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Bureau of Insurance

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

Review and Evaluation of LD 425, An Act To Require
Private Insurance Coverage for Certain Services for
Children with Disabilities

December 2009

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Table of Contents

I.	Executive Summary -----	1
II.	Background-----	3
III.	Social Impact of Mandating the Benefit -----	4
IV.	Financial Impact of Mandating the Benefit-----	10
V.	Medical Efficacy of Mandating the Benefit-----	14
VI.	The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations-----	15
VII.	Appendices -----	16
	■ Appendix A: Letter from the Committee on Insurance and Financial Services with Proposed Legislation	
	■ Appendix B: Cumulative Impact of Mandates	

I. Executive Summary

LD 425 would require that all individual and group health insurance policies provide early intervention services for children ages birth to 36 months identified with a developmental disability or delay as described in the federal Individuals with Disabilities Education Act (IDEA). The coverage would require a referral from the child's primary care provider. The policy, contract, or certificate can limit coverage to \$3,200 per year for each child not to exceed \$9,600 by the child's third birthday.

Studies have shown that children's brains develop most quickly in the early years of life, resulting in the need and desire for early intervention services for children with disabilities. These services:

1. Enhance the child's development;
2. Provide support and assistance to the family; and
3. Maximize the child's and family's benefit to society.¹

In 2007 there were 996 children in Maine under the age of 36 months (approximately 2.38 percent of the population in this age range) who were receiving early intervention services through the federal program IDEA Part C.² Many of these children may also be covered by health insurance since many of the insurers in Maine currently cover the benefits required by LD 425. It is possible that parents contact Child Development Services (CDS) in Maine for services rather than submitting claims to their insurance company, even when the services are covered by insurance.

Programs are currently available to provide early intervention services for children in Maine who do not have insurance and qualify.

Testimony indicated that budget deficits in Maine have resulted in narrowing of eligibility criteria for early intervention services, which may result in some "minimally involved" children being ineligible for the services through CDS that otherwise would have helped them succeed.

A number of states have mandates similar to LD 425. In other states there have been efforts to encourage patients to first submit their claims to private insurers before accessing public programs. In Arizona, for example, the state will pay cost

¹ *Ericdigests.org* <<http://www.ericdigests.org/pre-928/help.htm>>

² *Source U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), OMB #1820-0557 "Infants and Toddlers Receiving Early Intervention Services in Accordance with Part C " 2007. Data updated as of July 15, 2008.*

sharing for the individual, if they submit claims to their insurance company first.³

To the extent that these services are covered by MaineCare or IDEA Part C and, after the mandate, will be paid for by private insurance, the cost will be shifted from the public payers to the private payers. Based on claims data provided by MaineCare for enrollees with other third party coverage, we estimate that up to \$250,000 could be shifted to insurance plans from MaineCare payments.

The increase in claims cost, and therefore premiums, will depend on the increase in services that will be paid for by private insurance as a result of this bill over what is currently being covered by private insurance. Since most health insurers do currently cover many of these services, if they are submitted as claims, the increase in claims would be less than the total cost for early intervention services. Insurers in Maine estimated increases in premiums from \$0.22 to \$0.80 per member per month. Our independent estimate is that premiums would increase approximately \$0.12 to \$0.24 per member per month, for an average of approximately \$0.18 per member per month or 0.05 percent (one-twentieth of one percent). This does not reflect any potential savings from possible reductions in the need for future health services because there are no definitive studies demonstrating or quantifying these savings.

³ AZDES.GOV <https://egov.azdes.gov/CMSInternet/uploadedFiles/Arizona_Early_Intervention_Program/tab_3_use_of_insurance.pdf>.

II. Background

The Joint Standing Committee on Insurance and Financial Services of the 124th Maine Legislature directed the Bureau of Insurance (the Bureau) to review LD 425, An Act to Require Private Insurance Coverage for Certain Services for Children with Disabilities. The review was conducted as required by 24-A M.R.S.A., § 2752. This review was a collaborative effort of NovaRest, Inc. and the Bureau.

