PROPOSED
MANDATED HEALTH INSURANCE BENEFIT
FOR
COVERAGE FOR WOMEN'S HEALTH SERVICES
LD 1079

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

Prepared by the
Bureau of Insurance
January 1996

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EXECUTIVE SUMMARY

The Joint Standing Committee on Banking and Insurance of the 117th Maine Legislature on May 9, 1995, directed the Bureau of Insurance to review LD 1079 "An Act to Improve Coverage for Women's Health Services." The review was to be conducted using the criteria outlined in 24-A M.R.S.A. § 2752 regarding the social and financial impact of the proposed mandate, and the medical efficacy of the procedures covered under the proposal.

LD 1079 sets a maximum deductible of no more than $5 for screening mammograms for all health insurance policies under the current mandate for coverage. Additionally, HMOs would be required to provide screening mammograms on the same schedule as the current mandate. Insurance carriers and HMOs would be prohibited from denying coverage or limiting coverage because a person has been diagnosed as having a fibrocystic breast condition or has had a breast implantation. All plans would be required to provide coverage for the treatment of breast cancer by dose-intensive chemotherapy, autologous bone marrow transplants or stem cell transplants. LD 1079 also requires plans that designate certain physicians as primary care physicians (PCPs) to include physicians providing gynecological and obstetrical services (OB/Gyns) as primary care physicians.

Preventive care benefits are currently available through the standardized plans for individuals and small groups though not

many of these plans have been issued yet. Most insurance carriers and HMOs also offer products to individuals and groups of all sizes with preventive care benefits. If preventive care benefits are covered, typically they are provided with a low copay or at 100% with no deductible.

Insurance companies are currently prevented from denying coverage or limiting coverage for any health reason under the continuity of coverage law in most situations. Placing a specific prohibition for conditions related to fibrocystic breast condition or breast implantation would not significantly change current practice except for those obtaining insurance who had no previous insurance coverage.

Insurance plans typically exclude experimental procedures. Because some breast cancer treatments fall into this category, coverage of the treatment may be denied. These decisions are sometimes reversed by insurance companies due to appeals or court suits. Mandating certain breast cancer treatments could be requiring coverage of treatments not completely researched and proven effective.

Maine has a very high incidence of cancer cases, ranking 46th nationally. Breast cancer is the most diagnosed of new cancers and the second major cause of cancer death in women.

Eight states have some type of mandate regarding bone marrow transplants for the treatment of breast cancer. The National Association of Insurance Commissioners (NAIC) is working on a draft model law designed to provide minimum standards of coverage for health services that insurance companies may have previously deemed experimental. Some states have laws or pending legislation regarding OB/Gyns as PCPs or require direct access for those services by an OB/Gyn.

There is strong evidence of the medical efficacy of screening mammograms, and the cost is sufficiently high to deter some women from obtaining this service. While research studies have been done on bone marrow transplants, the findings are not conclusive enough to say that these treatments work better or as well as conventional treatment.

There may be an increase in utilization of screening mammography services by only requiring a copay of $5. There are no cost estimates available of how much premiums would increase due to this mandate at the time this report was prepared.

BACKGROUND

The Joint Standing Committee on Banking and Insurance of the 117th Maine Legislature on May 9, 1995, directed the Bureau of Insurance to review LD 1079 "An Act to Improve Coverage for Women's Health Services." The review was to be conducted using the criteria outlined in 24-A M.R.S.A. § 2752 regarding the social and financial impact of the proposed mandate, and the medical efficacy of the procedures covered under the proposal.

LD 1079 sets a maximum deductible of no more than $5 for screening mammograms for all health insurance policies under the current mandate for coverage. Additionally, HMOs would be required to provide screening mammograms on the same schedule as the current mandate. Insurance carriers and HMOs would be prohibited from denying coverage or limiting coverage because a person has been diagnosed as having a fibrocystic breast condition or has had a breast implantation. All plans would be required to provide coverage for the treatment of breast cancer by dose-intensive chemotherapy, autologous bone marrow transplants or stem cell transplants (referred to as "bone marrow transplants" in the remainder of the report). The effective date proposed was January 1, 1996.

