A Report to the Joint Standing Committee on Banking and Insurance of the 118th Maine Legislature

Review and Evaluation of Proposed L.D. 1556, An Act to Establish the Breast Care Patient Protection Act - Mastectomy and Related Provisions

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EXECUTIVE SUMMARY

The Joint Standing Committee on Banking and Insurance requested this review and evaluation of LD 1556, "An Act to Establish the Breast Care Patient Protection Act." This report presents the findings with respect to the following provisions of LD 1556.

- Inpatient coverage following a mastectomy, lumpectomy or lymph node dissection for breast cancer for a period of time determined to be medically appropriate by the attending physician and patient.
- Written notice of the coverage to be provided to each enrollee.
- Terms may not be modified by the enrollee.

The distinction between breast cancer and breast disease which is being considered is expected to only have a negligible impact on the cost of the mandate. The breast disease definition is more inclusive and was reflected in our report.

An additional provision of LD 1556 expands the current mandated screening mammogram benefit. This provision has been evaluated in a separate report.

Mastectomy length of stay legislation is currently the issue being most frequently evaluated by State legislatures. Ninety-six mastectomy bills have been introduced in 30 states during the first quarter of 1997. Three states have passed this legislation.

Breast cancer is a significant health concern. The average woman has a one in eight risk of being diagnosed with breast cancer during her lifetime. More than 110,000 mastectomies are performed annually in the United States. It is estimated that approximately 550 mastectomies are performed each year in Maine. Health insurers in Maine currently provide coverage for the breast cancer treatments specified in LD 1556. However, concerns have arisen regarding restrictions that insurers may establish regarding the location of treatment (whether outpatient instead of inpatient) and length of inpatient hospital stay. These restrictions could lead to inappropriate care. The

frequency of such inappropriate care and whether this frequency is increasing or decreasing has not been measured. Professional health insurance organizations made policy statements which support the physician and patient decision on the location for breast removal.

More mastectomies are now being performed on an outpatient basis (from 1.6% in 1991 to 7.6% in 1995) and the average length of stay for mastectomy procedures has been decreasing (from 5.4 days in northeast region in 1991 to 3.9 days in 1995). However, it is not clear that these developments have lead to an increase in inappropriate care. Medical studies indicate a relatively high level of patient satisfaction with mastectomies performed at an outpatient setting and indicate some positive psychological advantages.

Several issues with respect to patient concerns with managed health care arise in the consideration of the mandates evaluated in this report:

- Would managed health care activities that attempt to most efficiently provide high quality care be disrupted?
- Should patients be protected by legislation, or the marketplace, from managed health care activities which sacrifice quality of care to increase profits?
- Should regulation on managed health care activities proceed on a comprehensive basis or address specific areas of concern? Are the concerns with respect to breast cancer sufficient to merit unique consideration?

The key consideration is how to obtain the benefits from managed health care activities while protecting the interests of patients.

BACKGROUND

The Joint Standing Committee on Banking and Insurance of the 118th Maine Legislature requested that the Bureau of Insurance prepare a review and evaluation of LD 1556 "An Act to Establish to Breast Cancer Patient Protection Act." The Bureau of Insurance has contracted with William M. Mercer, Incorporated to prepare the review and evaluation. This review has been conducted consistent with the criteria outlined in 24-A M.R.S.A. § 2752. This criteria is to consider the social impact, financial impact and medical efficacy of the proposed act. The Joint Standing Committee on Banking and Insurance requested that the review reflect an amendment to LD 1556 which was proposed on April 11, 1997 and the impact of expanding the language to require coverage for breast disease instead of breast cancer. This report presents the findings from this requested review and evaluation for the LD 1556 provisions related to mastectomy, lumpectomy or lymph node dissection for breast disease. A separate report presents the findings for the screening mammogram provision in LD 1556.

Amended LD 1556 requires group and individual health insurance policies to provide inpatient coverage following a mastectomy, lumpectomy, or lymph node dissection for treatment of breast cancer for a period of time determined to be medically appropriate by the attending physician and patient. The amendment replaced a provision in LD 1556 which required a specified minimum length of coverage for those procedures.

Additional provisions of LD 1556 require that written notice of the coverage be provided to each enrollee and that the terms and conditions of the coverage may not be modified by the enrollee to be less than the required minimum coverage.

Throughout this report, these provisions (i.e., period of time determined by physician and patient, reconstruction, notification and modification of terms) are referred to as being the mastectomy and related provisions in LD 1556.

