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A Report to the Joint Standing Committee on Insurance and Financial Services of the 124th Maine Legislature

Review and Evaluation of LD 1198
An Act To Reform Insurance Coverage To Include
Diagnosis for Autism Spectrum Disorders

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I. Executive Summary

Autism is a complex developmental disability that typically appears during the first three years of life and is the result of a neurological disorder that affects the normal functioning of the brain, impacting development in the areas of social interaction and communication skills. Both children and adults with autism typically show difficulties in verbal and non-verbal communication, social interactions, and leisure or play activities.¹ Diagnoses of autism spectrum disorders (ASD) are on the rise in the United States and in the State of Maine. Although it is unclear whether the actual incidence is on the rise or if the diagnosis is becoming more prevalent due to a broader definition of ASD and better efforts in diagnosis, it is a serious public health concern either way.² ASDs include autism, Asperger syndrome and pervasive developmental disorder not otherwise specified (PPD-NOS).

The current mental health parity mandate in Maine requires group health insurance contracts, other than those covering employers with 20 or fewer employees, to provide benefits at least equal to those for physical illnesses for a person receiving medical treatment for eleven categories of mental illness as defined in the Diagnostic and Statistical Manual (DSM), including ASD. However, many insurance companies will not cover services related to applied behavioral analysis (ABA), because it is considered educational or experimental or because it is not considered to be restorative. Also, Maine law does not currently require ABA therapists to be licensed. It is unusual for health insurance to reimburse providers that are not licensed by the state. Although there are a wide variety of treatments available for autism, ABA is one of the main treatments at this time.

Also, many policies limit the number of visits for services such as speech therapy for both physical and mental illnesses. In addition, some insurers will not cover services such as speech therapy to treat autism because they consider it a developmental delay and not a medical issue. They cover it for rehabilitation but not for habilitation.

LD 1198, An Act To Reform Insurance Coverage To Include Diagnosis for Autism Spectrum Disorders would require policies, contracts, or certificates issued covering employers with 50 or more employees to cover ASD for an individual covered under the policy, contract, or certificate who is 21 years of age or under. Policies would be required to provide coverage for medically necessary treatments of ASD. This would specifically cover habilitative services, including ABA. LD 1198 would prohibit a policy, contract or certificate from placing any limits on the number of visits. The coverage may be limited to \$36,000 per year, adjusted annually for inflation after January 1, 2011.

¹ Autism Society of America <http://www.autism-society.org/site/PageServer>

² "Is there an ASD epidemic?" <<http://www.cdc.gov/ncbddd/autism/topics.html>>

The Joint Standing Committee on Insurance and Financial Services of the 124th Maine Legislature directed the Bureau of Insurance to review LD 1198. The Committee asked that the report include analysis of the extent to which Maine's mental health parity law currently covers autism and the impact of amending LD 1198 to require coverage in all individual and group policies rather than only large group policies.

To date, 19 states have adopted similar mandates and 16 states are considering bills with similar mandates. Fifteen states do not have or are not currently considering similar mandates.³

In addition to private insurance, coverage for ASD is also available through MaineCare, including the Katie Beckett program. These programs do ensure that every child who qualifies can receive diagnostic and treatment services.

The treatments aimed at lessening of symptoms are a major benefit to autistic individuals and are deemed most helpful if the intervention occurs at an early age. Testimony presented by the Maine Developmental Disabilities Council in support of LD 1198 stated that 40 percent of young children with Pervasive Developmental Disorders who receive intensive early intervention services will be able to be in a regular education classroom with little or no extra support when they enter public school.

According to the Center for Autism Related Disorders, ABA is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree. The Disability Rights Center in Augusta, Maine submitted testimony in support of LD 1198 citing that developmental therapies such as ABA, especially provided intensely at an early age, mitigate the impact of disorders such as autism, and allow individuals to lead a more productive, healthier, and happier life. ABA therapy attempts to change behavior through positive and negative reinforcements. The U.S. Surgeon General states that 30 years of research on the ABA approach have shown very positive outcomes when ABA is used as an early-intervention tool for autism.⁴

In order to effectively implement ABA, there are multiple components to the treatment, each with a cost. Both parents and any other major caretakers must be trained in ABA, which costs between \$175-1,000 per person. Children can also be enrolled in schools and clinics that specialize in ABA treatment, but the cost of such schools ranges from \$16,000-25,000 per year. It is possible to set up ABA treatment at home using therapists in training or

³ Autismvotes.org<www.autismvotes.org/site/c.frKNI3PCImE/b.3909861/k.B9DF/State_Initiatives.htm>

college students who have taken a workshop in the ABA approach which costs \$5,000-20,000 per year. A qualified, full-time ABA therapist costs approximately \$30,000-50,000 per year. Because of the success of ABA and the evidence indicating that training should be intensive (25-40 hours/week), there is very high demand for ABA-trained therapists.⁵

The primary driver of the increase in health care costs and health insurance premiums as a result of LD 1198 is the cost of ABA therapy. Currently in Maine there are 26 certified ABA therapists, mostly in southern counties. Licensed psychologists may also provide ABA therapy, but in general, it appears that the number of available providers may be limited in Maine. Because of the limited number of therapists and relatively low hourly fees charged compared to other states, cost increases will be low at first. If ABA is covered by health insurance, we assume that the number of therapists will increase and fees may also increase with the increased demand, although the increased number of providers may partially offset the upward pressure on fees.

Insurers estimate that the increase in premiums from this mandate would be between \$1.48 per member per month (PMPM) and \$5.00 PMPM.

We estimate the initial premium increase for insured plans would be approximately \$1.65 PMPM or 0.5% of premium. Once there are adequate providers for the individuals that would benefit from ABA therapy, the increase in premiums could be as high as \$2.30 PMPM or 0.7% of premium. If the maximum benefit of \$36,000 is not permitted by the federal Mental Health Parity Act, the premium increase for this benefit could be as high as \$2.95 PMPM or 0.8% of premium. These estimates do not reflect any potential long-term savings in health care costs because many of these treatments are relatively new and there are no definitive studies demonstrating or quantifying these savings. However, research does indicate that by providing services and support to autistic children, they can obtain substantial gains in most areas of life. The benefit of these services may minimize the likelihood of institutionalization of individuals with disabilities and maximize the potential for their independent living in society. Increased early intervention treatment would also reduce needs for special education in the public schools for some children and lead to savings in the schools.

LD 1198 would shift some of the cost from MaineCare to the private insurance market. Based on MaineCare claims data for 2008, we estimate a possible annual shift of up to \$2 million for the bill as written and up to \$4 million if the mandate applies to all group and individual policies. Not all services that MaineCare provides may be required to be

⁴ U.S. Department of Health and Human Services. 1999. "Mental Health: A Report of the Surgeon General - Executive Summary." U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Rockville, MD.

⁵ <http://autism.healingthresholds.com/therapy/applied-behavior-analysis#cost>

reimbursed by this mandate.

It is unclear how the calendar year cap of \$36,000 under the proposed bill would apply to coverage of ASD that is also required by state and federal mental health parity mandates. If the \$36,000 cap applies to all ASD treatment, it may conflict with these laws. The federal Mental Health Parity Act requires that if a large employer provides coverage for mental health services, the plan may only apply cost-sharing and treatment limitations to mental health that are no more restrictive than those applied to medical and surgical benefits. Although the Legislature can create an exception to Maine's mental health parity law, it cannot change the federal law. One possibility would be to apply the \$36,000 cap only to the additional services mandated by LD 1198 that are not covered by the federal mandate, such as habilitative services or those above an otherwise applicable visit limitation.

For our cost estimates, we assumed that the \$36,000 cap would apply to the amount actually paid by the insurer after applying deductibles and cost-sharing provisions. However, the language could be interpreted to apply to the total covered cost before reduction for cost-sharing. If the committee proceeds with this bill, clarification of the language would be important.

Because LD 1198 would only require coverage for treatment that is medically necessary, it is not clear whether denials for some services would continue if carriers consider them not medically necessary but primarily educational. If the committee proceeds with this bill, some clarification on this point would also be helpful.

II. Background

The Joint Standing Committee on Insurance and Financial Services of the 124th Maine Legislature directed the Bureau of Insurance (the Bureau) to review LD 1198, An Act To Reform Insurance Coverage To Include Diagnosis for Autism Spectrum Disorders. The Committee asked that the report include analysis of the extent to which Maine's mental health parity law currently covers autism and the impact of amending LD 1198 to require coverage in all individual and group policies. The review was conducted as required by 24-A M.R.S.A., § 2752. This review was a collaborative effort of NovaRest, Inc. and the Bureau.

