Bureau of Insurance

A Report to the Joint Standing Committee on Banking and Insurance of the 119th Maine Legislature

Review and Evaluation of Proposed LD 1158

An Act to Ensure Equality in Mental Health Coverage for Children and Adults

December 22, 1999

Table of Contents

I. Executive Summary

The Joint Standing Committee on Banking and Insurance of the 119th Maine Legislature directed the Bureau of Insurance to review LD 1158, An Act to Ensure Equality in Mental Health Coverage for Children and Adults. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of the Risk Finance and Insurance Practice of William M. Mercer, Inc. and the Maine Bureau of Insurance.

LD 1158 would amend sections of Maine Law pertaining to individual and group health insurance plans. Appendix A includes the amendments to the applicable sections of Maine Law. For the listed illnesses and mental health care for children, LD 1158 requires that coverage be at least as comprehensive as that available for other conditions covered under the plan. For ease of communication, the term "benefit parity" is used throughout this report to reference this requirement. The proposed amendment mandates the following changes:

- Extends the provisions associated with mental health benefit parity to all individual and small group (employers with 20 or fewer employees) health plans.
- Adds eating disorders to the list of mental illnesses for which benefit parity is required.
- For children under age 18, LD 1158 requires benefit parity for other mental illnesses. (These are listed in the mental disorders section of the Diagnostic and Statistical Manual of Mental Health Disorders, 4th edition, DMS 4 as periodically revised.)
- By referencing the mental disorders section of the Diagnostic and Statistical Manual of Mental Health Disorders, 4th edition, DMS 4, LD 1158 requires coverage for certain learning disorders that are not typically covered by health plans.
- Adds licensed master's-level social workers to the list of professionals authorized to diagnose individuals as having a listed mental health condition. (It also adds "medical doctor," but this does not appear to add anything to the existing language, which includes allopathic or osteopathic physicians.)
- Requires that health insurers add the amount paid by patients for mental health services not covered by health care contracts to the annual reports provided to the Superintendent of Insurance.
- Requires that managed care organizations engaged by health plans to manage mental health benefits comply with rules established by the Superintendent of Insurance.

Treatment for alcoholism and chemical dependency are specifically excluded from the requirements

stipulated by LD 1158.

The current law only requires benefit parity for seven listed mental illnesses for health plans sponsored by large groups (employee groups with more than 20 employees). Plans provided by these employers must also meet minimum standards established for all other mental health benefits. The mandated benefit parity (for listed conditions only) is an option for individuals and employers with less than 20 employees. Due to the potential for adverse selection, electing an individual fee-for-service plan that provides benefit parity for the listed mental illnesses can add $1,500 to the policyholder's monthly premium. HMO plans with benefit parity are currently available for a reasonable premium increment. Employees are generally limited to the health plan offered by their employer.

According to the Center for Mental Health Services between 2.8% and 5.3% of Maine residents have serious mental health conditions. Twenty-two percent of the population is estimated to need mental health care at some point in their lives. Testimony provided by the Maine Psychological Association indicates that the incidence of anorexia and bulimia nervosa among young women in the United States is 0.5% and 2.5%, respectively. Our research indicates that children account for approximately 50% of mental health insurance payments. More comprehensive mental health coverage would benefit a significant number of Maine residents.

Although increased mental health coverage would undoubtedly benefit individuals or family members with serious mental disorders, there would be significant premium increases for individual and small group plans. These plans are likely to have limited mental health benefits and are the more susceptible to adverse selection than large group plans. Studies have shown that effective managed care reduces the cost of mental health benefits and would substantially lower the added premium required for plans that apply managed care to mental health benefits. The presumption is that the rules promulgated under the proposed law would not limit the current effectiveness of behavioral health managed care.

Since large group health plans currently meet the benefit parity and minimum standards requirements, LD 1158 has a considerably less significant impact on large employer premiums. Table A displays the estimated premium increases for the various health plan categories.

Table A
Estimated Premium Increases

Health Plan	Fee-for-Service	Comprehensive Managed Care
Individual	3.6%	1.2%
Small Group	2.6%	0.9%
Large Group	0.3%	0.1%

Individual and small group policyholders, who would experience the most significant premium increases, are also the most likely to reduce benefits or discontinue health insurance. Rates for individual health coverage have already increased sharply in the last two years. The Congressional Budget Office estimates that each one percent increase in health insurance premium drives 200,000 to 300,000 Americans off the insurance rolls. The potential increase in the uninsured population is a significant concern in assessing the impact of LD 1158.

With the advances in mental health treatment, mental health disorders do not generally present risks to insurers that are greater than the risks associated with medical disorders. Limits specific to mental health benefits are difficult to justify from a risk perspective. In our review of the testimony provided by the opponents to LD 1158, we found no attempt to argue this point. Proponents argue that the early diagnosis and treatment of mental disorders in children is particularly crucial to successful outcomes for children. Treating eating disorders in young women is essential to avoid costly medical care and improve their capacity to successfully function in a normal environment. Proponents also argue that the listed mental illnesses are biologically based and, therefore, should be covered by health plans to the extent that physical conditions are covered.

