A Report to the Joint Standing Committee on Insurance and Financial Services of the 127th Maine Legislature

Review of Financial Impact of PUBLIC Law, Chapter 635, LD 1198

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

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Prepared by:

Jac Joubert FSA, MAAA

of Oliver Wyman Actuarial Consulting, an actuarial consulting firm

Marti Hooper, ASA, MAAA

of the Maine Bureau of Insurance

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Background

Public Law Chapter 635, LD 1198 directs the Bureau of Insurance to produce a report to the Joint Standing Committee on Insurance and Financial Services of the 127th Maine Legislature regarding the financial impact of the Act to Reform Insurance Coverage to Include Diagnosis and Treatment for Autism Spectrum Disorders. Specifically for the report the Bureau shall:

- Compare the projected cost impact of this mandated benefit prior to enactment and the actual cost impact of the mandated benefit based on premium information after enactment.
- Analyze the number of children receiving coverage under the mandated benefit, the costs of treatment services for autism spectrum disorders, including applied behavior analysis (ABA), and the extent to which the requirement for coverage of applied behavior analysis has affected the actual cost impact of the mandated benefit on health insurance premiums.

The Bureau has produced prior reports to the Committee related to mandated benefits for autism spectrum disorders that should be referenced.

- In December 2009 the Bureau provided an initial report on LD 1198.
- In January 2014 the Bureau provided a report on LD 347, An Act To Amend Coverage for Diagnosis of Autism Spectrum Disorders. (LD 347 initially was drafted to expand coverage for autism spectrum disorders to persons 21 years of age and under starting on January 1, 2014. In the final adopted version benefits were only expanded to those aged 10 and under.)

Analysis

Autism Spectrum Disorder (ASD) encompasses a variety of related neurobiological developmental disorders with varying degrees of impairment in the areas of reasoning, social interaction and communication (including non-verbal) skills. ASDs include Autistic Disorder, Pervasive Developmental Disorder - Not Otherwise Specified (PDD-NOS, including atypical autism), Rett's Disorder, Childhood Disintegrative Disorder and Asperger's Disorder.

Prevalence of ASDs continue to rise in the United States. Since the prior report to the Committee the U.S. Centers for Disease Control have published updated statistics showing a continued increase in autism prevalence from the previously reported 1 in 88 children, to 1 in 68 in the most recent set of data. Both of these numbers are well above the approximately six per 1,000 people reported in 2000[1].

Maine has similarly seen growth in ASD prevalence, as evidenced by a more than three-fold increase in the number of individuals under the age of 18 served by the Department of Health and Human Services (DHHS) between 2000 and 2006.[2] School systems in Maine have similarly experienced a steady increase in children diagnosed and seeking treatment for Autism Spectrum Disorders. In a report to the 126th Maine Legislature, the Maine Developmental Disabilities Council indicated that autism cases increased almost 4-fold over the most recent 10 years, equivalent to an annual growth rate of 15%.[3] Based on the data provided by MaineCare, growth in individuals with ASD has occurred across all age groups, including a 28% increase for those under age 5 that are within the scope of LD 1198[4].

Thirty-seven states, including Maine, have specific autism mandates requiring certain insurers to provide coverage for autism spectrum disorder: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia, and Wisconsin.[5]

[1] Centers for Disease Control and Prevention, *Autism Spectrum Disorders: Data & Statistics*, http://www.cdc.gov/ncbddd/autism/data.html.
[2] http://www maine.gov/dhhs/2007_autism_report.pdf
[3] Page 7 of report available at http://www maineddc.org/uploads/PDFs/MDDC%20report%20to%20legislature%203-13.pdf
[4] Calculated from page 8 of http://www maine.gov/dhhs/reports/autism_spectrum_disorders-report.pdf
[5] http://www.asha.org/Advocacy/state/States-Specific-Autism-Mandates/.

Coverage in Maine:

State and federal mental health parity applies with regards to Autism Spectrum Disorders. Consequently group and individual insurance plans are required to provide coverage for diagnosis and treatment of ASD, similar to coverage for any other illness or disorder subject to medical necessity. In prior reports carriers indicated denials for coverage were due to out-of-network providers, lack of medical necessity, experimental or investigational service and hours for ABA exceeding those preauthorized.[6]

Maine's benchmark plan used to establish the Essential Health Benefits for Affordable Care Act (ACA)-compliant plans includes mental health parity coverage. All new individual and small group plans cover benefits at least equal to those for physical illnesses for a person receiving medical treatment for any of the categories of mental illness as defined in the Diagnostic and Statistical Manual (DSM), including ASD.

The ACA extends mental health parity to pre-reform grandfathered and non-grandfathered plans. Consequently, these plans provide mental health benefits at parity for renewals on or after July 1, 2014.