The current mental health parity mandate in Maine requires group contracts, other than those covering employers with 20 or fewer employees, to provide benefits at least equal to those for physical illnesses for a person receiving medical treatment for eleven categories of mental illness as defined in the Diagnostic and Statistical Manual (DSM). One of the specified categories is autism spectrum disorders (ASD). ASDs include autism, Asperger syndrome and pervasive developmental disorder not otherwise specified (PPD-NOS).

In addition, the federal Mental Health Parity Act requires that insured or self-insured plans covering employers with 50 or more employees, if they provide coverage for mental health services, apply cost-sharing requirements (deductibles, co-payments, coinsurance) and treatment limitations (limitations on the frequency of treatment, number of visits, etc) to mental health services that are no more restrictive than those applied to medical and surgical benefits.

Carriers offering small group health plans and individual coverage are required to offer the mental health parity level as a rider for additional premium if requested. This coverage tends to be very expensive due to the potential for adverse selection if only those needing it purchase the coverage.

Anthem currently covers mental health services at the same benefit level as medical treatment for groups of all sizes, not just those with more than 20 employees, as a result of state and federal guaranteed issue laws⁶ and Anthem business decisions. Other carriers may also be extending the mental health parity to groups of all sizes but the Bureau is not aware of any at this time.

LD 1198, if amended, could require all individual and group health insurance policies to provide coverage for ASD for those 21 years of age or under. Coverage would include

⁶ 24-A M.R.S.A. § 2808-B and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

assessments, evaluations, and tests by a licensed physician or psychologist to diagnose any ASD. Also, LD 1198 would eliminate any limits on the number of visits covered for autism but would allow an annual maximum of \$36,000. This maximum could conflict with state and federal law to the extent it applies to services that are subject to mental health parity laws.

All policies would be required to provide coverage for treatment of ASD when a licensed physician or psychologist has submitted documentation that the treatment is medically necessary. A licensed physician or psychologist may be required to confirm and document the need for ongoing treatment at least on an annual basis.

LD 1198 defines treatment of ASD to include the following types of care prescribed, provided or ordered for an individual diagnosed with ASD:

- (1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible;
- (2) Prescribed pharmaceuticals;
- (3) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and
- (4) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

The policy, contract, or certificate may not include any limits on the number of visits. The policy, contract, or certificate may limit coverage to \$36,000 per year, except that, beginning January 1, 2011, the maximum benefit must be adjusted annually for inflation using the medical care component of the United States Department of Labor Consumer Price Index for urban wage earners. An insurer may not apply payments for coverage unrelated to ASD to any maximum benefit established under this paragraph.

Except as otherwise described, a policy, contract or certificate may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that those provisions are not inconsistent with the mandate.

Under the current Maine mental health parity mandate, limits on the number of visits are not prohibited if they are also applied to physical illness. LD 1198 would no longer allow these limits on the number of visits for ASD. Additional services for ASD would also be required by LD 1198 when medically necessary, specifically habilitative services including applied behavior analysis. These services have typically been denied for insurance coverage as educational or investigational or because they are not considered to be restorative. It is not

clear whether denials for some of these services would continue with this mandate if carriers consider them not medically necessary but primarily educational.

It is also unclear how the calendar year cap of \$36,000 under the proposed bill would apply to coverage of ASD that is also required by state and federal mental health parity mandates. If the \$36,000 cap applies to all ASD treatment, it may conflict with these laws. Although the Legislature can create an exception to Maine's mental health parity law, it cannot change the federal law. One possible remedy would be to apply the \$36,000 cap only to the additional services mandated by LD 1198 that are not covered by the federal mental health parity law, such as habilitative services or those above an otherwise applicable visit limitation.

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.*

ASD is on the rise in the United States and in the State of Maine. At the national level, there has been a dramatic increase in prevalence of Pervasive Developmental Disorders (PDD), especially autism. Previously it was estimated that autism affects two to six of every 1,000 people, but more recent studies have increased that estimate to one in every 150⁷. It is currently the fastest growing developmental disability being diagnosed with a 10-17 percent annual growth rate⁸. While the US population increased by 13 percent during the 1990s, autism increased by 172 percent.⁹ Although it is unclear whether the actual incidence is on the rise or if the diagnosis is becoming more prevalent due to a broader definition of ASD and better efforts in diagnosis, it is a serious public health concern either way.¹⁰

Some of the symptoms of ASD are delays and difficulties in social development and communication skills, and usually some kind of repetitive behavior. People with autism have social impairments and often lack the intuition about others that many people take for granted.¹¹ Autism is typically something that parents recognize and presumably seek diagnosis and treatment for at an early age.

The State of Maine school system has seen steady increases in children diagnosed and seeking treatment for ASD. The following statistics from the U.S Department of Education show clearly the increase of parents seeking special assistance for their children with ASD.¹²

- Average annual increase of 18 percent in the number of children served in Maine schools under the category of autism.
- 100 percent increase in transition-aged youth—the number of youth ages 14-18 served in Maine schools under the autism category has doubled over a five-year period.

⁷ Centers of Disease Control and Prevention (2001)

⁸ Autism-society.org <http://www.autism-society.org/site/PageServer?pagename=asa_media_home>

⁹ U.S. Department of Education's "Twenty-First Annual Report to Congress on Implementation of Individuals with Disabilities Education Act" (1999)

¹⁰ "Is there an ASD epidemic?" <<http://www.cdc.gov/ncbddd/autism/topics.html>>

¹¹ www.raising-special-kids.com < <http://www.raising-special-kids.com/autism-spectrum-disorder.html>>

¹² Maineddc.org <<http://www.maineddc.org/pdd-systems.html>>

- 95 percent increase in number of students with autism—the number of students in the autism category in public schools in the fall of 2007 is nearly double the number in that category in the fall of 2003.

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

Services for ASD including assessments, evaluations, and tests by a licensed physician or psychologist to diagnose ASD are available through private medical providers and through the school system.

Because autism therapies vary so widely, it is difficult to calculate all of the individual professionals that can assist in the treatment of autism, but there are many licensed professionals in the State of Maine practicing speech, occupational, nutritional, physical, and physiological therapies.

Applied behavioral analysis (ABA) therapists in the State of Maine are not required at this time to obtain a state license. Most ABA therapists complete a certification process that requires approximately 225 hours of class work and 1,500 hours of supervised practice. ABA assistants complete 135 hours of class work and 1,000 hours of supervised practice. There are currently 26 certified ABA therapists (including assistants) in the State of Maine with most located in the southern counties. There are also several facilities (schools, daycares, etc.) that purport to be an ABA facility, but are not actually supervised by a certified ABA therapist.

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

The current mental health parity mandate in Maine requires group contracts, other than those covering employers with 20 or fewer employees, to provide benefits at least equal to those for physical illnesses for a person receiving medical treatment for eleven categories of mental illness as defined in the Diagnostic and Statistical Manual (DSM). One of the specified categories is pervasive developmental disorders, also known as ASD. In addition, the federal Mental Health Parity Act requires that insured or self-insured plans covering employers with 50 or more employees, if they provide coverage for mental health services, apply cost-sharing requirements (deductibles, co-payments, coinsurance) and treatment limitations (limitations on the frequency of treatment, number of visits, etc) to mental health services that are no more restrictive than those applied to medical and surgical benefits.

As a general rule with regard to ASD, most insurance plans will provide coverage for diagnosis and treatment of autism the same as any other illness or disorder. However the coverage is limited by deductibles, co-payments, and/or coinsurance. Also, most plans do

have annual limits for therapies such as physical, occupational, and speech therapy.

Cathy Dionne, a parent with an autistic child, presented testimony in support of LD 1198. She stated “I always wondered why the burden kept shifting to MaineCare. My husband’s insurance was considered the best plan unless you have a child with autism.”

According to the survey of commercial insurance companies regarding this matter it was revealed that some insurance companies will not cover services related to ABA, which can be denied because they are considered educational and experimental. Some insurers will not cover services such as speech therapy because it is considered a developmental delay, not a medical issue.

The family of an autistic child sued Blue Cross of Michigan for allegedly failing to acknowledge that a treatment known as ABA is scientifically valid. Blue Cross Blue Shield of Michigan settled shortly after plaintiff’s counsel obtained a court order requiring Blue Cross to produce documents from their files that validated the effectiveness of ABA.¹³

The following are the responses from commercial insurance carriers to the State of Maine’s Request for Information pertaining to LD 1198 Autism Proposed Mandate Information request dated 6/16/09. We are not opining on the validity of the following assumptions or conclusions, but rather are repeating them as provided.