Proponents argue that the cost of the additional benefits is not significant enough to justify forgoing the enactment of LD 1158. One argument presented is that the cost of early and effective treatment will be offset by reductions in absenteeism and the avoidance of more costly care resulting from the inadequacy or delay of treatment. However, the estimated increase is most significant for individual and small group policyholders. Some of these policyholders will either reduce their health insurance coverage or discontinue it. Given the scope and broad application of LD 1158, there are likely to be unintended consequences.

The addition of licensed master's-level social workers to the list of professionals authorized to diagnose individuals as having a listed mental health condition appears to conflict with licensing laws which do not permit social workers at any level to diagnose organic mental illness.

An additional issue arose during the course of this study. The U.S. Health Care Financing Administration (HCFA) issued an advisory letter to the state of Virginia concerning a mental health mandate similar to Maine's. HCFA determined that Virginia's law is inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This issue is discussed further in Appendix E.

It should be noted that LD 1158 as currently constructed appears to have technical shortcomings that are counter to the stated intent of the legislation. The bill and amendment as drafted would amend Title 24 but not 24-A. This means it would affect only Blue Cross Blue Shield of Maine and not other insurers and HMOs. The wording adds individual to subsection 5-C but not to subsection 4. This means individual policies would have to cover listed conditions but not unlisted. Also, subsection 5-D appears duplicative of 5-C. Additionally, the bill would repeal the exemption for CHAMPUS supplement plans.

This report is based on our understanding of the intent of LD 1158 as expressed in the testimony and summary that accompanied the bill. Our assumption is that LD 1158 would apply to all individual and group health plans offered in Maine.

II. Background

The Joint Standing Committee on Banking and Insurance of the 119th Maine Legislature directed the Bureau of Insurance to review LD 1158, An Act to Ensure Equality in Mental Health Coverage for Children and Adults. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of the Risk Finance and Insurance Practice of William M. Mercer, Inc. and the Maine Bureau of Insurance.

The bill and amendment as drafted would amend Title 24 but not 24-A. This means it would affect only Blue Cross Blue Shield of Maine and not other insurers and HMOs. The wording adds individual to subsection 5-C but not to subsection 4. This means individual policies would have to cover listed conditions but not unlisted. Also, subsection 5-D appears duplicative of 5-C. Our understanding of the legislative intent of LD 1158 is that it would apply to all carriers and would apply equally to group and individual coverage. This report reflects that understanding.

Two additional drafting issues were noted. The bill would repeal the exemption for CHAMPUS supplement plans. The other drafting question pertains to adding "medical doctors". Our assumption is that medical doctors are either allopathic or osteopathic physicians and are already included as providers under the current law.

LD 1158 would amend sections of Maine Law pertaining to individual and group health plans. Appendix A includes the amendments to the applicable sections of Maine Law. For the listed illnesses and mental health care for children, LD 1158 requires that coverage be at least as comprehensive as that available for other conditions covered under the plan. For ease of communication, the term "benefit" parity is used though out this report. The proposed amendment mandates the following changes:

- Extends the provisions associated with mental health benefit parity to all individual and small group (employers with 20 or fewer employees) health plans. Under the current law, insurers are only required to offer plans that meet the mental health benefit parity provisions of the current law.

- Adds eating disorders to the list of mental illnesses for which benefit parity is required.

- For children under age 18, LD 1158 requires benefit parity for other mental illnesses. (These are listed in the mental disorders section of the Diagnostic and Statistical Manual of Mental Health Disorders, 4th edition, DMS 4 as periodically revised.)

- By referencing the mental disorders section of the Diagnostic and Statistical Manual of Mental Health Disorders, 4th edition, DMS 4, LD 1158 requires coverage for certain learning disorders not typically covered by health plans.

- Adds licensed master's-level social workers to the list of professionals authorized to diagnose individuals as having a listed mental health condition. (The current law authorizes licensed allopathic or osteopathic physicians and licensed psychologists who are trained and have received a doctorate in psychology to diagnose the listed conditions.)

- Requires that health insurers add the amount paid by patients for mental health services not covered by health care contracts to the annual reports to the Superintendent of Insurance.

- Requires that managed care organizations engaged by health plans to manage mental health benefits comply with rules established by the Superintendent of Insurance.

Treatment for alcoholism and chemical dependency are specifically excluded from the provisions proposed under LD 1158. The proposed expanded list of mental illnesses includes:

1) Schizophrenia
2) Bipolar disorder
3) Pervasive developmental disorder or autism
4) Paranoia
5) Panic disorder
6) Obsessive-compulsive disorder
7) Major depressive disorder
8) Eating Disorders
    a) Bulimia
    b) Anorexia

Since the current law requires benefit parity for the seven listed mental illnesses for health plans for large employee groups, the additional exposure to claims is substantially less than that for individual plans and plans sponsored by small groups with 20 or fewer employees.

