PROPOSED
MANDATED HEALTH INSURANCE BENEFIT
FOR
BASIC HEALTH CARE NEEDS OF WOMEN
LD 1385 and LD 752

A Report to the
Joint Standing Committee on
Banking and Insurance
of the
117th Maine Legislature

Prepared by the
Bureau of Insurance
January 1996

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EXECUTIVE SUMMARY

The Joint Standing Committee on Banking and Insurance of the 117th Maine Legislature on May 15, 1995, directed the Bureau of Insurance to review LD 1385 "An Act Ensure That Basic Health Care Needs of Women Are Covered in Insurance Policies" and on April 5, 1995, LD 752 "An Act to Include Obstetricians and Gynecologists as Primary Care Providers." The review was to be conducted using the criteria outlined in 24-A M.R.S.A. §2752 regarding the social and financial impact of the proposed mandate, and the medical efficacy of the procedures covered under the proposal.

LD 1385 requires all health insurance policies to provide coverage for prenatal care, annual pap tests, annual rectal and colon exams, additional screening mammograms and tests for sexually transmitted diseases to be effective December 1, 1995. Currently screening mammograms are required to be covered once every 2 years for women between the ages of 40 and 49 and then every year at age 50 and older. This mandate would also require coverage for a baseline mammogram for women between the ages of 35 and 39 and any additional tests for women determined to be at a high risk of breast cancer.

LD 752 requires all health insurance policies and HMOs to cover gynecological and obstetrical services including semiannual exams effective January 1, 1996. Under both LD 1385 and LD 752, managed care plans would be required to permit physicians specializing in

gynecological and obstetrical services to serve as primary care physicians.

The cost of various preventive tests and their exclusion from many insurance plans, combined with the lack of information about the tests, are major reasons for the high number of women not receiving basic preventive services.

Preventive care benefits are currently available through the standardized plans for individuals and small groups, though not many of these plans have been issued yet. Some insurance carriers also offer products to individuals and groups of all sizes with preventive care benefits. If preventive care benefits are covered typically they are provided at 100% with no deductible. HMOs are more likely to have preventive care services and these are provided with low or no copays.

If health coverage is offered, employers are required to provide maternity care benefits in the same manner as other medical benefits. As a result, many private plans now include maternity coverage. Unfortunately, many women do not have access to employer-based group coverage because they or their spouses are unemployed or work for employers who do not offer health benefits. Providing prenatal care based on ability to pay would require subsidies from either other policyholders or another source. This benefit structure is commonly used for public programs but may not be adaptable to insurance products.

Some managed care plans offer one or more self referred visits to an OB/Gyn or have some OB/Gyns as Primary Care Physicians (PCPs). In addition, Blue Cross Blue Shield of Maine has eight OB/Gyns practicing as PCPs.

There may be an increase in utilization of cancer screening tests and prenatal services in plans where there is no coverage currently. The only cost estimates of how much premiums would increase due to this mandate available at the time this report was prepared were provided by Blue Cross for the annual or semi-annual preventive health exams. The premiums would increase the monthly cost under a nonmanaged care group plan by $6.35 for family coverage and $2.54 for an individual. The additional coverage of the baseline mammogram as proposed by LD 1385 would increase premiums from $.09 to $.25 per month depending on the type of plan.

BACKGROUND

The Joint Standing Committee on Banking and Insurance of the 117th Maine Legislature on May 15, 1995, directed the Bureau of Insurance to review LD 1385 "An Act Ensure That Basic Health Care Needs of Women Are Covered in Insurance Policies" and on April 5, 1995, LD 752 "An Act to Include Obstetricians and Gynecologists as Primary Care Providers." Because of the similarity between these two proposed mandates they are considered together in this report. The review was to be conducted using the criteria outlined in 24-A M.R.S.A. § 2752 regarding the social and financial impact of the proposed mandate, and the medical efficacy of the procedures covered under the proposal.

LD 1385 requires all health insurance policies to provide coverage for prenatal care, annual pap tests, annual rectal and colon exams and additional screening mammograms to be effective December 1, 1995. Currently screening mammograms are required to be covered once every 2 years for women between the ages of 40 and 49 and then every year at age 50 and older. This mandate would also require coverage for a baseline mammogram for women between the ages of 35 and 39 and any additional tests for women determined to be at a high risk of breast cancer.

LD 752 requires all health insurance policies and HMOs to cover gynecological and obstetrical services including semiannual exams effective January 1, 1996. Under both LD 1385 and LD 752, managed

care plans would be required to permit physicians specializing in gynecological and obstetrical services to serve as primary care physicians.

Currently mammograms, while mandated for coverage, could be subject to a deductible, depending on the type of policy. For those who do not usually meet their deductibles this may act as a disincentive to have the test done. Managed care plans and the standardized plans required to be offered to individuals and groups do have preventive care benefits with little or no copay.

If health coverage is offered, employers are required to provide maternity care benefits in the same manner as other medical benefits. As a result, many private plans now include maternity coverage. Unfortunately, many women do not have access to employer-based group coverage because they or their spouses are unemployed or work for employers who do not offer health benefits. Providing prenatal care based on ability to pay would require subsidies from either other policyholders or another source. This benefit structure is commonly used for public programs but may not be adaptable to insurance products.

Some managed care plans offer one or more self referred visits to an OB/Gyn or have some OB/Gyns as Primary Care Physicians (PCPs). In addition, Blue Cross Blue Shield of Maine has eight OB/Gyns practicing as PCPs.

EVALUATION OF LD 1385 AND LD 752 BASED ON REQUIRED CRITERIA

SOCIAL IMPACT

A. The social impact of mandating the benefit which shall include:

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

Prenatal care is a basic health service for women. Lack of care impacts the woman, her infant and the community. Maine was ranked 4th for prenatal care in the ReliStar State Health Rankings for 1995 with 81.7% receiving care. In addition Maine ranked number 1 compared to other states for having low infant mortality (an indicator of prenatal care) with 5.4 deaths per 1,000 births.

Breast cancer incidence rates for women have increased about 2% a year since 1980 nationwide, but recently leveled off at about 110 per 100,000. From the Bureau's annual mammography report, breast cancer claims increased slightly to 1.6% of total health care claims for 1994. Most of the recent rise in rates is believed to be due to marked increases in mammography utilization, allowing the detection of early stage breast cancers. In the Bureau's report, diagnostic mammograms decreased slightly from those reported in 1993 but the number of screening mammograms increased

21%. Overall Maine ranks 46th for incidence of cancer according to the ReliStar study with 573 cases per 100,000 population.

According to a survey conducted for the Commonwealth Fund by Louis Harris and Associates, women were more likely to have seen their obstetrician-gynecologist than any other doctor in the last two years, and 52% consider them to be their primary-care physicians.

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

These services are readily available throughout the state in hospitals, doctor's offices, family planning centers, and in rural health centers.

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

Statistics from the 1992 Maine PRAMS (Pregnancy Risk Assessment Monitoring System) on payment sources for prenatal care show that 55% of women were covered by insurance, 33.1% were covered by Medicaid, 7.1% by cash and 4.8% by other sources. Since enactment of the Pregnancy Discrimination Act in 1978 and Maine's Human Rights Law, employers offering health coverage have been required to provide maternity care benefits in the same manner as other medical benefits. As a result, many private plans now include maternity coverage. Many women do not have access to employer-

based group coverage because they or their spouses are unemployed or work for employers who do not offer health benefits. In addition, if the cost to the employee is too high, the availability of an employer-based insurance plan does not ensure enrollment.