LD 425 would require that all individual and group health insurance policies provide early intervention services for children ages birth to 36 months with identified developmental disabilities or delays, as described in the federal Individuals with Disabilities Education Act (IDEA), Part C, 20 USC, § 1411, et seq. Coverage would include services from licensed occupational therapists, physical therapists, speech-language pathologists, or clinical social workers.

The coverage would require a referral from the child's primary care provider, and the policy, contract, or certificate can limit coverage to \$3,200 per year for each child not to exceed \$9,600 by the child's third birthday. There may also be provision for maximum benefits, coinsurance, reasonable limitations, and deductibles.

III. Social Impact of Mandating the Benefit

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

At the present time it is estimated that 1.9 percent of US children under the age of 36 months are affected with a developmental disability.⁴

It is difficult to know for certain the total number of children under the age of three who need early intervention services in Maine. In 2007 there were 996 children under the age of 36 months (2.38 percent of the population in this age range) who were receiving early intervention services through the federal program IDEA Part C from Child Development Services (CDS) in Maine.⁵

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

Services are available in Maine at this time. There are 746 speech-language pathologists, 940 occupational therapists, 2,429 clinical social workers, and 1,318 physical therapists licensed in Maine.

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

Maine has one of the highest populations of insured citizens throughout the United States with only 9.1 percent of the population being uninsured.⁶ According to responses received from commercial insurance companies, some coverage for early intervention is available through most insurance companies. Anthem stated that they do not cover speech therapy for deficiencies resulting from mental retardation or dysfunctions that are self-correcting. Cigna stated that "Although Early Intervention services are not mandated in ME, claim data reveals significant coverage for short term rehab services for members ages birth to 3 years old." The coverage appears to be the same as any other insured person would receive despite their diagnosis.

Aetna stated that services related to developmental disabilities are not currently covered by their plans because coverage is either limited to acute conditions responding to short term therapies or the plan language

⁴ United States Census Bureau -< <http://www.census.gov/hhes/www/disability/sipp/disab05/d05tb4.pdf>>.

⁵ Source U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), OMB #1820-0557 "Infants and Toddlers Receiving Early Intervention Services in Accordance with Part C," 2007. Data updated as of July 15, 2008.

⁶ U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States 2007 (released August 2008), available at

specifically excludes treatment for developmental delays.

Harvard Pilgrim reviewed their claims and found very few claims for the various diagnoses that are typically covered by Early Intervention. They believed this could be because these services are provided through CDS. Of the claims they did receive, \$3,000 in claims were denied mostly for exceeding contractual limits on therapy services.

Most insurers noted that under the federal IDEA law, the states and not the insurers are required to provide early intervention, special education and related services to all children under the age of five. One insurer suggested “that it remains appropriate for these services to be paid for through this program and not by shifting costs onto those purchasing health insurance.”⁷

Infants and toddlers (birth to age 2) with disabilities and their families receive early intervention services under IDEA Part C. Children and youth (ages 3-21) receive special education and related services under IDEA Part B. These services are to include occupational therapists, physical therapists, speech-language pathologists, and clinical social workers despite any insurance coverage.

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

The federal IDEA law requires that no child under age five should go without the assistance of early intervention. Child Development Services (CDS) within the Maine Department of Education was established by Maine law to implement the entitlements under IDEA.

At this time, CDS meets the early intervention needs of both insured and uninsured children, but there are some delays or lack of available providers. CDS reported services were not provided 45 times due to no available opening and 30 times due to no provider available during the past year.

Additionally, the Katie Beckett program offers additional eligibility to MaineCare for children with serious health conditions.⁸ These benefits would

[2] <<http://www.census.gov/prod/2008pubs/p60-235.pdf>>.

⁷ Harvard Pilgrim Health Care 8/24/09 response to the Bureau’s request for information regarding LD 425

⁸ Maine.gov <<http://www.maine.gov/dhhs/ocfs/cbhs/eligibility/katiebeckett.html>>.

be applicable to early intervention services for those children that are eligible.

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

In a new study published in the journal *Pediatrics*, Paul T. Shattuck, Ph.D., professor of social work at Washington University in St. Louis, found that Maine families caring for children with special needs shouldered an extra out of pocket expense of \$762.51 each year.⁹ This expense includes deductibles and coinsurance required through private insurance companies, which would not be affected by this proposal.