In 1983, the mental health mandate was enacted for plans sponsored by large groups. The Bureau of Insurance adopted Rule Chapter 330 to establish minimum benefit requirements. This rule was amended in July of 1993 to increase the minimum requirements. Another law was passed that required benefit parity for biologically based mental illnesses. These mandates do not apply to apply to individual or small group plans. With regard to individual and small group plans, insurers are only required to offer plans that provide benefit parity for the biologically based mental illnesses.

On December 13, 1999, the U.S. Surgeon General issued a major report on mental health. While this has obvious relevance to our report, its release was too late to enable us to reflect its findings.

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.

According to the Center for Mental Health Services, between 2.8% and 5.3% of Maine residents have serious mental health conditions. Twenty-two percent of the population is estimated to need mental health care at some point in their lives. Testimony provided by the Maine Psychological Association indicates that the incidence of anorexia and bulimia nervosa among young women in the United States is 0.5% and 2.5%, respectively. Our research indicates that children account for approximately 50% of mental health insurance payments.

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

Inpatient psychiatric services are available to Maine residents in a variety of settings. These include general hospitals, psychiatric hospitals, residential facilities and out-of-state facilities. Mental health treatment is provided by psychiatrists, physicians, licensed clinical social workers, psychologists, psychiatric nurses and other professionals.

3. The extent to which insurance coverage for this treatment is already available.

Insurance is currently available for the treatment of mental illness. Insurers are required to offer plans that provide coverage that meet minimum standards established by legislation for mental illnesses in the individual and small group markets. Large groups are required to provide benefits for the treatment of the listed mental illnesses that are as comprehensive as those available for medical conditions. For large groups, benefits for other conditions must meet minimum standards established by rules promulgated by the Bureau of Insurance.

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.

Health plans providing mental health coverage are generally available for purchase by individuals and employers. However, employer's health plans generally do not fully meet requirements proposed under LD 1158. Policy limitations in combination with a person's limited financial resources could make it difficult to obtain care for an individual or covered family member with a persistent and serious mental illness.

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

Although individuals can purchase a policy that provides benefit parity for the listed mental illnesses, excluding eating disorders, the premium may be prohibitive. Such policies, when offered as a choice, are subject to severe adverse selection. Individuals (or individuals with family members) who have pre-existing mental illness disorders or are prone to these disorders will elect plans with mental health parity. Those that believe a mental illness episode is unlikely will elect not to pay the additional premium for plans that provide mental health benefit parity. A rider to add mental health parity for the listed illnesses could cost $1,500 per month. This would not provide benefit parity for eating disorders and non-listed mental illnesses for children.

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

Mental health treatment is currently available for the listed and other mental illnesses for both adults and children.

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 Committee on Banking and Insurance, the demand for this legislation is from organizations that advocate for the mentally ill or disabled. The National Alliance for the Mentally Ill, the Maine Public Health Association, the Maine Psychological Association, Alliance for the Mentally Ill of Maine and Maine Medical Center have submitted written testimony in favor of this legislation.

Proponents argue that the cost of the additional benefits is not significant enough to justify forgoing the enactment of LD 1158. One argument presented is that the cost of early and effective treatment will be offset by reductions in absenteeism and the

avoidance of more costly care resulting from the inadequacy or delay of treatment. The early diagnosis and treatment of mental disorders in children is particularly crucial to successful outcomes for children. Treating eating disorders in young women is essential to avoid costly medical care and improve their capacity to successfully function in a normal environment. Innovations in mental health treatment have produced more rapid and favorable outcomes. Proponents also argue that the listed mental illnesses are biologically based and, therefore, should be covered by health plans to the extent that physical conditions are covered.

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.*

Nine states have enacted laws requiring varying degrees of mental health benefit parity. These states are Arizona, Indiana, Maine, Maryland, Minnesota, New Hampshire, North Carolina, Texas and Vermont. Other states have passed a variety of laws to improve mental health coverage but do not specifically mandate benefit parity. Four of the nine states exempt small businesses from benefit parity mandate.

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 State of Maine Department of Mental Health, Mental Retardation and Substance Abuse Services provided informative studies pertaining to the cost and benefit issues pertaining to mental health parity. No specific findings were cited.

11. *Alternatives to meeting the identified need.*

Low-income or disabled individuals may qualify for Medicare and/or Medicaid benefits.

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 requirements of LD 1158 are not inconsistent with the role of insurance and the concept of managed care. Health plans currently offer mental health benefits and the covered mental health benefits are frequently subject to managed care practices.

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

Historically, there has been a social stigma attached to mental illness. That stigma still exists. With increased knowledge of these conditions and treatment advances, this stigma has become less intense and pervasive. There is the potential that more comprehensive insurance coverage would support more effective treatment. This may, in turn, produce more successful outcomes, which would help to reduce this social stigma.

