A Report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services of the 130th Maine Legislature

Review and Evaluation of LD 1357
An Act to Require Private Insurance Coverage for Postpartum Care

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I. Executive Summary

The Joint Standing Committee on Health Coverage, Insurance and Financial Services (Committee) of the 130th Maine Legislature directed the Bureau of Insurance (Bureau) to review LD 1357 An Act to Require Private Insurance Coverage for Postpartum Care. The review was conducted as required by 24-A M.R.S.A § 2752 to answer prescribed questions about the bill including the estimated cost. This document and review are a collaborative effort of NovaRest, Inc. and the Bureau of Insurance, and are intended to respond to the Committee's request.

LD 1357 is to be reviewed and evaluated using the amendment proposed by Sen. Carney, the bill's sponsor, clarifying the intent that the bill apply to both individual and group health insurance policies. We understand the bill to apply to the individual, small group, and large group markets.

LD 1357 proposes that an insurer or health maintenance organization that issues individual and group contracts providing maternity benefits shall provide coverage for services related to postpartum care,[1] including coverage for development of a postpartum care plan; contact with the patient 3 weeks at the end of pregnancy; a comprehensive postpartum visit, including a full assessment of the patient's physical, social and psychological well-being; treatment of complications of pregnancy and childbirth, including pelvic floor disorders and postpartum depression; assessment of risk factors for cardiovascular disease; and care related to pregnancy loss. Coverage must encompass the recommendations outlined in the "Optimizing Postpartum Care" opinion published May 2018 by the American College of Obstetricians and Gynecologists (ACOG), support postpartum care as an ongoing process rather than an isolated visit, and include services and support necessary to transition a patient to a healthy and stable condition.

This report includes information from several sources to provide more than one perspective on the proposed mandate with the intention of providing a totally unbiased report. As a result, there may be some conflicting information within the contents. Although we only used sources that we considered credible, we do not offer any opinions regarding whether one source is more credible than another, leaving it to the reader to develop his/her own conclusions.

The Affordable Care Act (ACA) describes a broad set of benefits that must be included in any Essential Health Benefits (EHB) package. In its December 2011 bulletin, the Department of Health and Human Services (HHS) provided guidance on the types of health benefit plans each state could consider when determining a benchmark EHB plan for its residents. Each state had the opportunity

[1] Postpartum care includes care for live birth, miscarriage, and still born births.

to update its benchmark plan effective for 2017. Maine has chosen the small group Anthem Health Plans of Maine (Anthem BCBS) PPO Off Exchange Blue Choice as its 2017-2022 benchmark plan. It is important to note that the ACA requires states to fund the cost of any mandates that are not included in the state specific EHB benchmark plan. The EHB benchmark plan currently covers one postpartum care visit, pelvic floor disorders where medically necessary, and mental health benefits. Therefore, NovaRest believes all services and treatments described in LD 1357 are covered to some extent by the EHB benchmark plan. Therefore, we believe this bill is an expansion of current coverage and does not prescribe any new benefits, but this is not a legal interpretation, nor should it be considered legal advice.

NovaRest anticipates this bill will result in increases in health insurance premiums of approximately 0.1% of premiums.

To develop this estimate, NovaRest relied upon publicly available information, the National Association of Insurance Commissioner's 2020 Maine Supplemental Health Care Exhibits, a carrier survey facilitated by the Maine Bureau of Insurance, and an interview of Dr. Romeo Lucas, D.O. The following carriers responded to the survey.

- Aetna
- Anthem
- Harvard Pilgrim
- Cigna
- Community Health Options
- United Healthcare

II. Background

The American College of Obstetricians and Gynecologists (ACOG) published a Committee Opinion in May 2018 titled, "Optimizing Postpartum Care" where they made recommendations on postpartum care, emphasizing that postpartum care should become an ongoing, individualized process as opposed to a single visit. [2] ACOG emphasizes that the weeks following birth are critical.

[2] The American College of Obstetricians and Gynecologists. "Optimizing Postpartum Care." May 2018. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/05/optimizing-postpartum-care.pdf. Accessed September 17, 2021.

The ACOG report states that more than one half of maternal pregnancy-related deaths occur after the birth of the infant.[3] The CDC reports that about 1/3 of deaths happen during pregnancy, about 1/3 happen at delivery or in the week after, and about 1/3 happen from 1 week to 1 year postpartum.[4] In the case of pregnancy loss from miscarriage or stillbirth, Dr. Lucas stressed the importance of post-pregnancy care particularly related to mental health care.

Current estimates are that up to 40% of women do not attend a postpartum visit.[5] There are many reasons why patients do not attend a postpartum visit. These include financial reasons, misunderstanding of importance, access to provider office, and lack of days off from employment. 23% of employed women return to work within 10 days postpartum and 22% return to work between 10-40 days postpartum.[6]

LD 1357 requires coverage for postpartum care consistent with recommendations outlined in the opinion. The recommendations include many of the explicit requirements in LD 1357 including a postpartum care plan, contact with the patient within three weeks of the end of pregnancy (which could be via a phone call), a comprehensive postpartum visit, assessment of risk factors for cardiovascular disease, care related to pregnancy loss, and other recommendations. By requiring carriers to cover additional medical provider visits, patients would only have to pay their cost-sharing requirements for the ACOG recommended care. Postpartum care is an EHB benefit, and all but one carrier that responded to our survey indicate they are currently compliant with ACOG recommendations and cover more than one postpartum visit. One carrier indicated they currently only cover one postpartum visit, and they would expect a cost impact for additional visits, but they did not provide a dollar impact.

LD 1357 also requires coverage for treatment of complications of pregnancy and childbirth including pelvic floor disorders and postpartum depression. A study from BlueCross BlueShield showed a 16.4% increase in pregnancy complications and 14.2% increase in childbirth complications from 2014 to 2018.[7] The primary diagnoses noted for pregnancy complications were gestational diabetes and preeclampsia which both increased by double digits.[8] For childbirth complications, eclampsia, cardiomyopathy, embolism, sepsis, and respiratory distress

[3] Ibid.
[4] Centers for Disease Control and Prevention. "Pregnancy Related Deaths." May 2019. https://www.cdc.gov/vitalsigns/maternal-deaths/index.html. October 11, 2021.
[5] The American College of Obstetricians and Gynecologists. "Optimizing Postpartum Care."
[6] Ibid.
[7] BlueCross BlueShield. "Trends in Pregnancy and Childbirth Complications in the U.S." June 17, 2020. https://www.bcbs.com/the-health-of-america/reports/trends-in-pregnancy-and-childbirth-complications-in-the-us. Accessed September 20, 2021.
[8] Ibid

all increased by double digits.[9] Approximately 10% of mothers experience postpartum depression.[10] In addition, approximately 24% of mothers experience pelvic floor disorders,[11] and while we were not able to find an estimate of the number that would be considered medically necessary, 1.5 to 1.8 of 1000 cases are expected to result in pelvic organ prolapse surgery and about half of that would result in continence surgery. [12] Applied to our estimates this means approximately 5% of pelvic floor disorder cases would require surgery. Our understanding of the EHB benefits and a survey of carriers indicate postpartum depression is currently covered, and pregnancy and childbirth complications are covered where medically necessary. However, pelvic floor disorders are often considered "cosmetic." Therefore, most cases are not covered, and enrollees would be required to pay fully out-of-pocket for care.