This study also states that 91.2 percent of U.S. families caring for children with special needs experienced an added financial burden.¹⁰ The article indicated that this burden varied by state and ranged from \$560 to \$970 per year.

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

There is a large public demand for early intervention services. There are three primary reasons for intervening early with a child:¹¹

1. To enhance the child's development;
2. To provide support and assistance to the family; and
3. To maximize the child's and family's benefit to society.

Studies have shown that children's brains develop most quickly in the early years of life, resulting in the need and desire for early intervention services for children with disabilities. Karnes and Lee (1978) have noted that "only through early identification and appropriate programming can children develop their potential."

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

Currently, children are able to receive early intervention services as necessary, either through state and federally funded programs or through private insurance.

⁹WUSTL.edu <<http://news-info.wustl.edu/news/page/normal/11870.html>>.

¹⁰Esciencenews.com

<<http://esciencenews.com/articles/2008/07/10/cost-raising-a-child-with-special-needs-where-does-your-state-rank>>.

¹¹Barbara J Smith in an article on Handicapped and Gifted Children available at [Ericdigests.org](http://ericdigests.org)

There was no testimony provided to the Joint Standing Committee on Insurance and Financial Services from parents of children with disabilities indicating that their child was unable to receive or afford treatment due to lack of insurance coverage. However, testimony was provided that indicated budget deficits in Maine have resulted in narrowing of eligibility criteria for early intervention services. One pediatric physical therapist indicated in her testimony that as a result, some “minimally involved” children are not eligible for the services through CDS that would help them succeed.¹²

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

No information is available.

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

Many states have passed mandates similar to that proposed in LD 425 for the use of private insurance with Part C services. The following is a list of these states and their requirements.

- **Colorado** requires coverage of Part C services by public medical assistance and private health insurance up to \$5,725, per calendar or policy year.
- **Connecticut** requires coverage of Part C services up to \$3,200 annually and exempts these costs from counting against any lifetime caps in a family's policy.
- **Indiana** requires insurers to reimburse early intervention services if they are otherwise covered under a policy and exempts these payments from counting against any lifetime caps.
- **Virginia** requires coverage of Part C services up to \$5,000 annually and exempts these costs from counting against any lifetime caps in a family's policy. The state also applies these provisions in a separate act to the insurance program for state employees.
- **Massachusetts** mandates that both indemnity and managed care plans cover \$5,200 in early intervention services per year per child and an aggregate benefit of \$15,600 over the total enrollment period.

<<http://www.ericdigests.org/pre-928/help.htm>>

¹² Testimony by pediatric physical therapist, Ada Guarino before the Joint Standing Committee on Insurance and Financial Services on March 30, 2009

- **New Hampshire** requires coverage for Children's Early Intervention Therapy Services up to \$3,200 per child per year not to exceed \$9,600 by the child's third birthday.
- **New Mexico** requires coverage for children, from birth through three years of age, for or under the family, infant, toddler program administered by the department of health, provided eligibility criteria are met, for a maximum benefit of \$3,500 annually for medically necessary early intervention services. The services are provided as part of an individualized family service plan and delivered by certified and licensed personnel working in early intervention programs that are approved by the department of health. No payment shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract.
- **New York** requires insurers to reimburse early intervention services if they are otherwise covered under a policy and exempts these payments from counting against any lifetime caps.
- **Rhode Island** requires coverage of Part C services up to \$5,000 annually per dependent child and exempts these costs from counting against any lifetime cap in a family's policy.¹³

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

No information was provided by the state health planning agency.

11. *Alternatives to meeting the identified need.*

No alternatives to meeting the need have been identified or proposed.

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

The benefit is a medical need and is not inconsistent with the role of insurance. As indicated above these services are often covered by insurance.

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

There is little stigma attached for receiving these services up to the age of three, although there may be some stigma attached for older children.

¹³ *NECTAC.org* <<http://nectac.org/topics/finance/statelegis.asp>>.

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

Although there are no definitive studies, the use of early intervention services may reduce the need for some future mental and possibly physical health services as children are able to function on a more age appropriate basis.