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

To offset the added cost of LD 1158, employers may reduce policy benefits, increase the employees' share of the premium or discontinue providing health insurance. The Congressional Budget Office estimates that each one percent increase in health insurance premium drives 200,000 to 300,000 Americans from the insurance rolls. Given the individual and small group premium increases estimated for LD 1158, benefit reductions or discontinuation of health insurance are likely to occur among individual and small group purchasers.

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 employees with self-insured plans.*

State legislation that imposes benefit mandates will heighten an employer's concern with regard to future costs and make self-insurance a more attractive alternative. The 1998 Mercer/ Foster Higgins National Survey of Employer-sponsored Health Plans indicates that 36 percent of the large employers (500 or more employees) in the Northeast self-insure health plans.

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

Healthsource estimated that LD 1158 would increase the cost of state employee health insurance plan by $80,000 annually. This translates into an approximate premium increase of 0.1%. This estimate matches Mercer's estimated premium increment for large group HMO plans.

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.

LD 1158 would increase the demand for mental health services. Coverage limitations may have forced individuals to curtail or forgo mental health treatment. To the extent coverage for these treatments is increased, these individuals would be able to receive additional treatment.

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.

The use of mental health treatment is likely to increase with the availability of more generous mental health benefits. LD 1158 does not appear to preclude applying managed care or fraud detection to minimize inappropriate use of mental health treatment.

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

Early diagnosis and comprehensive treatment of mental illness may reduce the cost associated with absenteeism and reduce the need for related medical care.

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

LD 1158 does not preclude insurers from applying managed care and fraud detection to mental health claims. Nonetheless, insurers have expressed concern that the rules issued pertaining to behavioral managed care organizations could impair their capacity to manage mental health benefits.

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

This legislation could increase the number of providers and would add to the types of

providers who can diagnose a listed condition for purposes of triggering parity benefits under health insurance plans.

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.*

The impact of LD 1158 on health insurance premiums varies by market segment and type of plan. Individual fee-for-service plan premiums are estimated to increase by 3.6%. This estimate presumes that the plan currently covers the mental health benefits similar to those specified by the Maine Bureau of Insurance rules for a basic individual health plan with a $500 annual deductible. The incremental premium estimates were developed to cover the cost of increasing this baseline mental health coverage to meet the requirements stipulated by LD 1158. It should be noted that this baseline benefit coverage is applicable to all mental illnesses and does not include any specific provisions for the listed (or biologically based) mental illnesses. Table B outlines the benefit changes underlying the estimates. Since individual plans can be purchased with a wide array of deductible and coinsurance options, the estimated cost impact of LD 1158 on a specific plan could vary significantly from the 3.6% estimated increase. There are two factors that contribute to the increase. One is the increased scope of benefits. The other is increased utilization. The benefit utilization underlying the claim experience is understated as a result of the application of the low maximums. The higher coinsurance typically applicable to mental health benefits is also likely to have discouraged those who needed care. Studies indicate that effective managed care reduces the impact of increased mental health benefits. Accordingly, the estimated premium impact for HMO or other plans that delegate mental health benefit administration to managed care organizations that specialize in behavioral health is reduced from 3.6% to 1.2% as shown in Table A.

Table B displays the baseline mental health benefits used to calculate the impact of LD 1158 on small group plans. Since the groups with 20 or fewer employees are currently exempt from mental health mandates, small group health plans tend to have limited mental health benefits. The estimated average premium increase of 2.6% is required bring a plan into compliance with LD 1158. For those plans that utilize managed care organizations that specialize in managing the care for mental illnesses, the estimated premium increase is reduced to 0.8%.

For plans sold to large employers, the benefit adjustments are far less significant than those required for individual and small employer plans. Current legislation requires benefit parity for seven of the eight listed illnesses and establishes minimum standards

for other benefits. The baseline mental health benefits are shown in Table B. The estimated average premium increase for large employers is 0.3%. Applying comprehensive managed care to mental health benefits reduces the premium increase to 0.1%.

Table A summarizes the estimated benefit increases. The calculation of these estimates is depicted in Appendix D. The data, as noted, was derived from Mercer's databases and client files. Our estimates are reasonably comparable to mental health parity estimates provided in published studies. Previous Maine mandates have moved the large group health plans closer to benefit parity than plans in other states without mental health benefit parity requirements. For this reason, Mercer's estimates are lower than those reported by other sources. The benefit changes required for individual and small group plans, to meet the requirements of LD 1158, are more significant for these products. Enriching the mental health benefits is likely to increase the frequency of services covered. The premium increases would be less pronounced when comprehensive benefit management is applied. This presumes that the rules promulgated under the proposed law would not limit the current effectiveness of behavioral health managed care.

There will be administrative costs associated with communicating and implementing the benefit changes required by LD 1158. Insurers who participate in the large group market currently have the administrative capacity to identify and separately administer the listed illnesses. The percentages in Table A are based on the benefit increases. Applying these to the premium, which covers benefits and administrative costs, should cover the increased benefit and administrative costs.

