Bureau of Insurance

A Report to the Joint Standing Committee on Insurance and Financial Services of the 122nd Maine Legislature

Follow-up Review and Evaluation of
Public Law 2003, ch. 20, Part VV,
Required Parity for Mental Health Coverage

January 1, 2006

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I. Executive Summary

Public Law 2003, ch. 20, Part VV directed the Bureau of Insurance to review and evaluate the financial impact, social impact and medical efficacy of the revised mental health and substance abuse parity mandate in the same manner as required for proposed mandated health benefits legislation. Additionally, the report was to include a comparison of the projected cost impact of this mandated benefit prior to enactment and the actual cost impact of the mandated benefit based on premium information after enactment. The law requires this report to be submitted to the Joint Standing Committee on Insurance and Financial Services by January 1, 2006.

The revised mental health and substance abuse parity mandate was effective on October 1, 2003 and amended the previous mental health mandate. Among other changes, it requires parity (benefits equal to those for physical illness) for an expanded list of diagnoses.

The new requirements do not apply to individual coverage or to employers with 20 or fewer employees. Also, the revised mandate does not apply to federal/state funded programs, such as Medicaid, or federally funded programs, such as Medicare and the Veterans Benefits Administration. Single employer self-funded health plans are be exempt through the federal Employee Retirement Income Security Act (ERISA) of 1974.

In general, mental health services have shown to be effective in reducing suicide, reducing substance abuse, improving quality of life, decreasing absenteeism, and improving health for multiple conditions. General health can be improved from the treatment of eating disorders and other disorders that have a direct impact on the physical well being of the patient. Any improvements in outcomes resulting from Maine's revised mental health parity law are also dependent on changes in access to care, utilization of care, and the appropriateness and effectiveness of treatment.

Thirty-four states have passed laws on mental health parity. These laws have varied significantly in what they require. Most studies of federal and state mental health parity laws have found minimal increases in cost or utilization. Researchers have found that with the implementation of mental health parity, health plans have increased the use of mental health managed care, which has offset cost increases. A recent California study found a net increase in total health care costs from their parity legislation of 0.2115%.[1]

Other mental health parity analysis has suggested that the increase in mental health services may be somewhat offset by a saving in medical services that may result from untreated mental health conditions.[2]

[1] *Analysis of Senate Bill 572 Mental Health Benefits; A Report to the 2005-2006 California Legislature*; April 16, 2005

[2] National Advisory Mental Health Council, *Insurance Parity for Mental Health: Cost, Access, and Quality* , June 2000

The revised parity mandate enacted in 2003 was based on LD 1627 from the previous legislative session. From the report the Bureau prepared in 2002 for LD 1627, the expected impact on premiums was originally expected to be between 0.44% and 0.83% for large group plans.

It is too soon after the effective date for the revised parity mandate in Maine to have sufficient data to determine the ultimate impact on premiums and administrative expenses. Data reported by carriers indicates that 2004 mental health costs were approximately 3.14% of total group claims and substance abuse claims are approximately .58% of total group claims compared to 3.02% and .59% respectively in 2003. These statistics would lead us to conclude that the revisions to the mandate had little or no impact on claims costs, but it may take time for practice protocols and public awareness to react to the new law.

It had been assumed that the parity legislation would yield potential savings within MaineCare (Medicaid), as more services would be reimbursed by private insurance. Since the revised law does not require parity with MaineCare services and MaineCare provides some services that private insurance does not cover, the projected savings have not been realized.

Even though the parity legislation has not achieved the anticipated cost savings to date, the Commissioners of the Departments of Administrative and Financial Affairs and of Health and Human Services reported in January 2005[3] that the following had been accomplished:

- Misunderstandings in claims submissions by providers has been clarified;
- The Department of Health and Human Services (DHHS) and providers now have an understanding of which specific services are covered by individual private insurers and which are not covered;
- Some of the billing and paperwork burden for providers has been lessened, and DHHS has a clear understanding of which services are appropriate for cost avoidance;
- The Maine Association of Mental Health Services is considering options for services and supports for mental health providers for more cost effective claims management.

This report was prepared by Marti Hooper, CEBS of the Maine Bureau of Insurance with assistance from Donna Novak, FCA, ASA, MAAA of NovaRest, Inc.

[3] January 27, 2005 report submitted by the Commissioner of Administrative and Financial Services and the Commissioner of Health and Human Services to the Joint Standing Committees on Insurance and Financial Services and Appropriations and Financial Services

II. Background

Public Law 2003, ch. 20, Part VV directed the Bureau of Insurance to review and evaluate the financial impact, social impact and medical efficacy of the revised mental health and substance abuse parity mandate in the same manner as required for proposed mandated health benefits legislation. Additionally, the report was to include a comparison of the projected cost impact of this mandated benefit prior to enactment and the actual cost impact of the mandated benefit based on premium information after enactment. The legislation required that, as part of the assessment of the medical efficacy of the mandate, the Bureau consult with the Department of Human Services, the Department of Behavioral and Developmental Services, and providers of mental health services to determine whether the mandate has increased early intervention and treatment for mental illness and reduced the severity of mental illness experienced by residents of this State. The law requires this report to be submitted to the Joint Standing Committee on Insurance and Financial Services by January 1, 2006.

The term "mental health parity" generally refers to insurance coverage for mental health services that are not more restrictive or limited than coverage for other health services. The definition of what is considered a mental illness varies significantly between federal and state parity laws. Also, the way in which benefits must mirror benefits for other health services vary. For example the federal law requires lifetime limits to be the same for mental health and medical, but copayments may vary between the types of services.

Revised Mandate

The revised mental health and substance abuse parity mandate was effective for policies issued or renewed on or after October 1, 2003 and amended the previous mental health mandate. Among other changes, it requires parity (benefits equal to those for physical illness) for an expanded list of diagnoses.

Group contracts, other than those covering employers with 20 or fewer employees, must provide benefits at least equal to those for physical illnesses for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual (DSM), except for those that are designated as "V" codes by the DSM:

(1) Psychotic disorders, including schizophrenia;
(2) Dissociative disorders;
(3) Mood disorders;
(4) Anxiety disorders;
(5) Personality disorders;
(6) Paraphilias;
(7) Attention deficit and disruptive behavior disorders;
(8) Pervasive developmental disorders;
(9) Tic disorders;

(10) Eating disorders, including bulimia and anorexia; and
(11) Substance abuse-related disorders.

Other new provisions added to the mental health parity mandate include:

- If coverage for physical illness is provided on an expense-incurred basis, the coverage for mental illness may be delivered separately under a managed care system.
- A policy may not have separate maximums, deductibles, coinsurance or limits for physical illnesses and listed mental illnesses. The plan may not impose a limitation on coverage for listed mental illnesses unless that same limitation is also imposed on the coverage for physical illnesses.
- If the policy requires coinsurance for physical illness but instead requires copayments for mental illness, the copayments required for coverage of listed mental illnesses must be actuarially equivalent to the coinsurance requirements for coverage of a physical illness.
- A medication management visit associated with a listed mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits.

Prior to the 2003 revision, the mental health mandate required coverage of medically necessary health care for mental illness to include inpatient care, day treatment services, and outpatient services. The revised mandate also includes home health care services. Home health care services are defined as services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if hospitalization or confinement in a residential treatment facility would otherwise have been required. Home health care services must be prescribed in writing by a physician or psychologist. Hospitalization cannot be required as an antecedent.

III. Social Impact

A. Social Impact of Mandating the Benefit

1. The extent to which the treatment or service is utilized by a significant portion of the population.

Approximately 20% of the United States population is estimated to have a mental disorder each year.[4] Mental health and counseling services are used by a significant portion of the population. According to the Center for Mental Health Services, between 2.8% and 5.3% of Maine residents have serious mental health conditions.[5] They also estimate that 22% of the population will need mental health care at some point in their lives.

A study published by the Maine Office of Substance Abuse (OSA) indicates that approximately 52,923 Maine adults had an alcohol use disorder in 2000, and an additional 21,169 adults had a drug use disorder.[6] Marijuana is the most frequently used illegal drug. Although the use of other illegal drugs is increasing, there is a relatively low prevalence rate in Maine. A more recent report by OSA states that in 2004, approximately 14,925 individuals were admitted for substance abuse treatment.[7]

2. The extent to which the service or treatment is available to the population.

Substance abuse and mental health treatment is available to Maine residents in a variety of settings. These include general hospitals, psychiatric hospitals, residential facilities and out-of-state facilities. Substance abuse treatment is provided by psychiatrists, physicians, licensed clinical social workers, licensed counselors, psychologists and licensed alcohol and substance abuse counselors. There are more than 100 agencies licensed in Maine to provide substance abuse services.