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

As premiums increase due to mandated benefits some employers choose to self-insure in order to have more control over the benefits that they provide to employees and to control the cost of health insurance premiums. There is no evidence that this benefit is not currently being offered by employers with self-insured plans.

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

Anthem estimates a premium increase of \$0.22 per member per month.

IV. Financial Impact of Mandating Benefits.

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

The cost of the service may increase to the extent coverage shifts to private insurance because services covered through IDEA Part C are paid by CDS at MaineCare reimbursement rates, which are typically lower than those paid by private payors.

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.*

Earlier access to the services may increase the appropriate use of the service to the extent that an individual had an insurance policy that did not cover these services and there was a wait to apply for IDEA Part C.

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

The mandated treatment would not serve as an alternative for other services.

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

LD 425 does not prohibit health plans from covering the services with the same medical management used for other services.

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

Since these services are being covered today through IDEA Part C and private insurance it is unlikely that the proposed coverage would affect the number or types of providers.

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

Based on 2008 utilization in Connecticut, Anthem estimated the impact as follows:

Small group:

	With co-pay		With co-insurance	
	PMPM	% Premium	PMPM	% Premium
HMO	\$ 0.21	0.04%	\$0.27 @ 0%	0.06%
PPO	\$ 0.21	0.04%	\$0.22 @ 20%	0.05%

Large group:

	With co-pay		With co-insurance	
	PMPM	% Premium	PMPM	% Premium
HMO	\$ 0.21	0.04%	\$0.27 @ 0%	0.06%
PPO	\$ 0.21	0.04%	\$0.22 @ 0%	0.05%

Anthem anticipates that similar increases would apply to individual products, although the increases will likely be higher because of the increased risk of adverse selection. They anticipate that there would be a slight increase in administrative costs. Indirect costs are unknown.

Aetna estimates an increase in premium of 0.2 percent of premium and Harvard Pilgrim estimates an increase of \$0.80 per member per month (PMPM).

Cigna was unable to estimate the increase but anticipated that there would be an increase.

A study conducted in Virginia for their early intervention mandate, which covers services up to \$5,000,¹⁴ estimated that the total premium increase for the coverage of early intervention services in 2007 was 1.06 percent for single individual coverage, 0.54 percent for family individual coverage, 1.00 percent for single group coverage, and 0.57 percent for family group coverage.¹⁵

The increase in claims cost and therefore premiums will depend on the

¹⁴ *Infantva.org* <<http://www.infantva.org/pr-InsuranceMandate.htm>>.

¹⁵ <http://leg1.state.va.us>

<<http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/01259cb33bfda80a852574f300483f70?OpenDocument>>.

increase in services that will be paid for by private insurance over what is currently being covered by private insurance, which would be less than the Virginia estimate. Currently, private insurance covers many of these services, but it is possible that families are receiving services through CDS as IDEA Part C instead of through their current insurance. Therefore the increase in claims costs will come from increases in insurance claims for policies that do not currently cover some early intervention services.

In other states there have been efforts to encourage patients to first submit their claims to private insurers before accessing public programs. Arizona, for example, will pay cost sharing for the individual, if they submit claims to their insurance company first.¹⁶

We estimate that if individuals file claims with their insurance company with passage of this mandate, the increase in premiums would be \$0.12 to \$0.24 PMPM, for an average of approximately \$0.18 PMPM or 0.05 percent (one-twentieth of one percent). This is based on our estimate of the percent of these services that are already being covered by insurance compared to what additional claims would be covered after the mandate was implemented. We also assumed that for each child, the maximum amount of \$3,200 would be spent per year per child. We made this assumption based on testimony concerning the total cost of early intervention services being significantly in excess of \$3,200 per year. Our estimate does not reflect any potential savings from possible reductions in the need for future health services because there are no definitive studies demonstrating or quantifying these savings.

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

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

8. *The impact on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.*

¹⁶ Azdes.gov <https://egov.azdes.gov/CMSInternet/uploadedFiles/Arizona_Early_Intervention_Program/tab_3_use_of_insurance.pdf>.

The intention is that these services would reduce the total cost of health care that would exist if the services were not available or used.