There are currently no statutes in the State of Maine which mandate coverage for mastectomy and related procedures, with the exception of reconstructive surgery following a mastectomy.

SOCIAL IMPACT

The M.R.S.A. statute includes a list of specific questions which must be addressed in reviewing the social impact of mandated benefits legislation. Those questions and our findings with respect to the mastectomy and related provisions in LD 1556 are as follows:

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

Breast cancer is the most common form of cancer in women in the United States. The average woman faces a one in eight lifetime risk of being diagnosed with breast cancer. Breast cancer is the leading cause of death in the United States for women between the ages of 40 and 55. It is estimated that there were more than 185,000 new cases of female breast cancer in the United States in 1996. Nearly 45,000 women have died from this disease in the United States in 1996. More than 110,000 mastectomies were performed in the United States in 1995. It is estimated that approximately 550 mastectomies are performed each year in Maine.

The risk of women developing breast cancer has been increasing. The incidence of breast cancer has been increasing at an annual rate of 1% for the past 50 years.

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

Breast cancer treatment is available to Maine residents. Breast cancer can often be treated effectively, especially if detected early, through mastectomy, lumpectomy or lymph node dissection followed by radiation therapy. The surgery may involve removing the entire breast (total mastectomy) or removing only the affected tissue (partial mastectomy).

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

Insurance coverage for mastectomy, lumpectomy or lymph node is already available in Maine. Health insurance policies covering hospital services currently provide benefits for medically appropriate mastectomy, lumpectomy, or lymph node treatment and breast reconstruction. The mastectomy and related provisions would prohibit insurers from requiring treatments for mastectomy, lumpectomy, or lymph node dissection which would be contrary to the desires of the physician and patient. In particular, a concern has been raised that these treatments would be required to be performed at an outpatient setting and this would result in inappropriate care.

The Blue Cross Blue Shield Association and the American Association of Health Plans made the following policy statements with respect to mastectomy and related provisions.

- "Blue Cross and Blue Shield Plan coverage policies support the physician-patient decision on whether to perform breast removal surgery on an inpatient or outpatient basis. The physician decision related to the medically appropriate site of care and length of stay should be based on the best available scientific information, clinical evidence, and the unique needs of the patient."

- "It is the policy of the American Association of Health Plans that the decision about whether outpatient or inpatient care best meets the needs of a woman undergoing removal of a breast should be made by the woman's physician after consultation with the patient. Health plans do not and should not require outpatient care for removal of a breast. As a matter of practice, physicians should make all medical treatment decisions based on the best available scientific information and the unique characteristics of each patient."

A summary of commercial insurance organizations coverage of mastectomy and related treatments is provided as Appendix B. Blue Cross Blue Shield of Maine indicated that coverage was provided on an outpatient basis with approval for inpatient treatment if complications occur. The other three commercial insurers surveyed indicated that coverage was provided as recommended by the physician.

A summary of coverage for mastectomy and related provision provided by HMOs can also be found in Appendix B.

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:"

Coverage for mastectomy, lumpectomy, or lymph node dissection and reconstructive surgery is generally available through commercial insurance sold in the State of Maine. The mandate specifies that mastectomy, lumpectomy, or lymph node dissection treatment for breast cancer cover the location and length of hospital stay determined to be medically appropriate by the attending physician and patient. The concern is that health insurers would impose requirements for treatments for breast cancer at an outpatient setting or an early discharge from a hospital which would deprive the patient of necessary care.

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:"

Financial hardship would be a consideration in the situation where a patient desires treatment at an inpatient setting and the insurer requires alternative treatment (i.e., either outpatient or at home) in order for the services to be covered. As mentioned in the response to social impact question #3, Blue Cross

and Blue Shield of Maine provides coverage for inpatient treatment only if complications arise.

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

The public and providers have raised concerns that health insurers would require treatment periods for mastectomy, lumpectomy, or lymph node dissection which would not be appropriate or acceptable. Some health insurers in Maine have protocols which specify that some mastectomies, lumpectomies, or lymph node dissections should be performed at an outpatient setting.

As evidence of these concerns, President Clinton named a commission to protect patients from arbitrary rules and assure that quality care is not sacrificed for profits. The commission is charged to develop a "Consumer Bill of Rights." The Health Care Financing Administration banned all managed care plans that contract with Medicare from performing mastectomies at an outpatient setting.

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:"

The previous mentioned concerns for these treatments is connected with the demand for coverage since mastectomy and related procedures are expensive and beyond the ability of most people to pay out-of-pocket. For example, the average hospital charge per admission for a total mastectomy (DRG 258) was $6,870 in the United States in 1995.