The current mandate requires coverage for mammograms once every 2 years for women between the ages of 40 and 49 and then every year for women age 50 and older. There is also coverage of diagnostic mammograms: that is, if the patient presents symptoms of a disease or if the patient is considered "high risk." The criteria used by Blue Cross/Blue Shield to determine eligibility for mammograms are included in the appendix. The benefit may be subject to a deductible and coinsurance depending on the type of plan.

In a survey conducted for The Commonwealth Fund by Louis Harris and Associates, Inc., one-fifth of all women said that their insurance doesn't pay for preventive health care.

HMOs and some insurance policies cover preventive and prenatal services including PAP smears. The standardized plans cover preventive and prenatal services at 100%. Diagnostic tests are generally covered at the same level as other medical expenses. Blue Cross already has 8 OB/Gyns practicing as Primary Care Physicians. See the list in Appendix C.

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

In 1992, 86.4% of women received prenatal care in the first trimester, thus 13.6% of women did not enter care appropriately. In addition, 11.1% women surveyed by PRAMS in relation to barriers to care indicated they were not eligible for Medicaid and could not obtain health insurance.

A study conducted by the Commonwealth Fund at UCLA Center for Health Policy Research reported that insurance coverage "affects access to clinical preventive services." Twenty-six percent of uninsured women 18 to 64 had not had "a routine medical checkup" in the previous three years, compared to only 14% of women with insurance coverage. Also, eight out of ten women ages 40 to 64 "who are both uninsured and lack a usual source of care" had not received a "recent" breast exam or mammogram.

These services are readily available throughout the state in hospitals, doctor's offices, family planning centers, and in rural health centers.

5. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

The price of screenings - which aren't reimbursed under some private health plans - was the reason most frequently cited (51%) for not getting preventive services according to The Commonwealth Fund survey. The survey found that poor women are twice as likely not to get annual pap smears.

If women use a family planning center or rural health center in their area, cost is based upon the ability to pay. Access and affordability are both enhanced by family planning fee schedules, which use a "sliding scale" for payments. This means that those women who have lower income (and possibly no health insurance) pay for services (including PAP Tests) at a lower rate. Fees range from $5 to $8. These fees represent the cost for the procedure and interpretation: however, a PAP test is usually performed in conjunction with a physical examination so there are additional costs involved. Family Planning Centers are currently operating near their capacity; if they are to service a larger segment of the population, additional monetary and personnel resources must be found.

Since screening tests are not a result of a disease process, persons who cannot readily afford the cost could be expected to forgo the service.

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

While current utilization may not be high for screening tests, oncologist and radiologists as well as consumers who are aware of the benefits of these procedures support them. Breast cancer is the most diagnosed of new cancers and the second major cause of cancer death in women. From the American Cancer Society's Cancer Facts report, the estimated number of new cases in Maine for 1995 of breast cancer is 910 and uterus(includes cervix) cancer is 160. The estimated mortality for Maine in 1995 is 250 for breast cancer and 30 for uterus.

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

One of the more common complaints of HMO coverage is that a woman has to get a referral to see their OB/Gyn for routine visits.

8. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts;

No information available.

9. The likelihood of achieving the objectives of meeting the consumer need as evidenced by the experience of other states;

A summary of mandated coverage in other states is included in Appendix B. According to the National Association of Insurance Commissioners (NAIC) most states have a mandate for mammograms and some include a baseline mammogram between ages 35 - 39. 15 states mandate coverage of PAP smears. 13 states have some type of maternity mandate. Several are mandated offers of maternity coverage and others only apply to HMOs. Six states have laws and seven have pending legislation regarding OB/Gyns as primary care physicians or require direct access for those services delivered by an OB/Gyn.

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 available.

11. The alternatives to meeting the identified need;

Currently, 35 family planning centers statewide offer reduced fees for low income women. However, family planning reports that they deal mostly with women in their late teens and twenties. According to the Maine Cancer Registry, women in their late twenties and early thirties (where the highest incidence of cervical cancer occurs in Maine) are not being screened as frequently. Family planning has in place a sliding scale payment

system, whereby fees are based upon the client's income. If this program were publicized and expanded, it would overtax the limited facilities and increase state subsidies to family planning.

Instead of designating OB/Gyns as Primary Care Physicians, a policy could allow one or more visits a year without getting a referral to the OB/Gyn.

12. Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance;

Health insurance was designed originally to deal with low frequency, high cost occurrences (catastrophes), but the role of health insurance has since changed substantially and more recently is being expanded to include benefits for preventive procedures and services. With an indemnity or re-active health care plan, health insurance is based on risk sharing. With preventive care, there is no risk --everyone in the target population needs and uses the service. Under re-active health insurance plan, that is, one which deals with existing problems, it is more economical for the consumer to budget for a scheduled service such as screening tests, rather than paying the additional premium to have insurance coverage.

A pro-active plan, which deals with health maintenance before a disease exists, would find screening tests consistent with its

policy and within the scope of insurance coverage: this type of coverage is seen in Health Maintenance Organizations (HMOs) and also in preventive care benefit riders and the standardized plans.

Providing prenatal care based on ability to pay requires subsidies from either other policyholders or another source. This benefit structure is commonly used for public programs but may not be adaptable to insurance products.

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

There is no apparent social stigma.

14. The impact of this benefit upon the availability of other benefits currently being offered; and

No input received.

15. The impact of the benefit as it relates to employers shifting to self-insurance plans.

Cost could be a factor for screening tests, but is negligible and not considered the major reason for companies shifting to self-insurance. Employers already are required to offer maternity care benefits in the same manner as other medical benefits.

FINANCIAL IMPACT

B. The financial impact of mandating the benefit which shall include:

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

No information.

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;

Since screening tests are performed on a schedule, it is unlikely that inappropriate use will increase with this mandate. Current American Cancer Society guidelines establish appropriate use of screening mammograms similar to those proposed for mammograms. Pap smears are recommended annually with a pelvic examination. After three or more consecutive annual examinations with normal findings, the Pap test may be performed less frequently at the discretion of the physician.

Recently though, the U.S. Preventive Services Task Force released a report recommending changes in the way preventive health care is

delivered. This report in the form of a revised edition of the 1989 Guide to Clinical Preventive Services is causing controversy about how often and what types of tests should be used for screening cancer.

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

Early detection and treatment of cancer is much less costly than surgery and or terminal care which must be provided if the cancer is detected at a later stage. With early detection of cancer, about 92% would survive.

In an 1985 report, the Institute of Medicine calculated that each dollar spent on providing more adequate prenatal care to low-income, poorly educated women could reduce total expenditures for direct medical care of their low birthweight infants by $3.38 during the first year of life.

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

Utilization could be controlled by following American Cancer Society guidelines or the Guide to Clinical Preventive Services for screening tests. There are also standards for appropriate prenatal care.

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

No information available.

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

Blue Cross Blue Shield of Maine estimates that the OB/Gyn exams including pap smears required by these mandates would increase the monthly cost under a nonmanaged care group plan by $6.35 for family coverage and $2.54 for an individual. The cost increase for individual policies would be $10.36 per month for a family and $4.71 per month for an individual. Requiring the additional coverage of the baseline mammogram as proposed by LD 1385 would increase premiums from $.09 to $.25 per month according to Blue Cross depending on the type of plan.

