee and Retiree Health and Welfare Benefits Program (State plan). The bill also requires certain insurers, nonprofit health service plans, and health maintenance organizations (collectively carriers) to provide coverage for an “obesity treatment and management program” to an individual who has been diagnosed with obesity, diabetes, or other obesity-related conditions. **The bill’s provisions governing the State plan take effect October 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; review of filings and complaints can likely be handled with existing budgeted resources. State plan expenditures increase by a significant amount, likely tens of millions of dollars, beginning in FY 2027, as discussed below.

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

Small Business Effect: None.

Analysis

Bill Summary:

State Employee and Retiree Health and Welfare Benefits Program

The obesity treatment and management program included in the State plan must (1) be developed in consultation with the Secretary of Health; (2) promote evidence-based, intensive, multicomponent behavioral and lifestyle modification interventions that support healthy weight management for individuals diagnosed with obesity, diabetes, and other obesity-related conditions; (3) for the purpose of preventing or delaying the onset of type 2 diabetes, include structured behavioral change sessions approved by the federal Centers for Disease Control and Prevention (CDC); (4) provide coverage for medication approved by the federal Food and Drug Administration (FDA) for chronic weight management in individuals diagnosed with obesity, diabetes, and other obesity-related conditions, as well as metabolic and bariatric surgery; and (5) provide services in office-based, virtual, and community-based settings to support State employee access.

The program may apply utilization management and prior authorization requirements to determine medical necessity for the treatment of obesity if such determinations are made using the same standards applied to the treatment of other chronic diseases and not applied in a manner that is more restrictive than those used for comparable medical or surgical benefits.

Mandated Health Insurance Coverage for Obesity Treatment and Management Program

An “obesity treatment and management program” required to be covered by a carrier means a program that (1) promotes evidence-based, intensive, multicomponent behavioral and lifestyle modification interventions that support healthy weight management for individuals diagnosed with obesity, diabetes, and other obesity-related conditions; (2) for the purpose of preventing or delaying the onset of type 2 diabetes, includes structured behavioral change sessions approved by CDC; (3) provides FDA-approved medication for chronic weight management in individuals diagnosed with obesity, diabetes, and other obesity-related conditions, as well as metabolic and bariatric surgery; and (4) provides services in office-based, virtual, and community-based settings to support access.

Current Law:

State Employee and Retiree Health and Welfare Benefits Program

The State plan is established in statute to provide health insurance benefit options to State employees and retirees. The Secretary of Budget and Management is charged with developing and administering the State plan, including selecting the insurance options to

be offered. The Secretary must include a wellness program in the State plan (developed in consultation with the Secretary of Health) that promotes the goals of the State Health Improvement Process and aims to achieve savings over time.

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**.

State Expenditures:

State Employee and Retiree Health and Welfare Benefits Program

The State plan is largely self-insured for its medical contracts and, as such, except for the one fully insured integrated health model medical plan (Kaiser), is not subject to State health insurance mandates. However, the State plan generally provides coverage as otherwise required under State law.

The State plan currently covers metabolic and bariatric surgery when consistent with guidelines approved by National Institutes of Health and deemed medically necessary. It also offers diabetes and weight loss programs (through carriers) and provides diabetic patients with a complementary cellular glucometer, unlimited test strips, diabetes coaching, and digital tools to support nutrition, exercise, and education (through the prescription benefits manager contract). Carriers offer a variety of discounted exercise/gym memberships and weight loss support through weight management programs. Each carrier reimburses up to \$150 for weight loss programs and all plans offer support through coaching. Prescription drug coverage under the State plan *excludes* weight loss drugs.

The Department of Budget and Management estimates that, assuming standard prior authorization for obesity coverage, typically available obesity management programs, and average utilization levels based on plan sponsors that currently provide such

coverage, State plan expenditures (general, special, and federal funds) increase by between \$25.0 million and \$40.0 million annually to implement the bill's prescription drug coverage component, and by an additional \$2.0 million to \$5.0 million annually for the program's treatment components.

To the extent that the obesity management and treatment program reduces obesity rates among enrollees, there may be long-term reductions in State plan spending on chronic diseases associated with obesity, such as heart disease, type 2 diabetes, and certain types of cancer. This estimate does not reflect such savings as they cannot be reliably projected.

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: Legislation with related provisions (mandating coverage for prescription weight loss drugs) has been introduced within the last three years. See HB 1031 of 2025.

Designated Cross File: None.

Information Source(s): Department of Budget and Management; Maryland Department of Health; 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