Mental health treatment is provided by psychiatrists, physicians, licensed clinical social workers, psychologists, psychiatric nurses and other professionals. In 2005 there were 564 licensed psychologists, 258 licensed psychiatrists, 138 psychiatric clinical nurses, 20 licensed pastoral counselors, 750 licensed clinical professional

[4] *Analysis of Senate Bill 572 Mental Health Benefits; A Report to the 2005-2006 California Legislature*; April 16, 2005
[5] Mental Health News Alert-Grant Opportunities, 1999, page 13.
[6] Maine Office of Substance Abuse, The Economic Costs of Alcohol and Drug Abuse in Maine, 2000.
[7] Maine Office of Substance Abuse, Annual Report 2004.

counselors, 116 licensed marriage and family therapists and 1,842 licensed clinical social workers in Maine.

3. *The extent to which insurance coverage for this treatment or service is already available;*

The revised mental health and substance abuse parity mandate amended the previous mental health mandate. Among other changes, it requires parity (benefits equal to those for physical illness) for an expanded list of diagnoses.

Group contracts, other than those covering employers with 20 or fewer employees, must provide benefits at least equal to those for physical illnesses for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual (DSM), except for those that are designated as "V" codes by the DSM:

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(8) Pervasive developmental disorders;
(9) Tic disorders;
(10) Eating disorders, including bulimia and anorexia; and
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Other new provisions added to the mental health parity mandate include:

- If coverage for physical illness is provided on an expense-incurred basis, the coverage for mental illness may be delivered separately under a managed care system.
- A policy may not have separate maximums, deductibles, coinsurance or limits for physical illnesses and listed mental illnesses. The plan may not impose a limitation on coverage for listed mental illnesses unless that same limitation is also imposed on the coverage for physical illnesses.
- If the policy requires coinsurance for physical illness but instead requires copayments for mental illness, the copayments required for coverage of listed mental illnesses must be actuarially equivalent to the coinsurance requirements for coverage of a physical illness.
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Prior to the 2003 revision, the mental health mandate required coverage of medically necessary health care for mental illness to include inpatient care, day treatment services, and outpatient services. The revised mandate also includes home health care services. Home health care services are defined as services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if hospitalization or confinement in a residential treatment facility would otherwise have been required. Home health care services must be prescribed in writing by a physician or psychologist. Hospitalization cannot be required as an antecedent.

As of January 1, 2006 health plans are required to reimburse licensed pastoral counselor and marriage and family therapists providing mental health treatment.

The new requirements do not apply to individual coverage or to employers with 20 or fewer employees. The mandated offer for individuals and employers with 20 or fewer employees has not changed.

4. *If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.*

Coverage is available for persons with substance abuse and mental health problems.

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

Health plans providing substance abuse and mental health benefits are generally available for purchase by individuals and employers. However, prior to the enactment of the revised parity laws, health plans generally did not fully meet requirements in the revised mandate.

A study done by the National Advisory Mental Health Council in 2000[8] concluded that even limited reductions in co-insurance rates and deductibles can increase access for those that need mental health services the most. These individuals are often low income and deductibles, co-insurance, and copays that exceed those charged for medical services can serve as a barrier to accessing care.

Among the 5.5 million adults who did not receive treatment nationally but

[8] National Advisory Mental Health Council, *Insurance Parity for Mental Health: Cost, Access, and Quality*, June 2000 Substance Abuse and Mental Health Services Administration. (2004). *Results from the 2003 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-25, DHHS Publication No. SMA 04-3964). Rockville, MD.

perceived an unmet need for treatment in the past year, the following were the five most commonly reported reasons for not receiving treatment: cost or insurance issues (45.1 percent), not feeling a need for treatment (at the time) or thinking the problem could be handled without treatment (40.6 percent), not knowing where to go for services (22.9 percent), perceived stigma associated with receiving treatment (22.8 percent), and did not have time (18.1 percent). Less commonly reported reasons were "treatment would not help" (10.3 percent), "fear of being committed or having to take medicine" (7.2 percent), and reasons relating to access barriers other than cost (3.7 percent).[9]

6. *The level of public demand and the level of demand from providers for this treatment or service.*

The treatment and services are currently available; the mandate only expanded the insurance coverage.

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

Based on the testimony provided to the Joint Standing Committee on Banking and Insurance when the revised mandate was proposed, the demand for mental health parity legislation is from health care professionals, organizations that advocate for health care professionals, citizens that have experienced high costs for mental health services that were not covered by insurance and organizations that advocate for those with mental health or substance abuse disorders. The Maine Medical Association, the Maine Psychological Association, the Mid-Maine Alliance for the Mentally Ill, the Association of Mental Health Services, Consumers for Affordable Health Care and the Maine Clinical Counselors Association submitted written testimony in favor of this legislation.

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.*

No information is available.

9. *The likelihood of meeting a consumer need as evidenced by the experience in other states.*

Thirty-four states have passed laws on mental health parity (See Appendix C). These laws have varied significantly in what they require. In 2005, at least seven states

[9] Substance Abuse and Mental Health Services Administration. (2004). *Results from the 2003 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-25, DHHS Publication No. SMA 04-3964).

required parity for all mental health conditions listed in the DSM-IV and others have limited parity to certain sets of illnesses. The more commonly covered sets of conditions are referred to as either serious mental illness[10] (SMI) or biologically based mental illness (BBMI). Other states have mandated a certain number of inpatient hospitalization days and outpatient visits related to mental illness that a health plan must provide.

Most studies of federal and state mental health parity laws have found minimal increases in cost or utilization. Researchers have found that with the implementation of mental health parity, health plans have increased the use of mental health managed care. This has offset cost increases and in some cases, costs have decreased due to the health care management.

California did an extensive study of their mental health parity legislation and found:[11]

- the following positive impacts:
  - most aspects of implementation had gone smoothly
  - health insurance benefits for mental health services had been expanded
  - adverse consequences in the health insurance market did not occur
  - health insurance premiums did not increase substantially, and
  - employers did not drop health coverage for their employees or become self-insured to avoid the state's parity mandate.

- the following negative impacts:
  - implementation of parity for selected conditions (SMI) and serious emotional disturbances (SED) of a child, rather than all mental health diagnoses, created administrative challenges and confusion
  - several large health insurers changed coverage to managed behavioral health organizations (MBHOs) from integrated physician services, disrupting care for some consumers, and
  - consumers were not well informed about changes and providers often had to act as intermediaries for their patients.

10. The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

The Bureau of Insurance met with representatives of the Department of Health and Human Services office of Behavioral and Developmental Services regarding the impact of mental health parity. They discussed whether the mandate has increased

[10] Approximately a quarter of those with mental illness have a condition considered to be a serious mental illness.
[11] *Analysis of Senate Bill 572 Mental Health Benefits; A Report to the 2005-2006 California Legislature*; April 16, 2005

early intervention and treatment for mental illness and reduced the severity of mental illness experienced by residents of Maine. The consensus was that due to the short time that the increased parity mandate has been in place and the difficulty of collecting that type of information, it is currently not possible to determine if there has been an increase in early intervention. There is no mechanism in place currently to measure the severity of mental illness experienced by residents in Maine or whether the severity is changing.

It is estimated that as of January 2005, 9.4 % of the MaineCare population of 262,934 also has private insurance. There was no available breakdown of adults and children.

11. Alternatives to meeting the identified need.

Health plans in Maine were surveyed with this question and responded:

CIGNA Behavioral Health

- There needs to be better clarification to the following statement, "Co-payments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any co-payment or coinsurance required under the policy or contract for a benefit or coverage for a physical illness." This becomes an area where the intent is good but the devil is in the details. Because behavioral health visits are more frequent than usual medical visits, leaving the mapping of the visit type open to interpretation could allow a plan to set up co-payments equal to a medical office visit, (typical $20 - 50) which could be prohibitive for access to behavioral health. Would suggest clarification of mapping behavioral health visits to a type of medical visit that has a frequency similar to behavioral health, (rehabilitation visits, physical therapy, etc areas where there are lower co-payments).
- Would suggest a definition of treatment to be included to clearly differentiate it from "custodial care" as a part of unlimited benefits.
- Unlimited benefits for substance abuse has been an area of concern around the potential for creating a never ending cycle of coverage for a chronic relapsing disease where entries into multiple intensive higher levels of care because of a lack of ambulatory care follow up is not uncommon. Would suggest language that places a stipulation around ambulatory care follow up as a way to assure continuation of unlimited benefits in this arena. For example, "Access to unlimited benefits for substance abuse require that post discharge from any inpatient setting where the primary diagnosis is substance dependency there must be evidence of initiation of ambulatory services, (partial hospitalization, Intensive outpatient, and/or straight

outpatient visits) and engagement (3 ambulatory visits within 30 days HEDIS AOD definition)."

Anthem Blue Cross and Blue Shield responded that they would like to see clarifications to define what management of services is permitted within the law.