The increase in premium due to providing other benefits in the proposed mandate and designating OB/Gyns as PCPs could not be determined. See Appendix C for more details.

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

No information available.

8. The impact of this coverage on the total cost of health care; and

Initially there may be an increase in cost due to the utilization of preventive care services but diagnosing and treating conditions at earlier stages is less expensive than at later stage. Over the long run this may help slow the rate of increase of health care costs.

9. The effects on the cost of health care to employers and employees, including the financial impact on small employers, medium-sized employers, and large employers.

This mandate should not have much impact on premiums. Employers are already required by a Human Rights law to provide medical benefits for maternity care if they provide insurance coverage of other disabling illnesses. In addition, some employers already cover preventive care services especially if they have a managed care plan.

MEDICAL EFFICACY

C. The medical efficacy of mandating the benefit which shall include:

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

Early treatment of cervical cancer is not only less expensive than later intervention; if detected soon enough, the cancer can be cured without affecting the patient's ability to bear children. Additionally, precancerous cells can be detected, so a woman can be treated before the cancer even develops.

Studies have shown that screening mammography can lead to early detection and treatment of breast cancer, which increases the survival rate and quality of life of those involved. Breast cancers detected at a size under 5 millimeters in diameter have a ninety percent cure rate: currently in Maine, approximately one third of breast cancer patients die. Breast cancer is one of the most common forms of cancer death in women in Maine.

Several screening methods exist for early detection of colorectal cancer. These include the Fecal Occult Blood Test, Digital Rectal Examination and Sigmoidoscopy. The American Cancer Society

recommends Fecal Occult Blood Testing every year for individuals age 50 and older, Digital Rectal Examination every year for individuals age 40 and older and Sigmoidoscopy every three to five years for individuals age 50 and older. The U.S. Preventive Services Task Force's Guide to Clinical Preventive Services states that there is insufficient evidence to recommend for or against screening tests for colorectal cancer in asymptotic persons.

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

Not applicable.

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

Not applicable.

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

Not applicable.

BALANCING THE EFFECTS

D. The effects of balancing the social, economic, and medical efficacy considerations which shall include:

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

Prenatal care is a basic health service for women. Lack of care impacts the woman, her infant and the community. Maine's infant mortality rate in 1992 was 5.6 per 1000 (Year 2000 goal is 5 per 1000). It is important to assure women have improved access to prenatal care. It is also cost effective. In an 1985 report, the Institute of Medicine calculated that each dollar spent on providing more adequate prenatal care to low-income, poorly educated women could reduce total expenditures for direct medical care of their low birthweight infants by $3.38 during the first year of life.

The Human Rights Act, Title 5 M.R.S.A., Chapter 337 requires all employers regardless of size who provide medical benefits for their employees to also provide medical benefits for pregnancy. While not required to be provided through insurance, the Bureau issued Bulletin 162 to strongly encourage the inclusion of a maternity benefits in the insurance policy to assure the provision of benefits at a reasonable cost.

The findings of a recent survey conducted for The Commonwealth Fund show that women face major barriers to adequate care. The survey found that one-third of women are at risk for undetected treatable conditions.

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

Preventive and prenatal care services are already available for small group and individual policies from the standardized plans that are required to be offered. Large groups can usually negotiate with a carrier for benefits they desire.

APPENDIX A

LD 1385 and LD 752

Charge to the Bureau

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DALE McCORMICK, DISTRICT 18

COLLEEN McCARTHY, LEGISLATIVE ANALYST
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ONE HUNDRED AND SEVENTEENTH LEGISLATURE

COMMITTEE ON BANKING AND INSURANCE

May 15, 1995

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

Dear Mrs. Hooper:

24-A MRSA § 2752 requires the Joint Standing Committee on Banking and Insurance to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing. Pursuant to that statute, we request the Bureau prepare a review and evaluation of the following proposal:

LD 1385 - An Act to Ensure That Basic Health Care Needs of Women Are Covered in Insurance Policies.

A copy of the bill is enclosed. Please prepare the evaluation using the guidelines set out in 24-A MRSA § 2752 and submit the report to the committee on or before January 1, 1996. If you have any questions, please feel free to contact either one of us.

Sincerely,

Joel Abromson

I. Joel Abromson
Senate Chair

Marc J. Vigue

f/ Marc J. Vigue
House Chair

RECEIVED
95 MAY 17 AM 9:59
MAINE BUREAU OF INSURANCE

BAN/cmm

117th MAINE LEGISLATURE

FIRST REGULAR SESSION-1995

Legislative Document No. 1385

H.P. 976 House of Representatives, April 19, 1995

An Act to Ensure That Basic Health Care Needs of Women Are Covered in Insurance Policies.

Received by the Clerk of the House on April 14, 1995. Referred to the Committee on Banking and Insurance and ordered printed pursuant to Joint Rule 14.

JOSEPH W. MAYO, Clerk

Presented by Representative DONNELLY of Presque Isle.
Cosponsored by Representatives: LEMONT of Kittery, MADORE of Augusta, MORRISON of Bangor, SAXL of Portland, SIMONEAU of Thomaston, Senators: LONGLEY of Waldo, McCORMICK of Kennebec, PARADIS of Aroostook, RAND of Cumberland.

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

Sec. 1. 24 MRSA §2320-C is enacted to read:

§2320-C. Basic coverage

1. **Required coverage.** All individual and group nonprofit medical service plan contracts and all nonprofit health care plan contracts must provide coverage for the services listed in subsection 2 performed by providers that meet the standards established by the Department of Human Services.

2. **Covered services.** The following services are covered under this section:

A. All prenatal care, including any care during a pregnancy that is determined by a physician to be medically necessary and one office visit following birth, with a copayment being charged based upon ability to pay and according to a sliding fee scale determined by the Superintendent of Insurance after consultation with organizations subject to this section;

B. Annual Pap tests;

C. If the patient is 40 years of age or older, annual rectal and colon exams;

D. Screening mammograms as defined in section 2320-A according to the following schedule:

(1) At least one time for women between the ages of 35 and 39;

(2) At least once every 2 years for women between the ages of 40 and 49;

(3) At least annually for women age 50 and older; and

(4) Any additional tests recommended by a physician for women who are determined to be at a high risk of breast cancer; and

E. Tests for the presence of the human immunodeficiency antigen or an antibody to the human immunodeficiency virus or for the presence of a sexually transmitted disease.

3. **Application.** This section applies to all contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after December 1, 1995. For

purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

4. Reports. Each nonprofit hospital and medical care service organization subject to this section shall report to the superintendent its experience for each calendar year beginning with 1996 no later than April 30th of the following calendar year. The report must include the information required and be presented in the form prescribed by the superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.

Sec. 2. 24 MRSA §2332-F is enacted to read:

§2332-F. Obstetricians and gynecologists to serve as primary care physicians

All individual and group nonprofit medical service plan contracts and all nonprofit health care plan contracts that provide for managed patient care must permit otherwise eligible physicians who specialize in obstetrics and gynecology to serve as primary care physicians.