Please note, LD 1357 does not prohibit individual or group health insurers from applying cost sharing. Some public testimony referenced financial difficulties receiving care for benefits which appear to be currently covered, for example mental health care related to postpartum depression. Enrollees who cannot afford the cost sharing related to current or proposed benefits may still have financial concerns about pursuing recommended care.

The extent to which current coverage for postpartum care is limited, including parameters for treatment of pelvic floor injuries.

Regarding the postpartum care, four carriers indicated the current coverage for postpartum care follows the ACOG recommendations and there would be no limitations. Aetna covers routine postpartum care[13] and additional services during the postpartum period, however, it appears they only consider the postpartum period to be 6 weeks. Harvard Pilgrim covers maternity care including medically necessary prenatal, postpartum and delivery care, but noted guidance broadens the scope of postpartum care beyond their current guidelines. They currently cover one visit at 6 weeks. NovaRest assumes all but one carrier in the individual and group health insurer markets currently follow the ACOG recommendation for additional visits.

Regarding treatment of pelvic floor injuries, three carriers indicated they are currently covered. Two carriers indicated they are covered when medically necessary. One carrier noted that except in the presence of very severe diastasis recti, there is usually no significant functional

[9] Ibid
[10] Ibid
[11] Memon, Hafsa U, and Victoria L Handa. "Vaginal childbirth and pelvic floor disorders." Women's health (London, England) vol. 9,3 (2013): 265-77; quiz 276-7. doi:10.2217/whe.13.17
[12] Barber, Matthew D, and Christopher Maher. "Epidemiology and outcome assessment of pelvic organ prolapse." International urogynecology journal vol. 24,11 (2013): 1783-90. doi:10.1007/s00192-013-2169-9.
[13] Aetna did not define what they consider routine postpartum care.

impairment associated with a diagnosis of pelvic floor injuries; therefore, they consider a great majority of cases to be generally cosmetic in nature, and therefore not covered. NovaRest assumes that care in cases not considered medically necessary would not be covered currently. As a proxy for medically necessary, NovaRest assumes cases requiring surgery (for pelvic floor prolapse or continence surgery) would be considered medically necessary, which is approximately 10% of pelvic floor disorder cases.[14]

The potential impact of bundled payments on access to and coverage of postpartum care.

Bundled payments were discussed in a New England Journal of Medicine article from 2018.[15] No carriers that responded to our survey currently have any bundled payment arrangements, so NovaRest estimates there will be no impact currently.

While the ACOG recommendation appears to be primarily a provider recommendation, providers may not be incentivized to follow recommendations if they are not appropriately reimbursed by insurance carriers. Eventually, as providers begin to follow the ACOG recommendations, we expect those that charge for bundled payments covering all services of pregnancy in one payment amount will be increasing their fees to be paid by the insurance carriers to encompass the recommended standard of care.

Dr. Romeo Lucas, D.O. stated, "while it is appropriate and important for new mothers to be seen in the postpartum period for discussion/recognition of pelvic floor or abdominal wall disorders, the full evaluation and any subsequent treatment of a post-operative/post-delivery pelvic floor or abdominal wall disorder should be covered by insurance as separate from any global reimbursement."

An analysis of the recommendations outlined in the "Optimizing Postpartum Care" opinion published May 2018 by the American College of Obstetricians and Gynecologists and the extent to which those recommendations are not reflected in current coverage.

Four carriers indicated the current coverage for postpartum care follows the ACOG recommendations and there would be no limitations. One carrier covers maternity care including medically necessary prenatal, postpartum and delivery care, but noted that the ACOG recommendations would broaden the scope of postpartum care beyond their current guidelines of only one visit around 6 weeks postpartum.

[14] Barber, Matthew D, and Christopher Maher. "Epidemiology and outcome assessment of pelvic organ prolapse."
[15] Horwitz, Mara M.; Molina, Rose L.; and Snowden, Jonathan M. "Postpartum Care in the United States — New Policies for a New Paradigm" The New England Journal of Medicine. 379;18 nejm.org November 1, 2018.

The extent to which the bill expands coverage beyond the State's essential health benefits package and, if so, the estimated costs to the State to defray the costs of including coverage in qualified health plans.

All benefits proposed by LD 1357 would be covered to some extent by the EHB benchmark plan. Therefore, we would not consider them to be new benefits. In particular, coverage for postpartum care as recommended by ACOG and pelvic floor disorders will be an expansion of coverage for some carriers. It appears complications of pregnancy and childbirth, assessment of risk factors for cardiovascular disease, care related to pregnancy loss, and postpartum depression are already covered under the EHB benchmark plan.

We assume a total increase in incurred health care cost of $1.4 million dollars, or a PMPM cost of $0.54 which represents approximately 0.1% of premiums. We expect $0.13 PMPM is driven by additional postpartum visits and $0.41 PMPM is driven by additional treatment for pelvic floor disorders.

III. Social Impact

A. Social Impact of Mandating the Benefit

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

There were 11,537 live births in Maine in 2020.[16] Using the National Association of Insurance Commissioners (NAIC) 2020 Supplemental Health Care Exhibit (SHCE) count of covered lives in the individual, small group, and large group markets against the 2020 Vintage Population Estimates from census.gov, we estimate 25% of the Maine population is covered in the individual, small group, and large group markets. We therefore estimate approximately 3,000 live births in the individual and group health insurer markets. All of these would be eligible for the recommended postpartum coverage and care plan.

The CDC performed a study which found approximately 16% of pregnancies end in miscarriage or stillbirth[17], meaning approximately 750 pregnancies would be eligible for pregnancy loss care.

[16] Maine Center for Disease Control and Prevention. "Births." November 15, 2021. https://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/births.shtml. Accessed September 17, 2021.
[17] Centers for Disease Control and Prevention. "U.S. Pregnancy Rate Lowest in Two Decades." December 15, 1999. https://www.cdc.gov/nchs/pressroom/99facts/pregrate.htm. Accessed September 20, 2021.

Blue Cross and Blue Shield performed a study which estimated that approximately 20% of pregnancies experience complications, approximately 2% of childbirths experience complications, and 10% of pregnancies result in postpartum depression.[18] The Blue Cross and Blue Shield analysis did not appear to consider pelvic floor disorders. Based on an NIH study approximately 24% of pregnancies result in pelvic floor disorders.[19]. As a proxy for medically necessary, NovaRest assumes cases requiring surgery (for pelvic floor prolapse or continence surgery) would be considered medically necessary, which is approximately 10% of pelvic floor disorder cases.[20]

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

LD 1357 would require coverage for services related to postpartum care, as well as treatment for complications of pregnancy and childbirth including pelvic floor disorders and postpartum depression. The treatments and services appear to require a multi-disciplinary team consisting of obstetricians, gynecologists, nurses, physical therapists, and mental health professionals; however, the services, tests, and medications required appear to be widely available.