LD 1198 (a copy of which is attached as Appendix A) specifically mandated coverage for ASD, including services related to applied behavior analysis (ABA), subject to an annual dollar limit. Mandated coverage was limited to those age 5 years or younger. Subsequently LD 347 (a copy attached as Appendix B) expanded mandated coverage to those aged 10 or younger, starting on January 1, 2014. There are 112 qualified ABA providers in Maine, listed in Appendix C[7]. ABA providers are not licensed in Maine but receive certification from a national association. The insurance carriers contract directly with very few of these providers. See Appendix C for each carrier's response regarding coverage of the ABA providers.

The ACA contains provisions requiring coverage for individuals with pre-existing conditions, including autism. Most health insurance plans (with the exception of short term medical plans) are no longer allowed to deny, limit, exclude or charge more for coverage to anyone based on a pre-existing condition, including autism and related conditions.[8] Maine previously had prohibited pre-existing condition limitations for those with continuous coverage or to a maximum of 12 months without continuous coverage.

The ACA further eliminated the ability of carriers to impose annual dollar limits for individual and small group plans (such as the dollar limit of $36,000 included with LD 1198 for ABA). Generally, issuers had

[6] http://www.maine.gov/pfr/legislative/documents/LD_347_%20Autism_%20Mandate.pdf, page 6
[7] http://www.bacb.com/index.php?page=100155
[8] U.S. Department of Health & Human Services, *The Affordable Care Act and Autism and Related Conditions*,

initially substituted dollar caps with equivalent visit limits. While large group plans may continue using annual dollar limits under the ACA for other benefits, they are not allowed to apply dollar limits to ASD due to the combined requirements of state and federal mental health parity laws. In response to inquiries from the Bureau, most companies indicated that they do not administer benefit limitations as it relates to ASD.

Separately, the federal Individuals with Disabilities in Education Act (IDEA) requires school districts to provide disabled students with a "free appropriate public education." School-age children with autism receive services in schools, as required by IDEA, to help them learn in an appropriate fashion despite their developmental disability. While this requires schools to provide some services to individuals with autism, this does not cover the full scope of services contemplated in the Maine mandated benefits as outlined in LD 1198 and LD 347.

Review of Financial Impact:

Actual levels of autism-related costs appear to be lower than originally estimated by both the Bureau and the different carriers when originally evaluating LD 1198.

The table below shows the original estimates included in the 2009 report to the Joint Committee.[9] CIGNA and Harvard Pilgrim were unable to provide cost estimates at that time.

Entity / Source	Estimate for coverage to age 21
Bureau of Insurance contractor: NovaRest Consulting	$1.65 - $2.30 PMPM (0.5% - 0.7% of premium)
United HealthCare	$1.48 - $4.23 PMPM
Aetna	0.5% of premium
Anthem	$1.96 - $2.52 PMPM (0.25 - 0.65% of premium)
MEGA	$5 PMPM

PMPM=Per member, per month

The draft bill considered at the time would provide coverage for ASD through age 21, whereas LD 1198, once enacted provided for mandated coverage only through age 5. It was expected that the services accessed would be most costly and intensive for the pre-school ages. Coverage was limited for applied behavior analysis to $36,000 per year. Because the mandate only applied to those up to age five, the

www hhs.gov/autism/factsheet-aca-autism html#.UgPC2dbn-_Y (2001).

[9] Available at http://www maine.gov/pfr/legislative/documents/LD_1198_Autism_Mandate_Final_Report_Corrected.pdf

estimate was further reduced to 0.3% of premium.[10]

As part of this review carriers were asked to provide actual experience for comparison purposes. Carriers provided data as far back as 2010 to provide baseline information. Due both to the changes in the benefits (reducing the maximum age limit from age 21 to age 5) and specific limitations in carrier data in some instances, we were unable to make a direct comparison with prior estimates. The following table provides some overview of increases in costs relative to 2010 levels.

Entity / Source	**Range of observed costs**	**Increase from 2010**
Aetna	$0.02 - $0.12 PMPM	<=$0.10 PMPM
Anthem	$0.23 - $0.25 PMPM	<=$0.05 PMPM
CIGNA	$7,000 - $27,000 Total cost	<$25,000 per year
Harvard Pilgrim	$35,000 - $60,000 Total cost	$30,000 - $50,000 per year

For comparison purposes data from the Maine All Payer Claims Database from the Maine Health Data Organization (MHDO) was also considered.

Commercial data from MHDO	**2010**	**2011**	**2012**	**2013**
Individuals under 6 with ASD and ABA Treatment Claims	63	62	52	57
Insured Individuals under 6 with ASD conditions	241	236	218	200
Cost of ABA Treatments (Per Child)	$70,771 ($1,123)	$42,476 ($685)	$54,743 ($1,053)	$85,665 ($1,503)
Aggregate Cost of ASD-related Claims (Per Child)	$599,025 ($2,486)	$650,259 ($2,755)	$528,290 ($2,423)	$611,410 ($3,057)

- Claims costs for commercial carriers for just ABA-treatments for ASD individuals under the age of 6 was 20% higher in 2013 than in 2010, after having shown decreases in 2011 and 2012.
- Aggregate total dollars of paid claims for all treatments for this population where ASD-related diagnoses were present increased by 8.5% (or just over $50,000) for commercial carriers in 2011. Aggregate claims levels have since reduced, with 2013 claims at only 2% above 2010 levels.
- In contrast, the financial outlays under MaineCare for ASD-related claims have increased exponentially over the same period, with an almost 30% increase in total paid claims with ASD

[10] See page 23 of http://www maine.gov/pfr/legislative/documents/LD_347_%20Autism_%20Mandate.pdf

diagnoses present. The pattern is almost fully explained by increases in the cost of ABA-related therapies where a 10-fold increase had been observed.