12. *Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.*

The coverage of mental health benefits is not inconsistent with the role of insurance. Managed care is used successfully with the coverage of mental health benefits.

13. *The impact of any social stigma attached to the benefit upon the market.*

Historically, there has been a social stigma attached to substance abuse and mental health treatment, but this stigma is lessening. With increased knowledge of these conditions and treatment advances, this stigma has become less intense and pervasive.

14. *The impact of this benefit upon the other benefits currently offered.*

According to a report published by the National Health Care Purchasing Institute;

> "General medical costs for those with mental disorders have been linked to somatic diseases as well as to significantly higher rates of emergency room use, including visits for injuries, poisoning, neoplasm, and circulatory system complaints.
>
> A landmark study published in 1993 on the costs of depression in the United States estimated that $12 billion was spent for health care, compared to the almost $24 billion that was borne by employers for lost work time and reduced productivity. More recent evidence suggests that this estimate is too low.
>
> A recent study in a large U.S. company found that total medical expenditures of those with mental disorders were four-and-a-half times higher than those with none. For people with two or more concurrent disorders, medical expenditures increased tenfold."[12]

[12] Goff, Veronica and Patricia Pittman, *Making the Case for Improving Mental Health Care*; September 2002

15. *The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.*

There should be no measurable shift given the limited change in percentage of claims reported by carriers in Maine for mental health and substance abuse.

16. *The impact of making the benefit applicable to the state employee health insurance program.*

Anthem Blue Cross and Blue Shield reported that, it is difficult to distinguish the impact of parity alone due to the other changes occurring at nearly the same time as the parity change. The estimated impact provided by Anthem Blue Cross and Blue Shield for the state employee health plan was $360,000 on an annual basis which would have impacted premiums by approximately 0.25%

IV. Financial Impact

B. Financial Impact of Mandating Benefits.

1. The extent to which the proposed insurance coverage would increase or decrease the cost of the service or treatment over the next five years.

The increase in benefits due to the revised law is likely to increase the demand for substance abuse and mental health treatment. When demand increases, it is often accompanied by an increase in the cost of the service.

2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.

In a 1999 report on mental health, the Surgeon General estimated that almost one-half of those receiving services for mental health did not have a diagnosable mental health problem.[13] This would indicate that, if these services were covered without managed care techniques in place, inappropriate utilization would increase. The revised law does not appear to preclude applying managed care or fraud detection to combat inappropriate use of services or treatment.

With the additional coverage and the use of managed care techniques, the appropriate use of treatment may increase.

3. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

Without the use of mental health managed care techniques, more expensive providers and settings may inappropriately be substituted for less expensive providers due to the insurance coverage. Managed care techniques can be used to ensure that the most cost effective treatment is used.

4. The methods which will be instituted to manage the utilization and costs of the proposed mandates.

Mental health parity requirements are often implemented by health plans with the additional use of utilization and cost management. The increase in access is balanced by the use of utilization management mechanisms to ensure the cost

[13] Mental Health: A Report of the Surgeon General, 1999

effective use of services. There is also an increased use of provider networks that have negotiated rates with health plans to control the cost of services.

5. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

In general, the number of providers of a service increases with the availability of reimbursement for that service. In 1995, prior to the mental health parity mandate for listed conditions and mandating coverage for Licensed Clinical Professional Counselors, it was reported that there were 474 Licensed Clinical Professional Counselors in Maine[14] and currently it is reported that there are 750.[15] Also, there were 289 licensed psychologists, 134 licensed psychiatrists, and 521 licensed clinical social workers in 1995 compared to 564, 258, [16] and 1842 respectively in 2005. This may indicate that mandating the increased coverage for mental health benefits in general will stimulate a growth in mental health providers.

6. *The extent to which the insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

It is too soon after the effective date for the revised parity mandate to have sufficient data to determine the ultimate impact on premiums and administrative expenses.

The following table shows the percentage of total health care claims that represent mental health and substance abuse in 2003 and 2004. Because the revised law took effect on policy anniversaries on or after October 1, 2003, it was not fully implemented until September 2004. Therefore, the 2003 experience reflects benefit levels prior to the new law with the exception of the last few months for the relatively few groups with anniversaries in the last quarter. The 2004 experience reflects a full year under the new law for groups with anniversaries in the last quarter and for relatively large number of groups with a January 1 anniversary. For other groups, it reflects between four and eleven months under the new law.

The following statistics show a small change in mental health and substance abuse cost compared to all of health care. This would lead us to conclude that the mandate had little or no impact on claims costs, but it may take time for practice protocols and public awareness to react to the new law.

[14] Bureau of Insurance Review of LD 68, April 1995
[15] Data received from the Professional and Financial Department, Office of Licensing and Registration and the Department of Health and Human Services, Office of Data, Research and Vital Statistics
[16] Maine Board of Licensure in Medicine

Summary of Mandated Group Mental Health/Substance Abuse Benefits Report[17]

2003

	Substance Abuse Benefit by Type		Mental Health Benefits by Type		
	Inpatient	Outpatient	Inpatient	Outpatient	Day Treatment
All Products	55.23%	44.77%	28.67%	70.60%	0.74%
Managed Care	54.63%	45.37%	28.07%	70.93%	1.00%
Non-Managed Care	57.45%	42.55%	29.95%	69.87%	0.18%

2004

	Substance Abuse Benefit by Type		Mental Health Benefits by Type		
	Inpatient	Outpatient	Inpatient	Outpatient	Day Treatment
All Products	52.83%	47.17%	26.75%	72.89%	0.36%
Managed Care	52.11%	47.89%	25.90%	73.65%	0.45%
Non-Managed Care	54.75%	45.25%	28.78%	71.07%	0.15%

2003

	Percent of Total Claims	
	Substance Abuse	Mental Health
All Products	0.59%	3.02%
Managed Care	0.65%	2.87%
Non-Managed Care	0.45%	3.39%

2004

	Percent of Total Claims	
	Substance Abuse	Mental Health
All Products	0.58%	3.14%
Managed Care	0.56%	2.94%
Non-Managed Care	0.65%	3.76%

7. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

   Effective treatment of substance abuse and mental health problems may result in reduced costs for incarceration, absenteeism, accidents and severe medical conditions.

8. *The impact on the total cost of health care, including potential benefits and savings*

[17] Maine Bureau of Insurance, http://www.state.me.us/pfr/120_Legis/reports/ins_AnnualMandatedReport2004.htm

to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.

Other mental health parity analysis has suggested that the increase in mental health services may be somewhat offset by a saving in medical services that may result from untreated mental health conditions.[18] It is logical to believe that individuals with improved mental health will experience improved physical health due to their improved mental state. Depressed individuals may not take as good physical care of themselves and extreme cases may lead to suicide attempts or automobile accidents as a result of substance abuse.

A recent California study found a net increase in total health care costs from their parity mandate of 0.2115%.[19]

9. *The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

The revised parity mandate enacted in 2003 was based on LD 1627 from the previous legislative session. The table below shows the expected impact on large group premiums from the Bureau's 2002 report on LD 1627.

Original Estimated Large Group Premium Increases for LD 1627					
Fee-for-Service			Comprehensive Managed Care		
SA	**MH**	**Total**	**SA**	**MH**	**Total**
0.18%	0.65%	0.83%	0.23%	0.21%	0.44%

It is too early to have the data to provide an analysis of the ultimate premium impact compared to the original estimate. As of the writing of this report, data was only available through the end of 2004 or beginning of 2005. At that time, the mandate had not been effective for all groups for a full year and the market may not have had sufficient time to react to the mandate. As practice protocols change and

[18] National Advisory Mental Health Council, *Insurance Parity for Mental Health: Cost, Access, and Quality* , June 2000
[19] *Analysis of Senate Bill 572 Mental Health Benefits; A Report to the 2005-2006 California Legislature;* April 16, 2005

public awareness increases, we may see more of an impact. When surveyed concerning premium impact the health plans in Maine responded:

CIGNA Behavioral Health reported that they had not calculated savings or increases in premiums so they were unable to respond to this item.

Aetna reported "With regards to the expanded parity mandate, Aetna effectively made no change to our premiums, or administrative expenses for the change in Mental Health benefits for any of our Maine products. For Substance Abuse the premium change was a .1%. Overall we have seen no changes due to the mandate."

Anthem Blue Cross and Blue Shield responded: "We believe that the ultimate cost impact was" an increase of "approximately 10%" of mental health claims "due to the impact of parity although due to a number of simultaneous variables it is difficult to measure definitively. The new parity law became effective, on renewal, as of October 1, 2003. Soon thereafter, on January 1, 2004, Anthem implemented fee increases for most products. Additionally, on January 1, 2004, Anthem Behavioral Health took over as the new vendor for behavioral health services. The combination of parity, fee increases, and a new vendor resulted in extremely high behavioral health trends and makes it difficult to assign a value to the impact of parity alone."