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

Delivery and all inpatient services related to maternity care is covered under the EHB benchmark plan. It is unclear if all complications related to pregnancy and childbirth (excluding pelvic floor disorders) are covered under the EHB benchmark plan; however, the responses from the carriers appear to indicate they are covered and no additional cost appeared to be included; therefore we believe they are currently covered.

Regarding the postpartum care, which includes development of a postpartum plan, contact with the patient within 3 weeks of the end of pregnancy (which may be a phone visit), a comprehensive postpartum visit, and assessment of risk factors for cardiovascular disease, and care related to pregnancy loss, four carriers indicated the current coverage for postpartum care follows the ACOG recommendations and there would be no limitations. Aetna covers routine postpartum care[21] and additional services during the postpartum period; however, it appears they

[18] BlueCross BlueShield. "Trends in Pregnancy and Childbirth Complications in the U.S." June 17, 2020. https://www.bcbs.com/the-health-of-america/reports/trends-in-pregnancy-and-childbirth-complications-in-the-us. Accessed September 20, 2021.
[19] Memon, Hafsa U, and Victoria L Handa. "Vaginal childbirth and pelvic floor disorders."
[20] Barber, Matthew D, and Christopher Maher. "Epidemiology and outcome assessment of pelvic organ prolapse."
[21] Aetna did not define what they consider routine postpartum care.

only consider the postpartum period to be 6 weeks. Harvard Pilgrim covers maternity care including medically necessary prenatal, postpartum and delivery care, but noted guidance broadens the scope of postpartum care beyond their current guidelines which only requires one visit around 6 weeks postpartum. We believe LD 1357 would result in an expansion of current coverage but would not be considered a new benefit.

Regarding treatment of pelvic floor injuries, the EHB benchmark plan includes reconstructive surgeries, procedures, and services when considered medically necessary. They do not provide benefits for cosmetic services intended solely to change or improve appearance, or to treat emotional, psychiatric or psychological conditions. Three carriers indicated pelvic floor injuries are currently covered. Three carriers indicated they are covered when medically necessary. One carrier noted that except in the presence of very severe diastasis recti, there is usually no significant functional impairment associated with a diagnosis of pelvic floor injuries. Therefore, they consider a great majority of cases to be generally cosmetic in nature. Generally, it appears the majority of pelvic floor injuries are not considered to be medically necessary, and therefore will not be covered. This is consistent with several public comments submitted regarding LD1357.

The United States Preventive Services Task Force (USPSTF) recommends "screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up." [22] This recommendation is rated with a B meaning it must be provided to enrollees in qualified health plans without cost sharing. The EHB benchmark plan includes a section on Mental Health and Substance Abuse Services, where they indicate inpatient, outpatient, and residential services are available from several provider types. They do include an exclusion list for certain services; however, it does not indicate postpartum depression. While these services would appear to be subject to cost sharing, we believe treatment for postpartum depression is currently covered.

[22] US Preventive Service Task Force. Final Recommendation Statement. "Depression in Adults: Screening." January 26, 2016. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening. September 30, 2021.

	More than one postpartum visit	**Pelvic floor disorder treatment**	**Postpartum depression treatment**	**Other pregnancy complications**	**Other childbirth complications**
EHB Benchmark	Not Covered	Medically Necessary	Medically Necessary	Medically Necessary	Medically Necessary
Aetna	Covered	Covered	Covered	Covered	Covered
Anthem	Covered	Medically Necessary	Medically Necessary	Medically Necessary	Medically Necessary
Cigna	Covered	Medically Necessary	Medically Necessary	Medically Necessary	Medically Necessary
Community Health Options	Covered	Covered	Covered	Covered	Covered
Harvard	Not Covered	Medically Necessary	Medically Necessary	Medically Necessary	Medically Necessary
United Healthcare	Covered	Covered	Covered	Covered	Covered

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.

Without coverage, people would have to pay fully out-of-pocket for treatment and services or forgo care. Additionally, according to Dr. Lucas, many patients do not realize certain complications indicate a problem without additional contact with their medical provider. Even where these complications are currently covered, if there is no contact with their medical provider, patients may not recognize the need to seek treatment for complications before they become larger medical problems.

However, coverage does not appear to be the only reason people do not pursue recommended care. The ACOG paper noted up to 40% of patients do not attend any postpartum visit.[23] In Maine, at least one postpartum visit is currently covered, and it appears many still do not attend. This may be for a variety of reasons other than coverage or lack of it, including lack of paid leave, lack of transportation, caring for other children, and lack of understanding of the importance of follow-up care.

[23] The American College of Obstetricians and Gynecologists. "Optimizing Postpartum Care."

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

Generally, the lack of coverage would result in people having to pursue the recommended treatment and pay fully out-of-pocket for visits with medical professionals. Many public comments discussed out-of-pocket costs for care which is now recommended by a major provider organization (ACOG) to achieve optimal results for the parents or the child.

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

Much of the language for this bill is based on recommendations from ACOG, which is a provider organization. We do not know the total demand from private citizens for the treatments and services covered by LD 1357, but quite a few public comments were submitted by private citizens in support of the bill.

The Maine Public Health Association included a comment in support of LD 1357. In their public comment, they noted that "the World Health Organization calls for routine evaluation of all women at 3 days, 1-2 weeks and 6 weeks postpartum and the National Institute for Health Care and Excellence recommends mental health screenings at 10-14 days after birth." [24] They also noted U.S. has a high maternal mortality rate compared to other developed nations.

The Maine Osteopathic Association provided testimony stating, "This ensures the health of the mother not only as far as transitioning into the non-pregnant state but also with regard to optimizing outcomes as far as future fertility and delivery. Ultimately, access to quality post-partum care results in a long-term reduction in healthcare costs."

The Maine Medical Association provided a breakdown of the timing of visits and indicated comprehensive care has profound effects, increasing the identification of behavioral issues.

[24]Maine Public Health Association. "Testimony of Maine Public Health Association in Support of: LD 1357: An Act to Require Private Insurance Coverage for Postpartum Care." http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=160233. Accessed September 21, 2021.

Connie Adler, MD testified that postpartum depression affects 10-16% of women postpartum, with 46% diagnosed after 6 weeks, and 6% after the first 5 months postpartum. Stopping treatment too early could result in poor bonding and developmental delay for the infant. Other conditions in the first year are mastitis, thyroiditis, deep vein thrombosis and pulmonary embolism.

Dr. Lucas reiterated the importance of contact between medical providers and mothers in the postpartum period. There are many complications of pregnancy and childbirth which can be treated effectively if caught early but can have serious long-term complications if left untreated. There are numerous reasons why conditions are left untreated (financial, education, work, scheduling conflicts etc.), but more contact between patients and medical providers will allow more conditions to be caught early.