LD 1079 also requires plans that designate certain physicians as primary care physicians to include physicians providing

gynecological and obstetrical services (OB/Gyns) as primary care physicians (PCPs).

Currently mammograms could be subject to a deductible, and for those who do not usually meet their deductibles this would act as a disincentive to have the test done. Managed care plans and the standardized plans required to be offered to individuals and groups do have preventive care benefits with little or no copay. Some managed care plans offer one or more self referred visits to an OB/Gyn or have some OB/Gyns as Primary Care Physicians.

Bone marrow transplants have typically been denied for insurance coverage because they are determined to be experimental treatments. Recently courts have overturned decisions of the insurance companies or the companies have settled out of court agreeing to pay for the treatment.

EVALUATION OF LD 1079 BASED ON REQUIRED CRITERIA

SOCIAL IMPACT

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

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

Breast cancer incidence rates for women have increased about 2% a year since 1980 nationwide, but recently leveled off at about 110 per 100,000. From the Bureau's annual report, breast cancer claims increased slightly to 1.6% of total health care claims for 1994. Most of the recent rise in cancer rates is believed to be due to marked increases in mammography utilization, allowing the detection of early stage breast cancers. In the Bureau's report, diagnostic mammograms decreased slightly from those reported in 1993 but the number of screening mammograms increased 21%. Overall Maine ranks 46th for incidence of cancer according to the ReliStar State Health Rankings for 1995 with 573 cases per 100,000 population.

Over a thousand transplants are in done in the U.S. Breast cancer is the most common disease for which a bone marrow transplant is now used.

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

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

Mammography services are readily available throughout the state.

There are over 115 major academic centers routinely using bone marrow transplants (BMT) for breast cancer in the United States and in Europe.

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

Mammograms are required to be covered but are typically subject to deductible and coinsurance levels. The standardized plans required to be offered by carriers in the individual and small group market cover preventive care services including mammograms at 100% and not subject to the deductible and the HMO plans cover preventive care services with no copay.

Insurance companies are currently prevented from denying coverage or limiting coverage for any health reason including fibrocystic breast or previous breast implantation. If there is no prior coverage a preexisting condition may only be excluded for 12 months. Pre-existing conditions are defined as conditions manifesting symptoms that would cause a ordinarily prudent person to seek medical advice, diagnosis, care or treatment recommended or received during the 12 months immediately preceding the effective date of the policy. Other health policies such as disability policies are not required to comply with this provision and may be placing exclusions or denying coverage for persons with fibrocystic breast condition. As written, this mandate does not apply to disability policies.

Insurance plans typically exclude experimental procedures. Because some breast cancer treatments fall in this category, coverage of the treatment may be denied. The exclusion provisions can be ambiguous or misleading to consumers. Decisions not to cover the treatments are sometimes reversed by insurance companies due to appeals or court suits.

Some managed care plans currently have OB/Gyns as PCPs or allow self-referred visits.

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;

See Question 5.

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;

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

Bone marrow or stem cell transplants can cost from $120,000 to $150,00, making it very difficult for an individual to afford without insurance coverage.

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

While current utilization may not be high for screening tests, oncologist and radiologists as well as consumers who are aware of the benefits of these procedures support them. Breast cancer is the most diagnosed of new cancers and the second major cause of cancer death in women. The estimated number of new cases in Maine for 1995 of breast cancer is 910 and the estimated mortality is 250.

Bone marrow transplants are not utilized by large portion of the population but their coverage has substantial impact on the individual affected.

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;

As reported by the NY Times, "the last five years have brought a dramatic increase in lawsuits provoked by insurance industry denials for medically advanced treatments like bone marrow. Any move to straighten out the debate would certainly be welcomed by patients and health care providers, as well as by judges who are forced to make painful decisions."

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

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

No information available.