Harvard said the revised parity mandate did not require any changes in their coverage because they were already covering at the mandated level. They do not have many members and so cannot give credible numbers of impact.

United Healthcare said they have a very small block of business affected by the mandate. There are no large groups as of 12/31/04 and only 7 small groups with a total of 16 employees.

10. The effect of the proposed mandates on cost-shifting between private and public payers of health care coverage and on the overall cost of the health care delivery system in this State.

It had been assumed that the parity legislation would yield potential savings within MaineCare (Medicaid), as more services would be reimbursed by private insurance. MaineCare had 24,688 members with a private open health plan. This was 9.4% of the MaineCare population of 262,934 as of January 21, 2005. The revised law does not require parity with MaineCare services and MaineCare provides some services that private insurance does not cover.

A work group, known as the Parity Group, established by the Commissioner of the

Department of Administrative and Financial Affairs that included staff representing the Commissioner of Professional and Financial Regulation, the Commissioner of Human Services, the Commissioner of Behavioral and Developmental Services, the Superintendent of Insurance, the Maine Association of Mental Health Services (MAMHS), the Maine Association of Health Plans (MAHP), individual insurance providers including Anthem Blue Cross/Blue Shield, Aetna, Inc., CIGNA, MPHC (Pacificare), and the Maine State Chamber. The group held meetings between April 2003 and October 2004 when it concluded its work. The following is taken from their January 2005 report.[20]

Impact of Parity Legislation on MaineCare Recoupment

Maine has been a national leader in ensuring that commercial insurance policies cover treatment for mental illness. The Governor included an expansion of Maine's mental health parity in Part VV of the 2003/2004 state budget. Private insurance companies were mandated to provide coverage for 11 psychiatric disorders for medically necessary mental health services, including: inpatient services, day treatment services, outpatient services, and home health care.

The benefits for any of the identified mental illnesses must be no less extensive than the benefits for medical treatment for physical illnesses.

The parity legislation was anticipated to produce savings to the MaineCare budget, based on the assumption that MaineCare was paying for medically necessary mental health treatment for individuals who also had private insurance in addition to their MaineCare coverage. Parity legislation made private insurance coverage for behavioral health services the same as coverage for insured physical health services, not the same as are covered MaineCare services.

MaineCare developed medical care and support services for children, families, and adults with a complex set of needs, and at times as a result of Consent Decree requirements. Many of these services are much broader than those offered by private insurance and are frequently offered by "other qualified staff (OQS)". Private insurance provides coverage for these services delivered by licensed clinical staff, except instances where a program is covered rather than individual.

[20] January 27, 2005 report submitted by the Commissioner of Administrative and Financial Services and the Commissioner of Health and Human Services to the Joint Standing Committees on Insurance and Financial Services and Appropriations and Financial Services

Implementing

The Parity Group pursued issues raised in Section FF to assure that parity was being maximized and that providers had sufficient knowledge and skills to submit claims for covered services.

The Parity Group did work in four main areas:

Educational Forums and Consultation
Coding Matrix
Cost Avoidance
Unbundling Private Non-Medical Institutions (PNMI) Services

Education Forums and Consultation

Private health insurers delivered a variety of group trainings and individual consultation to providers to assist with claims including submission, coding, and covered services.

Coding Matrix

A great deal of time was spent by DHHS and Individual insurance providers to develop a matrix displaying MaineCare services and codes, HIPAA codes, and the comparable service and codes from private insurers. This work was done to provide clarity to MaineCare regarding when to deny claims from providers that should be correctly shifted to private insurers

Cost Avoidance

The Bureau of Medical Services (BMS) notified mental health providers that they would be returning bills to providers if the client had both MaineCare and private insurance, and the mental health services were covered by private insurance. The coding matrix provided the basis for this process, called “cost avoidance”.

Unbundling PNMI

The Parity Group considered unbundling PNMI Services in order to bill private insurers for covered services. PNMI services are largely a milieu treatment model in which there are not clear distinctions by time or by staff member for a billable unit. Many of the services are provided by staff under the supervision of a licensed staff member. It is likely that it would cost more money for both the provider and the state to have services separated and billed separately. The completion of forms, multiple claim submissions,

and review and approval procedures would all increase with unbundled services. The group concluded that unbundling PNMI services was not a viable strategy to maximize parity coverage.

Conclusions

Even though the Parity legislation did not achieve the anticipated cost savings, the Parity Group believes that the following has been accomplished:

- Misunderstandings in claims submissions by providers has been clarified;
- DHHS and providers now have an understanding of which specific services are covered by individual private insurers and which are not covered;
- Some of the billing and paperwork burden for providers has been lessened, and DHHS has a clear understanding of which services are appropriate for cost avoidance;
- The Maine Association of Mental Health Services is considering options for services and supports for mental health providers for more cost effective claims management.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

1. The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.

In general, mental health services have shown to be effective in reducing suicide, reducing substance abuse, improving quality of life and decreasing absenteeism. General health can be improved from the treatment of eating disorders and other disorders that have a direct impact on the physical well being of the patient. Additionally, mental health services have been found to have a positive effect on the treatment outcomes of individuals with chronic conditions such as diabetes and epilepsy.

A report published by the National Health Care Purchasing Institute reports that:[21]

> Over the past decade, new medications and talk therapies have improved the outlook for people with the most serious and persistent mental illnesses. In fact, the Surgeon General has concluded that most people can be managed effectively with currently available treatments.
>
> Evidence indicates that short-term interpersonal and cognitive behavioral therapies are highly effective for major depression, especially when used in conjunction with medication. Selective serotonin reuptake inhibitors, such as Prozac and Zoloft, effectively treat most forms of depression and anxiety disorders. Many of the newer medications have fewer side effects and easier dosing regimens. The recently introduced antipsychotic drugs may also be helping more people with psychotic and bipolar disorders to enter the workforce.
>
> Much of the research on the impact of effective treatment on the workplace has concentrated on depression—where the treatment appears to reduce social role dysfunction, increase retention, and reduce hospitalization and long-term disability rates. In an economic analysis comparing depression treatment costs to lost productivity costs, 45 to 98 percent of treatment costs were offset by increased productivity

[21] Goff, Veronica and Patricia Pittman, *Making the Case for Improving Mental Health Care*; September 2002

The literature search done by The California Health Benefits Review Program reported that: [22]

> Some studies report that parity laws have increased access for both adults and children (Zukevas et al., 2000). Some studies report mixed evidence in terms of improvements in access under parity (Ma and McGuire, 1998; Pacula and Sturm, 2000; Sturm et al., 1998; Goldman et al., 1999). One study (Zuvekas et al., 2000), which was requested by the National Mental Health Advisory Council (NMHAC), examined the effects of a state mental health parity mandate combined with carve-out managed care on costs, utilization, and access for a large employer group (over 100,000 employees) subject to parity. About 75,000 continuously enrolled members under age 55 were studied using proprietary enrollment and claims data.
>
> The study, which extended over a four-year period (one year before parity to three years after parity) found that the proportion of the population receiving some mental health services (overall treated prevalence rate) increased from 5.0% to 7.3%. The overall increase in employee, spouse, and dependent use of outpatient services (i.e., hospital outpatient departments, emergency rooms, providers' offices, and clinics) over the four-year period was 50%. The mean number of visits for those with any outpatient use remained about the same over this period.

2. *If the legislation seeks to mandate coverage of an additional class of practitioners:*

   a. *The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.*

      This legislation did not mandate an additional class of practitioners.

   b. *The methods of the appropriate professional organization that assure clinical proficiency.*

      This legislation did not mandate an additional class of practitioners.

[22] *Analysis of Senate Bill 572 Mental Health Benefits; A Report to the 2005-2006 California Legislature*; April 16, 2005

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations.

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.

The National Institute of Mental Health Reports that;

> "Data developed by the *Global Burden of Disease* study conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness, including suicide, accounts for over 15 percent of the burden of disease in established market economies, such as the United States. This is more than the disease burden caused by all cancers.
>
> This *Global Burden of Disease* study developed a single measure to allow comparison of the burden of disease across many different disease conditions. This measure was called Disability Adjusted Life Years (DALYs). DALYs measure lost years of healthy life regardless of whether the years were lost to premature death or disability. The disability component of this measure is weighted for severity of the disability. For example, disability caused by major depression was found to be equivalent to blindness or paraplegia whereas active psychosis seen in schizophrenia produces disability equal to quadriplegia.
>
> Using the DALYs measure, major depression ranked second only to ischemic heart disease in magnitude of disease burden in established market economies. Schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder also contributed significantly to the total burden of illness attributable to mental disorders."[23]

Potential benefits include reduced suicides, reduced inpatient psychiatric care, reduced symptomatic distress, improved quality of life, health improvements for co-morbid conditions, and other social outcomes. Any improvements in outcomes resulting from Maine's revised mental health parity are dependent on

[23] The National Institute of Mental Health, *The Impact of Mental Illness on Society*, May 14, 2004

changes in access to care, utilization of care, and the appropriateness and effectiveness of treatment.