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

For the postpartum care, LD 1357 language is based on a recommendation by the American College of Obstetricians and Gynecologists, which is a provider organization. The public hearing for this bill received 34 comments from the public and providers, all of which were in support of LD 1357.

The Maine Women's Lobby, ACLU, and Personalized Pediatrics of Maine all provided testimony in support of LD 1357.

Michelle Boyer's testimony indicated Blue Cross and Blue Shield denied her claim for pelvic floor disorder physical therapy, and after an appeal they approved 12 visits in a 36-month period. She then noted that more visits were required which she paid for fully out of pocket at a cost of thousands of dollars.

Heather Drake's testimony indicated the physical therapy was a $400 bill to be paid weekly, which she could not afford and therefore was not able to continue treatment.

Eric Jones testified that his partner recently gave birth and immediately needed to spend over $1,000 dollars in pelvic floor physical therapy.

Janna Rayworth indicated she spent thousands of dollars on physical therapy postpartum to fix very common pregnancy and birth-related injuries.

Alayna Marchessault indicated insurance did not cover any of her pelvic floor physical therapy and she paid $780. She had two appointments prior to giving birth and four appointments after giving birth. She experienced an atypically short labor and no perineal tearing, which accelerated healing in the early weeks postpartum.

Amy Marchessault paid close to $6,000 for personalized care and pelvic floor PT out of pocket, and the insurance carrier did not pay any costs.

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.

While many states have adopted coverage to enhance postpartum care, we were unable to find experience studies on the effectiveness of the benefits in meeting a consumer need. Below are some other state or federal programs that implemented enhanced postpartum care.

Pregnancy-related Medicaid services are required through 60 days postpartum, but a provision in the American Rescue Plan Act of 2021 gives states a new option to extend Medicaid postpartum coverage to 12 months via a state plan amendment (SPA).[25] 25 states (including Maine) have proposed to extend Medicaid postpartum coverage. [26]

Washington 48.43.115 includes language requiring that "Covered eligible services may not be denied for follow-up care, including in-person care, as ordered by the attending provider in consultation with the mother."

Rhode Island § 27-20-75 requires coverage for doula services for up to 12 months postpartum.

Florida 641.31 requires HMOs to cover a postpartum assessment, physical assessments and any medically necessary clinical tests in keeping up with prevailing medical standards.

[25] Kaiser Family Foundation. "Medicaid Postpartum Coverage Extension Tracker." September 16, 2021. https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/. Accessed September 21, 2021.
[26] Ibid.

The District of Columbia § 31-3861 defines the postpartum period as lasting up to 12 months after delivery.

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.

Superintendent of Insurance Eric Cioppa recommended the effective date for LD 1357 be moved from July 1, 2022 to a January 1 date in order for carriers to properly implement the required change, as plan changes are only allowed for ACA plans on January 1.

Additionally, he noted that if the mandate is a new mandate previously excluded from the EHB, it would be subject to the requirement for the State to defray the cost. If it is determined to be an expansion of an existing mandate rather than a new mandate it is his understanding that the State would not have to defray the cost.

11. The alternatives to meeting the identified need.

We do not know of any alternatives, and no alternatives were provided by the carriers.

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 coverage required by LD 1357 is not inconsistent with the role of insurance to provide medically necessary services for a condition

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

Most carriers in the market only cover medically necessary treatment for pelvic floor disorders and consider most disorders "cosmetic," which they believe will resolve itself in many cases. We have received public testimony stating treatment for issues such as incontinence is not considered medically necessary but is a major concern for patients. LD 1357 would expand coverage for pelvic floor disorders beyond what some carriers currently consider medically necessary.

There may be some social stigma around incontinence since it is usually associated with aging.

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

Five of the six carriers that responded, representing 77% of the total membership for the six carriers, already provide the postpartum care that would be required by the bill.

Regarding treatment for complications of pregnancy and childbirth, pelvic floor disorders appear to be covered primarily when medically necessary thus LD 1357 would expand coverage to those treatments that are now considered cosmetic. Postpartum depression is already covered.

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

As premiums increase due to mandated benefits, some employers choose to self-insure in order to have more control over the benefits that they provide to employees and control the cost of health insurance premiums. Since this mandate will have a minimal impact on premiums it is unlikely this will impact any shifting to self-insurance.

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

Anthem estimated the impact to the state employee plan to be $1.43 PMPM.[27]

IV. Financial Impact

B. Financial Impact of Mandating Benefits

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

The services and treatments appear to be widely available and we do not expect the proposed insurance coverage to increase or decrease the cost over the next five years.

[27] NovaRest, Inc. does not have information on how Anthem developed their cost estimate and cannot comment on the magnitude.

2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.

The proposed insurance coverage may lead to more enrollees pursuing postpartum care as well as additional care for complications from pregnancy and childbirth; however, this additional care is recommended by ACOG and therefore would be considered appropriate use. Additionally, more enrollees would pursue care for pelvic floor disorders which are currently considered "cosmetic" by health insurance carriers; however, the Dr. Lucas insisted no pelvic floor disorders should be considered "cosmetic" and furthermore treatment and prevention of pelvic floor disorders should not be considered "elective". NovaRest believes additional treatment for pelvic floor disorder would also be appropriate use.

We assume providers will follow the ACOG recommendation and recommendations on complications from pregnancy and childbirth. Therefore, we do not believe it would increase inappropriate use.

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

We do not know of alternative treatments.

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

There is no language in the bill that prohibits medical management. If treatment is not having an impact, the medical management would be able to discontinue treatment.

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

The services and treatments appear to be widely available and we do not expect the proposed insurance coverage to affect the number and type of providers over the next five years.

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.

Carrier Estimate:

Aetna: "We do not anticipate any impact to costs as this benefit is covered. Similar to our concerns expressed with LD 1003, the ambiguity regarding "coverage" should be very specifically defined as mandated coverage generally leads the member to believe the payor pays 100%. We would also like to see the State further define what they expect a postpartum period to be. When we look at the manner in which the industry would generally define postpartum, this is 6 weeks from delivery. In general, that would include follow up visits for uncomplicated postpartum visits. We need to be clear around what is being sought. Further, "pelvic floor injury" should be more specifically defined. It does not specifically cite pelvic floor injury treatment by the OBGYN, simply that which would be treated in the postpartum period. Maine has a very limited number of PTs working in this space."

Anthem: "Postpartum care is currently included in the maternity services covered under our Individual, Small Group and Large Group plans. Treatment of pelvic floor dysfunction is subject to utilization management processes. Care for pregnancy loss may include office visits, behavioral health, gene testing and pathology on the placenta, with gene testing subject to the utilization management process The Per Member Per Month (PMPM) cost estimates for coverage under the proposed mandate are as follows:

Individual	$1.46
Small Group	$1.32
Large Group	$1.52

In developing the premium impact estimate, we assumed the average birth rate for Anthem population is the same as U.S. general population and estimated the costs associated with post-partum cost followed by each delivery that includes post-partum office visits and treatment of pregnancy related medical and behavioral health concerns. To the extent that a greater birth rate and/or associated post-partum cares were rendered, the costs described above would be greater. Maternity care is currently reimbursed under a global payment arrangement. To the extent the proposed mandate would require coverage of additional services, it may result an increase to that payment. Given that the proposal would increase health insurance costs for consumers and businesses, particularly at a time when the State is focused on lowering health insurance costs,

particularly for small businesses, Anthem does not support passage of this legislation."