CIGNA's Response:

CIGNA covers ASD per the Maine mental health mandate which requires mental health treatment to be the same as any other physical illness. However, as with medical health care, procedures considered to be investigational or experimental are not covered. CIGNA does cover medically necessary medical work-up including history and physical, medically necessary labs & other diagnostic studies performed to rule out underlying conditions. We do cover psychiatric visits to include medication management of behaviors and standard outpatient therapy. Inpatient hospitalization, if needed due to excessive behavior, is also covered. CIGNA covers genetic testing for ASD as medically necessary for confirmation testing for FMR1 gene mutation when fragile X syndrome is suspected in the presence of either dysmorphic features or mental retardation; for confirmation testing for MECP2 gene mutations when Rett’s Disorder is suspected; for carrier testing when there is a positive family history of fragile X syndrome or Rett’s disorder in a first or second degree relative and the couple has the capacity and intention to reproduce and for prenatal or pre-implantation genetic diagnosis (PGD) testing when either parent is a known carrier of a disease-causing mutation of genes FMR1 or MECP2. Currently no limits are applied to care provided for ASD that would not be otherwise applied for a physical illness, consistent with

¹³ Law.com <<http://www.law.com/jsp/article.jsp?id=1202431667002>>

the Maine Mental Health mandate. The \$36,000 maximum benefit limit included in the ME mandate is in place in other states. Speech, physical and occupational therapy is covered for autism when mandated and limits for autism are likely to be the same for autism as for any disorder. Currently, if no mandates exist then coverage for services related to the diagnosis and treatment of autism varies depending on the service, that is, the service drives coverage and denial reason. In general, under current standard exclusion language, we do not cover rehabilitative services for autism/autism spectrum disorders as they are not considered to be restorative.

In addition, therapies that are considered primarily educational and training in nature are not covered. With regard to applied behavioral analysis & other intensive intervention programs, we consider these techniques experimental, investigational or unproven and thus not covered under standard plans as their effectiveness has not been demonstrated.

Aetna's Response:

Autism spectrum disorder is currently covered by Aetna for services under certain circumstances. Services related to behavioral health, medically necessary physical and occupational therapy are covered unless specifically excluded by the Plan. Services related to applied behavioral analysis (ABA) are denied as educational and considered not covered. Speech therapy services are not covered under Aetna's HMO plans and are denied as developmental delay. With respect to Aetna's PPO/Traditional plans, if not covered by the Plan or mandated by legislation, speech therapy is not be [sic] covered.

Anthem's Response:

Group and individual plans provide coverage for the diagnosis and treatment of autism or pervasive development disorder. Coverage of services is subject to overall benefit plan design, including deductibles, co-payments and coinsurance requirements. Additionally, coverage is subject to plan dollar limitations such as the annual limitations for physical, occupational and speech therapy. Coverage of autism is made available or is included as part of the overall benefit design at the same benefit level provided for medical treatment for physical illnesses.

UnitedHealthcare's Response

Our current coverage is governed by the requirements of 24-A MRSA 2843 Mental Illnesses. Under this mandate ..., we cover outpatient testing, diagnosis, assessment and evaluation for all disorders classified as pervasive developmental disorders including autism and related autism spectrum disorders. These services are not subject to any visit limits.

Outpatient, inpatient and intermediate treatment is covered on the same basis as for physical illness depending on the place of service. In addition, the following intermediate treatment venues are available for pervasive developmental disorders subject to Mental

Health/Substance Abuse Designee authorization: (1) Residential treatment centers, (2) Partial hospital/day treatment programs, (3) Intensive outpatient programs.

Additional services mandated by LD 1198 that are currently covered include pharmaceuticals, counseling services (in residential treatment centers and as part of day treatment programs), and outpatient physical, speech and occupational therapy subject to the same visit limits as apply to physical illnesses.

Regarding claims data, we are unable to provide complete data at this time due to time restraints. Since autism is not set up as a discrete benefit in our claims systems, isolating claims and payment data specific to autism related services will have to be done manually. This is a time-consuming process that we will accomplish as soon as possible.

The following services specific to autism and autism spectrum disorders are not covered regardless of whether treatment is short or long term:

- 1. Sensory Integration*
- 2. Applied behavior analysis*
- 3. Lovaas Therapy*
- 4. Music Therapy*

In all four cases, the reason for denial is that the effectiveness of these treatments is considered unproven.

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 for therapies such as ABA or speech therapy is typically denied by insurers because they are considered educational or experimental. However, these services are usually covered within the MaineCare program, including the Katie Beckett program. The Katie Beckett Program provides MaineCare eligibility for children with serious health conditions without regard to the parents' income or assets. A premium is required. If families do qualify for the Katie Beckett and other programs, navigating the system can be time consuming. Autism advocates believe that the amount of time required to deal with denials for coverage and qualification for new coverage creates inconsistent and uncoordinated care which will result in negative setbacks for treatment.¹⁴

A recent article states:

“Families that refuse to allow their children to suffer through the inadequate Medicaid system and are denied coverage by their private health insurance carriers often end up paying for therapies out of their own pockets. For these families, the financial burden is immense.

¹⁴ Autismvotes.org <autism advocates believe that the amount of time required to deal with denials for coverage and qualification for

Without the negotiating powers of an insurance company behind them, out-of-pocket prices are extremely high. Parents can often spend upwards of \$50,000 per year on autism-related therapies, and they are often forced to risk their own futures and the futures of their non-autistic children to pay for necessary autism-related therapies. Children whose parents cannot afford to pay for behavioral and other therapies and who cannot access adequate therapies through the Medicaid system simply go without these interventions.”¹⁵

It has been documented that services such as ABA are most effective in treating children with ASD. The U.S. Surgeon General states that 30 years of research on the ABA approach has shown very positive outcomes when ABA is used as an early-intervention tool for autism.¹⁶

Other services such as speech therapies may not be covered by insurance, or may have such low limits that it would not meet the needs of an autistic child. As a result, many families are forced to find other avenues for funds to pay for ABA through charity programs, or go without.

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

Due to denials and the added time necessary to receive coverage and meet insurance requirements, many families with autistic children will experience various financial troubles. In terms of the particular financial hardship associated with caring for an ASD child, researchers noted that 57 percent of such families had to reduce or stop working because of their child's needs which reduces their financial resources.¹⁷

A wide spectrum of therapies is available and many can cause a financial burden to families. The cost for ABA therapy in particular is so high that it almost always results in financial hardship to families. The following are some of the costs related to ABA.

- In order to effectively implement ABA, both parents and any other major caretakers must be trained in ABA. Workshops covering the basics of ABA treatment can last from two to seven days, and cost between \$175-1,000 per person. Online ABA courses are especially useful for parents who do not live in a large city.

new coverage creates inconsistent and uncoordinated care which will result in negative setbacks for treatment.>

¹⁵ Eight arguments defining the justification for autism insurance reform legislation (Feb. 2009)

http://www.autismvotes.org/atf/cf/{2A179B73-96E2-44C3-8816-1B1C0BE5334B}/Arguments_for_private_insurance_%20coverage.pdf

¹⁶ U.S. Department of Health and Human Services. 1999. "Mental Health: A Report of the Surgeon General - Executive Summary." U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Rockville, MD.

¹⁷ Medicinenet.com <<http://www.medicinenet.com/script/main/art.asp?articlekey=94608>>

- Children can be enrolled in schools and clinics that specialize in ABA treatment. These can be found in most major cities and university towns. The cost of such schools can range from \$16,000-25,000 per year. However, some schools offer scholarships to parents in need.
- It is possible to set up ABA treatment at home using therapists in training or college students who have taken a workshop in the ABA approach. This can cost \$5,000-20,000 per year and requires a great deal of time organizing and structuring the program.
- A qualified, full-time (30 hours/week or more) ABA therapist devoted to an autistic child costs approximately \$30,000-50,000 per year, but because of the success of ABA and the evidence indicating that training should be intensive (25-40 hours/week), there is very high demand for ABA-trained therapists, and it may be difficult to find one who is available .¹⁸

One parent with a child diagnosed with autism testified that her son “needs the help that these proven therapies and interventions provide. His future depends on it. The financial burden that we have endured is unconscionable as is the fact that the lack of these treatments and interventions directly impact him daily.”

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

With autism on the rise, the demand for treatment is extremely high. There are many advocacy groups for autism across the nation who support and seek legislation requiring services that serve the autism community. With one out of every 150 children in the United States being diagnosed with autism,¹⁹ it now affects a significant portion of the population. There are many treatment options and many conflicting opinions on each and every treatment in the professional and general community. Although it is noted by most that there is no cure for autism, it is believed that treatment can reduce the signs and symptoms of autism and help patients become more productive, less dependent individuals.