Sec. 3. 24-A MRSA §2745-C is enacted to read:

§2745-C. Basic coverage

1. Required coverage. All individual insurance policies must provide coverage for the services listed in subsection 2 performed by providers that meet the standards established by the Department of Human Services.

2. Covered services. The following services are covered under this section:

A. All prenatal care, including any care during a pregnancy that is determined by a physician to be medically necessary and one office visit following birth, with a copayment being charged based upon ability to pay and according to a sliding fee scale determined by the superintendent after consultation with organizations subject to this section;

B. Annual Pap tests;

C. If the patient is 40 years of age or older, annual rectal and colon exams;

D. Screening mammograms as defined in section 2745-A according to the following schedule:

(1) At least one time for women between the ages of 35 and 39;

(2) At least once every 2 years for women between the ages of 40 and 49;

(3) At least annually for women age 50 and older; and

(4) Any additional tests recommended by a physician for women who are determined to be at a high risk of breast cancer; and

E. Tests for the presence of the human immunodeficiency antigen or an antibody to the human immunodeficiency virus or for the presence of a sexually transmitted disease.

3. Application. This section applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after December 1, 1995. For purposes of this section, all policies and contracts are deemed to be renewed no later than the next yearly anniversary of the policy or contract date.

4. Reports. Each insurer that issues policies subject to this section shall report to the superintendent its experience for each calendar year beginning with 1996 no later than April 30th of the following calendar year. The report must include the information required and be presented in the form prescribed by the superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.

Sec. 4. 24-A MRSA §2754 is enacted to read:

§2754. Obstetricians and gynecologists to serve as primary care physicians

All individual insurance policies that provide for managed patient care must permit otherwise eligible physicians who specialize in obstetrics and gynecology to serve as primary care physicians.

Sec. 5. 24-A MRSA §2837-C is enacted to read:

§2837-C. Basic coverage

1. Required coverage. All group insurance policies must provide coverage for the services listed in subsection 2 performed by providers that meet the standards established by the Department of Human Services.

2. Covered services. The following services are covered under this section:

A. All prenatal care, including any care during a pregnancy that is determined by a physician to be medically necessary and one office visit following birth, with a copayment being charged based upon ability to pay and according to a sliding fee scale determined by the superintendent after consultation with organizations subject to this section;

B. Annual Pap tests;

C. If the patient is 40 years of age or older, annual rectal and colon exams;

D. Screening mammograms as defined in section 2837-A according to the following schedule:

(1) At least one time for women between the ages of 35 and 39;

(2) At least once every 2 years for women between the ages of 40 and 49;

(3) At least annually for women age 50 and older; and

(4) Any additional tests recommended by a physician for women who are determined to be at a high risk of breast cancer; and

E. Tests for the presence of the human immunodeficiency antigen or an antibody to the human immunodeficiency virus or for the presence of a sexually transmitted disease.

3. Application. This section applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after December 1, 1995. For purposes of this section, all policies and contracts are deemed to be renewed no later than the next yearly anniversary of the policy or contract date.

4. Reports. Each insurer that issues policies subject to this section shall report to the superintendent its experience for each calendar year beginning with 1996 no later than April 30th of the following calendar year. The report must include the information required and be presented in the form prescribed by the superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.

Sec. 6. 24-A MRSA §2851-A is enacted to read:

§2851-A. Obstetricians and gynecologists to serve as primary care physicians

All group insurance policies that provide for managed patient care must permit otherwise eligible physicians who specialize in obstetrics and gynecology to serve as primary care physicians.

STATEMENT OF FACT

This bill provides that health insurance policies must include coverage for prenatal care, annual Pap tests, mammograms, rectal and colon exams for women age 40 and older, human immunodeficiency virus and sexually transmitted disease. The bill also requires that physicians whose specialty is obstetrics and gynecology be eligible to be primary care physicians under a managed care program.

April 5, 1995

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

Dear Mrs. Hooper:

24-A MRSA § 2752 requires the Joint Standing Committee on Banking and Insurance to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing. Pursuant to that statute, we request the Bureau prepare a review and evaluation of the following proposal:

LD 752 - An Act to Include Obstetricians and Gynecologists as Primary Care Providers.

A copy of the bill is enclosed. Please prepare the evaluation using the guidelines set out in 24-A MRSA § 2752 and submit the report to the committee as soon as possible. If you have any questions, please feel free to contact either one of us.

Sincerely,

I. Joel Abromson
Senate Chair

Marc J. Vigue
House Chair

BAN/cmm

117th MAINE LEGISLATURE

FIRST REGULAR SESSION-1995

Legislative Document No. 752

S.P. 280 In Senate, March 7, 1995

An Act to Include Obstetricians and Gynecologists as Primary Care Providers.

Reference to the Committee on Banking and Insurance suggested and ordered printed.

MAY M. ROSS
Secretary of the Senate

Presented by Senator MILLS of Somerset.
Cosponsored by Senator: RAND of Cumberland, Representative: MERES of Norridgewock.

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

Sec. 1. 24 MRSA §2332-F is enacted to read:

§2332-F. Gynecological and obstetrical services

1. Required designation. An individual or group nonprofit medical services plan contract or a nonprofit health care plan contract that designates certain physicians as primary care physicians must include physicians providing gynecological and obstetrical services as primary care physicians.

2. Required coverage. An individual or group nonprofit medical services plan contract or a nonprofit health care plan contract must provide the following gynecological and obstetrical services when provided by a physician:

A. Semiannual gynecological examinations, including routine pelvic and clinical breast examinations and Pap smears;

B. Gynecological and obstetrical services required as a result of services pursuant to paragraph A; and

C. Gynecological and obstetrical services required as a result of an acute health care condition or pregnancy.

3. Written notice. An individual or group nonprofit medical services plan contract or a nonprofit health care plan contract must provide within the contract written notice of the availability of services provided pursuant to this section.

4. Application. This section applies to any contract executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1996. For purposes of this section, a contract is deemed to be renewed no later than the next anniversary of the contract date.

Sec. 2. 24-A MRSA §2745-C is enacted to read:

§2745-C. Gynecological and obstetrical services

1. Required designation. Individual insurance policies, except those designed to cover only specific diseases, accidental injury or dental procedures, that designate certain physicians as primary care physicians must include physicians providing gynecological and obstetrical services as primary care physicians.

2. Required coverage. An individual health insurance policy must provide the following gynecological and obstetrical services when provided by a physician:

A. Semiannual gynecological examinations, including routine pelvic and clinical breast examinations and Pap smears;

B. Gynecological and obstetrical services required as a result of services pursuant to paragraph A; and

C. Gynecological and obstetrical services required as a result of an acute health care condition or pregnancy.

3. Written notice. An individual health insurance policy must provide within the policy written notice of the availability of services provided pursuant to this section.

4. Application. This section applies to any policy executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1996. For purposes of this section, a policy is deemed to be renewed no later than the next anniversary of the policy date.

Sec. 3. 24-A MRSA §2850-A is enacted to read:

§2850-A. Gynecological and obstetrical services

1. Primary care. An insurance policy or contract, except a policy or contract that covers only dental procedures, accidental injury or specific diseases, that designates certain physicians as primary care physicians must include physicians providing gynecological and obstetrical services as primary care physicians.