Cigna: "Our standard coverage already covers the postpartum care services outlined in this legislation to the extent it is limited to medically necessary procedures as opposed to cosmetic. Therefore, we would anticipate a small, but not significant, impact."

Community Health Options: "Community Health Options does not anticipate any additional cost as the result of this proposed mandate."

Harvard[28]**: "**The estimate of the mandate to require additional coverage for additional post-partum visits that would be covered beyond post-partum visits. The estimated impact would be significant. Due to the lack of fully credible experience at the segment level, estimates cannot be provided … separately for individual, small group, and large group plans. However, it appears that individual plans would tend to be impacted at the lower end of the range, while small and large group plans would be impacted at the higher end of the range."

United Healthcare: "Postpartum care is already covered and therefore no additional costs are expected. No additional savings are expected since postpartum care is already currently covered."

NovaRest Estimate:

NovaRest estimates a net cost of $0.54 PMPM, or 0.1% of premium. Our research indicates recommended coverage for mental health treatment related to postpartum depression and child loss are currently covered as an EHB benefit. Additionally, medically necessary care for complications from pregnancy and childbirth appear to be covered as an EHB benefit. Postpartum testing and assessments also appear to be covered as an EHB benefit. LD 1357 would likely result in additional cost due to enhanced postpartum care to be consistent with the ACOG recommendations, and for additional coverage for pelvic floor disorders which are currently considered "cosmetic."

We estimate an increase of $0.13 PMPM or about 0.02% of premium for enhanced postpartum care to be consistent with the ACOG recommendations. The cost estimate was developed using the following sources.

[28] Harvard indicated they believe the estimated impact to be significant but did not actually provide a cost estimate or a range.

- Assume 3.5 additional visits under ACOG guidance
- Assume $150 cost per visit[29]
- 11,537 in live births in Maine in 2020.[30]
- 25% of Maine under age 65 population covered in the private market.[31,32]
- One carrier, representing 23% of private market, does not currently provide coverage per ACOG guidelines.
- Claims, premiums and member months all from 2020 Maine Supplemental Health Care Exhibit.

We estimate an increase of $0.41 PMPM or about 0.07% of premium for pelvic floor disorder (PFD) care. The cost estimate was developed using the following sources.

- 11,537 in live births in Maine in 2020.[33]
- 62% of pregnancies result in live birth, 16% result in miscarriage or stillbirth.[34]
- 25% of Maine under age 65 population covered in the private market.[35,36]
- 24% of women impacted with pelvic floor disorder.[37]
- Medically necessary cases are currently covered. Assume cases that require surgery (pelvic organ prolapse and incontinence surgery) are medically necessary.
- Pelvic organ prolapse incidence rate 1.5 to 1.8 per 1,000 women years, incontinence surgery performed twice as commonly.[38]
- Recommend 4-8 hour long sessions.[39]
- $150 to $300 per session.[40]

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[29] "Postpartum Maternity Checkup Cost." https://children.costhelper.com/post-partum-doctor-visit html. Accessed September 27, 2021.
[30] "Births." Division of Public Health Systems. https://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/births.shtml. Accessed September 27, 2021.
[31] "State Population by Characteristics: 2010-2020." Vintage 2020 State Population Estimates. Single Year of Age and Sex for the Civilian Population Table. July 22, 2021. https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-state-detail.html. Accessed September 27, 2021.
[32] National Association of Insurance Commissioners. Supplemental Health Care Exhibit Maine 2020.
[33] "Births." Division of Public Health Systems.
[34] "U.S. Pregnancy Rate Lowest in Two Decades." National Center for Health Statistics. December 15, 1999. https://www.cdc.gov/nchs/pressroom/99facts/pregrate.htm. Accessed September 27, 2021.
[35] "State Population by Characteristics: 2010-2020." Vintage 2020 State Population Estimates. Single Year of Age and Sex for the Civilian Population Table.
[36] National Association of Insurance Commissioners. Supplemental Health Care Exhibit Maine 2020.
[37] Memon, Hafsa U, and Victoria L Handa. "Vaginal childbirth and pelvic floor disorders."
[38] Barber, Matthew D, and Christopher Maher. "Epidemiology and outcome assessment of pelvic organ prolapse."
[39] Wallace, Shannon L et al. "Pelvic floor physical therapy in the treatment of pelvic floor dysfunction in women." Current opinion in obstetrics & gynecology vol. 31,6 (2019): 485-493. doi:10.1097/GCO.0000000000000584
[40] Fraticelli DPT, MBA, CFP, "How Much Does Physical Therapy Cost?" January 9, 2019. https://www.ptprogress.com/how-much-does-physical-therapy-cost/. Accessed September 27, 2021.

- Claims, premiums and member months all from 2020 Maine Supplemental Health Care Exhibit.

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.

We don't believe there will 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.

Senator Stacy Brenner provided a public comment that missing follow up could fail to treat chronic conditions such as high blood pressure, diabetes or debilitating depression which can impact a child's development.

Connie Adler, MD testified that postpartum depression affects 10-16% of women postpartum, with 46% diagnosed after 6 weeks, and 6% after the first 5 months postpartum. Stopping treatment too early could result in poor bonding and developmental delay for the infant. Other conditions in the first year are mastitis, thyroiditis, deep vein thrombosis and pulmonary embolism.

Dr. Lucas discussed depression, postpartum bleeding, and breast-feeding issues which can be treated effectively if caught early but could lead to long-term costs if left untreated.

Anthem stated, "We have not identified any studies of the ACOG recommendations. There is research indicating that post-partum depression screening may have cost effectiveness benefits in health and quality of life measures (Screening for and Treating Postpartum Depression and Psychosis: A Cost-Effectiveness Analysis Conclusions for Practice Screening for and treating postpartum depression is a cost-effective intervention and should be considered as part of usual postnatal care, which aligns with the recently proposed recommendations from the U.S. Preventive Services Task Force. Matern Child Health J 2017 Apr;21). There is also some data to show that diet interventions to assist safe weight loss post-partum may improve outcomes and save money (such as intense provider counselling)."

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.

There is concern that the broad language of the bill will lead to use of health care services that are not medically necessary, which would have the effect of increasing premiums

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.

