SB 891

Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 891 (Senator Gile, *et al.*)
Finance Health

Health, Health Insurance, and Health Occupations - Perinatal Behavioral Health Conditions

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This bill requires certain health care providers to screen for a "perinatal behavioral health condition." Certain insurers, nonprofit health services plans, and health maintenance organizations (collectively carriers), as well as Medicaid, must provide coverage for such screenings. The bill alters existing requirements on the Maryland Department of Health (MDH) to identify written information about perinatal mood and anxiety disorders and requires certain health care providers and hospitals to provide certain information to patients. MDH must identify and develop training programs that improve early identification of perinatal behavioral health conditions. The bill also (1) requires a carrier to provide a certain standing referral; (2) requires certain health occupations boards to grant continuing education credits for perinatal behavioral health condition training; and (3) imposes a study and reporting requirement on the Maryland Health Care Commission (MHCC). **The bill's study and reporting requirement takes effect July 1, 2026; all other provisions take effect January 1, 2027, and insurance provisions 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. MDH, including Medicaid, the health occupations boards, and MHCC, can implement the bill's requirements using existing budgeted resources. No impact on the State Employee and Retiree Health and Welfare Benefits Program (State plan), as discussed below.

Local Effect: No likely increase in health care expenditures for local governments that purchase fully insured plans. Revenues are not affected.

Small Business Effect: Minimal.

Analysis

Bill Summary: "Perinatal behavioral health condition" means a behavioral health condition occurring during pregnancy or within one year after the conclusion of a pregnancy, including a pregnancy that does not result in a live birth. "Perinatal behavioral health condition" includes postpartum depression.

Perinatal Behavioral Health Screening

A health care provider who evaluates and manages pregnancy or postpartum care must conduct a screening for perinatal behavioral health conditions at well visits within the first year of the child's life, as determined appropriate by the treating health care provider.

MDH must identify acceptable screening tools, which must be validated, routinely used, free, easy to administer and score, and available in multiple languages. MDH must assist health care providers with accessing resources and referral services through the Maryland Behavioral Health Integration in Pediatric Primary Care, the Maternal Health Innovation Program, and Postpartum Support International to assist providers in finding timely and effective care for individuals identified as at risk for a perinatal behavioral health condition.

Coverage for Screening for Perinatal Behavioral Health Conditions

A carrier and Medicaid, effective January 1, 2027, must provide coverage for screening for perinatal behavioral health conditions at well visits within the first year of the child's life, as determined appropriate by the treating health care provider.

Information about Perinatal Behavioral Health Conditions

MDH must identify specified written information about perinatal *behavioral health conditions* (rather than mood and anxiety disorders under current law). In addition to current recipients of this information, MDH must provide the information to each local Supplemental Nutrition Program for Women, Infants, and Children (WIC) agency in the State.

This information must also be provided by a hospital to a birthing parent on discharge from the birthing hospital. A health care provider who evaluates and manages perinatal care must provide this information (or other appropriate information on perinatal behavioral health conditions) to a patient at least once during each trimester.

Identification and Development of Training Programs

MDH, in consultation with the State Board of Physicians, the State Board of Nursing, and Postpartum Support International, must identify and develop training programs that improve early identification of perinatal *behavioral health conditions* (rather than postpartum depression and perinatal mood and anxiety disorders as under current law). MDH must provide a list of training programs on request.

Health Occupations Continuing Education Requirements

Each health occupations board that requires a licensee or certificate holder to complete continuing education as a condition of license or certificate renewal must grant at least two hours of continuing education credits for every one hour of continuing education on perinatal behavioral health conditions identified by MDH.

Each health occupations board may adopt regulations to carry out this requirement, including regulations establishing the maximum number of continuing education credits that may be granted.

Standing Referral to a Behavioral Health Care Provider

An individual entitled to health care benefits under a policy or plan issue or delivered in Maryland by a carrier (a member) must receive a standing referral to a behavioral health care provider acting within the scope of the provider's license (including a psychiatrist, psychologist, licensed social worker-clinical, or licensed professional counselor) for (1) the behavioral health services recognized by the U.S Preventive Services Task Force (USPSTF) as preventive benefits and (2) the duration of the member's pregnancy and one year after the conclusion of the pregnancy. A written treatment plan may not be required for this standing referral.

Maryland Health Care Commission Study

By December 1, 2026, MHCC must conduct an analysis on the impact of (1) requiring Medicaid, the State plan, and carriers to provide coverage for screening for perinatal behavioral health conditions at each prenatal visit, at least once every six weeks after giving birth, and at each well child visit within the first year of the child's life and (2) prohibiting these entities from either imposing a copayment or coinsurance requirement or deductible that is greater than that for similar coverages or imposing any copayment, coinsurance, or deductible. MHCC must report on its findings and recommendations to the Senate Finance Committee and the House Health Committee.