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

No information was available regarding the level of interest from collective bargaining organizations.

9. "The likelihood of achieving the objectives of meeting the consumer needs as evidenced by the experience of other states:"

Mastectomy mandated length of stay benefits is currently the issue being most frequently evaluated by State legislatures. Ninety-six mastectomy bills were introduced in State legislatures during the first quarter of 1997. Twenty-three states are evaluating mandated minimum lengths of stay for mastectomy, lumpectomy, or lymph node dissection. Seven additional states (including Maine) are considering that mandating lengths of stay for the mastectomy and related services be determined by the physician and patient. The Blue Cross Blue Shield Association reported that mandated lengths of stay for mastectomy, lumpectomy, or lymph node dissection has been rejected in Iowa and Maryland, and has been deferred for further study in Virginia and Wisconsin. Three states recently passed similar mandated mastectomy legislation.

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

The Maine Bureau of Health did not provide findings with respect to the social impact of these mandated benefits.

11. "The alternatives to meeting the identified need:"

No alternatives are available.

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

The primary role of health insurance is to provide financial protection from catastrophic illnesses. Coverage for the mastectomy and related provisions is currently available and is consistent with the role of health insurance.

The escalating cost of health insurance led to developments referred to as managed health care. In managed health care, insurers and providers attempt to most efficiently deliver quality health care through negotiated arrangements and through following medical protocols. This mandate would disrupt managed health care activities by removing the influence that insurers could have on the location and length of treatment for these mastectomies and related procedures. Whether this is desirable or undesirable depends on the determination of whether managed care is beneficial through efficiently delivering high quality care or is harmful through sacrificing quality to reduce costs. Related issues are whether regulation or the market should make this determination and whether breast cancer should be uniquely regulated.

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

No social stigma is attached to this mandated benefit.

14. "The impact of this benefit upon the availability of other benefits currently being offered:"

The cost of this mandate is small. Any impact on the availability of other benefits would be too insignificant to detect.

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

Based solely on the impact of this mandate, the small financial impact should not influence employers to shift to self-insurance plans.

FINANCIAL IMPACT

The M.R.S.A. statute includes a list of specific questions which must be addressed in reviewing the financial impact of mandated benefits legislation. Those questions and our findings with respect to the mastectomy and related provisions in LD 1556 are as follows.

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:"

The proposed mandate would have a negligible impact on the unit cost of mastectomy and related services. There is a possibility that inpatient lengths of stay would increase and that a portion of the small number of services currently performed at an outpatient setting would be moved to an inpatient setting. Some of these procedures would probably continue to be provided at an outpatient setting. These developments could tend to slightly increase the unit cost of outpatient treatments due to spreading fixed costs over a smaller volume of services. The unit cost of inpatient treatment could have a slight decrease. These impacts would be negligible and mostly offsetting.

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:"

As mentioned above, the proposed mandate would increase inpatient lengths of stay and move the location of some mastectomy procedures from an outpatient to an inpatient setting. The concern is that health insurer requirements for breast cancer treatments at outpatient setting or for an early discharge from a hospital would deprive patients of appropriate care. The medical perspective on the appropriateness of these treatments is presented in the Medical Efficacy section of this report.

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 mandate would lead to changes in the location of mastectomy services and lead to longer inpatient lengths of stay. More mastectomy procedures would be performed on an inpatient basis. Services performed at an inpatient location are more expensive than those performed on an outpatient location. The concern is whether mastectomies currently performed at an outpatient location result in an acceptable quality of care.

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

The proposed mandate places the determination of the treatment period at the discretion of the physician and patient. Utilization would now depend solely on the physician perspective on the appropriateness of the services and the personal preferences of the patient. Costs would continue to be managed through negotiated arrangements between insurers and providers.

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

The shift of a few treatments from an outpatient to an inpatient setting and an increase in the inpatient length of stay would have only a minimal impact on the number and types of providers.

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 the policyholder:"

The mastectomy and related provisions in LD 1556 is expected to result in an extremely small increase in insurance premiums. Although breast cancer is a significant health concern for women in Maine, mastectomies and related provisions represent only a very small portion of total surgical procedures. Our estimate is that health insurance premiums would increase by .07% (or .0007). Most of this increase is assumed to be caused by longer lengths of inpatient stay (i.e., an additional 1.5 days per stay.) A much smaller portion of this increase (approximately 5% of the total) is assumed to be caused by transferring one-half of the mastectomies performed at an outpatient setting to an inpatient setting.