These services also reduce educational costs by minimizing the need for special education and related services after infants and toddlers with disabilities reach school age. In addition, they minimize the likelihood of institutionalization of individuals with disabilities and maximize the potential for their independent living in society, although there are no definitive studies demonstrating or quantifying these savings.

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

Since many of these services are being provided today, the mandate would not have a significant impact on the cost of health care. Some costs would be shifted from public payers to private insurance. As stated above, we estimate that the increase in premiums would be \$0.12 to \$0.24 PMPM including administrative cost. We do not anticipate any indirect costs.

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

To the extent that these services are covered by MaineCare or IDEA Part C and, after the mandate, will be paid for by private insurance, the cost will be shifted from the public payers to the private payers. Based on claims data provided by MaineCare for enrollees with other third party coverage, we estimate that up to \$250,000 could be shifted to insurance plans from MaineCare payments.

V. The Medical Efficacy of Mandating the Benefit.

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

Through the years, early intervention services have proven to be crucial to the healthy development of infants and toddlers with disabilities, minimizing their potential for developmental delay. "The sooner you can start working with a child, the better chance he has of reaching his potential in daily living," says Barbara Jarvis, special projects manager, Easter Seals North Georgia. "By focusing in on a child's needs early-on in their development, you are giving them the head start they need to keep up with their peers."¹⁷

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

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

This legislation does not require additional practitioners.

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

Coverage would include services from licensed occupational therapists, physical therapists, speech-language pathologists, or clinical social workers. All of these medical providers are licensed by state licensing boards in Maine, which assure the clinical proficiency of these providers.

¹⁷ *Easterseals.com* <http://www.easterseals.com/site/PageServer?pagename=ntl_early_intervention>.

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

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

Children are currently receiving federal and state coverage of early intervention services through the federal program IDEA Part C in Maine.¹⁸ Many of these children may also be covered by health insurance and many of the insurers in Maine do currently cover the benefits required by LD 425. The primary effect of mandating the benefit would be to shift some of the costs to private insurance from the current public programs providing the services. This could ensure continued access or improved access to early intervention services if CDS or MaineCare narrows the eligibility criteria.

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

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

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

The Bureau's estimates of the premium increases due to existing mandates are displayed in Appendix B. We anticipate that this bill would increase overall premiums by approximately \$0.18 PMPM, or 0.05 percent)percent (one-twentieth of one percent).

¹⁸ Source U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), OMB #1820-0557 "Infants and Toddlers Receiving Early Intervention Services in Accordance with Part C, " 2007. Data updated as of July 15, 2008.

VII. Appendices

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

Appendix B: Cumulative Impact of Mandates in Maine

Following are the estimated claim costs for the existing mandates:

- ♦ **Mental Health** (Enacted 1983) – The mandate applies only to group plans. It applies to all group HMO plans but does not apply to non-HMO employee group plans covering 20 or fewer employees. Mental health parity for listed conditions was effective 7/1/96 but does not apply to any employer with 20 or fewer employees, whether under HMO or other coverage. The list of conditions for which parity is required was expanded effective 10/1/03. Using annual experience reports from the carriers, the percentage of mental health claims paid has been tracked since 1984 and has historically been between 3% and 4% of total group health claims. The percentage was in the 3.27% to 3.47% range from 1998 to 2002 but then decreased, reaching 2.62% in 2007 and 2.60% in 2008. The percentage of claims is further broken out by HMO and other health plans, but the relationship is inconsistent from year to year. The continued decrease in mental health claims occurred despite the fact that an expansion of the list of conditions for which parity is required was fully implemented in 2005. We estimate a continuation of 2008 levels going forward. For HMO plans covering employers with 20 or fewer employees, we use half the value for larger groups to reflect the fact that parity does not apply. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent. However, this overstatement is at least partially offset by the fact that the data is an aggregate of all groups, while groups of 20 or fewer are exempt from the parity requirement in the case of HMO coverage and from the entire mandate in the case of non-HMO coverage.
- ♦ **Substance Abuse** (Enacted 1983) – The mandate applies only to groups of more than 20 and originally did not apply to HMOs. Effective 10/1/03, substance abuse was added to the list of mental health conditions for which parity is required. This applies to HMOs as well as other carriers. Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage showed a downward trend from 1989 to 2000 when it reached 0.31%. It then increased and leveled off at a range of 0.55% to 0.72% for 2002 through 2008 (low of 0.55% in 2008, high of 0.72% in 2006) despite implementation of the parity requirement. The long-term decrease was probably due to utilization review, which sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 to 34% in 2008. The percentage of claims is further broken out by HMO and other health plans, but the relationship is inconsistent from year to year. We estimate substance abuse benefits will remain at the current levels going forward. Although it is likely that some of these costs would be