Table A
Estimated Premium Increases

Health Plan	Fee-for-Service	Comprehensive Mental Health Managed Care
Individual	3.6%	1.2%
Small Group	2.6%	0.8%
Large Group	0.3%	0.1%

Table B Mental Health Benefit Changes Required LD 1158			
Health Plan Classification	**Mental Health Condition**	**Baseline Benefits**	**LD 1158 Benefits**
Individual	8 listed illnesses	$7,500 lifetime maximum Inpatient,15 days per calendar year at 80% Outpatient, 50%, $500 calendar year maximum	Benefit parity
	Eating disorders		Benefit parity
	Other – under age 18		Benefit parity
	Other – 18 and older		Coverage required
Small Group (1-20)	8 listed illnesses	$10,000 lifetime maximum Inpatient, 20 days per calendar year at 80% Outpatient, 50%, $1,000 calendar year maximum	Benefit parity
	Eating disorders		Benefit parity
	Other – under age 18		Benefit parity
	Other – 18 and older		Coverage required
Large Group (20+)	8 listed illnesses	Benefit Parity	No mandated change
	Eating disorders	Inpatient, 30 days per calendar year at 80% Outpatient, 50%, $1,500 calendar year maximum	Benefit parity
	Other – under age 18		Benefit parity
	Other – 18 and older		No mandated change

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.*

For some mental illnesses, there appear to be costs savings that offset the cost of treatment. For example, depressed workers were found to have between 1.5 and 3.2 more short-term disability days in a thirty-day period than other workers had. The salary equivalent productivity loss on average is between$182 and $395. These workplace costs are nearly as large as the direct cost of successful treatment.[1]

[1] Depression in the Workplace: Effects on Short–term Disability, Health Affairs, September/October 1999

8. *The impact on the total cost of health care.*

Health insurance premiums would increase. More adequate coverage may produce savings in other areas. Unattended mental disorders may disrupt work productivity and lead to otherwise avoidable costly medical care.

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.

Mental health care benefits those in need of these services. Advances in drug therapy combined with psychotherapy have improved patient outcomes. Individuals, who several years ago would have required institutionalization, now with treatment, can lead normal and independent lives. A study produced by the Connecticut-Massachusetts VA Mental Health Center noted that inpatient mental health cost fell by 30.5%. Some of this reduction is attributable to the increased prevalence of managed behavioral health care. The AHCPR Clinical Practice Guidelines for Depression states that once identified, depression can almost always be treated successfully, either with medication, psychotherapy or a combination of both.

2. If the legislation seeks to mandate coverage of an additional class of practitioners relative to those already covered.

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

LD 1158 adds licensed master's level social workers as providers who can diagnose a listed condition for purposes of triggering parity benefits under health insurance plans. However, this appears to conflict with the licensing laws, as Title 32 M.R.S.A. § 7053-A states, "No social worker at any level may diagnose organic mental illness or treat any illness by organic therapy."

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

Managed care should continue to support clinical proficiency.

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.

As stated earlier in this report, benefit limitations in combination with a person's limited financial resources can make it difficult to obtain care for an individual or covered family member with a persistent and serious mental illness. While LD 1158 does not offer any relief for those who are uninsured, more comprehensive mental health coverage would benefit a significant number of Maine residents. However, the impact on premiums would also be significant.

The premium increments would be the most significant for individual and small group fee-for-service plans. Individuals and small employers may elect to increase deductibles and coinsurance or discontinue coverage to avoid the higher cost. This market segment, individuals and small employers, is the most susceptible to an increase in the number of uninsured. According to the Office of Health Policy's Chartbook on Children's Insurance Status, the chance of a child being uninsured is inversely related to the size of the firm in which his or her family adult is employed. Twenty-four percent of the children whose family adults are employed by firms with less than ten employees are uninsured. For family adults employed in firms with more that 1,000 employees, only 8% of the children are uninsured. In the individual market, rates have increased sharply in recent months and are already unaffordable to many.

The estimated premium increase is less significant for large employers than it is for individuals and small employers. It is likely that the need to offset the added cost will be less urgent. For employer health plans that incorporate behavioral managed care, the estimated premium increase is less significant.

Although LD 1158 would lead to increased mental health care for children and adults, there is a significant premium increment for plans that currently provide limited mental health care coverage. As a result of the current law, which imposes more stringent requirements on large groups, and the price sensitivity characteristic of the individual and small employer market segment, individual and small employer health plans are the most likely to have health plans with limited mental health benefits. This population of individual purchasers and small group employees is also the most inclined to discontinue

insurance coverage when confronted with a premium increase. The impact of LD 1158 on the number of uninsured Maine residents is a major consideration.

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

Employers and individuals now have the option to purchase policies with benefits similar to those required by LD 1158. For individuals, this has not been a reasonable alternative since only those in need are likely to elect the benefit. The resulting selection has led to prohibitively high premiums.