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

The level of public demand to have treatment for autism covered is high from providers and the autism community. Because there is such a wide variety of treatments available and

¹⁸Autism.healingthresholds.com < <http://autism.healingthresholds.com/therapy/applied-behavior-analysis#cost>.>

¹⁹ Centers of Disease Control and Prevention (2001)

autism is not a one size fits all disorder, parents often find themselves trying many different therapies at the same time or switching to new therapies when one has had no result for their child. The expenses incurred during this trial and error process can be overwhelming for families and thus may impact a physician's choice to prescribe a certain treatment. In a letter from a parent of a child with ASD who provided testimony in support of LD 1198, he stated that they have found success with natural supplements. However, their visits with a naturopath and the supplements themselves are not covered by their insurance, so they have had to bear the cost themselves. Advocates therefore feel that if private insurance were to cover more of the cost of these therapies, it would relieve the burden felt by many families and physicians. Below is a sample list of treatments available for autism.

Psychological, Educational, and Therapeutic Interventions

- Animal Therapy
- Applied Behavior Analysis (ABA)
- Art Therapy
- Auditory Integration Therapy (AIT)
- Augmentative and Alternative Communication (AAC)
- Developmental Therapies
- Facilitated Communication
- Glasses
- Holding Therapy
- Music Therapy
- Oral-Motor Training/Therapy
- Patterning
- Picture Exchange Communication System (PECS)
- Project TEACCH (Treatment and Education of Autistic and related Communication-handicapped Children)
- Psychoanalytic and Humanistic Play Therapy
- Recreational Sports/Exercise
- Relationship Development Intervention (RDI)
- Sensory Integrative Therapy (Sensory Integration, SI, or SIT)
- Socialization related classes
- Social Skills Groups
- Social Stories
- Son Rise (Options)
- Video Modeling
- Vision Therapy
- Anti-Fungal Medication
- Anti-Yeast Medication
- Chelation Therapy
- Craniosacral Therapy
- Herbs and Homeopathic Treatments
- Hyperbaric Oxygen Therapy
- Iridology
- Magnets
- Medications
- Secretin

- Special Diets
- Vitamin and Supplement Therapy²⁰

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.

The satisfaction rate of consumers in states that have passed reform laws in regard to autism coverage is evident on autism support Web site discussions. A common theme of these discussions is which states have passed such reform, and many people post comments that they are considering moving to a state that has passed reform. At this time, all but 15 states are considering or have already passed reform legislation regarding coverage of autism. The following list from the Autism Speaks Web site shows the number of states that have passed or are introducing legislation for insurance reform in regard to autism.

No information is available on the impact of the mandate on insurance claims in other states, in part because the passage of many of these mandates was very recent.

States with autism insurance reform laws

- Arizona
- California
- Colorado
- Connecticut
- Florida
- Illinois
- Indiana
- Kansas
- Louisiana
- Maryland
- Montana
- Nevada
- New Jersey
- New Mexico
- Pennsylvania
- South Carolina
- Tennessee
- Texas
- Wisconsin

States that have introduced autism insurance reform bills

- Alabama

²⁰Asatonline.org < http://www.asatonline.org/resources/treatments_desc.htm.>

- Alaska
- Arkansas
- Delaware
- Georgia
- Idaho
- Kentucky
- Maine
- Massachusetts
- Michigan
- Mississippi
- Missouri
- New Hampshire
- New York
- Ohio
- Oregon
- Washington, DC

States not currently pursuing autism insurance reform

- Hawaii
- Iowa
- Minnesota
- Nebraska
- North Carolina
- North Dakota
- Oklahoma
- Rhode Island
- South Dakota
- Utah
- Vermont
- Virginia
- Washington
- West Virginia
- Wyoming^{21 22}

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.

No information was provided by the state health planning agency.

11. The alternatives to meeting the identified need.

The following are the responses from commercial insurance carriers to the Bureau's Request for Information pertaining to LD 1198 Autism Proposed Mandate Information request dated 6/16/09. We are not opining on the validity of the following assumptions or conclusions, but rather are repeating them as provided.

²¹ www.autismvotes.org/site/c.frKNI3PCImE/b.3909861/k.B9DF/State_Initiatives.htm.

²² National Association of Insurance Commissioners, Autism Survey Results, December 3, 2009
<http://www.naic.org/documents/committees_d_ccwg_autism_survey_091203.doc>

UnitedHealthcare suggested some modifications to the bill including:

- *The bill adjusts the annual cap by the medical component of CPI. Therefore, in only a few short years the cap will double. UnitedHealthcare would suggest that adjustment be struck from the bill.*
- *Since Maine law currently defines Autism as a biologically based mental illness, the definition could trigger federal preemption of the \$36,000 cap by the federal mental health parity act. If so, UnitedHealthcare believes that should be addressed by the legislature, otherwise the premium impact will be considerably more.*
- *The language should be clarified to ensure that schools must comply with all existing state/federal requirements related to providing services to children diagnosed with an ASD.*
- *Requiring licensure/certification standards for treating providers.*
- *Requiring coverage of "medically necessary" assessments, evaluations or tests rather than coverage of just "any" assessment, evaluation or test.*
- *Notwithstanding the requirements of the bill, allowing carriers to subject coverage to the certificate of coverage, including the general limitations and exclusions.*
- *Adding sufficient time for all stakeholders to implement and comply with a new law.*

Anthem's survey response is as follows:

Anthem believes many alternatives to the mandate are available today and, therefore, the mandate is unnecessary.

First, Maine provides early intervention services for children from birth up to age 5 (or when the child enters school), at no or little cost to parents. As noted in the February 2009 report of the Maine Department of Health and Human Services, early intervention services include many of the services proposed to be covered by health insurance in LD 1198.²³ As described below, Maine has received additional federal funding for the early intervention program and will receive further additional federal funds this year, which will increase Maine's ability to provide, and parents' ability to access, early intervention services. There are also services available from the Department's Division of Children's Behavioral Health Services, such as behavioral management and counseling.²⁴

Second, the federal Individuals with Disabilities in Education Act (IDEA) requires school districts to provide disabled students with a "free appropriate public education." School-age autistic children up to age 21 receive services in schools, as required by IDEA, to help them learn in an appropriate fashion despite their

²³http://www.maine.gov/dhhs/reports/autism_act_report.pdf Specific services mentioned by the Department at page 13 of the report as provided in early intervention include speech, occupational, developmental, and physical therapy; counseling; medical care for co-morbid disorders; and social development.

²⁴ http://www.maine.gov/dhhs/reports/autism_act_report.pdf at page 14.

developmental disability. Recently, there has been an increase in federal funds available for states to provide to school districts for IDEA services. The American Recovery and Reinvestment Act of 2009 (ARRA), enacted in February 2009, provides a major increase in federal funding for special education, including \$12.2 billion for IDEA. This includes \$11.3 billion for Part B, \$400 million for IDEA preschool funding, and \$500 million for Part C. These funds are in addition to states' regular Part B and Part C allocations.²⁵ An additional \$35 billion in Title I, IDEA, and State Fiscal Stabilization Funds, as well as monies for other programs, is scheduled to be distributed to states between July 1 and September 30. Earlier this year, Maine received \$130 million in ARRA funds. Of this amount, \$29 million is for IDEA. The state is eligible to apply for an additional \$63.8 million this fall.²⁶ As of the end of June 2009, Maine school districts had already received the first installment of ARRA funds.²⁷ It would be important to understand how the ARRA funds will be used by school districts to fund and expand school programs and services.

Third, with respect to private health insurance, the state of Maine has already enacted an insurance benefit mandate and a mandated offer requirement which requires that insurers provide or offer benefits for outpatient mental health services, including for the diagnosis and treatment for pervasive developmental disorders, which is the overarching term in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition that encompasses autism spectrum disorders.²⁸ The benefits for outpatient mental health services already required to be offered or provided under existing law duplicate many of those proposed to be provided by LD 1198. Moreover, some of the services proposed to be covered by LD 1198 are commonly already covered by Maine health plans.

Finally, policymakers who want to ensure that families facing the real financial and other challenges posed by autism should develop safety net programs that meet their needs, rather than trying to impose autism-related costs on health insurance. Enacting an autism insurance benefit mandate will further drive up the cost of health insurance for Maine consumers, while benefiting a small percentage of the population.