The values indicate that the ASD mandate in Maine has had a very limited impact on observed claims costs for commercial carriers. It is not clear from the data provided why the impact would not have been closer to initial expectations. Additionally, these observed results appear low compared to the observed results from other states. Based on the observed year 1 costs observed across states, there had been significant variation in the impact across different mandates implemented, with an average impact of approximately $0.20 PMPM. Average cost impacts tended to increase over time, but for states with 3 years' worth of experience under the mandates, total costs still came to under $0.40 PMPM in 2014 dollars on average.[11] Even though mandates differ across different states, it is noteworthy that no state has seen impacts as large as those predicted by Maine carriers in 2009.

Review of Coverage Impact:

The responses from the carriers, coupled with publicly available information, also provided insight into the mandate impact on the coverage for autism services in the market.

All of the carriers showed comparatively flat levels of numbers of children accessing services over the period of the mandate and compared to 2010 base levels, as shown in the following table.

	Number of Children Under Age 6 Treated Per Carrier Responses[a]			
Carrier	**2010**	**2011**	**2012**	**2013**
Aetna	13	9	9	9
CIGNA	8	11	6	13
Harvard Pilgrim	12	17	18	26
Anthem	44	49	39	30

a – Data may differ from the data collected from the MHDO data, referenced elsewhere in this report. While generally consistent, data reported by carriers tended to show higher numbers of individuals with ASD treated under the mandate

MHDO data confirms the trends observed in the carrier data:

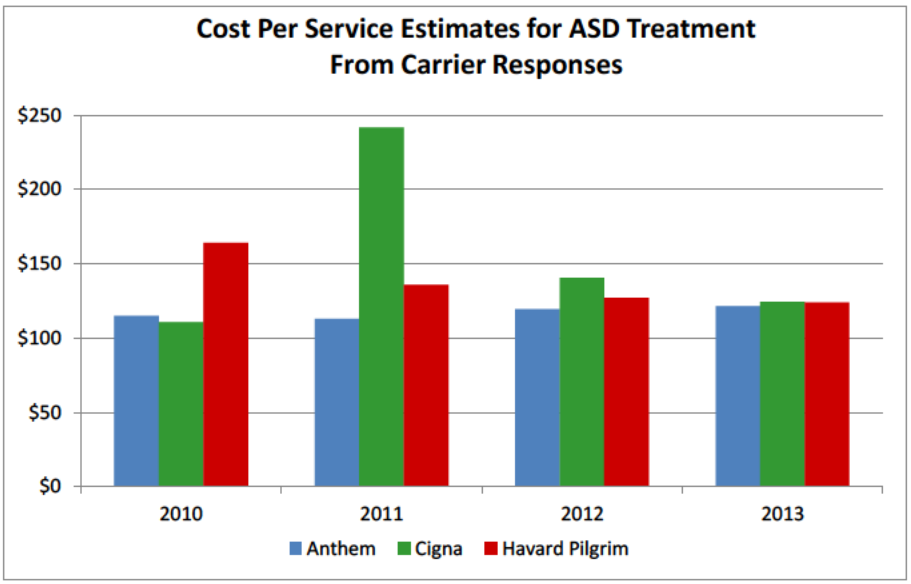
- Excluding MaineCare, the number of children under the age of 6 receiving ABA-treatment paid for by the commercial carriers decreased by 10% from 2010 levels (from

[11] Based on an analysis performed by Oliver Wyman for AutismSpeaks when considering the impact of Hawaii bill SB 2054.

63 to 57). In aggregate, the number of children with any claims with ASD-diagnoses present fell more rapidly, by over 17% to 200 in 2013.

- In contrast, MaineCare benefits for ABA-treatment to children under 6 with ASD increased by more than 120% over the period, from 121 in 2010 to 275 children in 2013. This represents 82% of all children receiving these benefits, up from 65% in 2010.

In developing estimates for the cost of treatment, using information provided by the carriers, we found that in general the average costs were well below the limits included in LD 1198, with no evidence of a significant increase in the price of treatment.



As the MHDO data is on a consistent basis, it allows for additional comparisons of costs per child with an ASD-diagnosis.

- Comparing 2013 costs per child for ABA-therapy for commercial carriers to the same costs in 2010 show an increase of 33% (equivalent to about 10% per year). However, these costs have shown significant volatility from year to year.
- MaineCare results show a very different picture. ABA paid claims per child have increased consistently over the period, and grew to more than 4-times the 2010 levels by 2013.