2. *The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.*

When coverage is optional, it is subject to adverse selection, where potential enrollees that know they will use the benefits enroll in health plans that cover their ailment. This drives the cost of the optional coverage up to the point where it is unaffordable.

3. *The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.*

The latest impact information can be found in Appendix B.

VII. Appendices

Appendix A: Public Law 2003, ch. 20, Part VV

PART VV

Sec. VV-1. 24 MRSA §2325-A, sub-§3, ¶¶A-1 and A-2 are enacted to read:

A-1. "Diagnostic and statistical manual" means the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association.

A-2. "Home health care services" means those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if:

(1) Hospitalization or confinement in a residential treatment facility would otherwise have been required if home health care services were not provided;

(2) Hospitalization or confinement in a residential treatment facility is not required as an antecedent to the provision of home health care services; and

(3) The services are prescribed in writing by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness.

Sec. VV-2. 24 MRSA §2325-A, sub-§3, ¶B-1 is enacted to read:

B-1. "Medically necessary health care" has the same meaning as in Title 24-A, section 4301-A, subsection 10-A.

Sec. VV-3. 24 MRSA §2325-A, sub-§3, ¶D, as enacted by PL 1983, c. 515, §4, is amended to read:

D. "Person suffering from a mental ~~or nervous condition~~ illness" means a person whose psychobiological processes are impaired severely enough to manifest problems in the areas of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory ~~which~~ that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion or physical well-being.

Sec. VV-4. 24 MRSA §2325-A, sub-§§4 and 5, as enacted by PL 1983, c. 515, §4, are amended to read:

4. Requirement. Every nonprofit hospital ~~or~~ and medical service organization ~~which~~ that issues group health care contracts providing coverage ~~for hospital care~~ to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for conditions arising from mental illness.

5. Services. Each group contract ~~shall~~ must provide~~, at a minimum~~ for medically necessary health care for a person suffering from mental illness. Medically necessary health care includes, but is not limited to, ~~for~~ the following ~~benefits~~ services for a person suffering from a mental ~~or nervous condition~~ illness:

A. Inpatient care;
B. Day treatment services; ~~and~~
C. Outpatient services~~.~~; and
D. Home health care services; and

Sec. VV-5. 24 MRSA §2325-A, sub-§5-C, as amended by PL 1995, c. 625, Pt. B, §6 and affected by §7 and amended by c. 637, §1, is further amended to read:

5-C. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph ~~A~~ A-1 is subject to this subsection.

~~A. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of human behavior:~~

~~(1) Schizophrenia;~~
~~(2) Bipolar disorder;~~
~~(3) Pervasive developmental disorder, or autism;~~
~~(4) Paranoia;~~
~~(5) Panic disorder;~~
~~(6) Obsessive-compulsive disorder; or~~
~~(7) Major depressive disorder.~~

A-1. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia;
(2) Dissociative disorders;
(3) Mood disorders;
(4) Anxiety disorders;
(5) Personality disorders;

(6) Paraphilias;
(7) Attention deficit and disruptive behavior disorders;
(8) Pervasive developmental disorders;
(9) Tic disorders;
(10) Eating disorders, including bulimia and anorexia; and
(11) Substance abuse-related disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State ~~on or after July 1, 1996~~ must provide benefits that meet the requirements of this paragraph. ~~For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.~~

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital ~~or~~ and medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary ~~and appropriate~~ health care. When making the determination of whether treatment is medically necessary ~~and appropriate~~ health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

(3) If benefits and coverage for treatment of physical illness are provided on an expense-incurred basis, the benefits and coverage required under this subsection may be delivered separately under a managed care system.

(4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.

(5) A health benefit plan may not impose a limitation on coverage or benefits for mental illness unless that same limitation is also imposed on the coverage and benefits for physical illness covered under the policy or contract.

(6) Copayments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance required under the

policy or contract for a benefit or coverage for a physical illness.
(7) For the purposes of this section, a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits.

This subsection does not apply to policies, contracts and certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.
~~This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A .~~

Sec. VV-6. 24 MRSA §2325-A, sub-§5-D, as amended by PL 1995, c. 637, §2, is further amended to read:

5-D. Mandated offer of coverage for certain mental illnesses. Except as otherwise provided, coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group nonprofit hospital and medical ~~services~~ service organization health care plan contracts is subject to this subsection.

A. All individual and group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of ~~human behavior~~ mental illness:

(1) Schizophrenia;
(2) Bipolar disorder;
(3) Pervasive developmental disorder, or autism;
(4) Paranoia;
(5) Panic disorder;
(6) Obsessive-compulsive disorder; or
(7) Major depressive disorder.

B. Every nonprofit hospital and medical ~~services~~ service organization and nonprofit health care plan must make available coverage in all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State ~~on or after July 1, 1996~~ that provides benefits meeting the requirements of this paragraph. ~~For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.~~

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital ~~or~~ and medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary ~~and appropriate~~ health care. When making the determination of whether treatment is medically necessary ~~and appropriate~~ health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual or group contract.

~~This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.~~

Sec. VV-7. 24 MRSA §2325-A, sub-§6, as enacted by PL 1983, c. 515, §4, is amended to read:

6. Contracts; providers. Subject to the approval by the Superintendent of Insurance pursuant to section 2305, a nonprofit hospital ~~or~~ and a medical service organization incorporated under this chapter shall offer contracts to providers authorizing the provision of mental health services within the scope of the provider's licensure.

Sec. VV-8. 24-A MRSA §2749-C, sub-§1, as amended by PL 1995, c. 637, §3, is further amended to read:

1. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A by all individual policies is subject to this section.

A. All individual policies must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of ~~human behavior~~ mental illness:

(1) Schizophrenia;
(2) Bipolar disorder;
(3) Pervasive developmental disorder, or autism;
(4) Paranoia;
(5) Panic disorder;
(6) Obsessive-compulsive disorder; or
(7) Major depressive disorder.

B. All individual policies and contracts executed, delivered, issued for delivery, continued or renewed in this State ~~on or after July 1, 1996~~ must make available coverage providing benefits that meet the requirements of this paragraph. ~~For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.~~

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary ~~and appropriate~~ health care. When making the determination of whether treatment is medically necessary ~~and appropriate~~ health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual policy.

~~This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.~~

Sec. VV-9. 24-A MRSA §2749-C, sub-§2, as enacted by PL 1995, c. 407, §5, is amended to read:

2. Contracts; providers. ~~Subject to approval by the superintendent pursuant to section 2305, an~~ An insurer incorporated under this chapter shall offer contracts to providers authorizing the provision of mental health services within the scope of the provider's licensure.

Sec. VV-10. 24-A MRSA §2843, sub-§3, ¶¶A-1 and A-2 are enacted to read:

A-1. "Diagnostic and statistical manual" means the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association.

A-2. "Home health care services" means those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if:

(1) Hospitalization or confinement in a residential treatment facility would otherwise have been required if home health care services were not provided;

(2) Hospitalization or confinement in a residential treatment facility is not required as an antecedent to the provision of home health care services; and

(3) The services are prescribed in writing by a licensed allopathic or

osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness.

Sec. VV-11. 24-A MRSA §2843, sub-§3, ¶B-1 is enacted to read:

B-1. "Medically necessary health care" has the same meaning as in section 4301-A, subsection 10-A.

Sec. VV-12. 24-A MRSA §2843, sub-§3, ¶D, as enacted by PL 1983, c. 515, §6, is amended to read:

D. "Person suffering from a mental ~~or nervous condition~~ illness" means a person whose psychobiological processes are impaired severely enough to manifest problems in the areas of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory ~~which~~ that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion or physical well-being.

Sec. VV-13. 24-A MRSA §2843, sub-§§4 and 5, as enacted by PL 1983, c. 515, §6, are amended to read:

4. Requirement. Every insurer ~~which~~ that issues group health care contracts providing coverage ~~for hospital care~~ to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for conditions arising from mental illness.

5. Services. Each group contract ~~shall~~ must provide~~, at a minimum,~~ for medically necessary health care for a person suffering from mental illness. Medically necessary health care includes, but is not limited to, the following ~~benefits~~ services for a person suffering from a mental ~~or nervous condition~~ illness:

A. Inpatient care;
B. Day treatment services; ~~and~~
C. Outpatient services~~.~~; and
D. Home health care services.

Sec. VV-14. 24-A MRSA §2843, sub-§5-C, as amended by PL 1995, c. 625, Pt. B, §8 and affected by §9 and amended by c. 637, §4, is further amended to read:

5-C. Coverage for treatment for certain mental illness. Coverage for medical treatment for mental illnesses listed in paragraph ~~A~~ A-1 is subject to this subsection.