Current Law:

Information about Perinatal Mood and Anxiety Disorders

MDH (in consultation with stakeholders) must identify up-to-date, evidence-based, written information about perinatal mood and anxiety disorders that (1) has been reviewed by medical experts and national/local organizations specializing in maternal mental health; (2) is designed for use by health care providers, pregnant/postpartum women, and the families of pregnant/postpartum women; (3) is culturally and linguistically appropriate for potential recipients of the information; (4) includes contact information for national/local maternal mental health programs; and (5) includes information addressing:

- the signs and symptoms of perinatal mood and anxiety disorders;
- perinatal medication usage;
- risk factors of perinatal mood and anxiety disorders (including perinatal loss and high-risk pregnancy);
- how and when to screen for symptoms of perinatal mood and anxiety disorders;
- brief intervention strategies; and
- evidence-based psychosocial treatments.

MDH must provide the information identified to health care facilities and providers that provide prenatal care, labor and delivery services, and postnatal care to expectant parents and make the information available on the MDH website.

Identification and Development of Training Programs

MDH (in collaboration with specified stakeholders) must identify and develop training programs that improve early identification of postpartum depression and perinatal mood and anxiety disorders. Any training programs developed by MDH must include continuing medical education programs developed by organizations that are accredited by the Accreditation Council for Continuing Medical Education.

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), which include mental health and substance use disorder services, including behavioral health treatment, as well as preventive and wellness services and chronic disease management.

Under the ACA, most health plans must cover preventive services with no cost sharing. This includes depression screening for adults and adolescents ages 12 and older and maternal depression screenings for mothers at well-baby visits. USPSTF recommends screening for depression and anxiety disorders in adults (including pregnant and postpartum persons).

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**.

Standing Referrals

Each carrier that does not allow direct access to specialists must establish and implement a procedure by which a member may receive a standing referral to a specialist. The procedure must provide for a standing referral if (1) the primary care physician, in consultation with the specialist, determines that the member needs continuing care from the specialist; (2) the member has a condition or disease that is life threatening, degenerative, chronic, or disabling and requires specialized medical care; and (3) the specialist has the appropriate expertise and is part of the carrier's provider panel. A treatment plan may limit the number of visits, limit the period of time in which the visits are authorized, and require the specialist to communicate regularly with the primary care physician regarding the treatment and health status of the member.

A carrier must provide a member who is pregnant with a standing referral to an obstetrician. After the member receives the standing referral, the obstetrician is responsible for the primary management of the member's pregnancy, including the issuance of referrals through the postpartum period. A written treatment plan may not be required when a standing referral is to an obstetrician.

State Expenditures:

Maryland Department of Health

Under the bill, MDH, in consultation with stakeholders, must identify specified screening tools for conducting the perinatal behavioral health screenings required under the bill, assist health care providers with accessing specified resources and referral services, and identify

and develop training programs that improve early identification of perinatal behavioral health conditions that may be used by health occupations licensees and certificate holders for continuing education. MDH must also provide specified written information about perinatal behavioral health conditions to each local WIC agency in the State. MDH advises that the Prevention and Health Promotion Administration can collaborate with stakeholders to identify or develop provider training programs and disseminate information using existing budgeted resources.

Also under the bill, each health occupations board may adopt regulations regarding continuing education credit hours on perinatal behavioral health conditions. MDH advises that the health occupations boards can adopt regulations using existing budgeted resources.

MHCC must conduct an analysis on the impact of (1) requiring Medicaid, the State plan, and carriers to provide coverage for screening for perinatal mental health conditions at each prenatal visit, at least once every six weeks after giving birth, and at each well child visit within the first year of the child's life and (2) prohibiting these entities from either imposing a copayment or coinsurance requirement or deductible that is greater than that for similar coverages or imposing any copayment, coinsurance, or deductible. MHCC must report on its findings and recommendations by December 1, 2026. MHCC advises that it can complete this analysis using existing budgeted resources.

Department of Budget and Management

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 exempt from most State health insurance mandates. However, the program generally provides coverage as otherwise required under State law.

Under the bill, a carrier must provide coverage for screening for perinatal behavioral health conditions at well child visits within the first year of the child's life, as determined appropriate by the treating health care provider. The Department of Budget and Management advises that, as this language aligns with the recommendations of USPSTF, there is no fiscal impact on the State plan.

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 any 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: HB 1118 (Delegate White Holland, *et al.*) - Health.

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