Harvard Pilgrim states:

If current estimates of the prevalence of ASD in the U.S. population are accurate (1 in 150 individuals), then this is a very common disorder that requires a combination of behavioral health, medical, educational and social services and treatments. Many of these services and therapies, such as ABA or social skills coaching, do not easily fit into the medical or behavioral health models of evidence-based, medically necessary treatment. Moreover, health insurance coverage is primarily designed to cover short-term, acute illnesses, or acute exacerbations of chronic illnesses or conditions.

²⁵ <http://www.ed.gov/news/pressreleases/2009/03/03072009.html> (IDEA Part B is assistance for education of all children with disabilities, and Part C is for children with disabilities ages 3 to kindergarten.)

²⁶ <http://www.ed.gov/news/pressreleases/2009/04/04282009e.html>

²⁷ <http://www.maine.gov/tools/whatsnew/index.php?topic=DOENews&id=75205&v=article>

²⁸ 24-A M.R.S.A §§ 2325-A, 2749-C, 2843, and 4234-A,

Traditionally, states have maintained programs to assist individuals without adequate financial resources to manage chronic, long-term conditions. Further, the federal government requires schools to develop individualized education plans (IEPs) and fund the appropriate programs and educational interventions for children with special needs, including ASD.

We believe that a mandate that shifts costs for the treatment of ASD largely to fully-insured employer groups that already are facing high premiums due to rising medical costs will only make coverage less affordable. We do not believe that funding for ASD services should fall solely on employers who voluntarily purchase fully-insured plans. It may also create further tension as health plans, schools and parents attempt to appropriately assign financial responsibility for services.

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 benefit is a medical need due to a mental health condition and coverage required by LD 1198 is not inconsistent with the role of insurance to provide medically necessary services for a condition, although there is some conflict between insurance carriers and proponents of the bill with regard to whether educational services are consistent with the role of insurance. Also, it is unusual for health insurance to reimburse providers that are not licensed by the state. ABA therapists are not currently subject to state licensure law.

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

There may be some stigma attached for receiving these services because of the stigma associated with having learning disabilities or from being diagnosed with a mental health condition.

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

Although it is believed by many advocates²⁹ that the use of these mandated services will reduce the need for some future mental and possibly physical health services as children are able to function better, the actual financial impact has not been determined. Some analyses have shown lower healthcare costs in later life when autistic children receive early treatment, but because many of these treatments are relatively new, these analyses usually depend on assumptions concerning outcomes and the cost savings in future education needs and productivity rather than on actual data.³⁰

²⁹ The Autism Society of America indicates a two-third savings. < http://www.autism-society.org/site/DocServer/02-16-2009_ASA_Publishes_Model_Legislation_for_Autism_In.pdf?docID=12061>. Also A-CHAMP indicates long term savings <http://www.autismactioncoalition.org/insurance_coverage.html>

³⁰ ABT Associates, "Autism Spectrum Disorders Mandated Benefits Review Panel Report Evidence Submitted Concerning Pennsylvania

Virginia's evaluation of its proposed autism mandate found that there was limited research on the impact on overall costs of providing treatments for children with ASDs. The Virginia evaluation predicted the proposed mandate would increase total health care costs in the short term. It mentioned a study that examined savings ranging from \$187,000 to \$203,000 per child for ages three to 22 years. However, these estimates reflect a range of assumptions that may or may not prove accurate about the percentage of children treated with early intensive behavior intervention that would function in the normal range as a result of therapy. The evaluation also mentioned a recently published study that found people with autism spend twice as much as the typical American over their lifetime on medical costs. By treating children with ASDs in an effective manner, it may be possible to reduce other health care costs in these individuals over the long term.³¹

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.

As premiums increase due to mandated benefits, some employers choose to self-insure in order to have more control over the benefits that they provide to employees and control the cost of health insurance premiums.

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

Anthem estimates a premium increase of \$1.90 per member per month.

HB 1150" June 18, 2008, <<http://www.dora.state.co.us/insurance/meet/MHBC/2009/SB09-244%20Autism/mhbcABTAutismReport032009.pdf>>

³¹ Virginia's Evaluation of House Bill 83: Mandated Coverage of Autism Spectrum Disorders, Joint Legislative Audit and Review Commission, Sept 2008

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.

It is possible that when ABA and other treatments that are currently not covered by insurance are covered by insurance, the cost of those treatments will increase due to increased demand, although the increased number of providers may partially offset the upward pressure on fees.

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 coverage of ABA and other treatments by insurance will increase the use of the treatments. It may increase inappropriate use as well, until protocols are developed concerning the amount of therapy that is useful.

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

The mandated coverage of ABA therapy will most likely replace other less expensive treatments such as diet, vitamins, and prescription medication currently being used when parents cannot afford ABA therapy.

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

LD 1198 does not prohibit health plans from covering the services with the same medical management used for other services.

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

Currently, there are 26 certified ABA therapists in Maine. Licensed psychologists may also provide ABA therapy, but in general, therapists may be in short supply. If ABA is covered by health insurance, it is likely that the number of ABA therapists will increase. Colorado's review of its proposed autism mandate noted that Colorado had just over 40 certified

individuals, or 33 per million children, whereas Florida, which does have mandated coverage, has over 1,000 certified individuals, or 250 per million children.³²

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

Our analysis indicates that the primary driver of the increase in health care costs and health insurance premiums as a result of LD 1198 is the cost of ABA therapy. In general, cost increases will be low at first because of the limited number of therapists available to provide therapy compared to the estimated number of children with ASD. After the availability of ABA therapy increases to meet the demand, the cost impact will also increase.

Another consideration in estimating the cost impact of LD 1198, is the application of the \$36,000 annual limit on benefit costs. It is possible that the federal Mental Health Parity Act will not allow for specific limits on benefits for ASD, since they are considered mental health benefits.

We estimate the initial premium increase for insured plans would be approximately \$1.65 PMPM. Once there are adequate providers for the individuals that would benefit from ABA therapy, the increase in premiums could be as high as \$2.30 PMPM. If the maximum benefit of \$36,000 is not permitted by the federal Mental Health Parity Act, the premium increase could be as high as \$2.95 PMPM. This is based on our estimate of the incidence of autism in Maine (one in 150), the percent of autistic children who could benefit from ABA therapy and would ultimately access it (average of 30 percent), the amount of services that will ultimately be used by the children using ABA (average of \$30,299 annually with a maximum benefit or \$34,909 without a maximum benefit). These averages reflect a mix of children whose expenses would exceed \$36,000 and children whose expenses would be less. Generally, preschool age children receiving 30 to 40 hours of therapy weekly will exceed this amount while older children who are in school will require fewer hours of therapy and therefore have lower costs. Our cost estimates also include the premium increase from services other than ABA that are currently not covered by insurance but would be required under LD 1198. Further detail regarding the methodology, data sources, and assumptions used to produce our cost estimates is shown in Appendix B.

For our cost estimates, we assumed that the \$36,000 cap applies to the amount actual paid by the insurer after applying deductibles and cost-sharing provisions. However, the language could be interpreted to apply to the total covered cost before reduction for cost-sharing. If

³² Commission on Mandated Health Insurance Benefits Review of SB09-244 –Concerning Health Insurance Benefits for the Treatment of Autism Spectrum Disorders, March 20, 2009.

the committee proceeds with this bill, clarification of the language would be important.

The following are responses from commercial insurance carriers to the Bureau's Request for Information pertaining to LD 1198 Autism Proposed Mandate Information request dated 6/16/09. We are not opining on the validity of the following assumptions or conclusions, but rather are repeating them as provided.

UnitedHealthcare estimates a \$1.48 to \$4.23 per member per month (PMPM) increase in premium. This range is based upon the new prevalence rate of 1 in 77 children with autism in Maine, an annual limit of \$36,000 and no lifetime limit.

Aetna, based on 2008 data, estimated autism costs per autistic member to be approximately \$15,800 annually, with \$13,900 of that being an incremental increase beyond the restorative therapies for autistic members that may currently be covered. According to Aetna, "This translates into a 0.5% increase to premiums, both incrementally and in total."

Anthem estimates premium increases for small and large group:

	Average PMPM increase	Average percentage increase
HMO	\$2.34	0.55%
PPO	\$1.96	0.65%
Fee for Service	\$2.52	0.25%

Anthem anticipates that similar increases would apply to individual products, although the increases will likely be higher because of the increased risk of adverse selection.