The number of ABA certified providers in Maine has increased markedly since the introduction of the mandate. The original 2009 analysis found 26 providers in Maine for ABA services and the 2014 report found 77 providers. As shown in Appendix C the number of providers had grown to

over 112 near the end of 2014. Consistent with the literature cited earlier in the report that show an increase in the diagnosis of ASD-related cases, this growth in ABA providers suggest the potential for increased delivery of services over time.

Carrier Responses:

The carrier responses provided additional insights into which claims are considered ASD-related and how they administer benefits related to ASD in compliance with Maine and federal law.

In the first table below, we outline the different definitions used by carriers to identify claims related to ASD. The second table summarizes the approaches adopted by each of the carriers to administer limitations on benefits. During 2014 the dollar limitation for ABA treatment in Maine law was preempted by the ACA, which prohibited annual or lifetime dollar limits. While the Maine mandate does not allow visit limits the carriers used hourly limits to provide an actuarial equivalent cap for these services. Limits since then have been removed to comply with federal mental health parity for 2015.

Entity	**Definition of ASD-related mandated claims**
CIGNA	Claims for individuals younger than 6 at the date of service with a diagnosis code of 299.xx. Claims include both ABA and therapeutic services
Anthem	Claims for individuals younger than 6 at the date of service with a procedure code within an Anthem-defined list. No filtering by diagnosis code is applied.
Aetna	Claims for individuals younger than 6 at the date of service with a diagnosis code indicating ASD and CPT procedure code within an Aetna-defined list.
Harvard Pilgrim	Any claims for individuals younger than 6 at the date of service with a diagnosis code of 299.xx in the first 5 positions of a claim.

Entity	**Approach to benefit limitations**
CIGNA	No age, dollar, or visit limits are applied on ABA therapy, nor on speech/ physical/ occupational therapy in Maine because they believe it is prohibited under the federal mental health parity regulations
Anthem	$36,000 annual limit replaced by a limit of 360 hour limit in the individual market in 2014, except for grandfathered plans where dollar limits had been retained. Limits are being removed in 2015, with the exception of small groups renewing under the ACA transitional policy.
Aetna	Aetna states that the pre-certified medically necessary services are covered up to the annual dollar limit. For products/segments where federal mental health parity applies no limits are applied.
Harvard Pilgrim	$36,000 annual limit replaced by a limit of 600 hour limit in 2014. Limits have been removed from 2015 forward.

Conclusion

LD 1198 as passed in 2010 mandated coverage for ASD-related services for individuals up to age 5 in Maine, subject to a dollar limit on ABA services. Subsequently the health care market has undergone a number of changes, including health care reform at the federal level, expanded mandates for ABA therapy through age 10 in Maine, and federal mental health parity.

Based on the data collected, the claims dollar impact of LD 1198 in the initial years since passing has been below initial expectations, with little evidence to date of these costs increasing over time for commercial carriers. Nevertheless, there is reason to be cautious about the costs related to the mandate on a go-forward basis:

- Population statistics point to increasing prevalence of ASD, suggesting the potential for an increased need in these services. To date, increased need has been met through MaineCare. MHDO data shows that the number of children covered, and the quantity and cost of ABA-treatment per child covered through MaineCare have both increased rapidly since 2010.
- Expanded mental health parity requires carriers to provide coverage for ASD similar to physical ailments, and dollar limits on ABA therapies have largely been phased out which could increase costs from previous levels.
- Finally, there is significant growth in the providers for ABA therapies, which suggests sufficient supply to support any future increases in utilization of these therapies.

For these reasons, historical costs may not be applicable on a go-forward basis.

This review was a collaborative effort of Oliver Wyman Actuarial Consulting and the Maine Bureau of Insurance.

Appendix A: Copy of the Legislation: LD 1998

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

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

Sec. 1. 24 MRSA §2317-B, sub-§12-F is enacted to read:

12-F. Title 24A, sections 2766, 2847R and 4258. Coverage for diagnosis and treatment of autism spectrum disorders, Title 24A, sections 2766, 2847R and 4258;

Sec. 2. 24-A MRSA §2766 is enacted to read:

§ 2766. Coverage for the diagnosis and treatment of autism spectrum disorders

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

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

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

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

(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. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

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

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

2. Required coverage. All individual health insurance policies and contracts must provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is 5

years of age or under in accordance with the following.

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

B. The policy or contract must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301A, subsection 10A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually.

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

D. The policy or contract may limit coverage for applied behavior analysis to $36,000 per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy or contract. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy or contract.

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

Sec. 3. 24-A MRSA §2847-R is enacted to read:

§ 2847-R. Coverage for the diagnosis and treatment of autism spectrum disorders

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

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

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

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

(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. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

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

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

2. Required coverage. All group health insurance policies, contracts and certificates must provide coverage for autism spectrum disorders for an individual covered under a policy, contract or certificate who is 5 years of age or under in accordance with the following.