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

It is not possible to precisely measure the impact of mandated benefits. However, it is possible to estimate an outside limit, the maximum possible increase in health insurance premiums resulting from mandates. Because various mandates apply to different categories of coverage, this maximum likewise varies. The Bureau's estimates of the maximum premium increases due to existing mandates and the proposed mandate are displayed in Table C.

Table C
Maximum Premium Increases

	Group (more than 20 employees)	Group (20 or fewer employees)	Individuals
Current Mandates			
Fee-for-Service Plans	7.54%	2.88%	2.87%
Managed Care Plans	7.12%	2.96%	2.86%
LD 1158			
Fee-for-Service Plans	0.30%	2.60%	3.60%
Managed Care Plans	0.10%	0.8%	1.20%
Cumulative Impact			
Fee-for-Service Plans	7.84%	5.48%	6.47%
Managed Care Plans	7.22%	3.76%	4.06%

These estimates are based on the estimated portion of claim costs that mandated benefits represent, as detailed in Appendix B. The true cost impact is less than this for two

reasons:

1. Some of these services would likely be provided even in the absence of a mandate.

2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering mental health and substance abuse may reduce claims for physical conditions. Covering social workers may reduce claims for more expensive providers such as psychiatrists and psychologists. Covering chiropractic services may reduce claims for back surgery. Covering screening mammograms may reduce claims for breast cancer treatment.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time. While some studies have estimated much higher costs for mandated benefits, these studies were not based on the specific mandates applicable in Maine and therefore are not relevant.

There is no indication that mandated benefits have impacted the availability of health insurance.

VII. Appendices

Appendix A:

STATE OF MAINE

ONE HUNDRED AND NINETEENTH LEGISLATURE

COMMITTEE ON BANKING AND INSURANCE

May 6, 1999

Marti Hooper
Senior Insurance Analyst
Life and Health Division
Bureau of Insurance
34 State House Station
Augusta, ME 04333

Dear Ms. Hooper:

Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on Banking and Insurance to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if a majority of the committee supports the mandate after a public hearing on the proposed legislation. Pursuant to that statute, we request the Bureau of Insurance prepare a review and evaluation of the following related proposals:

LD 1158 **An Act to Ensure Equality in Mental Health Coverage for Children and Adults**

LD 1493 **An Act Regarding Private Long-term Care Disability Insurance for Mental Illnesses**

A copy of each bill along with proposed committee amendments are enclosed. In conducting the review of the proposals, the committee asks that you focus on the proposed amendments. With regard to LD 1158 and LD 1493, the committee is interested in information on the differences between mandating these requirements in health insurance versus disability insurance. In LD 1158, one of the proposal's requirements is "parity" coverage for all conditions listed in the Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition, that are diagnosed in children under age 18; for adults, "parity" coverage is required for certain listed biologically-based mental illnesses. The committee is interested in information about the extent to which the Medicaid and Medicare programs provide coverage for mental health disorders.

Please prepare the evaluation using the guidelines set out in 24-A § 2752 and submit the report to the committee before the beginning of the Second Regular Session of the 119th Legislature if possible. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Very truly yours,

Lloyd P. LaFountain, III
Senate Chair

Jane W. Saxl
House Chair

cc: Rep. Joseph Brooks
Rep. Michael Saxl
Rep. Joseph Perry
Committee members

PROPOSED AMENDMENT TO LD 1158
AN ACT TO ENSURE EQUALITY IN MENTAL HEALTH COVERAGE FOR CHILDREN AND ADULTS

Be it enacted by the People of the State of Maine as follows:

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

A-1. "Health insurance plan" means a health insurance policy or health benefit plan offered by a health insurer. "Health insurance plan" includes a health benefit plan offered or administered by the State or by any subdivision or instrumentality of the State.

F. "Rate term or condition" means lifetime or annual payment limits, deductibles, copayments, coinsurance and any other cost-sharing requirements, out-of-pocket limits, visit limits and any other financial component of health insurance coverage that affects the insured.

Sec. 2. 24 MRSA §2325-A, sub-§5-A, as amended by PL 1989, c. 490, §1, is repealed.

Sec. 3. 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 is subject to this subsection.

A. All individual and 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 medical doctor, a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of human behavior or a licensed master's-level social worker:

(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~~.~~; or

(8) Eating disorders:

(a) Bulimia; and

(b) Anorexia.

Any person birth to 18 years of age with a mental health condition that falls under any of the diagnostic categories listed in the mental disorders section of the Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition, DMS 4, as periodically revised, is covered under this paragraph.

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.~~ A health insurance plan must provide coverage for treatment of a mental health condition and may not establish a rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required under a health insurance plan must be comprehensive for coverage of both mental health and physical health conditions.