~~A. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of~~

~~the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of human behavior:~~

~~(1) Schizophrenia;~~
~~(2) Bipolar disorder;~~
~~(3) Pervasive developmental disorder, or autism;~~
~~(4) Paranoia;~~
~~(5) Panic disorder;~~
~~(6) Obsessive-compulsive disorder; or~~
~~(7) Major depressive disorder.~~

A-1. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia;
(2) Dissociative disorders;
(3) Mood disorders;
(4) Anxiety disorders;
(5) Personality disorders;
(6) Paraphilias;
(7) Attention deficit and disruptive behavior disorders;
(8) Pervasive developmental disorders;
(9) Tic disorders;
(10) Eating disorders, including bulimia and anorexia; and
(11) Substance abuse-related disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State ~~on or after July 1, 1996~~ must provide benefits that meet the requirements of this paragraph. ~~For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.~~

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of ~~a nonprofit hospital or medical service organization~~ a reimbursing insurer, a provider of medical treatment for mental illness

shall furnish data substantiating that initial or continued treatment is medically necessary ~~and appropriate~~ health care. When making the determination of whether treatment is medically necessary ~~and appropriate~~ health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

(3) If benefits and coverage provided for treatment of physical illness are provided on an expense-incurred basis, the benefits and coverage required under this subsection may be delivered separately under a managed care system.

(4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.

(5) A health benefit plan may not impose a limitation on coverage or benefits for mental illness unless that same limitation is also imposed on the coverage and benefits for physical illness covered under the policy or contract.

(6) Copayments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance required under the policy or contract for a benefit or coverage for a physical illness.

(7) For the purposes of this section, a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits.

This subsection does not apply to policies, contracts and certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

~~This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.~~

Sec. VV-15. 24-A MRSA §2843, sub-§5-D, as amended by PL 1995, c. 637, §5, is further amended to read:

5-D. Mandated offer of coverage for certain mental illnesses. Except as otherwise provided in subsection 5-C, coverage for medical treatment for mental illnesses listed in paragraph A by all group contracts is subject to this subsection.

A. All group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of ~~human behavior~~ mental illness:

(1) Schizophrenia;
(2) Bipolar disorder;
(3) Pervasive developmental disorder, or autism;
(4) Paranoia;
(5) Panic disorder;
(6) Obsessive-compulsive disorder; or
(7) Major depressive disorder.

B. All group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State ~~on or after July 1, 1996~~ must make available coverage providing benefits that meet the requirements of this paragraph. ~~For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.~~

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.
(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary ~~and appropriate~~ health care. When making the determination of whether treatment is medically necessary ~~and appropriate~~ health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

~~This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.~~

Sec. VV-16. 24-A MRSA §4234-A, sub-§3, ¶¶A-1 and A-2 are enacted to read:

A-1. "Diagnostic and Statistical Manual" means the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association.
A-2. "Home health care services" means those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if:

(1) Hospitalization or confinement in a residential treatment facility would otherwise have been required if home health care services were not provided;
(2) Hospitalization or confinement in a residential treatment facility is not required as an antecedent to the provision of home health care services; and
(3) The services are prescribed in writing by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness.

Sec. VV-17. 24-A MRSA §4234-A, sub-§3, ¶B-1 is enacted to read:

B-1. "Medically necessary health care" has the same meaning as in section 4301-A, subsection 10-A.

Sec. VV-18. 24-A MRSA §4234-A, sub-§3, ¶D, as enacted by PL 1995, c. 407, §10, is amended to read:

D. "Person suffering from a mental ~~or nervous condition~~ illness" means a person whose psychobiological processes are impaired severely enough to manifest problems in the area of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the area of intellect, emotion or physical well-being.

Sec. VV-19. 24-A MRSA §4234-A, sub-§§4 and 5, as enacted by PL 1995, c. 407, §10, are amended to read:

4. Requirement. Every health maintenance organization that issues individual or group health care contracts providing coverage ~~for hospital care~~ to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for conditions arising from mental illness.

5. Services. Each individual or group contract must provide~~, at a minimum,~~ for medically necessary health care for a person suffering from mental illness. Medically necessary health care includes, but is not limited to, the following ~~benefits~~ services for a person suffering from a mental ~~or nervous condition~~ illness:

A. Inpatient services;
B. Day treatment services; ~~and~~
C. Outpatient services~~.~~; and
D. Home health care services.

Sec. VV-20. 24-A MRSA §4234-A, sub-§6, as amended by PL 1995, c. 637, §6, is further amended to read:

6. Coverage for treatment of certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph ~~A~~ A-1 is subject to this subsection.

~~A. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of human behavior:~~

~~(1) Schizophrenia;~~
~~(2) Bipolar disorder;~~
~~(3) Pervasive developmental disorder, or autism;~~
~~(4) Paranoia;~~
~~(5) Panic disorder;~~
~~(6) Obsessive-compulsive disorder; or~~
~~(7) Major depressive disorder.~~

A-1. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual, except for those designated as "V" codes in the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia;
(2) Dissociative disorders;
(3) Mood disorders;
(4) Anxiety disorders;
(5) Personality disorders;
(6) Paraphilias;
(7) Attention deficit and disruptive behavior disorders;
(8) Pervasive developmental disorders;
(9) Tic disorders;
(10) Eating disorders, including bulimia and anorexia; and
(11) Substance abuse-related disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State ~~on or after July 1, 1996~~ must provide benefits that meet the requirements of this paragraph. ~~For purposes of this paragraph, all~~

~~contracts are deemed renewed no later than the next yearly anniversary of the contract date.~~

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.
(2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary ~~and appropriate~~ health care. When making the determination of whether treatment is medically necessary ~~and appropriate~~ health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.
(3) If benefits and coverage for the treatment of physical illness are provided on an expense-incurred basis, the benefits and coverage required under this subsection may be delivered separately under a managed care system.
(4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.
(5) A health benefit plan may not impose a limitation on coverage or benefits for mental illness unless that same limitation is also imposed on the coverage and benefits for physical illness covered under the policy or contract.
(6) Copayments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance required under the policy or contract for a benefit or coverage for a physical illness.
(7) For the purposes of this section, a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits.

This subsection does not apply to policies, contracts or certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.
~~This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.~~

Sec. VV-21. 24-A MRSA §4234-A, sub-§7, as amended by PL 1995, c. 637, §7, is further amended to read:

7. Mandated offer of coverage for certain mental illnesses. Except as provided in subsection 6, coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group contracts is subject to this subsection.

A. All individual and group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of ~~human behavior~~ mental illness:

(1) Schizophrenia;
(2) Bipolar disorder;
(3) Pervasive developmental disorder, or autism;
(4) Paranoia;
(5) Panic disorder;
(6) Obsessive-compulsive disorder; or
(7) Major depressive disorder.

B. All individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State ~~on or after July 1, 1996~~ must make available coverage providing benefits that meet the requirements of this paragraph. ~~For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.~~

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary ~~and appropriate~~ health care. When making the determination of whether treatment is medically necessary ~~and appropriate~~ health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual or group contract.

~~This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.~~

Sec. VV-22. 24-A MRSA §4234-A, sub-§8, as enacted by PL 1995, c. 407, §10, is amended to read:

8. Contracts; providers. ~~Subject to approval by the superintendent pursuant to section 4204, a~~ A health maintenance organization incorporated under this chapter shall allow providers to contract, subject to the health maintenance organization's credentialling policy, for the provision of mental health services within the scope of the provider's licensure.

Sec. VV-23. 24-A MRSA §4234-A, sub-§8-A, as enacted by PL 1997, c. 174, §1, is amended to read:

8-A. Mental health services provided by counseling professionals. A health maintenance organization that issues individual or group health care contracts providing coverage for mental health services shall offer coverage for those services when performed by a counseling professional who is licensed by the State pursuant to Title 32, chapter 119 to assess and treat interpersonal and intrapersonal problems, has at least a ~~masters~~ master's degree in counseling or a related field from an accredited educational institution and has been employed as counselor for at least 2 years. Any contract providing coverage for the services of counseling professionals pursuant to this subsection may be subject to any reasonable limitations, maximum benefits, coinsurance, deductibles or exclusion provisions applicable to overall benefits under the contract. ~~This subsection applies to all contracts executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1998. For purposes of this subsection, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.~~

Sec. VV-24. 24-A MRSA §4234-A, sub-§11, as amended by PL 1995, c. 673, Pt. D, §8, is further amended to read:

11. Application. Except as otherwise provided, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State ~~on and after July 1, 1996~~. Contracts entered into with the State Government or the Federal Government to service Medicaid or Medicare populations may limit the services provided under such contracts consistent with the terms of those contracts if mental health services are provided to these populations by other means. ~~For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.~~

Sec. VV-25. Application. The requirements of this Part apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 2003. For purposes of this Part, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Sec. VV-26. Exemption from review. Notwithstanding the Maine Revised Statutes, Title 24-A, section 2752, this Part is enacted without review and evaluation by the Department of Professional and Financial Regulation, Bureau of Insurance.