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

A summary of mandated coverage in other states is included in Appendix B. Eight states have some type of mandate regarding bone marrow transplants for the treatment of breast cancer. The National Association of Insurance Commissioners (NAIC) is working on a draft model law designed to provide minimum standards of coverage for health services that insurance companies may have previously deemed experimental, clinical investigative or educational. Coverage could not be denied for treatments written up in peer-review medical literature that are demonstrated to be as effective as other standard treatments.

Illinois, Iowa, Florida, Minnesota and Texas have prohibitions against exclusions or denials of coverage due to a fibrocystic breast condition. Six states have laws and seven have pending legislation regarding OB/Gyns as primary care physicians or require direct access for those services delivered by an OB/Gyn.

A recent article in the St. Louis Post-Dispatch reported that Blue Cross and Blue Shield of Missouri started covering bone marrow transplants for breast cancer November 1, 1995 even though they had initially resisted covering the treatment and state law requiring coverage was not effective until January 1, 1996. Missouri law does allow a lifetime maximum of no less than $100,00 for the treatment.

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

No information available.

11. The alternatives to meeting the identified need;

Supporting the establishment of a national advisory board to oversee outcomes research on new technologies, like bone marrow transplants has been suggested as a partial remedy. Then the reimbursement for the patient care costs would be provided but would be restricted for use under the study protocols and within the academic centers. After the procedure is sufficiently studied it would be diffused out into the general public.

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

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

Health insurance was designed originally to deal with low frequency, high cost occurrences (catastrophes), but the role of health insurance is changing to include more benefits for common

procedures and services. Under a reactive health insurance plan, that is, one which deals with existing problems, it is more economical for the consumer to budget for scheduled service such as screening mammograms, rather than paying the additional premium to have insurance coverage. A proactive plan, which deals with health maintenance before a disease condition exists, would find screening mammograms consistent with its policy and within the scope of insurance coverage. This type of coverage is seen in HMO plans.

In a 1993 Blue Cross newsletter to Select subscribers, the question of who should pay for experimental treatments was discussed. Experimental or investigational treatments are typically not covered by insurance policies. In the past, research was often funded by federal research dollars - tax dollars provided to the National Institutes of Health for example, as well as research grants to drug companies. In recent years, however sources of funds have been reduced.

The federal government believes that if insurance carriers agree to pay for traditional methods of treating a sick person and experimental methods are used to replace traditional treatments, then insurance companies should pay benefits for the alternative treatments. On the other hand, many people don't want their money spent on untested, unproven treatments.

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

There is no apparent social stigma.

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

No input received.

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

Additional mandated benefits could be a factor - but is not considered the major reason for companies shifting to self-insurance plans. In the Employee Benefit Plan Review's 1994 Group Accident and Health Survey, they stated that the prevalence of self funding, as shown in the volume of Administrative Services Only (ASO) contracts and minimum premium business, has remained relatively constant over the last seven years. The drop in self-funded plans over the past few years has been directly offset by a similar rise in managed care plans.

FINANCIAL IMPACT

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

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

The unit cost of screening mammography is controlled by volume. If more incentive is given to receive a mammogram, higher utilization can be maintained, and lower unit costs could result.

The costs for transplants have been decreasing with improvements in technology and efforts to find the best place to provide the care. As an example, hospital stays averaged 24 to 37 days a few years ago and have dropped to only 5 to 8 days now. It is impossible to predict if these costs will continue to decrease if coverage is mandated.

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

Since screening tests are performed on a schedule, it is unlikely that inappropriate use will increase with this mandate. Current American Cancer Society guidelines establish appropriate use of screening mammograms similar to those proposed for mammograms.

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

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

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

Utilization could be controlled by following American Cancer Society guidelines for screening tests. Breast cancer treatments could be required to be preapproved and meet utilization review criteria.

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

No information available.

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

There are not cost estimates available of how much premiums would increase due to this mandate at the time this report was prepared.

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

No information available.

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

While screening tests will avoid greater cancer treatment costs from more advanced stage disease, the overall costs will increase initially. While bone marrow transplants are a low incidence treatment, the cost of each treatment is high.