The distinction between breast cancer and breast disease which is being considered is expected to only have a negligible impact on the cost of the mandate. The breast disease definition is more inclusive and was reflected in the .07% cost estimate.

Administrative expenses of health insurers would increase very slightly as a result of unique treatment for these mastectomy and related procedures and the notification requirements of the legislation.

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:"

The mandated mastectomy and related provisions are expected to result in a negligible increase in indirect costs. Examples of indirect costs are lost work time and training new employees. Employees may be out of work longer if inpatient lengths of stay increase and these treatments which can be appropriately performed at an outpatient location are instead performed at an inpatient location.

However, it is expected that the overall impact on indirect costs would be negligible.

8. "The impact of this coverage on the total cost of health care:"

The total cost of health care would increase very slightly as a result of this mandate. This small increase in total costs (.07%) would be partially offset from avoiding costs arising from correcting any problems which arise from inappropriate treatments.

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:"

The small increase to the insurance premium is not expected to lead to measurable decreases in the number of people or the range of benefits covered.

MEDICAL EFFICACY

The M.R.S.A. statute includes a list of specific questions which must be addressed in reviewing the medical efficacy of mandated benefits legislation. Those questions and our findings with respect to the mastectomy and related provisions in LD 1556 are as follows:

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:"

The portion of mastectomies performed in the United States at an outpatient setting has increased from 1.6% in 1991 to 7.6% in 1995. More than 110,000 mastectomies were performed in the United States in 1995. The average inpatient length of stay of mastectomy procedures in the Northeast region of the United States has decreased from 5.4 days in 1991 to 3.9 days in 1995. Some situations in which complications arose from inappropriate outpatient mastectomies have received public attention. Charges have been made that women were too often inappropriately discharged early from hospitals after "drive-through" mastectomies and that this practice would increase in the future. Legislation is being introduced in many states and at the federal level to mandate specified treatments for mastectomies.

However, some medical studies have indicated a high patient acceptance of current mastectomy treatments. For example, a study found in the April 1992 edition of *The American Surgeon* indicated that 81.5% of women receiving a radical mastectomy thought their discharge from the hospital the day after the mastectomy was appropriate. Ninety-two percent indicated they subsequently have had no medical difficulties. Studies published in *The American Surgeon,* December 1994 and February 1996, indicated that the quality of care was not

adversely impacted by outpatient treatment. The studies indicated that many patients received psychological advantage through having a better attitude toward recovery.

Although the proportion of outpatient treatment for mastectomy, lumpectomy, or lymph node dissection has increased, it cannot be conclusively stated that insurance company interference has materially increased the frequency of inappropriate care. In many situations, it appears that patients prefer and are comfortable with outpatient treatments.

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

The proposed mandate would not provide coverage for an additional class of practitioners.

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

Not applicable

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

Not applicable

BALANCING THE EFFECTS

The effects of balancing the social, economic, and medical efficacy considerations in the evaluation of the screening mastectomy, lumpectomy, or lymph node dissection provision in LD 1556 are addressed through the following comments.

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

Mandating these mastectomy and related provisions would provide greater assurance that these treatments would meet physician and patient desires with respect to location and length of stay. The cost of this mandate is the additional inpatient services for breast cancer which may or may not be medically appropriate.

There have been some publicized situations where inappropriate breast cancer treatment has been provided through insurer requirements. However, studies have indicated overall high patient satisfaction with some outpatient treatments for breast disease. Major insurers and HMOs have issued statements indicating support for the physician-patient decision on treatments. Their implication is that this mandate is not necessary since their practices are consistent with the desires of the mandate. The concern is whether the market will respond to eliminate inappropriate care for breast disease or whether regulatory intervention is necessary to assure that appropriate care is provided to breast cancer patients.

In the review of literature on this topic, several critics referred to a 'body part by body part' approach to managed health care legislation and questioned whether it is appropriate to only designate breast cancer for unique regulations. However, breast cancer is a significant health issue and abuses in these treatments have raised public concern.

While the cost of this bill and others in front of the legislature (mammograms and prostate screenings) may appear to be minimal when studied on an isolated basis, the cumulative costs of all mandates could adversely affect the health insurance system. Economic theory shows that as the cost of health insurance increases so does the number of uninsured.

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

The complexities and related administrative expenses make it impractical to mandate the availability of coverage. The additional cost of the mandate is quite small and coverage is currently provided from these services.

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118th MAINE LEGISLATURE

FIRST REGULAR SESSION-1997

Legislative Document No. 785

H.P. 594 House of Representatives, February 4, 1997

An Act to Require Certain Practices by Managed Care Plans.