Sec. VV-27. Bureau of Insurance report. The Department of Professional and Financial Regulation, Bureau of Insurance shall review and evaluate the financial impact, social impact and medical efficacy of the mandated health insurance benefit required in this Part after its enactment in the same manner as required for proposed mandated health benefits legislation in the Maine Revised Statutes, Title 24-A, section 2752. The bureau also shall include a comparison of the projected cost impact of this mandated benefit prior to enactment and the actual cost impact of the mandated benefit based on premium information after enactment. As part of its assessment of the medical efficacy of the mandate, the bureau shall consult with the Department of Human Services, the Department of Behavioral and Developmental Services and providers of mental health services to determine whether the mandate has increased early intervention and treatment for mental illness and reduced the severity of mental illness experienced by residents of this State. The bureau shall contract within the bureau's existing budgeted resources for any necessary consulting and actuarial expertise to complete the report required by this section. The bureau shall submit a report to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters by January 1, 2006.

Appendix B: Cumulative Impact of Mandates

Cumulative Impact of Mandates in Maine

Following are the estimated claim costs for the existing mandates:

- ***Mental Health*** (Enacted 1983) – The mandate applies only to group plans. It applies to all group HMO plans but does not apply to employee group indemnity plans covering 20 or fewer employees. Mental health parity for listed conditions was effective 7/1/96 but does not apply to any employer with 20 or fewer employees, whether under HMO or indemnity coverage. The list of conditions for which parity is required was expanded effective 10/1/03. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. The percentage had been decreasing in recent years from a high of 4.16% in 1997 to 3.02% in 2003 but increased slightly to 3.14% in 2004. For 2004, this broke down as 2.94% for managed care and 3.76% for indemnity plans. Although the expansion of the list of conditions for which parity is required and was not fully implemented until September 2004, it was in effect for all or most of the year for most groups. Either it had a very small impact or the impact was offset by other factors. We estimate a continuation of 2004 levels going forward. For HMO plans covering employers with 20 or fewer employees, we use half the value for larger groups to reflect the fact that parity does not apply. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent. However, this overstatement is offset by the fact that the data is an aggregate of all groups, while groups of 20 or fewer are exempt from the parity requirement in the case of HMO coverage and from the entire mandate in the case of indemnity coverage.

- ***Substance Abuse*** (Enacted 1983) – The mandate applies only to groups of more than 20 and originally did not apply to HMOs. Effective 10/1/03, substance abuse was added to the list of mental health conditions for which parity is required. This applies to HMOs as well as indemnity carriers. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage showed a downward trend from 1989 to 2000 when it reached 0.31%. It then increased to 0.37% in 2001 and to 0.66% in 2002, and decreased to 0.59% in 2003. In 2004, it decreased very slightly to 0.58% despite almost full implementation of the parity requirement. The long-term decrease was probably due to utilization review, which sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 to about 53% in 2004. The 0.58% for 2004 broke down as 0.56% for managed care plans and 0.65% for indemnity plans. This relationship reversed from the prior year and the difference does not appear to be significant. We estimate substance abuse benefits to remain at the current

aggregate level of 0.58%. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent. However, this overstatement is offset by the fact that the data is an aggregate of all groups, while the mandate applies only to groups larger than 20.

- ***Chiropractic*** (Enacted 1986) – The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the percentage increased from 0.84% in 1994 to a high of 1.51% in 2000. Since then, it decreased slightly to between 1.32% and 1.46% during 2001 to 2004. The level varies significantly between group and individual. The variation between HMOs and indemnity plans has decreased to an insignificant level. For 2004, the percentages for group plans were 1.40% for HMO plans and 1.36% for indemnity plans with an aggregate of 1.39%. For individual plans, it was 0.65% for HMO plans, and 0.62% for indemnity plans with an aggregate of 0.62%. We estimate the aggregate levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Screening Mammography*** (Enacted 1990) – The amount of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.7% in 2002, decreasing slightly to 0.67% in 2004, which may reflect increasing utilization of this service followed by a leveling off. This figure broke down as 0.65% for HMO plans, 0.71% for indemnity plans. We estimate 0.67% in all categories going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Dentists*** (Enacted 1975) – This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998) – At the time this mandate was being considered in 1995, Blue Cross and Blue Shield of Maine estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995) – At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996) – Our report on this mandate indicated that most of the 15 carriers surveyed in 1996 said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** (Enacted 1996) – Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996) – No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) (Enacted 1996) – This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997) – Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** (Enacted 1998) – The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our 1998 report did not resolve this conflict but stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998) – No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would

expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999) – This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999) – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999) – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000) – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000) – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001) – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001) – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001) – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ***Prosthetics*** (Enacted 2003) – This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20 and 0.08% for small employer groups and individuals.

- ***LCPCs*** (Enacted 2003) – This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

- Licensed Pastoral Counselors and Marriage & Family Therapists (Enacted 2005) – This mandate requires coverage of **licensed pastoral counselors and marriage & family therapists**. Our report indicated no measurable cost impact for this coverage.

These costs are summarized in the following table.

	COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS			
Year Enacted	**Benefit**	**Type of Contract Affected**	**Est. Maximum Cost as % of Premium**	
			Indemnity	**HMO**
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts	0[1]	0[1]
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.10%	--
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0[1]	--
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups of more than 20	0.58%	0.58%
1975 1983 1995 2003	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	3.76%	2.94%
		Groups of 20 or fewer	--	1.47%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	Group	1.39%	1.39%
		Individual	0.62%	0.62%
1990 1997	Benefits must be made available for screening **mammography**.	All Contracts	0.67%	0.67%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Prenatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.20%	0.20%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	0.01%	0
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.10%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%	0.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%	0.30%
1998	Coverage required for **prostrate cancer screening**.	All Contracts	0.07%	0

1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts	--	0.16%
1999	Prescription drug must include **contraceptives**.	All Contracts	0.80%	0.80%
1999	Coverage for **registered nurse first assistants**.	All Contracts	0	0
2000	Access to **clinical trials**.	All Contracts	0.46%	0.46%
2000	Access to **prescription drugs**.	All Managed Care Contracts	0	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0	0
2001	Access to **eye care**.	Plans with participating eye care professionals	0	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg	Groups >20	0.03%	0.03%
		All other	0.08%	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0	0
	Total cost for groups larger than 20:		**8.52%**	**7.82%**
	Total cost for groups of 20 or fewer:		**4.23%**	**5.82%**
	Total cost for individual contracts:		**3.45%**	**3.48%**

Appendix C
State Summary of Mental Health Mandates

MENTAL ILLNESS TREATMENT

STATE	CITATION	SUMMARY
AR	§ 23-99-506	Benefits for diagnosis and treatment of mental health and developmental disorders shall be provided under same terms and conditions as for treatment of other medical illnesses and conditions. Mandatory for groups, mandatory offer for individual policies and small groups. Does not apply to any plan where application would result in an 1.5% increase in the cost of coverage.
CA	Ins. § 10144.5; Health & Safety § 1374.72	Plans must include in-patient and out-patient care and prescription drugs for serious mental illness. Includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, autism, anorexia nervosa and bulimia.
CO	§§ 10-16-104(5)	Mandated coverage with at least specified minimum benefits in every group contract. Cover "biologically based" mental illness under the same terms and conditions as for other types of health care for physical illness. Includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, and panic disorder.
CT	§§ 38a-488a; 38a-514a	Mandated coverage with at least specified minimum benefits in every group contract. Includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, and panic disorder Coverage for biologically-based mental illness at least equal to coverage provided for medical or surgical conditions. Includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, and panic disorder. Does not include mental retardation, learning disorders, motor skills disorder, caffeine-related disorders, etc. May not have greater coinsurance and deductible, etc. than for physical illness.
DE	tit. 18 §§ 3343; 3566	Cover serious mental illnesses like schizophrenia, bipolar disorder, anorexia nervosa, etc. the same as other illness. May not place greater burden on policyholder by means of higher deductibles, limits in number of visits, etc. Sunsets 6/30/2002.
DC	§§ 31-4724; 31-3102; 31-3104	Mandated coverage with at least specified minimum benefits. Cannot restrict access to psychologist.
FL	§ 627.668	Every group or prepaid contract must offer coverage for mental illness to levels specified.
GA	§§ 33-24-28.1; 33-24-29	Mandated offering of coverage for treatment of mental disorders to the same extent as treatment for physical illnesses.