2. Required designation. An insurance policy or contract must provide the following gynecological and obstetrical services when provided by a physician:

A. Semiannual gynecological examinations, including routine pelvic and clinical breast examinations and Pap smears;

B. Gynecological and obstetrical services required as a result of services pursuant to paragraph A; and

C. Gynecological and obstetrical services required as a result of an acute health care condition or pregnancy.

3. Written notice. An insurance policy or contract must provide within the policy or contract written notice of the availability of services provided pursuant to this section.

4. Application. This section applies to a policy or contract executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1996. For purposes

of this subsection, a policy or contract is deemed to be renewed no later than the next anniversary of the policy or contract date.

Sec. 4. 24-A MRSA §4237 is enacted to read:

§4237. Gynecological and obstetrical services

1. Required designation. An individual or group contract subject to this chapter that designates certain physicians as primary care physicians must include physicians providing gynecological and obstetrical services as primary care physicians.

2. Required coverage. An individual or group contract subject to this chapter must provide the following gynecological and obstetrical services when provided by a physician:

A. Semiannual gynecological examinations, including routine pelvic and clinical breast examinations and Pap smears;

B. Gynecological and obstetrical services required as a result of services pursuant to paragraph A; and

C. Gynecological and obstetrical services required as a result of an acute health care condition or pregnancy.

3. Written notice. An individual or group contract must provide within the contract written notice of the availability of services provided pursuant to this section.

4. Application. This section applies to any individual or group contract executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1996. For purposes of this subsection, a contract is deemed to be renewed no later than the next anniversary of the contract date.

Sec. 5. Effective date. This Act takes effect January 1, 1996.

STATEMENT OF FACT

This bill makes identical changes in the requirements for individual health insurance, group health insurance and health care coverage provided by nonprofit hospital and medical service organizations and health maintenance organizations. All requirements take effect on January 1, 1996. The requirements include the following.

1. Plans that designate physicians as primary care providers must designate physicians providing gynecological and obstetrical services as primary care providers.

2. Coverage must be provided for semiannual gynecological examinations and gynecological and obstetrical services required as a result of those exams or as a result of an acute health care condition and pregnancy.

3. Written notice of gynecological and obstetrical service coverage must be provided.

APPENDIX B

States With Mandates

Cancer Facts and Figures - 1995

MANDATED BENEFITS:

MATERNITY CARE

State	Citation	Summary
CA	§ 12683 (group) (1982)	Group policy from which conversion is made that covers basic hospital or surgical expense shall offer coverage for pregnancy expenses.
CO	§ 10-16-104 (1992/1993)	Mandates coverage of normal pregnancy and childbirth in all group policies; does not apply to small employers with less than 15 employees.
GA	Reg. 290-5-37-.03 (HMOs) (1979)	Shall include prenatal, intrapartum and postnatal maternity care in its basic health care services.
IL	50 ILL. ADM. CODE 6101.130 (HMOs) (1976/1990)	Minimum standards shall include maternity care including prenatal and postnatal care.
ME	24-A § 2832 (group) (1975/1979)	Group and blanket health policies shall provide same maternity benefits for unmarried women and minor dependents as are provided to married insureds.
MA	c.175 § 47F (1985/1986)	Cover residents covered under health insurance policies for normal pregnancy.
MN	§ 62A.041 (1971/1989)	Cover maternity benefits same as any other illness, irrespective of whether covered person is married, or whether dependent child.
MT	Order of Insurance Commissioner 2/16/94	All policies shall not exclude maternity benefits, nor shall they charge an additional premium for a maternity rider.
NH	§§ 420-B:8, 420-C:4 (HMOs, PPOs)	Mandated offering of maternity coverage through optional rider if maternity care in not covered in the insurance policy or contract.
NJ	§ 17B:27-46.1b (1985)	Mandated offering of maternity coverage without regard to marital status of subscriber to same extent as coverage for other illness.
NY	§ 3221(k)(5)(A) (group) (1984/1992) § 3216(i)(10)(A) (individual) (1984/1992)	Mandated coverage to the same extent as provided for other illness or disease.
VT	Reg 89-1 (1989)	All policies must provide maternity coverage.
VA	§ 38.2-3414 (group) (1986)	Mandated offering of coverage for maternity care using same formula for reimbursement as other medical and surgical procedures.

MANDATED BENEFITS:

CANCER TESTS, MAMMOGRAPHY, PAP SMEARS, AND PROSTATE CANCER SCREENINGS

State	Citation	Summary
AK	§ 21.42.375 (1991)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Coverage for any age when family history of breast cancer, upon referral of physician. Coverage no less favorable than other radiological exams.
AZ	§ 20-826(I) (1988)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
AR	§ 23-79-140 (1989) (Group contracts)	Mandated offering: baseline mammogram ages 35-40, every 1-2 years ages 40-49 based on doctor's recommendation, yearly after age 50. Coverage for any age when doctor recommends. $50 minimum payment.
CA	I.C. § 10123.81 (1987/1988) I.C. § 10123.18 (1991) § 11512.155 (1991) (nonprofits) Health & Safety § 1367.66 (HMOs)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Pap smear annually. Pap smear annually. Pap smear annually.
CO	§ 10-16-104 (1992/1995)	Baseline mammogram ages 35-39, every two years 40-49 or yearly for high risk, annual screening 50-65; coverage shall be lesser of $60 or actual charges. This amount will be adjusted according to the Consumer Price Index. Provide coverage for prostate cancer screening, eff. 1-1-96.
CT	§ 38a-503 (1988)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
DE	tit. 18 § 3552 (1988/1993) (Group policies)	Pap smear, prostate cancer screening, mammograms on following schedule: baseline at age 35, every 2 years ages 40-50, yearly over age 50. Benefit should not exceed least expensive charge in area.
DC	§§ 35-2402 to 35-2403 (1991)	Baseline mammogram and annual screening. Pap smear annually. Not subject to co-insurance and deductibles.
FL	§ 627.6418 (1988/1995) (indivdual) § 627.6613 (1988/1995) (group)	Must cover baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over; mandated offer of coverage with no deductible or coinsurance for group and individual insurers.
GA	§ 33-29-3.2 (1990/1992) (individual) § 33-30-4.2 (1990/1992) (group)	Baseline mammogram ages 35-40, every 2 years ages 40-50, yearly 50 and over; annual pap smear, or as ordered by physician for women at risk, annual pap smear for women; annual prostate cancer screening for males 45 years of age and older, or 40 years of age and older when ordered by physician. Deductibles and exclusions subject to commissioner approval.
HI	§ 431:10A-116 (1990)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
ID	§ 41-2144 (individual) § 41-2218 (group) § 41-3441 (nonprofits) § 41-3936 (HMO)(1992)	Policies which cover mastectomies must cover mammograms: baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over; not to exceed $65 per exam.
IL	215 ILCS 5/356g	Baseline mammogram ages 35-39, every 1-2 years ages 40-49, every year age 50 (1981/1991) and over.
IN	§ 27-8-14.6 (1991)	Mandated offer of coverage for baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over in specified amount with no greater deductible than for illness.