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

B. The policy, contract or certificate must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301A, subsection 10A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually.

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

D. Notwithstanding section 2843 and to the extent allowed by federal law, the policy, contract or certificate may limit coverage for applied behavior analysis to $36,000 per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy, contract or certificate. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy, contract or certificate.

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

Sec. 4. 24-A MRSA §4258 is enacted to read:

§ 4258. Coverage for the diagnosis and treatment of autism spectrum disorders

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

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

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

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

(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. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

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

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

2. Required coverage. All individual and group health maintenance organization contracts must provide coverage for autism spectrum disorders for an individual covered under a contract who is 5 years of age or under in accordance with the following.

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

B. The contract must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301A, subsection 10A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually.

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

D. Notwithstanding section 4234A and to the extent allowed by federal law for group contracts, the contract may limit coverage for applied behavior analysis to $36,000 per year. A health maintenance organization may not apply payments for coverage unrelated to autism spectrum

disorders to any maximum benefit established under this paragraph.

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the contract. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the contract.

3. Limits; coinsurance; deductibles. Except as otherwise provided in this section, any contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the 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.

Sec. 5. Bureau of Insurance report. The Department of Professional and Financial Regulation, Bureau of Insurance shall review and evaluate the financial impact, social impact and medical efficacy of the mandated health insurance benefit required in this Act after its enactment in the same manner as required for proposed mandated health benefits legislation in the Maine Revised Statutes, Title 24A, section 2752. The bureau shall also compare the projected cost impact of this mandated benefit prior to enactment and the actual cost impact of the mandated benefit based on premium information after enactment. As part of its assessment of the financial impact of the mandate, the bureau shall analyze the number of children receiving coverage under the mandated benefit, the costs of treatment services for autism spectrum disorders, including applied behavior analysis, and the extent to which the requirement for coverage of applied behavior analysis has affected the actual cost impact of the mandated benefit on health insurance premiums. The bureau shall contract within the bureau's existing budgeted resources for any necessary consulting and actuarial expertise to complete the report required by this section. The bureau shall submit a report, including any recommendations for legislation, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters no later than February 1, 2015. The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out a bill based on the report to the First Regular Session of the 127th Legislature.

Sec. 6. Application. The requirements of this Act apply to all 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, 2011. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Effective July 12, 2010

Appendix B: Copy of the Legislation: LD 347

An Act To Amend Insurance Coverage for Diagnosis of Autism Spectrum Disorders

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

Sec. 1. 24-A MRSA §2768, sub-§2, as reallocated by PL 2011, c. 420, Pt. A, §24, is amended to read:

2. Required coverage. All individual health insurance policies and contracts must provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is ~~5~~10 years of age or under in accordance with the following.

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

B. The policy or contract must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually.

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

D. The policy or contract may limit coverage for applied behavior analysis to $36,000 per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy or contract. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy or contract.

Sec. 2. 24-A MRSA §2847-T, sub-§2, as reallocated by PL 2011, c. 420, Pt. A, §26, is amended to read:

2. Required coverage. All group health insurance policies, contracts and certificates must provide coverage for autism spectrum disorders for an individual covered under a policy, contract or certificate who is ~~5~~10 years of age or under in accordance with the following.

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

B. The policy, contract or certificate must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually.

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

D. Notwithstanding section 2843 and to the extent allowed by federal law, the policy, contract or certificate may limit coverage for applied behavior analysis to $36,000 per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy, contract or certificate. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy, contract or certificate.

Sec. 3. 24-A MRSA §4259, sub-§2, as reallocated by PL 2011, c. 420, Pt. A, §27, is amended to read:

2. Required coverage. All individual and group health maintenance organization contracts must provide coverage for autism spectrum disorders for an individual covered under a contract who is ~~5~~10 years of age or under in accordance with the following.

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

B. The contract must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually.

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

D. Notwithstanding section 4234-A and to the extent allowed by federal law for group contracts, the contract may limit coverage for applied behavior analysis to $36,000 per year. A health maintenance organization may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the contract. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the contract.

Sec. 4. Application. The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2015. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Effective 90 days following adjournment of the 126th Legislature, Second Regular Session, unless otherwise indicated.

Appendix C: Maine Applied Behavior Analysis Providers and Carrier Contracting

Coverage of ABA Providers by Insurance Carriers in Maine

Harvard and HPHC: Through United Behavioral Health (UBH) they contract with two ABA Agencies in Maine, Butterfly Effects LLC and United Cerebral Palsy of NE Maine. These agencies work with multiple BCBAs (Board Certified Behavioral Analysts) and Para-professionals to perform the services. UBH will work with any non-par ABA provider or BCBA and offer to have them join the network.

Maine Community Health Options (MCHO): MCHO has policies in place to credential ABA providers, and are working to operationalize them. For now, Provider Relations staff are directed to create single case agreements on a case-by-case basis whenever a consumer either (1) lets MCHO know in advance that they want to use an Out-of-Network provider for ABA services; or (2) they see that doctor, and MCHO starts seeing claims for treatments rendered.