The MEGA Life and Health Insurance Company did an estimate based on general population statistics. For treatment of Autism they estimated costs to be \$70,000, capped at \$36,000 per the proposed bill, and a frequency of 7 per 10,000. The results are $7/10,000 * \$36,000 = \25 or about \$2.00 PMPM. This is for autism; for other autism spectrum disorders, the frequency was estimated at 20 per 10,000 and a cost of \$20,000 per year, or about \$3.00 PMPM. Mega estimated the total costs for a general population might be in the \$5 - \$10 PMPM range. They felt when this is placed on a guaranteed issue insurance population, the costs are likely to escalate due to the anti-selection. Those that have children with these conditions will be willing to pay for insurance to get the expensive treatments. They estimate that the costs may double those quoted above. They mentioned one study in Pennsylvania indicated that costs could go as high as 11%, and not on a guaranteed issue basis.

Although **Cigna** continues to assess the impact of the proposed level of autism benefits in Maine, it indicated that the financial and utilization implications that would drive pricing for all policies remain unknown at this time.

Harvard Pilgrim could not estimate the impact on premiums since it had no experience with providing coverage for Applied Behavioral Analysis (ABA) or similar rehabilitative therapies, and the literature seems to indicate a wide variation in costs, depending on the training and degrees of the ABA therapist and the number of hours per week that are required.

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.

There would not be any additional cost effect beyond benefit and administrative costs.

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

Research indicates that by providing children with autism services and support they can obtain substantial gains in most areas of life. The benefit of these services may minimize the likelihood of institutionalization of individuals with disabilities and maximize the potential for their independent living in society. The intent is that these services would reduce the total cost of health care that would exist if the services were not available or used. However, there are no definitive studies demonstrating or quantifying these savings. Because individuals often change insurers or employers, positive effects may not impact the insurer or employer that covered the majority of the treatments.

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.

ABA services are currently not covered by insurers. This mandate would increase the coverage of these services and therefore the use of these services. This will increase the cost of health care.

Claims cost and administrative cost will increase, which will result in increases in premiums for employees and all sizes of employers. Long-term savings for insurance claims could not

be verified or quantified at this time with available information. Studies do suggest savings in education or productivity.

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.

To the extent that these services are currently covered by MaineCare and will be paid for by private insurance after the mandate is implemented, the cost will be shifted from the public payers to the private payers.

MaineCare data identifies individuals with private medical coverage but does not distinguish between insured and self-insured plans. Claims for autism are paid by MaineCare for those with other coverage that could be shifted to insurance with passage of this mandate. From this data we estimate a possible shift of up to \$2 million annually for the bill as written and up to \$4 million annually if the mandate applies to all group and individual policies. However, because many children with autism also have conditions such as depression, anxiety, or obsessive compulsive disorders, it is difficult to discern whether all of the services are to treat the autism or whether some are to treat the other conditions. Also, not all services that MaineCare provides may be required to be reimbursed by insurers under the proposed mandate.

In Pennsylvania it was estimated that their Medicaid program would save \$15 million in the first year after the implementation of their autism mandate.³³

³³ Pennsylvania Insurance Department letter dated March 6, 2008 to the PA Health Care Cost Containment Council

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.

With autism now considered a major health problem across the country, any steps taken toward treatment and lessening of symptoms would be a major benefit to society as a whole. As stated by Catherine Lord, the director of the University of Michigan Autism and Communication Disorders Center, “the best way to deal with autism is to intervene as early as possible to treat the condition.” She also stated that children who developed even some very simple speech skills prior to the first time they were evaluated at age two were far more likely to overcome the disorder.³⁴

In testimony in support of LD 1198, the Maine Developmental Disabilities Council stated that 40 percent of young children with Pervasive Developmental Disorders (PDDs) who receive intensive early intervention services will be able to be in a regular education classroom with little or no extra support when they enter public school. In Texas, which has required insurance coverage since 2007, the state estimates it is saving \$208,000 in long-term educational savings for each autistic child that has access to therapies.³⁵

With almost all children achieving some level of improvement after treatment, it is clear that there is a benefit to society. The cost of educating and caring for these children will go down, and some children will be able to mainstream into society as fully functioning citizens.

The Disability Rights Center in Augusta, Maine provided testimony in support of LD 1198 stating that developmental therapies such as applied behavioral analysis, especially provided intensely at an early age, mitigates the impact of disorders such as autism and allows individuals to lead a more productive, healthier, and happier life.

The Maine Department of Education and the Maine Department of Health and Human Services issued a report in October 2009 of a systematic review of the latest research on

³⁴ Early Intervention Lessens Impact Of Autism, March 2009, <http://allaboutautism.blogspot.com/2009/03/early-intervention-lessens-impact-of.html>

³⁵ Insurance coverage for autism an incredible investment May 09, Commentary by Joseph J. Roberts, Jr., New Jersey General Assembly Speaker

treatment for ASD. This review was designed to review the treatment literature for ASD. Over the course of a year, a committee including: state agency staff, providers, researchers, and others reviewed more than 150 studies of 43 different treatments for children with ASD.

The Committee objectively reviewed the research using a validated rubric, the Evaluative Method for Determining Evidence-Based Practice in Autism (Reichow, Volkmar, & Cicchetti, 2008), and assigned each intervention a level of evidence rating. The quality of each study was carefully evaluated using a set of primary and secondary quality indicators and factored into the determination of the level of evidence using a corresponding rating scale. They found established evidence in multiple strong or adequately rated studies that ABA has been proven effective as an early intensive behavioral intervention treatment for challenging behavior, communication challenges, and social skills.³⁶

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.

The U.S. Surgeon General states that 30 years of research on the ABA approach have shown very positive outcomes when ABA is used as an early-intervention tool for autism.

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

Behavior Analysts are not required to be licensed in Maine or many other states. Around 1999, the field of Behavior Analysis began credentialing practitioners. The Behavior Analyst Certification Board maintains a Web site (www.bacb.com) regarding certification and supervised practice requirements. In summary, the Behavior Analyst certification requires 225 classroom hours covering a range of graduate level ABA instruction, and 1500 hours of documented supervised field work. The Behavior Assistant Analyst certification requires 135 classroom hours and 1,000 hours of supervised field work.

³⁶ Interventions for Autism Spectrum Disorders, Report of the Children's Services Evidence-Based Practice Advisory Committee, October 2009

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 U.S. Centers for Disease Control estimates that one in 150 children have ASD and it is currently labeled as a serious problem due to the rapid increase in diagnosis of ASD in recent years.³⁷ Experts agree that it is important to treat this condition as early as possible to increase the likelihood of successful outcomes. The U.S. Surgeon General states that 30 years of research on the ABA approach have shown very positive outcomes when ABA is used as an early-intervention tool for autism. Increased early intervention treatment would reduce needs for special education in the public schools for some children and lead to savings in the schools.

Most insurance carriers will not cover services related to ABA because they consider it educational and/or experimental. This creates a significant financial burden for families with children that would benefit from ABA therapy. These families typically already have strained family finances due to the need to reduce their own work schedule in order to provide care for their child.

For children who do not have insurance and qualify, MaineCare will cover services for autistic children. The Katie Beckett program offers eligibility for MaineCare for children with serious health conditions such as ASD without regard to the parents' income or assets. A premium is required.³⁸ This mandate would shift some of the cost from MaineCare to the private insurance market.

The financial impact on insurance premiums will primarily come from coverage of ABA therapy and not affect self-insured plans that are not subject to insurance mandates. It is estimated that the impact on other premiums will start out lower due to a possible lack of ABA trained therapists and due to the fact that many of the children who could have benefited are older and may no longer be good candidates for ABA therapy. As more

³⁷ This is a clearly established fact. It is also stated in several of the pieces of evidence submitted such as the autism fact sheet from the National Institute for Child Health and Human Development which states "Autism is a complex neurobiological disorder" and from Volkmar F, Pauls D, 2003. Autism. The Lancet 362:1133-1141. stating, "Autism is a neuropsychiatric disorder".

qualified providers become available in Maine and young children, who can benefit the most and use the most intensive therapies, begin ABA therapy, it is estimated that the impact on premiums will increase.

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

Since this mandate would impact a very small percentage of the total population, it is likely that only those that would benefit from the services would purchase the coverage. This would result in an alternative coverage that would cost more than the cost of services when administrative charges were added to benefit costs. This cost would be reduced if the option was only available when the coverage was initially purchased, but then it would be less effective since many individuals would not believe that they will need the coverage and, therefore, would not purchase it.

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

The Bureau's estimates of the premium increases due to existing mandates are displayed in Appendix B. We anticipate that this bill would ultimately increase insured premiums³⁹ by approximately \$2.30 PMPM or 0.7 percent of premium.⁴⁰

³⁸ *Maine.gov* <<http://www.maine.gov/dhhs/ocfs/cbhs/eligibility/katiebeckett.html>>.