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

JOSEPH W. MAYO, Clerk

Presented by Representative AHEARNE of Madawaska.

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

Sec. 1. 24 MRSA §2320-C, as enacted by PL 1995, c. 295, §1, is repealed and the following enacted in its place:

§2320-C. Coverage for mastectomy surgery

1. Reconstructive surgery. All individual and group nonprofit and medical services plan contracts and all nonprofit health care plan contracts providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

2. Hospital stay. With respect to managed care plans, all individual and group nonprofit and medical services plan contracts and all nonprofit health care plan contracts providing coverage for mastectomy surgery must provide coverage for a minimum of 48 hours of in-patient hospital care following mastectomy surgery unless the patient and the physician elect a shorter hospital stay.

Sec. 2. 24-A MRSA §2745-C, as corrected by RR 1995, c. 1, §15, is repealed and the following enacted in its place:

§2745-C. Coverage for mastectomy surgery

1. Reconstructive surgery. All individual health policies providing coverage for mastectomy surgery, except those designed to cover only specific diseases, hospital indemnity or accidental injury, must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

2. Hospital stay. With respect to managed care plans, all individual health policies providing coverage for mastectomy surgery, except those designed to cover only specific diseases, hospital indemnity or accidental injury, must provide coverage for a minimum of 48 hours of in-patient hospital care following mastectomy surgery unless the patient and the physician elect a shorter hospital stay.

Sec. 3. 24-A MRSA §2837-C, as corrected by RR 1995, c. 1, §17, is repealed and the following enacted in its place:

§2837-C. Coverage for mastectomy surgery

1. Reconstructive surgery. All group health policies providing coverage for mastectomy surgery, except those designed to cover only specific diseases, hospital indemnity or accidental injury, must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

2. Hospital stay. With respect to managed care plans, all group health policies providing coverage for mastectomy surgery, except those designed to cover only specific diseases, hospital indemnity or accidental injury, must provide coverage for a minimum of 48 hours of in-patient hospital care following mastectomy surgery unless the patient and the physician elect a shorter hospital stay.

Sec. 4. 24-A MRSA §4237, as corrected by RR 1995, c. 1, §21, is repealed and the following enacted in its place:

§4237. Coverage for mastectomy surgery

1. Reconstructive surgery. All individual or group coverage subject to this chapter that provides for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

2. Hospital stay. With respect to managed care plans, all individual or group coverage subject to this chapter that provides for mastectomy surgery must provide coverage for a minimum of 48 hours of in-patient hospital care following mastectomy surgery unless the patient and the physician elect a shorter hospital stay.

Sec. 5. 24-A MRSA §4303, sub-§5 is enacted to read:

5. Prohibition on incentives to providers. A carrier offering a managed care plan may not provide a payment or other financial incentive to a participating provider for not referring enrollees in the managed care plan to a specialist and for not disclosing the seriousness of an enrollee's condition.

SUMMARY

This bill requires managed care plan policies and contracts offered by nonprofit hospital, medical or health plan services

organizations, insurers and health maintenance organizations to provide in-patient hospital coverage following mastectomy surgery.

The bill also prohibits nonprofit hospital, medical or health plan services organizations, insurers and health maintenance organizations offering managed care plans from providing payments or other financial incentives to participating providers for not referring patients to specialists and for not disclosing the seriousness of a patient's condition.

118th MAINE LEGISLATURE

FIRST REGULAR SESSION-1997

Legislative Document **No. 1556**

H.P. 1113 House of Representatives, March 18, 1997

An Act to Establish the Breast Care Patient Protection Act

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

JOSEPH W. MAYO, Clerk

Presented by Representative DAVIDSON of Brunswick.
Cosponsored by Senator GOLDTHWAIT of Hancock and
Representatives: AHEARNE of Madawaska, BRUNO of Raymond, KONTOS of Windham, MAYO of Bath, MITCHELL of Portland, SAXL of Bangor, Senators: ABROMSON of Cumberland, LaFOUNTAIN of York.

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

Sec. 1. 24 MRSA §2320-C, as corrected by RR 1995, c. 1, §13, is repealed and the following enacted in its place:

§2320-C. Coverage for mastectomy surgery

All individual and group nonprofit and medical services plan contracts and all nonprofit health care plan contracts providing coverage for mastectomy surgery must provide coverage for:

1. Inpatient care. Not less than 48 hours of inpatient care following a mastectomy.

Nothing in this subsection may be construed to require the provision of not less than 48 hours of inpatient coverage when the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual and group nonprofit and medical services plan contract or a nonprofit health care plan contract may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this subsection.