Aetna: Aetna is working on a targeted recruitment effort for ABA providers. Additionally, they plan to do an e-mail blast to all certified ABA providers with the assistance of the Board to encourage Certified ABA providers join the network countrywide - planned for end of 1st quarter 2015. Aetna asks that all groups that contract identify their focus/specialties. They include a document called the Behavioral Health Provider Profile with every contract to obtain this info. An ABA directory is maintained at http://www.aetna.com/docfind/cms/assets/pdf/ABA%20directory.pdf. Monthly reports are pulled to support the ABA directory and includes general Behavioral Health group/ providers who have selected a specialty of ABA ; however, there are not many providers selecting this focus. There is only one listed in this directory for Maine.

Redwing Services Inc	Funk Schliestett	Kristina	ME D	Eliot	YORK

It is possible that some providers work for/with mental health professionals with whom they contract. They have 3 new providers in Maine, 2 in the credentialing process and one that just received approval. They are hopeful to successfully contract with additional providers. If there is a geo access need for a member, the clinical area will review and approve the out of network provider at the in-network rate, so long as it is clinically necessary (ABA services require precertification).

Anthem: They have directly contracted with 8 ABA therapists as participating providers but there may be others whose services are being billed through a practice or facility in which they are employed.

ABA Providers in Maine

Name	City	Certification
Baker, Susan	Gray	BCBA
Beardsley, Erin	Gorham	BCBA
Bentley, Mary	New Gloucester	BCBA
Betters, Laura	Old Town	BCBA
Bickford, Rebekah	Buxton	BCBA
Bland, Clayton	Brunswick	BCBA
Boivin, Nicole	Limerick	BCBA-D
Bowie, Pamela	Mount Desert	BCBA
Brann, Marianne	Readfield	BCBA
Brophy, Laurie	Waterville	BCBA
Broughan, Leigh	Orono	BCBA
Brown, Russell	Waterford	BCBA
Bubier, Melissa	Turner	BCBA
Cameron, Elizabeth	Cape Elizabeth	BCBA-D
Campbell, Eric	Portland	BCBA
Carscallen, Lynda	Lyman	BCBA
Close, Jillian	Auburn	BCBA
Collins, Kacie	Portland	BCBA
Conley, Erin	South Portland	BCBA
Conley, Jill	Bangor	BCaBA
Constantine, Amy	Auburn	BCBA
Cote, Catherine	Lewiston	BCBA
Couture, Nicole	Gray	BCBA
Crowder, Helki	Lisbon Falls	BCaBA
Dana, Terese	Fryeburg	BCBA
Davis, Elizabeth	Bowdoin	BCBA
Edwards, Katrina	South Portland	BCBA
English, Larrie	Gorham	BCBA
Ferretti, Marcy	Kennebunk	BCBA
Foley-Ingersoll, Colleen	North Yarmouth	BCBA
Fredericks, Kelly	Cape Elizabeth	BCBA
Geren, Mark	Yarmouth	BCBA
Gilliam, Colleen	Wiscasset	BCaBA
Ginn, Alison	Windham	BCBA
Golonka, Adam	Yarmouth	BCBA
Gray, Meaghan	Brooksville	BCBA
Grebouski, Thomas	Berwick	BCBA-D

Name	City	Certification
Greenberg, Sacha	Portland	BCBA
Grondin, Betsy	Falmouth	BCBA
Groom, Sharaya	Yarmouth	BCBA
Guimond, Iris	Fort Kent	BCBA
Guptill, Derek	Denmark	BCBA
Hadley, Lindsae	Ellsworth	BCBA
Ham, Sara	Mexico	BCBA
Hamlin, Nicole	Kennebunk	BCBA
Haskell-Lehigh, Tiffany	Windham	BCBA
Hathaway, Michelle	Turner	BCBA
Hauber Wall, Lynda	Richmond	BCaBA
Hegg, Elisa	York	BCBA
Hinton, Nichole	Bath	BCaBA
Hunt, Danielle	North Yarmouth	BCBA
Hurst, Cheri	Brunswick	BCBA
Jarmuz-Smith, Susan	Falmouth	BCBA
Jefferson, Gretchen	Portland	BCBA-D
Johnson, Paul	Fort Fairfield	BCBA-D
Jones, Aaron	Bath	BCBA
Keyser, Lisa	Levant	BCBA
Kimball, Jonathan	Georgetown	BCBA-D
Kinney, Elisabeth	Ogunquit	BCBA
LaFlamme, Cheryl	Lewiston	BCBA
Lenehan, Lora	Kittery Point	BCBA
Lord, Kimberley	Lincolnville	BCBA
MacMath, Robert	Portland	BCBA
Manuel, Laura	South Portland	BCBA
Mathieu-Sher, Reva	Skowhegan	BCaBA
McAvoy, Jennifer	Lewiston	BCBA
McAvoy, Matthew	Lewiston	BCBA
McLellan, Christine	Gorham	BCBA
Moran, David	South China	BCBA
Morrell, Sandra	Portland	BCBA
Mozzoni, Michael	Bridgton	BCBA-D
Mulcunry, Devin	Portland	BCBA
Nau, Paul	Brunswick	BCBA-D
Nazaroff, Christine	Minot	BCBA
Nickerson, Shayna	Trenton	BCBA