MaineCare previously covered 60 days of postpartum care, but LD 265, which was passed on July 2, 2021, extended the time to 12 months.[41] We do not believe there will be cost shifting.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit

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

The ACOG recommendation noted the postpartum period "can present considerable challenges for women, including lack of sleep, fatigue, pain, breastfeeding difficulties, stress, new and onset or exacerbation of mental health disorders, lack of sexual desire, and urinary incontinence. Women also may need to navigate preexisting health and social issues, such as substance dependence, intimate partner violence, and other concerns."[42] With lack of coverage, a person may be unable to receive appropriate care for these issues, many of which can be chronic. In addition to posing health difficulties for the parent, these untreated issues may result in poor bonding and child development issues.

The pelvic floor disorders are generally not covered, except where medically necessary, and may result in long term effects for many women including incontinence, constipation, lower back pain, pelvic muscle spasms, and general pain/discomfort in the pelvic region, genitals or

[41] https://legislature.maine.gov/LawMakerWeb/summary.asp?ID=280078375
[42] The American College of Obstetricians and Gynecologists. "Optimizing Postpartum Care."

rectum.[43] Due to expenses or lack of education about treatment, mothers may not pursue treatment and would instead have a lower quality of life. Left untreated, the symptoms may worsen[44] which can be uncomfortable and painful and can cause long term damage.[45]

Senator Stacy Brenner provided a public comment that missing follow up could fail to treat chronic conditions such as high blood pressure, diabetes or debilitating depression which can impact a child's development.

Connie Adler, MD testified that postpartum depression affects 10-16% of women postpartum, with 46% diagnosed after 6 weeks, and 6% after the first 5 months postpartum. Stopping treatment too early could result in poor bonding and developmental delay for the infant. Other conditions in the first year are mastitis, thyroiditis, deep vein thrombosis and pulmonary embolism.

Dr. Lucas reiterated the importance of contact between medical providers and mothers in the postpartum period. There are many complications of pregnancy and childbirth which can be treated effectively if caught early but can have serious long-term complications if left untreated. There are numerous reasons why conditions are left untreated (financial, education, work, scheduling conflicts etc.), but more contact between patients and medical providers will allow more conditions to be caught early.

Regarding pelvic floor disorder Dr. Lucas indicated that even childbirth without complications has a significant impact on the human body and should be treated in the same way as surgery, with follow-up visitation for monitoring, physical therapy for strengthening, etc.

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

The bill will not apply to an additional class of practitioners.

[43] Kiara Anthony. "Pelvic Floor Dysfunction." September 18, 2018. https://www.healthline.com/health/pelvic-floor-dysfunction#TOC_TITLE_HDR_1. Accessed September 23, 2021.
[44] Per an interview with Dr. Romeo Lucas, D.O. and https://www.uclahealth.org/womens-pelvic-health/pelvic-floor-disorders
[45] The University of Kansas Health System. "Pelvic Floor Disorders." https://www.kansashealthsystem.com/care/conditions/pelvic-floor-disorders. Accessed September 30, 2021.

VI. Balancing the Effects

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

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

The ACOG recommendation defines the standard of postpartum care to ensure healthy outcomes for the family. If this coverage were not available, parents would have to pay out-of-pocket for care recommended by providers or not receive adequate care.
Even for those that do not use the benefit themselves, the peace of mind that the benefit is available has some benefit. Also having the benefit for relatives reduces stress on family members that would be concerned for loved ones.

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

It is likely that only those who would benefit from the services would purchase the optional coverage. This would result in an alternative coverage that would be very expensive. This cost would be reduced if the option were only available when the coverage was initially purchased, but it would then be less effective because many individuals would not anticipate needing the coverage and therefore would not purchase it.

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

We estimate an increase in cost of $0.54 PMPM for LD 1357, or about 0.10% of premiums.

The estimated cost of current Maine mandates is detailed in Appendix A. For most of these mandates, our estimate is based on the net impact on premiums as estimated at the time the mandate was enacted. Four of the mandates – mental health, substance abuse, chiropractic, and screening mammograms – require carriers to report annually the number of claims paid for these benefits and the estimates are based on that data. The true cost for the Maine mandates is impacted by the fact that:

1. Some services would be provided and reimbursed in the absence of a mandate.
2. Certain services or providers will reduce claims in other areas.
3. Some mandates are required by Federal law.

The addition of 0.1% of premiums for LD 1357 to the estimated cost of current Maine mandates, would result in a cumulative cost as shown below:

Total cost for groups larger than 20:	**12.69%**
Total cost for groups of 20 or fewer:	**12.74%**
Total cost for individual contracts:	**11.00%**

VII. Actuarial Memoranda

Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate of the proposed bill. Any judgments as to the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis by be incorrect. Appropriate staff is available to explain and/or clarify any matter presented herein. It is assumed that any user of this report will seek such explanations as to any matter in question.

NovaRest has developed projections in conformity with what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that actual future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by carrier, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings and inherent potential for normal random fluctuations in experience.

Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of the bill's consideration. The reliance of parties other than the Maine Bureau of Insurance and the Joint Standing Committee on Health Coverage, Insurance and Financial Services on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of information provided by carriers included in the data call. We also made assumptions based on information gained from interviews with medical professionals. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision. While we have relied on information without independent investigation or verification, the medical professionals we spoke to are fully qualified and knowledgeable in their field.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice. We have no conflicts of interest in performing this review and providing this report.

We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

VIII. Appendices

Appendix A: Cumulative Impact of Mandates

Bureau of Insurance
Cumulative Impact of Mandates in Maine

Report for the Year 2020

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

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

Mental health parity for group plans in Maine became effective July 1, 1996 and was expanded in 2003. The percentage of mental health group claims paid has been tracked since 1984 and has historically been between 3% - 4% of total group health claims. Claims jumped sharply in 2020 by 1.3% to 5.2% for groups after steadily declining by a half point per year for the previous 3 years.

Maine mental health parity was only a mandated offer for individual plans until it was included in the essential health benefits for ACA (Affordable Care Act) individual and small group plans beginning 2014. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) amended the PHS Act, ERISA, and the Code to provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits and extended parity to all individual plans. As expected, mental health claims have stabilized back to a lower level of 2.5% in 2017 after meeting pent-up demand of 9.4% in 2015. From 2018 to 2020 claims have increased slightly to an average of 3.5%, but still within a stabilized range.

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

Maine's mandate only applied to group coverage. Effective October 1, 2003, substance abuse was added to the list of mental health conditions for which parity is required. Effective on January 1, 2014, the federal Affordable Care Act requires substance abuse treatment benefits for individual and small group plans as part of the essential health benefits. The percentage of claims paid for group plans has been tracked since 1984. Substance abuse claims paid have remained flat at 1.2% average for the past 3 years of the total group health claims. Individual substance abuse health claims have also remained flat at 1.0% for the past 3 years. As expected, substance abuse claims have leveled out as pent-up demand is met, and carriers manage utilization.

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

This mandate requires coverage for the services of chiropractors to the extent that the same services would be covered if performed by a physician. Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1986 and, in 2020, was 0.80% of total health claims. Prior to 2014, the level has typically been lower for individual than for group. Individual claims at 0.4% in 2020 have continued a trend of lower than group claims since 2017 when they were equivalent.