MANDATED BENEFITS:

CANCER TESTS, MAMMOGRAPHY, PAP SMEARS, AND PROSTATE CANCER SCREENINGS

State	Citation	Summary
IA	§ 514C.4 (1989)	Baseline mammogram ages 35-39, every two years ages 40–49, every year age 50 and over.
KS	§ 40-2230 (1988)	Coverage for mammograms and pap smears performed at direction of doctor.
KY	§ 304.18-098 (group) § 304.38-1935 (HMOs) § 304.32-1591 (nonprofits) § 304.17-316 (individual) (1990)	Baseline mammogram ages 35-39, every two years ages 40–49, every year age 50 and over. May limit to $50 per screening, coinsurance and deductible no less favorable than for illness.
LA	§ 215.10 (1991)	Annual Pap test and mammography according to following schedule: Baseline mammogram ages 35-39, every two years ages 40–49, every year age 50 and over. Same conditions as benefits for other procedures.
ME	24-A § 2320-A (nonprofits) 24-A § 2745-A (indiv.) 24-A § 2837-A (group) (1991) Reg. 600 (1991)	One mammogram every two years age 40–49, yearly 50 or over. Same level of benefits as for other radiological procedures, no specific deductibles.
MD	48A § 468C (1986) § 477JJ (group) § 470L (indiv.) § 354JJ (nonprofits) (1991/1993)	Medicare supplement policies must provide up to $100 benefit for annual screening. Baseline mammogram ages 35-39, every two years ages 40–49, every year age 50 and over. No deductibles may be applied on coverage renewed or effective on or after 1-1-94.
MA	ch. 175 § 47G, ch. 176A § 8J, ch. 176G § 4 (1987)	Baseline mammogram ages 35-39, annual screening age 40 and older, plus annual pap screening.
MI	§§ 500.3406d, 500.3616 (group) 333.21054, 550.416 550.416A (1989)	Offer or include coverage for baseline mammogram ages 35–40, yearly after age 40.
MN	§ 62A.30 (1988)	Routine screening procedures, such as mammograms and pap smears, when ordered by physician.
MO	§ 376.782 (1990/1995)	Baseline mammogram ages 35-39, every two years ages 40–49, every year age 50 and over, upon the recommendation of a physician where the patient, her mother or her sister has a prior history of breast cancer; subject to same dollar limit, coinsurance and deductible as other radiological exams.
MT	§ 33-22-132 (1991)	Baseline mammogram ages 35-39, every two years ages 40–49, every year age 50 and over. Coinsurance and deductible no less favorable than for physical illness, minimum $70 payment.
NE	LB 68 (1995)	Baseline mammogram ages 35-39, every two years ages 40 –49, every year age 50 and over. Coverage shall not be less favorable than for other radiological exams. Mammogram supplier shall meet the standards of the federal Mammography Quality Standards Act of 1992.
NV	§ 689B.0374 (group) § 695C.1735 (HMOs) § 689A.0405 (individual) § 695B.1912 (nonprofits) (1989)	Annual Pap smear for women age 18 and older, baseline mammogram for women between ages of 35-40; annual mammogram for women 40 and older.
NH	§ 417-D:2 (1988)	Baseline mammogram ages 35-39, every two years ages 40–49, every year age 50 and over.

MANDATED BENEFITS:

CANCER TESTS, MAMMOGRAPHY, PAP SMEARS, AND PROSTATE CANCER SCREENINGS

State	Citation	Summary
NJ	§ 17B:27-46-1f (group) (1991) § 17:48-6g (hospital service corp.) § 17:48E-35.4 (group or individual health service corp.) 17B:26-2.1e (individual) § 17:48A-7f (group or individual medical service corp.)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
NM	§ 59A-22-39 (1990)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
	§ 59A-22-40 (1992)	Pap test yearly for women age 18 and older.
NY	§ 3216(i) (1989/1992) (indiv.) § 3221 (i) (1989/1992) (group)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over or at any age for high risk persons; annual pap smear.
NC	§ 58-51-57 § 58-67-76 (HMOs) § 58-65-92 (nonprofits) (1992) § 58-51-58	Pap smears and mammography covered with same deductibles and coinsurance as other procedures. Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over or at any age for high risk persons. Prostate-specific antigen(PSA) test coverage with same deductibles and coinsurance as other procedures.
ND	§ 26.1-36-09.1 (1989)	Baseline mammogram ages 35-39, every two years (or more frequently if ordered by doctor) ages 40-49, annually age 50 and over.
OH	§ 3923.52 (1992)	Baseline mammogram ages 35-39, every two years (or more frequently if ordered by doctor) ages 40-49, annually age 50 and over; not to exceed $85 per year or lower amount in contract; pap smear.
	§ 1742.40 (1992) (HMOs)	Baseline mammogram ages 35-39, every two years (or more frequently if ordered by doctor) ages 40-49, annually age 50 and over; not to exceed $85 per year or lower amount in contract; pap smear.
OK	tit. 36 § 6060 (1988/1989)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over, baseline limited to $75, and not subject to deductibles and coinsurance.
OR	HB 2971 (1993) SB 905 (1993)	Every health insurance policy shall provide coverage for breast cancer screening and pap smears.
PA	SB 1103 (1994)	Annual gynecological exam, including pelvic exam and clinical breast exam; routine pap smear.
RI	§ 42-62-26 (commercial insurers); §§ 27-20-17, 27-19-19, 27-41-30 (BC/BS & HMOs) (1988/1989)	Coverage for mammograms and pap smears in accordance with American Cancer Society Guidelines.
SD	§ 58-18-36 (group) (1990) § 58-41-35.5 (HMO) §§ 58-40-20, 58-38-22 (nonprofits) § 58-17-1.2 (indiv.) § 58-17A-4.1 (medigap)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
TN	§ 56-7-1012 (1989)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
TX	art. 3.70-2(H) (1987)	Annual screening for women age 35 and older.

MANDATED BENEFITS:

CANCER TESTS, MAMMOGRAPHY, PAP SMEARS, AND PROSTATE CANCER SCREENINGS

State	Citation	Summary
VT	§ 4100a (1991)	Annual screening for females 50 years or older, for those younger upon recommendation of provider; subject to same coinsurance and deductible as other radiological exams.
VA	§ 38.2-3418.1 (1989/1990)	Mandated offering: Baseline mammogram ages 35-40, every two years ages 40-49, yearly after age 50. $50 limit.
WA	§ 48.21.225 (1990) (group) § 48.46.275 (HMOs) § 48.44.325 (nonprofits) § 48.20.393 (individual)	Screening or diagnostic mammography services upon recommendation of physician.
WV	§§ 33-15-15 (individual) § 33-16C-4 (group) (1992)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 40 and over, pap smear annually for women; medical and laboratory services for annual checkup for prostate cancer for men age 50 and over.
WI	§ 632.895(8) (1990)	Two mammogram exams between ages 40-49, annually age 50 and older.