Name	City	Certification
Orlando, Linda	Brewer	BCBA
Pacholski, Courtney	China	BCBA
Packard, Julie	Windham	BCBA
Parent, Janet	South Berwick	BCBA
Payeur, Lindsay	Saco	BCBA
Pelletier, Kelly	Portland	BCBA
Pennabere, Lisa	Hallowell	BCaBA
Perry, Lora	Georgetown	BCBA
Plourde, Jessica	Westbrook	BCBA
Potter, Phillip	Camden	BCBA
Poulsen, April	Orono	BCBA
Prager, Kevin	Bath	BCBA
Pratt, Jamie	Yarmouth	BCBA-D
Pulsifer, David	Yarmouth	BCBA
Rabe, Marian	Bridgton	BCBA
Richard, Megghan	Windham	BCBA
Robbins, Alton	Old town	BCaBA
Roberson, Aleksandra	Wells	BCaBA
Roy, William	Buckfield	BCBA
Sanborn, Tami	Blue Hill	BCBA
Sastre, Sheri	Saco	BCBA
Scamman, Mary	Scarborough	BCBA
Schwalm, Jedediah	Camden	BCBA
Small, Cathleen	South Portland	BCBA-D
Smith, Monica	Rome	BCBA
Soucy-Camire, Johanne	Old Orchard Beach	BCBA
Steege, Mark	Gorham	BCBA-D
Steege, Lisa	Gorham	BCBA
Swan, Meaghan	Farmington	BCBA
Teske, Sarah	Eliot	BCBA
Thibadeau, Susan	Carrabassett Valley	BCBA-D
Thibodeau, Ariana	Porter	BCaBA
Tomasello, Allen	Bremen	BCaBA
Treworgy, Jamie	Hampden	BCBA
Vincent, Seth	Auburn	BCBA
Waite, Katelyn	Lewiston	BCBA
Williams, Danielle	Holden	BCBA

Appendix D: Cumulative Impact of Mandates

Bureau of Insurance

Cumulative Impact of Mandates in Maine

Report for the Year 2013

This report provides data for medical insurance coverage of mandates as required by 24-A M.R.S.A. §2752 and compiled by the Bureau of Insurance. While some data was provided through annual mandate reports by insurers, other figures were estimated as a part of the proposed mandates study. The following provides a brief description of each state mandate and the estimated claim cost as a percentage of premium. Many of these mandates are now required by the federal Affordable Care Act (ACA). In addition, the ACA requires benefits covered by the benchmark plan which includes all state mandates to be covered by all individual and small group plans effective January 1, 2014. A summary chart is provided at the end of this report.

- ***Mental Health*** (Enacted 1983)

Mental health parity in Maine became effective July 1, 1996, and was expanded effective October 1, 2003. The percentage of mental health claims paid has been tracked since 1984 and has historically been between 3% - 4% of total group health claims and was reported as 3.1% in 2013. Mental health claims stayed below 3.5%, despite the fact that an expansion of the list of conditions for which parity is required was fully implemented in 2005. Mental health coverage is included in the essential health benefits for individual and small group plans beginning 2014. This report includes claims as paid under the law requirements for 2013. Individual mental health claims were only 1.9% in 2013 as a mandated offer. We have assumed that individual mental health claims will increase under ACA and Federal mental health parity and will be similar to group claims in 2014.

- ***Substance Abuse*** (Enacted 1983)

Effective October 1, 2003, substance abuse was added to the list of mental health conditions for which parity is required. Effective on January 1, 2014 the federal Affordable Care Act requires substance abuse treatment benefits for individual and small group plans as part of the essential health benefits. The percentage of claims paid has been tracked since 1984. For 2013, substance abuse claims paid were 0.66% of the total health claims. We estimate substance abuse claims will remain at the current levels going forward.

- ***Chiropractic*** (Enacted 1986)

This mandate requires coverage for the services of chiropractors to the extent that the same services would be covered if performed by a physician. Using annual experience reports from the carriers, the

percentage of claims paid has been tracked since 1986 and, in 2013, was 0.78% of total health claims. The level has typically been lower for individual than for group. We estimate the current levels going forward. Although it is likely that some of these costs would have been 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)

This mandate requires that benefits be provided for screening mammography. We estimate the current level of 0.75% in all categories going forward. Coverage is required by ACA for preventive services.