All individual and group nonprofit and medical services plan contracts and all nonprofit health care plan contracts must provide immediate written notice prominently positioned in any literature or correspondence to each enrollee under the contract regarding the coverage required by this subsection; and

2. Reconstruction. Reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 2. 24 MRSA §2320-F is enacted to read:

§2320-F. Coverage of lymph node dissection for treatment of breast cancer

All individual and group nonprofit medical services plan contracts and all nonprofit health care plan contracts providing coverage for lymph node dissection for treatment of breast cancer must provide not less than 24 hours of inpatient care following a lymph node dissection.

Nothing in this section may be construed to require the provision of not less than 24 hours of inpatient coverage when

the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this section, an individual and group nonprofit medical services plan or nonprofit health care plan contract may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this section.

All individual or group nonprofit and medical services plan contracts and all nonprofit health care plan contracts must provide immediate written notice prominently positioned in any literature or correspondence to each enrollee under the plan regarding the coverage required by this section.

Sec. 3. 24-A MRSA §2745-C, as corrected by RR 1995, c. 1, §15, is repealed and the following enacted in its place:

§2745-C. Coverage for mastectomy surgery

All individual health policies providing coverage for mastectomy surgery, except those designed to cover only specific diseases, hospital indemnity or accidental injury must provide coverage for:

1. Inpatient care. Not less than 48 hours of inpatient care following a mastectomy.

Nothing in this subsection may be construed to require the provision of not less than 48 hours of inpatient coverage when the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual health policy may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this subsection.

All individual health policies must provide immediate written notice prominently positioned in any literature or correspondence to each enrollee under the policy regarding the coverage required by this subsection; and

2. Reconstruction. Reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 4. 24-A MRSA §2745-E is enacted to read:

§2745-E. Coverage for lymph node dissection for treatment of

breast cancer

All individual health policies providing coverage for lymph node dissection must provide not less than 24 hours of inpatient care following a lymph node dissection for treatment of breast cancer.

Nothing in this section may be construed to require the provision of not less than 24 hours of inpatient coverage when the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this section, an individual health policy may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this section.

All individual health policies subject to this section must provide immediate written notice prominently positioned in any literature or correspondence to each enrollee under the policy regarding the coverage required by this section.

Sec. 5. 24-A MRSA §2837-C, as corrected by RR 1995, c. 1, §17, is repealed and the following enacted in its place:

§2837-C. Coverage for mastectomy surgery

All group health policies providing coverage for mastectomy surgery, except those designed to cover only specific diseases, hospital indemnity or accidental injury must provide coverage for:

1. **Inpatient care.** Not less than 48 hours of inpatient care following a mastectomy.

Nothing in this subsection may be construed to require the provision of not less than 48 hours of inpatient coverage when the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, a group health policy may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this subsection.

All group health policies subject to this subsection must provide immediate written notice prominently positioned in any literature or correspondence to each enrollee under the group health policy regarding the coverage required by this subsection; and

2. **Reconstruction.** Reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient

elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 6. 24-A MRSA §2837-F is enacted to read:

§2837-F. Coverage for lymph node dissection for treatment of breast cancer

All group health policies providing coverage for lymph node dissection must provide not less than 24 hours of inpatient care following a lymph node dissection for treatment of breast cancer.

Nothing in this section may be construed to require the provision of not less than 24 hours of inpatient coverage when the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this section, a group health policy may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this section.

All group health policies subject to this section must provide immediate written notice prominently positioned in any literature or correspondence to each enrollee under the group health policy regarding the coverage required by this section.

Sec. 7. 24-A MRSA §4237, as corrected by RR 1995, c. 1, §21, is repealed and the following enacted in its place:

§4237. Coverage for mastectomy surgery

All individual or group coverage subject to this chapter that provides for mastectomy surgery must provide coverage for:

1. Inpatient care. Not less than 48 hours of inpatient care following a mastectomy.

Nothing in this subsection may be construed to require the provision of not less than 48 hours of inpatient coverage when the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual or group coverage contract may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this subsection.

All individual or group coverage subject to this subsection must provide immediate written notice prominently positioned in any literature or correspondence to each enrollee under the

individual or group coverage contract regarding the coverage required by this subsection; and

2. Reconstruction. Reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 8. 24-A MRSA §4243 is enacted to read:

§4253. Coverage for lymph node dissection for treatment of breast cancer

All individual or group coverage subject to this chapter that provides coverage for lymph node dissection must provide not less than 24 hours of inpatient care following a lymph node dissection for treatment of breast cancer.