APPENDIX C

Blue Cross and Blue Shield of Maine:

Mammogram Criteria

List of OB/Gyns that practice as PCPs

Rate Increase Estimates

BLUE SHIELD PRE-PAYMENT UTILIZATION REVIEW

TO: BLUE SHIELD, FEP, NATIONAL ACCOUNTS, COMP-CARE

FROM: UTILIZATION REVIEW

DATE: FEBRUARY 1, 1987

SUBJECT: X-RAY MAMMOGRAPHY FOR THE DETECTION AND EVALUATION OF BREAST DISEASE

GUIDELINE:

Level 1: Benefits for Mammography are payable for the following indications:

- When a breast mass is found on physical examination
- Signs of symptoms suggest possible malignancy
- History of cancer in other breast
- Gross fibrocystic disease
- Intraductal papillomatosis
- History of breast cancer in mother or sister
- Metastic disease of unknown origin

HMO and Select OB/GYN's that practice as
Primary Care Physicians

Prac Type:
B = Both PCP & Specialist
P = PCP
S = Specialist Only

Monday, December 11, 1995

Region/Grp ID	Prov_ID	First Name	Middle	Last Name	MD/DO	Grp Practice Name	City	HMO Prac Type	SB Prac Type
522-1079	014459	J.	Donald	Burgess	M.D.	Mere Point OB/GYN Associates	Brunswick	B	B
446-0663	000267	Arlene	J.	Cenedella	M.D.	Cenedella, M.D., P.A.	Presque Isle	B	B
622-1060	014462	Gregory	L.	Gimbel	M.D.	Mere Point OB/GYN Associates	Brunswick	S	B
529-0942	016924	Robert	K.	Greene	M.D.	State Street OB/GYN, P.A.	Portland	B	B
525-0935	016782	Richard	L.	Littlefield	D.O.		Skowhegan	B	B
529-0943	016923	Thomas	J.	Sunshine	M.D.	State Street OB/GYN, P.A.	Portland	B	B
198-0293	002447	James		Wilberg	M.D.	Southern Maine OB/GYN	Portland	B	B
138-0213	001837	William	T.	Yates	M.D.		Farmington	B	B

Monthly Rate Increases due to Key Provisions of Legislation on Women's Health Issues

Legislation	Group Products with Nonmanaged Care		Nongroup Products	
	Individual	Family	Individual	Family
LD752				
Semi-Annual OB/GYN exams including pap smears	$2.54	$6.35	$4.71	$10.36
Pre-natal care	Indeterminate	indeterminate	Indeterminate	indeterminate
OB/GYN. Physicians as PCPs	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Total	$2.54	$6.35	$4.71	$10.36
LD 1079				
OB/GYN. Physicians as PCPs	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Mammograms	already covered		already covered	
Total	$0.00	$0.00	$0.00	$0.00
LD 1385				
Annual OB/GYN exams including pap smears	$2.54	$6.35	$4.71	$10.36
Screening Mammograms for women age 35 to 39	$0.10	$0.25	$0.09	$0.20
HIV & STD Testing	not material	not material	not material	not material
OB/GYN. Physicians as PCPs	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Total	$2.64	$6.60	$4.80	$10.56

APPENDIX C

Blue Cross and Blue Shield of Maine:

Mammogram Criteria

List of OB/Gyns that practice as PCPs

Rate Increase Estimates

BLUE SHIELD PRE-PAYMENT UTILIZATION REVIEW

TO: BLUE SHIELD, FEP, NATIONAL ACCOUNTS, COMP-CARE

FROM: UTILIZATION REVIEW

DATE: FEBRUARY 1, 1987

SUBJECT: X-RAY MAMMOGRAPHY FOR THE DETECTION AND EVALUATION OF BR
DISEASE

GUIDELINE:

Level 1: Benefits for Mammography are payable for the follow
indications:

When a breast mass is found on physical examin

Signs of symptoms suggest possible malignancy

History of cancer in other breast

Gross fibrocystic disease

Intraductal papillomatosis

History of breast cancer in mother or sister

Metastic disease of unknown origin

HMO and Select OB/GYN's that practice as Primary Care Physicians

Monday, December 11, 1995

Prac Type:
B = Both PCP & Specialist
P = PCP
S = Specialist Only

Region/Grp ID	Prov_ID	First Name	Middle	Last Name	MD/DO	Grp Practice Name	City	HMO Prac Type	SB Prac Type
622-1079	014459	J.	Donald	Burgess	M.D.	Mere Point OB/GYN Associates	Brunswick	B	B
446-0663	000267	Arlene	J.	Cenedella	M.D.	Cenedella, M.D., P.A.	Presque Isle	B	B
622-1060	014462	Gregory	L.	Gimbel	M.D.	Mere Point OB/GYN Associates	Brunswick	S	B
529-0942	016924	Robert	K.	Greene	M.D.	State Street OB/GYN, P.A.	Portland	B	B
525-0935	016782	Richard	L.	Littlefield	D.O.		Skowhegan	B	B
529-0943	016923	Thomas	J.	Sunshine	M.D.	State Street OB/GYN, P.A.	Portland	B	B
196-0293	002447	James		Wilberg	M.D.	Southern Maine OB/GYN	Portland	B	B
138-0213	001837	William	T.	Yates	M.D.		Farmington	B	B

Monthly Rate Increases due to Key Provisions of Legislation on Women's Health Issues

Legislation	Group Products with Nonmanaged Care		Nongroup Products	
	Individual	Family	Individual	Family
LD752				
Semi-Annual OB/GYN exams including pap smears	$2.54	$6.35	$4.71	$10.36
Pre-natal care	Indeterminate	indeterminate	Indeterminate	indeterminate
OB/GYN. Physicians as PCPs	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Total	$2.54	$6.35	$4.71	$10.36
LD 1079				
OB/GYN. Physicians as PCPs	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Mammograms	already covered		already covered	
Total	$0.00	$0.00	$0.00	$0.00
LD 1385				
Annual OB/GYN exams including pap smears	$2.54	$6.35	$4.71	$10.36
Screening Mammograms for women age 35 to 39	$0.10	$0.25	$0.09	$0.20
HIV & STD Testing	not material	not material	not material	not material
OB/GYN. Physicians as PCPs	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Total	$2.64	$6.60	$4.80	$10.56

APPENDIX D

BUREAU REPORT ON HEALTH INSURANCE CLAIMS FOR MAMMOGRAPHY AND BREAST CANCER TREATMENT FOR 1994

Brian K. Atchinson
Superintendent

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Deputy Superintendent

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DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

REPORT OF THE SUPERINTENDENT OF INSURANCE ON HEALTH INSURANCE CLAIMS FOR MAMMOGRAPHY AND BREAST CANCER TREATMENT FOR THE YEAR 1994

This report is a compilation of the reports made by insurers to the Superintendent of Insurance as required by Title 24 M.R.S.A. §2320-A(4), 24-A M.R.S.A. §2745-A(4) and §2837-A(4).

Completed reports were received from 35 companies. There continue to be problems with access and accuracy of data from some companies. The information reported by each of these companies is listed on page 2.

The individual reports of those 35 companies are shown on page three of this report. Page two shows the totals for all companies, Blue Cross/Blue Shield of Maine (BC/BS) and its affiliate Blue Alliance Mutual Insurance Company (BAMICO) which comprise 70% of total group claims and 96% of total individual claims reported in Maine during 1994, and totals for all companies other than BC/BS and BAMICO. In addition, the percentage of total health care claims which went for mammography and breast cancer claims is shown.

The number of diagnostic mammograms covered in 1994 was 17,341 (14,076 group and 3,265 individual) and the number of screening mammograms was 19,312 (15,728 group and 3,584 individual). The number of diagnostic mammograms reported decreased slightly from those reported in 1993 but the number of screening mammograms increased 21%. All mammograms remained at 0.3% of total health care claims. Breast cancer claims increased slightly to 1.6% of total health care claims for 1994.