- ***Dentists*** (Enacted 1975)

This mandate requires coverage for dentists' services 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)

This mandate requires coverage for reconstruction of both breasts to produce a symmetrical appearance after a mastectomy. At the time this mandate was being considered in 1995, one carrier 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)

This mandate requires coverage for metabolic formula and prescribed modified low-protein food products. 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)

This mandate requires that benefits be provided for medically necessary diabetic supplies and equipment. Based on data collected in 2006, most carriers reported that there would be no cost increase or an insignificant cost increase because they already provide this coverage. Based on our report we estimate 0.2%.

- ***Minimum Maternity Stay*** (Enacted 1996)

This mandate requires that if a policy provides maternity benefits, the maternity (length of stay) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care." Based on carrier responses indicating that they did not limit maternity stays below those recommended, we estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996)

This mandate requires that benefits be provided for screening Pap smear tests. HMOs would typically cover these costs and, 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%. Coverage is required by ACA for preventive services.

- ***Annual GYN Exam Without Referral*** (Enacted 1996)

This mandate only affects HMO plans and similar plans, and it requires the provision of benefits for annual gynecological exams without prior approval from a primary care physician. 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; therefore, we include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997)

This mandate requires that benefits for breast cancer treatment be provided for a medically appropriate period of time as determined by the physician in consultation with the patient. Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** (Enacted 1998)

This mandate requires coverage of off-label prescription drugs in the treatment of cancer, HIV, and AIDS. Our 1998 report 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. Because the HMOs claimed to already cover off-label drugs, in which case there would be no additional cost; and, providers testified that claims have been denied on this basis, we include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998)

This mandate requires prostate cancer screenings. Our report estimated additional claims cost 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 approximately 0.07% of total premiums. Coverage is required by ACA for preventive services.

- ***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)

This mandate requires health plans that cover prescription drugs to cover contraceptives. Our report estimated an increase of premium of 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999)

This mandate requires health plans that cover surgical first assistants 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)

This mandate requires that coverage be provided for an eligible enrollee to participate in approved clinical trials. 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. Because carriers generally covered hospice care prior to the mandate, 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 a cost of 0.08% of premium 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 a hearing aid for each ear every 36 months for children age 18 and under. The mandate was phased-in between 2008 and 2010, and our report estimated a cost of 0.1% of premium.

- ***Infant Formulas*** (Enacted 2008)

This mandate requires coverage for amino acid-based elemental infant formulas for children two years of age and under, regardless of delivery method. This mandate is effective January 2009, and our report estimated a cost of 0.1% of premium.

- ***Colorectal Cancer Screening*** (Enacted 2008)

This mandate requires coverage for colorectal cancer screening. This mandate is effective January 2009. No carriers stated they denied coverage prior to this mandate; therefore, our report estimated no impact on premium. Coverage is required by ACA for preventive services.

- ***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 applies only to policies with dental coverage; therefore, there is no estimated impact on medical plan premiums.

- ***Autism Spectrum* Disorders** (Enacted 2010)

This mandate was effective January 2011 and required all contracts to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals five years of age or under. It was expanded to age 10 for January 2014 effective dates. A recent report estimated a cost of 0.3% of premium once the mandate is fully implemented if it included those under age 10. Based on that

estimate and recently reported experience we are estimating this going forward.

- ***Children's Early Intervention Services*** (Enacted 2010)

This mandate requires all contracts to provide coverage for children's early intervention services from birth to 36 months for a child identified with a developmental disability or delay. This mandate was effective January 2011, and our report estimated a cost of 0.05% of premium.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts	0.10%
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	All Contracts	0.66%
1975 1983 1995 2003	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups	3.07%
		Individual	3.07%
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.	Group	0.80%
		Individual	0.51%
1990 1997	Benefits must be made available for screening **mammography**.	Group	0.75%
		Individual	0.75%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	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%
1996	If policies provide maternity benefits, the **maternity (length of stay**) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care."	All Contracts	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%
1996	Benefits must be provided for **screening Pap tests**.	All	0.01%
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--
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%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%
1998	Coverage required for **prostate cancer screening**.	All Contracts	0.07%

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium
1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts	--
1999	Prescription drug must include **contraceptives**.	All Contracts	0.80%
1999	Coverage for **registered nurse first assistants**.	All Contracts	0
2000	Access to **clinical trials**.	All Contracts	0.19%
2000	Access to **prescription drugs**.	All Managed Care Contracts	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0
2001	Access to **eye care**.	Plans with participating eye care professionals	0
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg	Groups >20	0.03%
		All other	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0
2007	Coverage of hearing aids for children	All Contracts	0.1%
2008	Coverage for amino acid-based elemental **infant formulas**	All Contracts	0.1%
2008	Coverage for **colorectal cancer screening**	All Contracts	0
2009	Coverage for **independent dental hygienist**	All Contracts	0
2010	Coverage for **autism spectrum**	All Contracts	0.3%
2010	Coverage for **children's early intervention services**	All Contracts	0.05%
	Total cost for groups larger than 20:		**7.68%**
	Total cost for groups of 20 or fewer:		**7.73%**
	Total cost for individual contracts:		**7.44%**