Nothing in this section may be construed to require the provision of not less than 24 hours of inpatient coverage when the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirement of this section, an individual or group coverage contract may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this section.

All individual or group coverage subject to this section must provide immediate written notice prominently positioned in any literature or correspondence to each enrollee under the individual or group coverage contract regarding the coverage required by this section.

SUMMARY

This bill requires that medical insurance coverage provide a patient with not less than 48 hours of inpatient care following a mastectomy and not less than 24 hours of inpatient care following a lymph node dissection for treatment of breast cancer.

Committee: BAN **PROPOSED COMMITTEE AMENDMENT**
LA: CMM
File Name:G:\OPLAGEA\COMMTTEE\BAN\AMENDMTS\033202.DOC
LR (item)#: 0332 (02)
New Title?: Y
Add Emergency?: N
Date: April 11, 1997

COMMITTEE AMENDMENT "." TO L.D. 1556, An Act to Establish the Breast Care Patient Protection.

Amend the bill by striking out title and inserting in its place the following:

An Act to Establish the Breast Care Patient Protection Act

Further amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

Sec. 1. 24 MRSA § 2320-A, sub-§ 2 is repealed and the following enacted in its place:

2. Required coverage. All individual and group nonprofit medical services plan contracts and all nonprofit health care plan contracts must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Human Services' rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women age 40 and over.

Sec. 2. 24 MRSA §2320-C, as corrected by RR 1995, c. 1, §13, is repealed and the following enacted in its place:

§2320-C. Coverage for breast cancer treatment

1. Inpatient care. All individual and group nonprofit and medical services plan contracts and all nonprofit health care plan contracts providing coverage for medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual and group nonprofit and medical services plan contract or a nonprofit health care plan contract may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this subsection.

All individual and group nonprofit and medical services plan contracts and all nonprofit health care plan contracts must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. Reconstruction. All individual and group nonprofit and medical services plan contracts and all nonprofit health care plan contracts providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 3. 24 MRSA §2745-A, sub-§2 is repealed and the following is enacted in its place:

2. Required coverage. All individual insurance policies that cover radiologic procedures, except those designed to cover only specific diseases, accidental injury or dental procedures, must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Human Services' rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women age 40 and over.

Sec. 4. 24-A MRSA §2745-C, as corrected by RR 1995, c. 1, §15, is repealed and the following enacted in its place:

§2745-C. Coverage for breast cancer treatment

1. Inpatient care. All individual health policies providing coverage for medical and surgical benefits, except those designed to cover only specific diseases, hospital indemnity or accidental injury, shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual health policy may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this subsection.

All individual health policies must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. **Reconstruction.** All individual health policies providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 5. 24-A MRSA §2837-A, sub-§2 is repealed and the following is enacted in its place:

2. **Required coverage.** All group insurance policies that cover radiologic procedures, except those policies that cover only dental procedures, accidental injury or specific diseases, must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Human Services relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women age 40 and over.

Sec. 6. 24-A MRSA §2837-C, as corrected by RR 1995, c. 1, §17, is repealed and the following enacted in its place:

§2837-C. Coverage for breast cancer treatment

1. **Inpatient care.** All group health policies providing coverage for medical and surgical benefits, except those designed to cover only specific diseases, hospital indemnity or accidental injury, shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, a group health policy may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this subsection.

All group health policies must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. Reconstruction. All group health policies providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 7. 24-A MRSA §4237, as corrected by RR 1995, c. 1, §21, is repealed and the following enacted in its place:

§4237. Coverage for breast cancer treatment

1. Inpatient care. All individual or group coverage subject to this chapter that provides for mastectomy surgery providing coverage for medical and surgical benefits, except those designed to cover only specific diseases, hospital indemnity or accidental injury, shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual or group coverage contract may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required under this subsection.

All individual or group coverage subject to this subsection must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to

the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. Reconstruction. All individual or group coverage subject to this chapter that provides coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 7. 24-A MRSA § 4237-A is enacted to read:

§ 4237-A. Screening mammograms

1. Definition. For purposes of this section, "screening mammogram" means a radiologic procedure that is provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast.

2. Required coverage. All individual and group coverage subject to this chapter must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Human Services' rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women age 40 and over.