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.

Although the mandate by itself does not represent a large increase in premiums, the cumulative effect upon employers could cause:

- Small companies could elect to drop, or postpone plans to obtain, insurance coverage for employees,
- Medium-sized employers could drop other benefits and/or shift more of the cost to employees, and

- Large companies could shift to self insurance. Although the cost of mandates is not a major reason for this shift, it is a factor.

MEDICAL EFFICACY

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

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

Studies have shown that screening mammography can lead to early detection and treatment of breast cancer, which increases the survival rate and quality of life for those involved. Breast cancers detected at a size under 5 millimeters in diameter have a ninety percent cure rate.

While some research studies have been done on bone marrow transplants for breast cancer treatment, they have been mostly based on non-randomized comparisons. There are two major trials

in high-risk primary breast cancer, and there are two major trials in metastatic disease that are underway. None of them have been completed, and, in the primary disease setting, will not be available until near the turn of the century. To wait for the randomized trials and not permit the treatment option breaches the physician's feelings of responsibility to the patient.

Dr. Jeffrey Lerner, Vice President for Strategic Planning with ECRI stated during the NAIC public hearing regarding experimental treatments that a review of 1,500 articles and the North American Bone Marrow Registry confirms their findings that there is no evidence in the literature today that actually says that bone marrow transplants for metastatic breast cancer works either equivalently or as well as conventional treatment.

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

Not applicable.

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

Not applicable.

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

Not applicable.

BALANCING THE EFFECTS

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

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

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

While bone marrow transplants cost more than conventional-dose therapy, calculating the cost by the number of disease-free women years, the cost per disease-free women year is not much different for the different treatments.

Coverage of bone marrow transplants would not affect the cost of health care overall substantially, but has a large impact on the

individual families. As long as there continues to be disagreement about what cancer treatments should be covered by the insurance policy when deemed necessary by the medical community, the courts will continue to be asked to make these decisions.

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 mandated benefits of this proposal could be considered separately for the purposes of a mandated offer. If consumers and the physicians who serve them are educated as to the benefits of screening tests, a demand could be created among employee groups for their employers to offer coverage. If this scenario developed then the presence of a mandated offering would mean that the coverage would be available to the employer. Preventive care services are already available for small group and individual policies from the standardized plans that are required to be offered.

As for bone marrow transplants, because mandates are not viewed as desirable unless they are pressured by their certificate holders, only those groups which contain members who have a high probability of utilizing the service are likely to request coverage. This would lead to higher premiums for the coverage because the risk would not be spread over as many covered

individuals, and those with coverage are more likely to utilize the service.

APPENDIX A

LD 1079

Charge to the Bureau

SENATE

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ONE HUNDRED AND SEVENTEENTH LEGISLATURE

COMMITTEE ON BANKING AND INSURANCE

May 9, 1995

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

Dear Mrs. Hooper:

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

LD 1079 - An Act to Improve Coverage for Women's Health Services.

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

Sincerely,

I. Joel Abromson
Senate Chair

Marc J. Vigue
House Chair

BAN/cmm

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117th MAINE LEGISLATURE

FIRST REGULAR SESSION-1995

Legislative Document No. 1079

H.P. 782 House of Representatives, March 30, 1995

An Act to Improve Coverage for Women's Health Services.

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

JOSEPH W. MAYO, Clerk

Presented by Representative MITCHELL of Portland.
Cosponsored by Senator McCORMICK of Kennebec and
Representatives: BRENNAN of Portland, DAVIDSON of Brunswick, DORE of Auburn, FITZPATRICK of Durham, GERRY of Auburn, LOVETT of Scarborough, MADORE of Augusta, MARVIN of Cape Elizabeth, MITCHELL of Vassalboro, NADEAU of Saco, PINKHAM of Lamoine, POVICH of Ellsworth, SAXL of Portland, SHIAH of Bowdoinham, STEVENS of Orono, THOMPSON of Naples, WATSON of Farmingdale, WINGLASS of Auburn, Senators: BUSTIN of Kennebec, PARADIS of Aroostook, PINGREE of Knox, RAND of Cumberland.