³⁹ This impact would not affect self-insured groups.

⁴⁰ Note, this is the ultimate impact. The estimate for the initial impact is approximately \$1.65 PMPM. If the federal Mental Health Parity law does not permit the \$36,000 maximum benefit included in LD 1198, the ultimate premium impact is estimate to be approximately \$2.95 PMPM.

VII. Appendices

Appendix A: Letter from the Committee on Insurance and Financial Services with Proposed Legislation

SENATE

PETER B. BOWMAN, CHAIR
JUSTIN L. ALFOND
EARLE L. MCCORMICK

COLLEEN MCCARTHY REID, LEGISLATIVE ANALYST
JENNIFER RITCH-SMITH, COMMITTEE CLERK



HOUSE

SHARON ANGLIN TREAT, CHAIR
CHARLES R. PRIEST
PAULETTE G. BEAUDOIN
HENRY E.M. BECK
ADAM GOODE
EDWARD P. LEGG
TERRY K. MORRISON
WESLEY E. RICHARDSON
WINDOL C. WEAVER
LESLIE T. FOSSEL

STATE OF MAINE

ONE HUNDRED AND TWENTY-FOURTH LEGISLATURE

COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

June 10, 2009

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

Dear Ms. Hooper:

Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on Insurance and Financial Services to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing on the proposed legislation. Pursuant to that statute, we request that the Bureau of Insurance prepare a review and evaluation of **LD 1198, An Act to Reform Insurance Coverage To Include Diagnosis for Autism Spectrum Disorders**.

A copy of the bill is enclosed. Please prepare the evaluation using the guidelines set out in Title 24-A § 2752. In addition, we ask that the Bureau provide an analysis of the following issues:

- The extent to which the diagnosis and treatment of autism is covered under Maine's mental health parity law; and
- The impact of amending LD 1198 to require coverage in all individual and group policies rather than just group policies with more than 50 members.

Please submit the report to the committee before January 1, 2010 so the committee can take final action on LD 1198 before the January 22, 2010 deadline set by the presiding officers. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,

A handwritten signature in black ink, appearing to read "Bowman".

Peter B. Bowman
Senate Chair

A handwritten signature in black ink, appearing to read "Sharon Anglin Treat".

Sharon Anglin Treat
House Chair

cc: Members, Insurance and Financial Services Committee



124th MAINE LEGISLATURE

FIRST REGULAR SESSION-2009

Legislative Document

No. 1198

S.P. 446

In Senate, March 25, 2009

An Act To Reform Insurance Coverage To Include Diagnosis for Autism Spectrum Disorders

Reference to the Committee on Insurance and Financial Services suggested and ordered printed.

A handwritten signature in cursive script, reading "Joy J. O'Brien".

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator BOWMAN of York.

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

2 **Sec. 1. 24 MRSA §2317-B, sub-§19**, as enacted by PL 1999, c. 256, Pt. M, §10,
3 is amended to read:

4 **19. Title 24-A, chapter 67.** Medicare supplement insurance policies, Title 24-A,
5 chapter 67; and

6 **Sec. 2. 24 MRSA §2317-B, sub-§20**, as amended by PL 2003, c. 428, Pt. G, §1,
7 is further amended to read:

8 **20. Title 24-A, chapters 68 and 68-A.** Long-term care insurance, nursing home
9 care insurance and home health care insurance, Title 24-A, chapters 68 and 68-A; and

10 **Sec. 3. 24 MRSA §2317-B, sub-§21** is enacted to read:

11 **21. Title 24-A, sections 2847-Q and 4257.** Coverage for diagnosis and treatment of
12 autism spectrum disorders, Title 24-A, sections 2847-Q and 4257.

13 **Sec. 4. 24-A MRSA §2847-Q** is enacted to read:

14 **§2847-Q. Coverage for the diagnosis and treatment of autism spectrum disorders**

15 **1. Definitions.** As used in this section, unless the context otherwise indicates, the
16 following terms have the following meanings.

17 A. "Applied behavior analysis" means the design, implementation and evaluation of
18 environmental modifications using behavioral stimuli and consequences to produce
19 socially significant improvement in human behavior, including the use of direct
20 observation, measurement and functional analysis of the relations between
21 environment and behavior.

22 B. "Autism spectrum disorders" means any of the pervasive developmental disorders
23 as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition,
24 published by the American Psychiatric Association, including autistic disorder,
25 Asperger's disorder and pervasive developmental disorder not otherwise specified.

26 C. "Treatment of autism spectrum disorders" includes the following types of care
27 prescribed, provided or ordered for an individual diagnosed with an autism spectrum
28 disorder:

29 (1) Habilitative or rehabilitative services, including applied behavior analysis or
30 other professional or counseling services necessary to develop, maintain and
31 restore the functioning of an individual to the extent possible;

32 (2) Prescribed pharmaceuticals;

33 (3) Counseling services provided by a licensed psychiatrist, psychologist,
34 clinical professional counselor or clinical social worker; and

35 (4) Therapy services provided by a licensed or certified speech therapist,
36 occupational therapist or physical therapist.

1 **2. Required coverage.** All group health insurance policies, contracts and
2 certificates must provide coverage for autism spectrum disorders for an individual
3 covered under the policy, contract or certificate who is 21 years of age or under in
4 accordance with the following.

5 A. The policy, contract or certificate must provide coverage for any assessments,
6 evaluations or tests by a licensed physician or licensed psychologist to diagnose
7 whether an individual has an autism spectrum disorder.

8 B. The policy, contract or certificate must provide coverage for the treatment of
9 autism spectrum disorders when a licensed physician or licensed psychologist has
10 submitted documentation that the treatment is medically necessary health care as
11 defined in section 4301-A, subsection 10-A. A licensed physician or licensed
12 psychologist may be required to confirm and document ongoing medical necessity for
13 coverage provided under this section at least annually.

14 C. The policy, contract or certificate may not include any limits on the number of
15 visits.

16 D. The policy, contract or certificate may limit coverage to \$36,000 per year, except
17 that, beginning January 1, 2011, the maximum benefit must be adjusted annually for
18 inflation using the medical care component of the United States Department of Labor
19 Consumer Price Index for urban wage earners. An insurer may not apply payments
20 for coverage unrelated to autism spectrum disorders to any maximum benefit
21 established under this paragraph.

22 **3. Limits; coinsurance; deductibles.** Except as otherwise provided in this section,
23 any policy, contract or certificate that provides coverage for services under this section
24 may contain provisions for maximum benefits and coinsurance and reasonable
25 limitations, deductibles and exclusions to the extent that these provisions are not
26 inconsistent with the requirements of this section.

27 **4. Individualized education plan.** This section may not be construed to affect any
28 obligation to provide services to an individual with an autism spectrum disorder under an
29 individualized education plan or an individualized family service plan.

30 **5. Exceptions.** This section does not apply to employee group insurance policies
31 issued to employers with fewer than 50 employees insured under the group policy.

32 **Sec. 5. 24-A MRSA §4257** is enacted to read:

33 **§4257. Coverage for the diagnosis and treatment of autism spectrum disorders**

34 **1. Definitions.** As used in this section, unless the context otherwise indicates, the
35 following terms have the following meanings.

36 A. "Applied behavior analysis" means the design, implementation and evaluation of
37 environmental modifications using behavioral stimuli and consequences to produce
38 socially significant improvement in human behavior, including the use of direct
39 observation, measurement and functional analysis of the relations between
40 environment and behavior.

1 B. "Autism spectrum disorders" means any of the pervasive developmental disorders
2 as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition,
3 published by the American Psychiatric Association, including autistic disorder,
4 Asperger's disorder and pervasive developmental disorder not otherwise specified.

5 C. "Treatment of autism spectrum disorders" includes the following types of care
6 prescribed, provided or ordered for an individual diagnosed with an autism spectrum
7 disorder:

8 (1) Habilitative or rehabilitative services, including applied behavior analysis or
9 other professional or counseling services necessary to develop, maintain and
10 restore the functioning of an individual to the extent possible;

11 (2) Prescribed pharmaceuticals;

12 (3) Counseling services provided by a licensed psychiatrist, psychologist,
13 clinical professional counselor or clinical social worker; and

14 (4) Therapy services provided by a licensed or certified speech therapist,
15 occupational therapist or physical therapist.

16 **2. Required coverage.** All group health maintenance organization contracts and
17 certificates must provide coverage for autism spectrum disorders for an individual
18 covered under the contract or certificate who is 21 years of age or under in accordance
19 with the following.