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

- **Chiropractic** (Enacted 1986) – Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the percentage increased from 0.84% in 1994 to a high of 1.51% in 2000. Since then, it has decreased to 1.18% in 2008. In the past, the level was lower for individual than for group, but individual has increased to about the same level as group. The level does vary between HMOs and other plans. For 2008, the percentages were 1.30% for HMO plans and 1.06% for other plans. We estimate the current levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.
- **Screening Mammography** (Enacted 1990) – Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.7% in 2002 and has remained at about this level since then. There was no significant difference between HMO plans and other plans for group coverage. Recently, the U.S. Preventive Services Task Force recommended that screening mammograms begin at a later age and be done less frequently. While it is possible this will lead to reduced utilization, the American Cancer Society, the American College of Obstetricians and Gynecologists, and many oncologists have not accepted these recommendations. We therefore estimate the past level of 0.7% in all categories going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.
- **Dentists** (Enacted 1975) – This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.
- **Breast Reconstruction** (Enacted 1998) – At the time this mandate was being considered in 1995, Blue Cross and Blue Shield of Maine estimated the cost at \$0.20 per month per individual. We do not have a more recent estimate. We include 0.02% in

our estimate of the maximum cumulative impact of mandates.

- ♦ **Errors of Metabolism** (Enacted 1995) – At the time this mandate was being considered in 1995, Blue Cross estimated the cost at \$0.10 per month per individual. We do not have a more recent estimate. We include 0.01% in our estimate.
- ♦ **Diabetic Supplies** (Enacted 1996) – Our report on this mandate indicated that most of the 15 carriers surveyed in 1996 said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost \$.08 per month for an individual. Another said .5% of premium (\$.50 per member per month) and a third said 2%. We include 0.2% in our estimate.
- ♦ **Minimum Maternity Stay** (Enacted 1996) – Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.
- ♦ **Pap Smear Tests** (Enacted 1996) – No cost estimate is available. HMOs would typically cover these anyway. For non-HMO plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.
- ♦ **Annual GYN Exam Without Referral** (managed care plans) (Enacted 1996) – This only affects HMO plans and similar plans. No cost estimate is available. To the extent the Primary Care Physician (PCP) would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.
- ♦ **Breast Cancer Length of Stay** (Enacted 1997) – Our report estimated a cost of 0.07% of premium.
- ♦ **Off-label Use Prescription Drugs** (Enacted 1998) – The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our 1998 report did not resolve this conflict but stated a "high-end cost estimate" of about \$1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.
- ♦ **Prostate Cancer** (Enacted 1998) – No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for non-HMO plans would approximate \$0.10 per member per month. With the inclusion of administrative

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

- ♦ ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999) – This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.
- ♦ ***Coverage of Contraceptives*** (Enacted 1999) – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.
- ♦ ***Registered Nurse First Assistants*** (Enacted 1999) – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.
- ♦ ***Access to Clinical Trials*** (Enacted 2000) – Our report estimated a cost of 0.19% of premium.
- ♦ ***Access to Prescription Drugs*** (Enacted 2000) – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.
- ♦ ***Hospice Care*** (Enacted 2001) – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.
- ♦ ***Access to Eye Care*** (Enacted 2001) – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.
- ♦ ***Dental Anesthesia*** (Enacted 2001) – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.
- ♦ ***Prosthetics*** (Enacted 2003) – This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20 and 0.08% for small employer groups and individuals.
- ♦ ***LCPCs*** (Enacted 2003) – This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