Respectfully Submitted,

Brian K. Atchinson

BRIAN K. ATCHINSON
Superintendent

				SCREENING MAMMOGRAPHY REPORT 1994					# Screening		# Diagnostic	
	TOTAL		Screening Mammograms		Diagnostic Mammograms		Breast Cancer Treatment		Mammograms		Mammograms	
COMPANY	Individual	Group	Individual	Group	Individual	Group	Individual	Group	Individual	Group	Individual	Group
AETNA LIFE INS. CO.	$26,700	$16,688,186		$22,901		$17,855		$91,572		631		519
AETNA LIFE & ANNUITY	$2,377				$125		$332		0		1	
AID ASSOC. FOR LUTHERANS	$991		$0		$12		$0		0		1	
AMER CAS OF R PA	$2,000	$0	$0	$0	$0	$0	$0	$0	0	0	0	0
AMERICAN FAMILY LIFE	$1,299,240	$0	$0	$0	$0	$0	$0	$0	0	0	0	0
AMER REPUBLIC	$950,614	$20,802	$1,068	$0	$393	$0	$40,957	$0	28	0	45	0
BLUE ALLIANCE MUT	$2,373,100	$36,800,226	$1	$11	$0	$0	$10,330	$170,034	1	0	0	3
BCBS	$98,242,040	$281,428,008	$161,208	$461,976	$149,545	$428,392	$765,252	$2,197,170	3488	10025	3184	9122
CENTRAL STATES	$58,483		$0		$74		$0		0		1	
COMBINED	$184,746		$1,058		$0		$0		40		0	
CONN GEN LIFE	$0	$20,484,948	$0	$10,077	$0	$16,753	$0	$4,352,045	0	498	0	386
CONTINENTAL ASSURANCE	$2,241	$37,246	$0	$4,699	$0	$4,360	$0	$26,615	0	37	0	35
CONTINENTAL CASUALTY	$8,734	$120,458	$0	$0	$78	$0	$0	$0	0	0	1	0
CUNA MUTUAL	$0	$433,222	$0	$146	$0	$744	$0	$0	0	6	0	26
EMPLOYERS HEALTH	$190	$19,269	$0	$26	$0	$0	$0	$0	0	1	0	0
FIDEL SEC PAY POWER	$0	$10,987,608	$0	$15,380	$0	$22,130	$0	$84,105	0	630	0	701
FORTIS	$0	$114,932	$0	$64	$0	$106	$0	$0	0	2	0	2
GUARDIAN LIFE	$0	$3,1[illegible],193	$0	$3,428	$0	$2,916	$0	$76,701	0	99	0	98
HORACE MANN	$0	$34,393	$0	$0	$0	$0	$0	$0	0	0	0	0
JOHN ALDEN		$9,432,450		$9,596		$8,759		$215,616		182		
LINCOLN NATIONAL	$0	$74,653	$0	$0	$0	$26	$0	$0	0	0	0	1
METRAHEALTH	$49,234	$20,170,947	$0	$40,382	$0	$39,400	$548	$26,216	0	833	0	783
MUTUAL OF OMAHA	$0	$174,469	$618	$4,096	$1,121	$1,017	$262,771	$715	13	104	21	23
NEW YORK LIFE	$0	$15,663,279	$16	$42,086	$229	$37,398	$5,721	$266,767	0	1086	0	905
NORTHWESTERN NATIONAL		$1,270,037		$175		$280		$16,805		6		7
PIONEER	$607,140	$23,279	$0	$0	$0	$0	$0	$0	0	0	0	0
PRINCIPAL MUTUAL	$0	$13,395,842	$0	$17,234	$0	$23,253	$0	$71,962	$0.00	277	0	341
PROVIDENT L & A		$3,413,979	$0	$1,399	$0	$7,390	$0	$56,781	0	31	0	158
PRUDENTIAL	$946,721	$4,793,088	$51	$12,252	$288	$1,158	$1,947	$1,947	1	399	4	152
STATE MUTUAL	$0	$15,269,688	$0	$36,158	$0	$34,162	$0	$310,127	0	872	0	814
TRANSPORT LIFE	$19,551	$215,523	$0	$45	$0	$0	$0	$0	0	1	0	0
TRUSTMARK	$246,632	$0	$209	$0	$585	$0	$31,228	$0	2	NOT DETER	7	0
UNION BANKERS	$167,407	NA	$0	NA	$0	NA	$0	NA	0	NA	0	NA
UNITED OF OMAHA	$0	$31,512	$0	$198	$0	$0	$0	$0	0	2	0	0
TOTALS	$105,188,210	$454,262,596	$165,189	$682,329	$152,400	$646,099	$1,134,086	$7,969,358	3584	15728	3265	14076
BCBS/BAMICO	$100,615,209	$318,228,293	$161,269	$461,987	$149,545	$428,392	$781,582	$2,371,804	3500	10031	3184	9125
All Other	$4,573,001	$136,034,303	$3,920	$220,342	$2,855	$217,707	$352,504	$5,597,554	84	5697	81	4951
%BC			0.16%	0.15%	0.15%	0.13%	0.78%	0.75%				
% All Other			0.09%	0.16%	0.06%	0.16%	7.71%	4.11%				
% TOTAL			0.16%	0.15%	0.14%	0.14%	1.08%	1.75%				

Year 1994 SCREENING MAMMOGRAPHY

TOTAL OF 35 COMPANIES	INDIVIDUAL	GROUP	TOTAL
TOTAL MEDICAL CLAIMS IN ME	$105,188,210	$454,262,596	$559,450,806
SCREENING MAMMOGRAMS CLAIMS	$165,189	$682,329	$847,518
PERCENT OF TOTAL	0.16%	0.15%	0.15%
DIAGNOSTIC MAMMOGRAMS CLAIMS	$152,400	$646,099	$798,729
PERCENT OF TOTAL	0.14%	0.14%	0.14%
BREAST CANCER TREATMENT CLAIMS	$1,134,086	$7,969,358	$9,103,444
PERCENT OF TOTAL	1.08%	1.75%	1.63%
BLUE CROSS/BLUE SHIELD OF MAINE AND BAMICO			
TOTAL MEDICAL CLAIMS IN ME	$100,615,209	$318,228,293	$418,843,502
SCREENING MAMMOGRAMS CLAIMS	$161,269	$461,987	$623,256
PERCENT OF TOTAL	0.16%	0.15%	0.15%
DIAGNOSTIC MAMMOGRAMS CLAIMS	$149,545	$428,392	$577,937
PERCENT OF TOTAL	0.15%	0.13%	0.14%
BREAST CANCER TREATMENT CLAIMS	$781,562	$2,371,824	$3,153,386
PERCENT OF TOTAL	0.78%	0.75%	0.75%
ALL OTHER COMPANIES			
TOTAL MEDICAL CLAIMS IN ME	$4,573,001	$136,034,303	$140,607,304
SCREENING MAMMOGRAMS CLAIMS	$3,920	$220,342	$224,262
PERCENT OF TOTAL	0.09%	0.16%	0.16%
DIAGNOSTIC MAMMOGRAMS CLAIMS	$2,855	$217,707	$220,562
PERCENT OF TOTAL	0.06%	0.16%	0.16%
BREAST CANCER TREATMENT CLAIMS	$352,504	$5,597,554	$5,950,058
PERCENT OF TOTAL	7.71%	4.11%	4.23%

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