20 A. The contract or certificate must provide coverage for any assessments,
21 evaluations or tests by a licensed physician or licensed psychologist to diagnose
22 whether an individual has an autism spectrum disorder.

23 B. The contract or certificate must provide coverage for the treatment of autism
24 spectrum disorders when a licensed physician or licensed psychologist has submitted
25 documentation that the treatment is medically necessary health care as defined in
26 section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may
27 be required to confirm and document ongoing medical necessity for coverage
28 provided under this section at least annually.

29 C. The contract or certificate may not include any limits on the number of visits.

30 D. The contract or certificate may limit coverage to \$36,000 per year, except that,
31 beginning January 1, 2011, the maximum benefit must be adjusted annually for
32 inflation using the medical care component of the United States Department of Labor
33 Consumer Price Index for urban wage earners. A health maintenance organization
34 may not apply payments for coverage unrelated to autism spectrum disorders to any
35 maximum benefit established under this paragraph.

36 **3. Limits; coinsurance; deductibles.** Except as otherwise provided in this section,
37 any contract or certificate that provides coverage for services under this section may
38 contain provisions for maximum benefits and coinsurance and reasonable limitations,
39 deductibles and exclusions to the extent that these provisions are not inconsistent with the
40 requirements of this section.

4. Individualized education plan. This section may not be construed to affect any obligation to provide services to an individual with an autism spectrum disorder under an individualized education plan or an individualized family service plan.

5. Exceptions. This section does not apply to employee group health maintenance organization contracts issued to employers with fewer than 50 employees insured under the group contract.

Sec. 6. Application. The requirements of this Act apply to all group policies, contracts and certificates subject to this Act that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2010. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

SUMMARY

This bill requires group health insurance policies, contracts and certificates covering fewer than 50 members to provide coverage for the diagnosis and treatment of autism spectrum disorders for persons 21 years of age and under. Initially, coverage is subject to a maximum annual benefit of \$36,000 per year; beginning January 1, 2011, the maximum benefit must be adjusted annually for inflation using the medical care component of the United States Department of Labor Consumer Price Index. The provisions of this bill apply to group policies, contracts and certificates issued or renewed on or after January 1, 2010.

Appendix B: Premium Impact Estimate

The principal service driving the increase in premiums from LD 1198 is ABA therapy. Other services that are currently not fully covered by insurance, such as speech therapy, were also considered. We estimated the impact of ABA therapy on premiums using census demographic data, utilization assumptions from earlier studies, fee assumptions from earlier studies and published articles on fees for ABA therapy. Some of the assumptions used were taken from studies done in other states. We reviewed published articles on the use of ABA therapy to confirm the validity of the earlier actuarial assumptions, including cost and intensity of services, and to verify consistency between professional opinions and actuarial assumptions. ABA cost assumptions include:

1. The insured population by age category from the 2000 census was used to determine the population separated by pre-school, school age and adolescent groupings.
2. Incidence of autism of 1 in 150 was used. This estimate is widely accepted, although other estimates do exist. A minor adjustment was made to account for the fact that a family with an autistic child would be more likely to purchase insurance than the average family. A 5% increase was used.
3. Utilization of ABA therapy is most intense in the preschool ages. It was observed that only in the preschool ages is utilization high enough that costs are impacted by the \$36,000 maximum benefit specified in LD 1198. Not all autistic children are diagnosed and not all autistic children are good candidates for ABA therapy; therefore, even at the young ages the estimate does not assume that all autistic children will use ABA therapy.

The highest level of intensity used was an average of 1,500 hours a year per autistic child using ABA services. After applying the maximum benefit, the coverage actually paid for by insurance was approximately 800 hours.

Due to time constraints and treatment patterns, intensity lessens when children are school age and again later when they are adolescents. School age intensity for the children using the services was estimated to average half of pre-school age for an average of 750 hours a year until age 15 when the estimate was reduced to 400 hours. Four hundred hours represents an average of 8 hours a week for 50 weeks.

A separate assumption of utilization was used for the time period immediately after the implementation of LD 1198, since it appeared to be unlikely that ABA therapy would begin for older children. Rather, the first impact would be with younger children, who would then continue therapy into adolescence.

4. Published fees for ABA therapy vary greatly depending on education of the therapist

and area. Our assumptions came from published articles and earlier studies. We assumed that immediately after implementation of LD 1198, therapists would, on average, be less qualified until more therapists became certified. Therefore, we used an initial hourly rate of \$33.65 increasing to an ultimate hourly rate of \$45.

Appendix C: 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 non-HMO employee group 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 other coverage. The list of conditions for which parity is required was expanded effective 10/1/03. Using annual experience reports from the carriers, the percentage of mental health claims paid has been tracked since 1984 and has historically been between 3% and 4% of total group health claims. The percentage was in the 3.27% to 3.47% range from 1998 to 2002 but then decreased, reaching 2.62% in 2007 and 2.60% in 2008. The percentage of claims is further broken out by HMO and other health plans, but the relationship is inconsistent from year to year. The continued decrease in mental health claims occurred despite the fact that an expansion of the list of conditions for which parity is required was fully implemented in 2005. We estimate a continuation of 2008 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 at least partially 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 non-HMO 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 other carriers. Using annual experience reports from the carriers, the percentage 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 and leveled off at a range of 0.55% to 0.72% for 2002 through 2008 (low of 0.55% in 2008, high of 0.72% in 2006) despite 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 34% in 2008. The percentage of claims is further broken out by HMO and other health plans, but the relationship is inconsistent from year to year. We estimate substance abuse benefits will remain at the current 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. 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) – Using annual experience reports from the carriers, the percentage 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 has decreased to 1.13% in 2008. In the past, the level was lower for individual than for group, but individual has increased to about the same level as group. The level does vary between HMOs and other plans. For 2008, the percentages were 1.30% for HMO plans and 0.95% for other plans. We estimate the current 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) – Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.7% in 2002 and has remained at about this level since then. There was no significant difference between HMO plans and other plans for group coverage. Recently, the U.S. Preventive Services Task Force recommended that screening mammograms begin at a later age and be done less frequently. While it is possible this will lead to reduced utilization, the American Cancer Society, the American College of Obstetricians and Gynecologists, and many oncologists have not accepted these recommendations. We therefore estimate the past level of 0.7% 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 do not have a 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 do not have a 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 non-HMO 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 Primary Care Physician (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 non-HMO 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 0.19% 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.
- ***Hearing Aids*** (Enacted 2007) – This mandate requires coverage for \$1,400 for each ear every 36 months for children age 18 and under. The mandate is phased-in by requiring coverage from birth to age 5 effective 1/08, age 6-13 effective 1/09 and age 14-18 effective 1/10. Our report estimated a cost of 0.1% of premium once fully implemented.
- ***Infant Formulas*** (Enacted 2008) – This mandate requires coverage for amino acid-based

elemental infant formulas for children 2 years of age and under, regardless of delivery method. Our report estimated a cost of 0.1% of premium.

- **Colorectal Cancer Screening** (Enacted 2008) – This mandate requires coverage for colorectal cancer screening for persons fifty years of age or older, or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. No other carriers stated they denied coverage, therefore our report estimated no impact on premium.
- **Independent Dental Hygienist** (Enacted 2009) – This mandate requires individual dental insurance or health insurance that includes coverage for dental services to provide coverage for dental services performed by an independent practice dental hygienist. This mandate is effective 1/2010. This mandate applies only to policies with dental coverage, therefore there is no estimated impact on medical plan premiums.

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	
			Non-HMO	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	0.55%	0.55%
1975 1983 1995 2003	Benefits must be included for Mental Health Services, including psychologists and social workers.	Groups of more than 20	2.60%	2.60%
		Groups of 20 or fewer	--	1.30%
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	0.95%	1.30%
		Individual	0.95%	1.30%
1990 1997	Benefits must be made available for screening mammography.	Group	0.70%	0.70%
		Individual	0.70%	0.70%

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Non-HMO	HMO
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 prostate cancer screening .	All Contracts	0.07%	0
1999	Coverage of nurse practitioners and nurse midwives and allows nurse practitioners to serve 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	0.19%	0.19%
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
2007	Coverage of hearing aids for children	All Contracts	0.1%	0.1%
2008	Coverage for amino acid-based elemental infant formulas	All Contracts	0.1%	0.1%
2008	Coverage for colorectal cancer screening	All Contracts	0	0
2009	Coverage for independent dental hygienist	All Contracts	0	0
	Total cost for groups larger than 20:		6.85%	7.32%
	Total cost for groups of 20 or fewer:		3.75%	5.52%
	Total cost for individual contracts:		3.74%	4.12%