MENTAL ILLNESS TREATMENT (cont.)

8/04

STATE	CITATION	SUMMARY
HI	§§ 431M-1 to 431M-7	Every policy must include coverage with at least specified minimum benefit for mental health, and may not treat serious mental illness differently than other conditions in terms of service limits and terms. Serious mental illness is defined to include schizophrenia, schizoaffective disorder and bipolar mood disorder.
IL	215 ILCS 5/370c	Every group or prepaid contract must offer coverage for mental illness to same level as for other coverage. Serious metal illness includes schizophrenia, paranoid disorders, bipolar disorders, major depression, obsessive-compulsive disorders, etc.
IN	§§ 27-8-5-15.6, 27-13-7-14.8	May not impose treatment limitations or financial requirements different than for other medical coverage.
KS	§ 40-2,105 § 40-2,105a	Every policy must include coverage with at least specified minimum benefits. Group plan must include coverage for diagnosis and treatment of schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders, obsessive compulsive disorder, panic disorder, pervasive developmental disorder, including autism, attention deficit disorder and attention deficit hyperactive disorder subject to same coinsurance and deductibles as other coverage.
KY	§§ 304.17-318; 304.17A-661; 304.18-036; 304.32-165; 304.38-193	Mandated offering of coverage at least that offered for physical illness. A health benefit plan that provides coverage for treatment of a mental health condition shall provide coverage under the same terms and conditions as for treatment of a physical illness. Small group and individual plan exempt.

MENTAL ILLNESS TREATMENT (cont.)

STATE	CITATION	SUMMARY
LA	§ 22:669	Group plans must include coverage for severe mental illness and other mental disorders, such as schizophrenia, paranoia, bipolar disorder, autism, major depression, anorexia, bulimia, Aspergh's Disorder, Rett's Disorder, Tourette's Disorder, etc.
ME (5/04)	tit. 24 § 2325-A; 24-A §§ 2843; 2849-B; Ins. Reg. ch. 330	Mandated coverage with at least specified minimum benefits in every group contract. Coverage must be available to cover schizophrenia, paranoia, bipolar disorder, autism, major depression at same levels may coordinate benefits with medicine as treatment for physical disease. Does not apply to employer groups of 20 or less. May coordinate benefits with Medicare.
MD	Ins. § 15-802 Ins. § 15-840	Every policy must include coverage with at least specified minimum benefit. Provide coverage for medically necessary residential crisis services.
MA	§ 175:47B	Every policy must include coverage with at least specified minimum benefit.
MN	§ 62A.152	Mandated coverage with at least specified minimum benefits in every group contract.
MS	§§ 83-9-39 to 83-9-41	Group plans shall provide coverage; plans covering 100 or fewer employees may offer on optional basis. Does not apply if raises costs at least 1%. Formula included to measure. Must cover minimum of 30 days per year inpatient, 60 days per year partial hospitalization and 52 outpatient visits per year.
MO (8/04)	§§ 376.811; 376.814; 376.825 to 376.835; 376.1550	Mandated offer of coverage for list of disorders defined as "mental illness." Includes schizophrenic disorders and paranoid state, major depression, bipolar disorder, obsessive compulsive disorder, post-traumatic stress disorder, early childhood psychoses, alcohol and drug abuse, anorexia nervosa, bulimia and senile organic psychotic condition. May not establish rate and rules for payments that places a greater burden on insured for treatment of mental health than treatment of physical health.
MT	§§ 33-22-701 to 33-22-705 § 33-22-706	Mandated coverage with at least specified minimum benefits in every group contract. Does not apply if raises cost at least 1%. A policy must provide the same level of benefits for treatment of severe mental illness as for any other physical illness. Defines severe mental illness to include schizophrenia, bipolar disorder, major depression, autism, etc.

MENTAL ILLNESS TREATMENT (cont.) 5/05

STATE	CITATION	SUMMARY
NE	§§ 44-791 to 44-795	Group policy must cover biologically-based serious mental illness same as for other illnesses. Means any mental health condition that medical science affirms is caused by a biological disorder of the brain.
NV	§§ 689A.0455, 689B.0359, 695B.1938, 695C.1738	Must provide at least 40 days hospitalization each year and 40 visits of outpatient care each year for severe mental illness. Defined as schizophrenia, bipolar disorder, major depression, etc.
NH	§§ 415:18-a; 419:5-a, 420:5-a § 417-E:1	Mandated coverage with at least specified minimum benefits in every group contract. Cover "biologically based" mental illness under the same terms and conditions as for other types of health care for physical illness. Includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.
NJ	§§ 17:48-6v, 17:48A-7u, 17:48E-35.20, 17B:26-2.1s, 17B:27-46.1v, 17B:27A-7.5, 17B:27A-19.7	Provide coverage for biologically-based mental illness under the same terms and conditions as for other illness. Defined to include at least schizophrenia, bipolar disorder, major depression, autism, etc.
NY	Ins. Law § 3221(l)(5)(A)	Every group or prepaid contract must offer coverage for mental illness to levels specified.
NC (5/04)	§ 58-51-55	Policy that covers both physical and mental illness may not impose a lesser lifetime or annual dollar limit on mental health benefits than on physical illness benefits. Several exceptions noted.
ND	§ 26.1-36-09	Mandated coverage with at least specified minimum benefits in every group contract.
OK	tit. 36 §§ 6060.11 to 6060.12	Cover severe mental illness same as group coverage provided for other illness and disease. Must include same duration of coverage, amount limits, deductibles and coinsurance amounts. Include schizophrenia, bipolar disorder, major depression, etc. A health plan that experiences a greater than 2% increase in costs pursuant to providing treatment for severe mental illness is exempt from requirement.
OR	§ 743.556	Mandated coverage with at least specified minimum benefits in every group contract. Group policy may make coverage subject to the same provisions as for other types of health coverage. Must have same deductible and coinsurance amounts as for other illness.

MENTAL ILLNESS TREATMENT (cont.)

5/05

STATE	CITATION	SUMMARY
PA	§ 40-39-128	Coverage for serious mental illness must include a minimum of 30 inpatient and 60 outpatient days annually. No difference in annual or lifetime limits from other illnesses. Serious mental illness includes schizophrenia, bipolar disorder, obsessive compulsive disorder, major depression, panic disorder, anorexia nervosa, bulimia, schizo-affective disorder and delusional disorder.
RI	§§ 27-38.2-1 to 27-38.2-5	Cover mental illness same as coverage provided for other illness and disease. Must include same duration of coverage, amount limits, deductibles and coinsurance amounts. Include disorders listed by *Diagnostic and Statistical Manual of Mental Disorders*. Does not cover mental retardation, motor skills disorders or communication disorders.
SC	§ 38-71-737	Group policy with over 50 employees must cover severe mental health conditions, including bipolar disorders, depression, paranoia and schizophrenia, on the same basis as other medical conditions as of 6/30/2006
SD	§ 58-17-98	Mandated coverage for treatment and diagnosis of biologically-based mental illness, with same dollar limits, deductibles, coinsurance factors and restrictions as for other illnesses.
TN	§§ 56-7-2360; 56-7-2601	Coverage with specified minimum benefits in all group policies unless refused by insured. Coverage to either aggregate lifetime benefits or annual benefits.
TX	I.C. art. 3.51-14	Must offer specified benefits and same amount limits, deductibles and coinsurance factors for serious mental illness as for physical illness for group policies.
VT	tit. 8 § 4089b	At least one choice provided to the insured must place no greater burden on the insured than treatment for physical conditions for group policies.
VA	§§ 38.2-3412.1 to 38.2-3412.1:01	Mandated coverage same as other illness except may be limited to 30 days per policy year. Coverage for biologically based mental illness must be the same as for any other illness or condition.

MENTAL ILLNESS TREATMENT (cont.)

5/05

STATE	CITATION	SUMMARY
WA (5/05)	§ 48.21.240; HB 1154 (2005)	Mandated offering of coverage in group policies at least equal to minimums specified. Eff. 7/24/05, parity required between payments for claims for physical and mental services, including the amount of coinsurance and deductibles, prescription drug coverage, etc. Optional for plans renewed after 1/1/06; mandatory for plans renewed after 1/1/08 for groups of 50+; coverage for groups of 50 after 1/1/10.
WV	§ 33-16-3a	Cover expenses to treat serious mental illness. Include disorders listed by *Diagnostic and Statistical Manual of Mental Disorders*, including schizophrenia, bipolar disorder, depressive disorders, substance-related disorders, except related to caffeine or nicotine, anxiety disorders, and anorexia and bulimia. Costs need not exceed 2% of anticipated total cost of plan. Sunset 3/31/07.
WI	§ 632.89	Mandated coverage with at least specified minimum benefits in every group contract.