- ***Screening Mammography*** (Enacted 1990)

This mandate requires that benefits be provided for screening mammography. We estimate the current 2020 levels of 0.9% for group and 1.0% for individual going forward. Coverage is required by ACA for preventive services.

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

This mandate requires coverage for dentists' services to the extent that the same services would be covered if performed by a physician. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998)

This mandate requires coverage for reconstruction of both breasts to produce a symmetrical appearance after a mastectomy. At the time this mandate was being considered in 1995, one carrier estimated the cost at $0.20 per month per individual. We do not have a more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995)

This mandate requires coverage for metabolic formula and prescribed modified low-protein food products. At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We do not have a more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996)

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

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

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

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

This mandate requires that benefits be provided for screening Pap smear tests. HMOs would typically cover these costs and, for non-HMO plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%. Coverage is required by ACA for preventive services.

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

This mandate only affects HMO plans and similar plans, and it requires the provision of benefits for annual gynecological exams without prior approval from a primary care physician. To the extent the Primary Care Physician (PCP) would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher; therefore, we include 0.1%.

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

This mandate requires that benefits for breast cancer treatment be provided for a medically appropriate period of time as determined by the physician in consultation with the patient. Group claims in 2020 were 2.0% compared to individual claims at 1.4% with the combined impact remaining level with past years at 1.7%.

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

This mandate requires coverage of off-label prescription drugs in the treatment of cancer, HIV, and AIDS. Our 1998 report stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. Because the HMOs claimed to already cover off-label drugs, in which case there would be no additional cost; and providers testified that claims have been denied on this basis, we include half this amount, or 0.3%.

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

This mandate requires prostate cancer screenings. Our report estimated additional claims cost would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or approximately 0.07% of total premiums. Coverage is required by ACA for preventive services.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999)

This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999)

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

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

This mandate requires health plans that cover surgical first assistants to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000)

This mandate requires that coverage be provided for an eligible enrollee to participate in approved clinical trials. Our report estimated a cost of 0.19% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000)

This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001)

No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Because carriers generally covered hospice care prior to the mandate, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001)

This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001)

This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ***Prosthetics*** (Enacted 2003)

This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20, and a cost of 0.08% of premium for small employer groups and individuals.

- ***LCPCs*** (Enacted 2003)

This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

- ***Licensed Pastoral Counselors and Marriage & Family Therapists*** (Enacted 2005)

This mandate requires coverage of licensed pastoral counselors and marriage & family therapists. Our report indicated no measurable cost impact for this coverage.

- ***Hearing Aids*** (Enacted 2007 and revised 2019)

The prior mandate required coverage for a hearing aid for each ear every 36 months for children age 18 and under. The mandate was phased-in between 2008 and 2010, and our report estimated a cost of 0.1% of premium. For 1/2020 the hearing aid mandate is expanded to require adult hearing aids. Based on rate filings and a proposed mandate study we estimate 0.2% addition impact to rates to provide hearing aids to adults.

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

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

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

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

- ***Independent Dental Hygienist*** (Enacted 2009)

This mandate requires individual dental insurance or health insurance that includes coverage for dental services to provide coverage for dental services performed by an independent practice dental hygienist. This mandate applies only to policies with dental coverage; therefore, there is no estimated impact on medical plan premiums.

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

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

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

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

- ***Chemotherapy Oral Medications*** (Enacted 2014)

Policies that provide chemotherapy treatment must provide coverage for prescribed orally administered anticancer medications equivalent to the coverage for IV or injected anticancer medication. No material increase in premium is expected.

- ***Bone Marrow Donor Testing*** (Enacted 2014)

Reimbursement for human leukocyte antigen testing to register as a bone marrow donor. Limited to $150 per lifetime. May not be applied to any deductible or other cost share. No material increase in premium is expected.

- ***Dental Hygienist*** (Enacted 2014)

Coverage for services provided by a dental hygiene therapist for policies with dental coverage. No material increase in premium is expected.

- ***Abuse-Deterrent Opioid Analgesic Drugs*** (Enacted 2015)

Coverage for abuse-deterrent opioid analgesic drugs on a basis not less favorable than that for opioid analgesic drugs that are not abuse-deterrent and are covered by the health plan. No material increase in premium is expected.

- ***Preventive Health Services*** (Enacted 2018)

Coverage for preventive health services including evidence-based items or services with a rating of A or B in the United States Preventive Services Task Force or equivalent, preventive care and screenings and immunizations supported by the federal DHHS. Currently covered and no material increase in premium is expected.

- ***Naturopathic Doctor*** (Enacted 2018)

Coverage for services provided by a naturopathic doctor when those services are covered when provided by any other health care provided and within the lawful scope of practice of the naturopathic doctor. No material increase in costs is expected and if the services are a substitute for medical doctor services, there may be a decrease in cost for some patients.

- ***Abortion Coverage*** (Enacted 2019)

This mandate requires that health insurance carriers who provide coverage for maternity services also provide coverage for abortion services except for employers granted a religious exclusion.

- ***Coverage for certified registered nurse anesthetists (CRNA)*** (Enacted 2021)

This mandate requires insurers, health maintenance organizations and nonprofit hospitals or medical service organizations to provide coverage for the services of certified registered nurse anesthetists provided to individuals.

- ***Coverage for certified midwives.*** (Enacted 2021)

This mandate requires insurers, health maintenance organizations and nonprofit hospitals or medical service organizations to provide coverage under those contracts for services performed by a certified nurse midwife to a patient who is referred to the certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the certified nurse midwife.

- ***Coverage for HIV prevention drugs.*** (Enacted Federal 2021)

This mandate requires health insurance carriers to provide coverage for an enrollee for HIV prevention drugs that have been determined to be medically necessary by a health care provider.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts	0.10%
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups	1.24%
		Individual	1.13%
1975 1983 1995 2003	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups	5.15%
		Individual	3.58%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services.	Group	0.83%
		Individual	0.61%
1990 1997	Benefits must be made available for screening **mammography**.	Group	0.85%
		Individual	0.96%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%
1996	If policies provide maternity benefits, the **maternity (length of stay)** and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care."	All Contracts	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.20%
1996	Benefits must be provided for **screening Pap tests**.	All	0.01%
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	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	2.57%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%
1998	Coverage required for **prostate cancer screening**.	All Contracts	0.07%