SUMMARY

This amendment replaces the bill and requires that medical insurance coverage provide inpatient coverage for a period of time as determined by the physician and patient to be medically appropriate following a mastectomy, lumpectomy or a lymph node dissection for treatment of breast cancer.

The amendment also requires insurance coverage for annual mammograms for women age 40 and over and extends the provisions requiring coverage for annual mammograms to health maintenance organizations.

Summary of Health Maintenance Organizations Coverage of Mastectomy Length of Stays

Company	Type of Coverage
Healthsource	They have guidelines on practices that physicians should follow, but coverage is completely based on physician recommendations.
Harvard/Pilgrim Health Plan	There is no limitation of length of stay, coverage is based solely on physician's recommendations.
NYL Care of Maine	Coverage is based solely on physician's recommendations..
Blue Cross HMO	They cover these procedures as recommended by the physician.

Summary of Commercial Insurance Organizations Coverage of Mastectomy Length of Stays

Company	Type of Coverage
Blue Cross Blue Shield	Covered on an ambulatory basis (outpatient). If complications occur, approval for inpatient stay will be given after consultation with physician.
The Guardian	Covered as recommended by the physician.
Allmerica Financial	Determined on a case by case basis. They work closely with the physician to determine the length of stay.
CIGNA	Cover procedures as ordered by the physician.

STATE OF MAINE

ONE HUNDRED AND EIGHTEENTH LEGISLATURE

COMMITTEE ON BANKING AND INSURANCE

April 16, 1997

Rick Diamond
Senior Life and Health Actuary
Life and Health Division
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Mr. Diamond:

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

LD 1556 An Act to Establish the Breast Cancer Patient Protection Act

A copy of the bill is enclosed. Also enclosed is a proposed amendment to the bill discussed by the committee in advance of its decision to ask the Bureau to conduct a review and evaluation of the legislation. The amendment replaces the language in the bill that requires coverage for inpatient care of 48 hours and 24 hours respectively with language that requires coverage for inpatient care of a length determined as medically appropriate by the physician and patient. The amendment also proposes to amend the current statutory requirements for screening mammograms to require coverage for annual mammograms for women over age 40. The committee would ask that the Bureau conduct its review and evaluation in relation to the proposed amendment and address the social and financial impact and medical efficacy of adding the mammogram provision to the bill.

In addition, a suggestion was made to expand the language to require coverage for inpatient care for the treatment of breast disease, not only the treatment of breast cancer.

The committee would request that the study address, if possible, the impact of this expanded language if it were included in the bill.

Please prepare the evaluation using the guidelines set out in 24-A § 2752 and submit the report to the committee during the week of May 5th if possible. The committee would also ask that the report on LD 1060 requested by the committee in a prior letter also be submitted within this time frame. The committee has a deadline of May 9th to complete its work on all bills in light of the statutory adjournment date of May 31st set by the President of the Senate and the Speaker of the House.

If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,

Lloyd P. LaFountain, III
Senate Chair

Jane W. Saxl
House Chair

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
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BRIAN K. ATCHINSON
SUPERINTENDENT

RICHARD H. DIAMOND, FSA, MAAA
LIFE & HEALTH ACTUARY
Direct Dial (207) 624-8428
E-mail: Richard.H.Diamond@state.me.us

April 23, 1997

Senator Lloyd LaFountain, Chair
Representative Jane Saxl, Chair
Banking and Insurance Committee
115 State House Station
Augusta, ME 04333

Re: LD 1060 - An Act to Provide Health Insurance Coverage for Prostate Cancer Screening
LD 1556 - An Act to Establish the Breast Care Patient Protection Act
Requests for Review and Evaluation
Your Letters of March 11, 1997 and April 16, 1997

Dear Senator LaFountain and Representative Saxl:

The Bureau of Insurance would be pleased to provide the requested reports. As you know, we will employ a consultant, Tim Harrington of William M. Mercer, Inc., to prepare the reports.

When the Committee determined on April 9 that LD 1060 would be its top priority, Mr. Harrington indicated he could complete a report within four weeks, or by May 7. However, that did not include time for the Bureau's internal review of the report and any resulting changes to the report. We would like to add a week for this process, resulting in a final report by May 14. We will make every effort to provide the report sooner if possible.

For LD 1556, as amended, Mr. Harrington has again indicated that he can complete his report within four weeks, or by May 14. As with LD 1060, we would request an additional week for internal review and changes to the report, with a final report by May 21. Again, we will make every effort to provide the report sooner if possible.

Sincerely,

Richard H. Diamond, FSA, MAAA
Life & Health Actuary

cc: Colleen McCarthy-Reed