(2) At the request of a nonprofit hospital or 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. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

C. A health insurance plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health conditions may provide coverage for treatment of mental health conditions through a managed care organization as long as the managed care organization is in compliance with the rules adopted by the superintendent that ensure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the superintendent shall ensure that

timely and appropriate access to care is available; that quantity, location and specialty distribution of health care providers is adequate and that administrative or clinical protocols do not serve to reduce access to medically necessary treatment for an insured.

~~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. 4. 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 organization health care plan contracts is subject to this subsection.

A. All individual and group contracts must ~~make available coverage providing~~ 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 medical doctor, a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of human behavior or a licensed master's-level social worker:

(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~~.~~; or

(8) Eating disorders:

Appendix B: Cumulative Impact of Mandates

Following are the estimated claim costs for the existing mandates without the reductions:

- ***Mental Health*** - The mandate applies only to groups of more than 20. 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. Mental health parity for listed conditions was effective 7/1/96. The 1997 data showed a small increase to 4.16% of total group health claims. This figure represents our best estimate for future years.

- ***Substance Abuse*** - The mandate applies only to groups of more than 20 and does not apply to HMOs. 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 has shown a downward trend beginning in 1989 and continuing through the most recent data which was 0.5% for 1997. This is probably due to utilization review, which has sharply reduced the incidence of inpatient care. Inpatient claims have decreased from about 90% of the total to about 70%. We estimate the percentage to remain at the 0.5% level, although further decreases are possible.

- ***Chiropractic*** - The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. We therefore estimate 1% going forward.

- ***Screening Mammography*** - The amount of claims paid has been tracked since 1992 and have generally been in the range of 0.2% to 0.3%. We estimate 0.3% going forward.

- ***Dentists*** - 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*** - At the time this mandate was being considered in 1995, Blue Cross 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*** - 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*** - Our report on this mandate indicated that most of the 15 carriers surveyed 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/Member/Month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum maternity stay*** - 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*** - 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) - 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*** - The report estimated a cost of 0.07% of premium.

- ***Off-label use prescription drugs*** - 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. The report does not resolve this conflict but states 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*** - No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. The 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*** - 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*** – 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*** – Health plans that cover surgical first assisting are mandated to

cover register nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

These costs are summarized on 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[2]	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	0.1%	--
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 include for treatment of **alcoholism and drug dependency**.	Groups of more than 20 except HMOs	0.5%	--
1975 1983 1995	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	4.16%	4.16%
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.	All Contracts	1.0%	1.0%
1990 1997	Benefits must be made available for screening **mammography**.	All Contracts	0.3%	0.3%
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 Perinatal 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	0.2%	0.2%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	.01%	0
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.1%
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	.07%	.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.3%	0.3%
1998	Coverage required for **prostrate cancer screening**:	All Contracts	.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	0.8%	0.8%
1999	Coverage for registered nurse first assistance	All contracts	0	0
	Total cost for groups larger than 20:		**7.54%**	**7.12%**
	Total cost for groups of 20 or fewer:		**2.88%**	**2.96%**
	Total cost for individual contracts:		**2.87%**	**2.86%**

[2] This has become a standard benefit that would be included regardless of the mandate.

Appendix C: References

- Office of Health Planning Policy, the Assistant Secretary for Planning and Evaluation
  "Chartbook on Children's Health Insurance Status, Tabulations of Current Population Survey December 1998"

- Journal of American Medical Association
  "Does Brief Dynamic Psychotherapy Reduce the Relapse Rate of Panic Disorder", August 1996

- Mathematica Policy Research, Inc.
  "The Cost and Effects of Parity for Mental Health and Substance Abuse Benefits", 1998

- Medical Care, Volume 37, Number 5
  "Changes in Inpatient Mental Health Utilization and Costs, 1993 to 1995", November 1998

- Journal of American Medical Association
  "Psychotherapy of Depression", August 1996

- The Heritage Foundation
  "Rising Costs, Reduced Access: How Regulation Harms Health Consumers and the Uninsured", July 1999

- Healthcare Trends
  "Managed Behavioral Health Care: Current Realities and Future Potential, New directions for Healthcare Services", 1998

- American Psychological Association
  "Hard Actuarial Data Boosts Drive for Insurance Parity", May 1997

- Substance Abuse and Mental Administration
  "The Cost and Effects of Parity for Mental Health", March 1998

- Journal of American Medical Association
  "How Expensive Is Unlimited Mental Health Care Coverage Under Managed Care?" November 1997

- U.S. Census Bureau
  "Health Insurance Coverage, Table 1 and Table 8"

- Health Affairs
  "Depression in the Workplace: Effects on Short-term Disability", September/October 1999

- Center for Mental Health Services
  "Up To 7% of American Suffer from Severe Mental Illness", Federal Register, 6/24pp3380-97