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

PART A

Sec. A-1. 24 MRSA §2320-A, as amended by PL 1991, c. 701, §2, is further amended to read:

§2320-A. Breast health services

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 mammography 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:

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

B. At least once a year for women age 50 and over.

~~3. Application. This section applies to all contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after March 1, 1991. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.~~

4. Reports. Each nonprofit hospital and medical care service organization subject to this section shall report to the superintendent its experience for each calendar year ~~beginning with 1991 not~~ no later than April 30th of the following calendar year. The report must include the information required and be presented in the form prescribed by the superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.

5. Deductibles, copayments and coinsurance. An individual or group nonprofit medical services plan contract and a nonprofit health care plan contract may impose a deductible of no more than $5 and no other copayments for routine, low-dose screening mammograms.

6. Prohibited conduct. An individual or group nonprofit medical services plan contract and a nonprofit health care plan contract may not deny coverage or cancel, terminate or fail to renew the plan or contract or exclude, reduce or limit benefits, impose a waiting period or exclusion for a preexisting condition or otherwise limit or exclude coverage because a person has been diagnosed as having a fibrocystic breast condition or has had a breast implantation.

7. Required breast cancer treatment coverage. An individual or group nonprofit medical services plan contract and a nonprofit health care plan contract must provide coverage for the treatment of breast cancer by dose-intensive chemotherapy, autologous bone marrow transplants or stem cell transplants, subject to the same requirements for deductibles, copayments or coinsurance as other services under the contracts.

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

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

§2332-F. Gynecological and obstetrical services

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

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

PART B

Sec. B-1. 24-A MRSA §2745-A, as amended by PL 1991, c. 701, §6, is further amended to read:

§2745-A. Breast health services

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 mammography 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:

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

B. At least once a year for women age 50 and over.

~~**3. Application.** This section applies to all policies, contracts and certificates that cover radiologic procedures, except those policies that cover only dental procedures, accidental injury or specific diseases, executed, delivered, issued for delivery, continued or renewed in this State on or after March 1, 1991. For purposes of this section, all policies and contracts are deemed to be renewed no later than the next yearly anniversary of the policy or contract date.~~

4. Reports. Each insurer that issues policies subject to this section shall report to the superintendent its experience for each calendar year ~~beginning with 1991 not~~ no later than April 30th of the following calendar year. The report must include the information required and be presented in the form prescribed by the superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.

5. Deductibles, copayments and coinsurance. An individual insurance policy may impose a deductible of no more than $5 and no other copayments or coinsurance for routine, low-dose screening mammograms.

6. Prohibited conduct. An individual insurance policy may not deny coverage or cancel, terminate or fail to renew the policy or exclude, reduce or limit benefits, impose a waiting period or exclusion for a preexisting condition or otherwise limit or exclude coverage because a person has been diagnosed as having a fibrocystic breast condition or has had a breast implantation.

7. Required breast cancer treatment coverage. An individual insurance policy must provide coverage for the treatment of breast cancer by dose-intensive chemotherapy, autologous bone marrow transplants or stem cell transplants, subject to the same requirements for deductibles, copayments or coinsurance charges as other services under the policy.

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

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

§2745-C. Gynecological and obstetrical services

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

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

PART C

Sec. C-1. 24-A MRSA §2837-A, as amended by PL 1991, c. 701, §9, is further amended to read:

§2837-A. Breast health services

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 mammography 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:

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

B. At least once a year for women age 50 and over.

~~**3. Application.** This section applies to all policies, contracts and certificates that cover radiologic procedures, except those policies that cover only dental procedures, accidental injury or specific diseases, executed, delivered, issued for delivery, continued or renewed in this State on or after March 1, 1991. For purposes of this section, all policies and contracts are deemed to be renewed no later than the next yearly anniversary of the policy or contract date.~~

4. Reports. Each insurer that issues policies subject to this section shall report to the superintendent its experience for each calendar year ~~beginning with 1991 not~~ no later than April 30th of the following calendar year. The report must include the information required and be presented in the form prescribed by the superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.