- Licensed Pastoral Counselors and Marriage & Family Therapists (Enacted 2005) – This mandate requires coverage of **licensed pastoral counselors and marriage & family therapists**. Our report indicated no measurable cost impact for this coverage.
- **Hearing Aids** (Enacted 2007) – This mandate requires coverage for \$1,400 for each ear every 36 months for children age 18 and under. The mandate is phased-in by requiring coverage from birth to age 5 effective 1/08, age 6-13 effective 1/09 and age 14-18 effective 1/10. Our report estimated a cost of 0.1% of premium once fully implemented.
- **Infant Formulas** (Enacted 2008) – This mandate requires coverage for amino acid-based elemental infant formulas for children 2 years of age and under, regardless of delivery method. Our report estimated a cost of 0.1% of premium.
- **Colorectal Cancer Screening** (Enacted 2008) – This mandate requires coverage for colorectal cancer screening for persons fifty years of age or older, or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. No other carriers stated they denied coverage, therefore our report estimated no impact on premium.
- **Independent Dental Hygienist** (Enacted 2009) – This mandate requires individual dental insurance or health insurance that includes coverage for dental services to provide coverage for dental services performed by an independent practice dental hygienist. This mandate is effective 1/2010. This mandate applies only to policies with dental coverage, therefore there is no estimated impact on medical plan premiums.

These costs are summarized in the following table:

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Non-HMO	HMO
1975	Maternity benefits provided to married women must also be provided to unmarried women.	All Contracts	0 ¹	0 ¹
1975	Must include benefits for dentists' services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.10%	--
1975	Family Coverage must cover any children born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0 ¹	--
1983	Benefits must be included for treatment of alcoholism and drug dependency .+.01 -.01	Groups of more than 20	0.55%	0.55%

LD425, 124th Maine State Legislature
 An Act to Require Private Insurance Coverage for Certain Services for Children with Disabilities

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Non-HMO	HMO
1975 1983 1995 2003	Benefits must be included for Mental Health Services , including psychologists and social workers. +.50 -.40	Groups of more than 20	2.60%	2.60%
		Groups of 20 or fewer	--	1.30%
1986 1994 1995 1997	Benefits must be included for the services of chiropractors to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	Group	1.06%	1.30%
		Individual	1.06%	1.30%
1990 1997	Benefits must be made available for screening mammography .	Group	0.70%	0.70%
		Individual	0.70%	0.70%
1995	Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for metabolic formula and up to \$3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for maternity (length of stay) and newborn care, in accordance with "Guidelines for Prenatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat diabetes and approved self-management and education training.	All Contracts	0.20%	0.20%
1996	Benefits must be provided for screening Pap tests .	Group, HMOs	0.01%	0
1996	Benefits must be provided for annual gynecological exam without prior approval of primary care physician.	Group managed care	--	0.10%
1997	Benefits provided for breast cancer treatment for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%	0.07%
1998	Coverage required for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%	0.30%
1998	Coverage required for prostrate cancer screening .	All Contracts	0.07%	0
1999	Coverage of nurse practitioners and nurse midwives and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts	--	0.16%
1999	Prescription drug must include contraceptives .	All Contracts	0.80%	0.80%
1999	Coverage for registered nurse first assistants .	All Contracts	0	0
2000	Access to clinical trials .	All Contracts	0.19%	0.19%
2000	Access to prescription drugs .	All Managed Care Contracts	0	0
2001	Coverage of hospice care services for terminally ill.	All Contracts	0	0
2001	Access to eye care .	Plans with participating eye care professionals	0	0.04%
2001	Coverage of anesthesia and facility charges for certain dental procedures.	All Contracts	0.05%	0.05%

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Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Non-HMO	HMO
2003	Coverage for prosthetic devices to replace an arm or leg	Groups >20	0.03%	0.03%
		All other	0.08%	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0	0
2007	Coverage of hearing aids for children	All Contracts	0.1%	0.1%
2008	Coverage for amino acid-based elemental infant formulas	All Contracts	0.1%	0.1%
2008	Coverage for colorectal cancer screening	All Contracts	0	0
2009	Coverage for independent dental hygienist	All Contracts	0	0
	Total cost for groups larger than 20:		6.96%	7.32%
	Total cost for groups of 20 or fewer:		3.86%	5.52%
	Total cost for individual contracts:		3.85%	4.12%