1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serve as primary care providers.	All Managed Care Contracts	0.16%
1999	Prescription drug must include **contraceptives**.	All Contracts	0.80%
1999	Coverage for **registered nurse first assistants**.	All Contracts	0
2000	Access to **clinical trials**.	All Contracts	0.19%
2000	Access to **prescription drugs**.	All Managed Care Contracts	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0
2001	Access to **eye care**.	Plans with participating eye care professionals	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg	Groups >20	0.03%
		All other	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0
2007	Coverage of hearing aids for children	All Contracts	0.1%
2008	Coverage for amino acid-based elemental **infant formulas**	All Contracts	0.1%
2008	Coverage for **colorectal cancer screening**	All Contracts	0
2009	Coverage for **independent dental hygienist**	All Contracts	0
2010	Coverage for **autism spectrum**	All Contracts	0.3%
2010	Coverage for **children's early intervention services**	All Contracts	0.05%
2014	Coverage for **chemotherapy oral medications**	All Contracts	0
2014	Coverage for human **leukocyte antigen testing**	All Contracts	0
2014	Coverage for **dental hygienist**	All Contracts	0
2015	Coverage for **abuse-deterrent opioid analgesic medications**	All Contracts	0
2018	Coverage for **naturopath**	All Contracts	0
2018	Coverage for **preventive services**	All Contracts	0
2019	Coverage for **adult hearing aids**	All Contracts	0.20%
2019	Coverage for **abortion services**	Individual	0.14%
		Group	0.19%
2021	Coverage for **certified registered nurse anesthetists**	All Contracts	0
2021	Coverage for **certified midwives**	All Contracts	0
2021	Coverage for **HIV prevention drugs**	All Contracts	0
	Total cost for groups larger than 20:		**12.59%**
	Total cost for groups of 20 or fewer:		**12.64%**
	Total cost for individual contracts:		**10.90%**

Appendix B: Letter from the Committee on Health Coverage, Insurance and Financial Services with Proposed Legislation

STATE OF MAINE
ONE HUNDRED AND THIRTIETH LEGISLATURE
COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

June 30, 2021

Eric A. Cioppa
Superintendent
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Superintendent Cioppa:

Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on Health Coverage, Insurance and Financial Services to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing on the proposed legislation. Pursuant to that statute, we request that the Bureau of Insurance prepare a review and evaluation of **LD 1357, An Act To Require Private Insurance Coverage for Postpartum Care,** using the amendment proposed by the Sen. Carney, the bill's sponsor, that clarifies the intent that the bill apply to individual and group health insurance policies. A copy of the proposed amendment is attached.

During the committee's consideration of LD 1357, the committee identified several questions related to the current coverage for postpartum care. We ask that the Bureau also provide information on the following issues to the extent information is available:

- The extent to which current coverage for postpartum care is limited, including parameters for treatment of pelvic floor injuries;
- The potential impact of bundled payments on access to and coverage of postpartum care;
- An analysis of the recommendations outlined in the "Optimizing Postpartum Care" opinion published May 2018 by the American College of Obstetricians and Gynecologists and the extent to which those recommendations are not reflected in current coverage; and
- The extent to which the bill expands coverage beyond the State's essential benefits package and, if so, the estimated costs to the State to defray the costs of including the coverage in qualified health plans.

Please submit the report to the committee no later than January 1, 2022 so the committee can take final action on LD 1357 before the end of the Second Regular Session. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,

Sen. Heather B. Sanborn
Senate Chair

Rep. Denise A. Tepler
House Chair

Enclosure: Proposed Committee Amendment to LD 1357

cc: Marti Hooper, Bureau of Insurance
Sen. Anne Carney

100 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0100 TELEPHONE 207-287-1327

Appendix C: LD 1357 Original Bill

130th MAINE LEGISLATURE

FIRST SPECIAL SESSION-2021

Legislative Document **No. 1357**

S.P. 443 In Senate, April 7, 2021

An Act To Require Private Insurance Coverage for Postpartum Care

Received by the Secretary of the Senate on April 5, 2021. Referred to the Committee on Health Coverage, Insurance and Financial Services pursuant to Joint Rule 308.2 and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator CARNEY of Cumberland.
Cosponsored by Representative ZAGER of Portland and
Senators: BRENNER of Cumberland, VITELLI of Sagadahoc, Representative: PIERCE of Falmouth.

Printed on recycled paper

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

Sec. 1. 24-A MRSA §2743-B is enacted to read:

§2743-B. Maternity and postpartum care

An insurer that issues individual contracts providing maternity benefits shall provide coverage for services related to postpartum care, including coverage for development of a postpartum care plan; contact with the patient within 3 weeks of the end of pregnancy; a comprehensive postpartum visit, including a full assessment of the patient's physical, social and psychological well-being; treatment of complications of pregnancy and childbirth, including pelvic floor disorders and postpartum depression; assessment of risk factors for cardiovascular disease; and care related to pregnancy loss. Coverage must encompass the recommendations outlined in the "Optimizing Postpartum Care" opinion published May 2018 by the American College of Obstetricians and Gynecologists and support postpartum care as an ongoing process rather than an isolated visit and include services and support necessary to transition a patient to a healthy and stable condition.

Sec. 2. Application. This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2022. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

SUMMARY

This bill requires insurers, in individual policies that cover maternity benefits, to provide coverage for postpartum care that meets the recommendations of the American College of Obstetricians and Gynecologists.

Appendix D: LD 1357 Amendment

LD 1357
Draft Proposed Amendment
Proposed by Sponsor, Sen. Carney
For HCIFS Consideration

PROPOSED AMENDMENT to LD 1357,
An Act To Require Private Insurance Coverage for Postpartum Care

Amend the bill by adding after section 1 the following:

Sec. 2. 24-A MRSA §2834-D is enacted to read:

§2834-D. Maternity and postpartum care

An insurer that issues group contracts providing maternity benefits shall provide coverage for services related to postpartum care, including coverage for development of a postpartum care plan; contact with the patient within 3 weeks of the end of pregnancy; a comprehensive postpartum visit, including a full assessment of the patient's physical, social and psychological well-being; treatment of complications of pregnancy and childbirth, including pelvic floor disorders and postpartum depression; assessment of risk factors for cardiovascular disease; and care related to pregnancy loss. Coverage must encompass the recommendations outlined in the "Optimizing Postpartum Care" opinion published May 2018 by the American College of Obstetricians and Gynecologists and support postpartum care as an ongoing process rather than an isolated visit and include services and support necessary to transition a patient to a healthy and stable condition.

Sec. 3. 24-A MRSA §4234-F is enacted to read:

§4234-F. Maternity and postpartum care

A health maintenance organization that issues individual and group contracts providing maternity benefits shall provide coverage for services related to postpartum care, including coverage for development of a postpartum care plan; contact with the patient within 3 weeks of the end of pregnancy; a comprehensive postpartum visit, including a full assessment of the patient's physical, social and psychological well-being; treatment of complications of pregnancy and childbirth, including pelvic floor disorders and postpartum depression; assessment of risk factors for cardiovascular disease; and care related to pregnancy loss. Coverage must encompass the recommendations outlined in the "Optimizing Postpartum Care" opinion published May 2018 by the American College of Obstetricians and Gynecologists and support postpartum care as an ongoing process rather than an isolated visit and include services and support necessary to transition a patient to a healthy and stable condition.

Renumber the sections to read consecutively

SUMMARY

This amendment clarifies the sponsor's intent that the provisions in the bill apply to both individual and group contracts issued by insurers and health maintenance organizations.

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