Appendix D: LD 1158 Benefit Cost Estimates

Individual Health Plans

		Cost Per Member Per Month					
		Listed Illnesses	Eating Disorders	Other Mental Illnesses Under Age 18	Other Mental Illnesses 18 and Over	Total	Source
A	Current benefit cost without mental health managed care	$ 2.62	$ 0.26	$ 0.53	$ 0.46	$ 3.87	Mercer Database and Client Files
B	Utilization adjustment	1.7000	1.1000	1.6000	1.0000		Estimate
C	Benefit adjustment	1.7786	1.8077	1.7925	1.0217		Mercer Model
D	Benefit cost after LD 1158	$ 7.92	$ 0.52	$ 1.52	$ 0.47	$ 10.43	A x B x C
E	Estimated benefit increase	$ 5.30	$ 0.26	$ 0.99	$ 0.01	$ 6.56	D - A
F	Estimated total benefit Cost					$185.00	Mercer Database and Client Files
G	**Percent increase for plans without mental health managed care**	2.86%	0.14%	0.54%	0.01%	**3.55%**	E / F
H	Adjustment for mental health managed care					0.33	
I	**Percent increase for plans with mental health managed care**					**1.17%**	G x H

Small Group Health Plans

A	Current benefit cost without mental health managed care	$ 2.11	$ 0.22	$ 0.43	$ 0.36	$ 3.12	Mercer Database and Client Files
B	Utilization adjustment	1.7000	1.1000	1.6000	1.0000		Estimate
C	Benefit adjustment	1.6019	1.5455	1.6047	1.0000		Mercer Model
D	Benefit cost after LD 1158	$ 5.75	$ 0.37	$ 1.10	$ 0.36	$ 7.58	A x B x C
E	Estimated benefit increase	$ 3.64	$ 0.15	$ 0.67	$ -	$ 4.46	D - A
F	Estimated total benefit Cost					$175.00	Mercer Database and Client Files
G	**Percent increase for plans without mental health managed care**	2.08%	0.09%	0.38%	0.00%	**2.55%**	E / F
H	Adjustment for mental health managed care					0.33	
I	**Percent increase for plans with mental health managed care**					**0.84%**	G x H

Large Group Health Plans

A	Current benefit cost without mental health managed care	$ 2.25	$ 0.23	$ 0.45	$ 0.39	$ 3.32	Mercer Database and Client Files
B	Utilization adjustment	1.0000	1.1000	1.6000	1.0000		Estimate
C	Benefit adjustment	1.0000	1.2609	1.2889	1.0000		Mercer Model
D	Benefit cost after LD 1158	$ 2.25	$ 0.32	$ 0.93	$ 0.39	$ 3.89	A x B x C
E	Estimated benefit increase	$ -	$ 0.09	$ 0.48	$ -	$ 0.57	D - A
F	Estimated total benefit Cost					$165.00	Mercer Database and Client Files
G	**Percent increase for plans without mental health managed care**	0.00%	0.05%	0.29%	0.00%	**0.34%**	E / F
H	Adjustment for mental health managed care					0.33	
I	**Percent increase for plans with mental health managed care**					**0.11%**	G x H

Appendix E: Inconsistencies with HIPAA

On October 15, 1999, the U.S. Health Care Financing Administration (HCFA) sent an advisory letter to the state of Virginia concerning a mental health mandate similar to Maine's. HCFA determined that Virginia's law is inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA defines a small employer as one having from 2 to 50 employees. HIPAA requires any health plan offered to any small employer to be offered to all small employers (the "all products guarantee"). Virginia's mental health mandate exempts plans issued to employers with 25 or fewer employees. Since Virginia does not require plans sold to groups above 25 to be offered to groups below 25, HCFA considers Virginia's law inconsistent with HIPAA.

The letter goes on to state that Virginia's law is not pre-empted by HIPAA. Because the Virginia law permits but does not require practices that violate HIPAA, it is possible for carriers to comply with both laws. The letter further states that if Virginia does not enforce HIPAA requirements, HCFA may enforce them directly.

Maine's law is similar to Virginia's in that it contains an exemption for groups of 20 or fewer. Unlike Virginia, Maine requires carriers to offer plans covering the listed mental health conditions to employers of 20 or fewer. However, coverage for unlisted conditions is required only for groups over 20 and therefore is inconsistent with HIPAA under the reasoning in the HCFA letter.

LD 1158 would eliminate the exemption for groups of 20 or fewer and therefore eliminate the inconsistency. However, if this bill is not passed, or is amended to retain the exemption, the Legislature may want to consider other options to eliminate the inconsistency. Options include:

- Expand the mandate to apply to employers of 2 or more or to all groups.
- Expand the exemption to apply to all employers with 50 or fewer employees.
- Amend the existing mandated offer to include coverage of the unlisted conditions, at least for groups of 2 or more. This would eliminate the problem identified in the HCFA letter, since the plans sold to employers larger than 20 would be available to all small employers. However, it could be argued that the opposite situation – plans not meeting the mandate could still be offered to groups of 20 or fewer but could not be offered to groups over 20 – would similarly violate the all products guarantee. HCFA has not addressed this issue.
- Do nothing and leave it to HCFA to enforce the federal requirements.