5. Deductibles, copayments and coinsurance. A group insurance policy or contract may impose a deductible of no more than $5 and no other copayments or coinsurance for routine, low-dose screening mammograms.

6. Prohibited conduct. A group insurance policy or contract may not deny coverage or cancel, terminate or fail to renew the policy or contract or exclude, reduce or limit benefits, impose a waiting period or exclusion for a preexisting condition or otherwise limit or exclude coverage because a person has been diagnosed as having a fibrocystic breast condition or has had a breast implantation.

7. Required breast cancer treatment coverage. A group insurance policy or contract must provide coverage for the treatment of breast cancer by dose-intensive chemotherapy, autologous bone marrow transplants or stem cell transplants, subject to the same requirements for deductibles, copayments or coinsurance as other services under the policy or contract.

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

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

Sec. C-2. 24-A MRSA §2850-A is enacted to read:

§2850-A. Gynecological and obstetrical services

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

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

PART D

Sec. D-1. 24-A MRSA §§4237 and 4238 are enacted to read:

§4237. Breast health services

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 mammography coverage. An individual or group contract 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 policy or contract must reimburse for screening mammograms performed:

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

B. At least once a year for women age 50 and over.

3. Reports. Beginning in 1997, each health maintenance organization subject to this section shall report to the superintendent its experience for each calendar year no later than April 30th of the following calendar year. The report must include the information required and be presented in the form

prescribed by the superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.

4. Deductibles, copayments and coinsurance. An individual or group contract may impose a deductible of no more than $5 and no other copayments or coinsurance for routine, low-dose screening mammograms.

5. Prohibited conduct. An individual or group contract may not deny coverage or cancel, terminate or fail to renew a plan or contract or exclude, reduce or limit benefits, impose a waiting period or exclusion for a preexisting condition or otherwise limit or exclude coverage because a person has been diagnosed as having a fibrocystic breast condition or has had a breast implantation.

6. Required breast cancer treatment coverage. An individual or group contract must provide coverage for the treatment of breast cancer by dose-intensive chemotherapy, autologous bone marrow transplants or stem cell transplants, subject to the same requirements for deductibles, copayments or coinsurance as other requirements for services under the contract.

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

§4238. Gynecological and obstetrical services

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

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

PART E

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

STATEMENT OF FACT

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

1. Copayments and coinsurance may not be imposed for routine, low-dose screening mammograms. A deductible of no more than $5 may be charged.

2. Coverage may not be denied or in any way affected by a person having had a prior diagnosis for a fibrocystic breast condition or a breast implantation.

3. Coverage must be provided for breast cancer treatment, subject to the same deductibles, copayments and coinsurance as for other services.

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

APPENDIX B

States With Mandates

Cancer Facts and Figures 1995

MANDATED BENEFITS:

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

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

MANDATED BENEFITS:

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

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

MANDATED BENEFITS:

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

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

MANDATED BENEFITS:

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

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

MANDATED BENEFITS:

MISCELLANEOUS MANDATES:

State	Citation	Coverage
		TRANSPLANTS
FL	§ 627.4236 (1992)	Bone marrow transplant following albative therapy with curative intent.
GA	§ 33-30-4.1 (group) (1988)	Mandated offering of benefits for heart transplants; coverage levels same as for other physical illnesses.
	§ 33-30-4.4 (1995)	Mandated offer of benefits for bone marrow transplant for treatment of breast cancer
MA	§ 175:47M (group) (1992); § 176A:80 (hospital service plan); § 176G:4F (HMOs); § 32A:17A (state employeeplan)	Shall provide coverage for bone marrow transplant for person diagnosed with breast cancer that has progressed to metastatic disease.
MN	§ 62A.307	Must provide coverage for treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplant.
MO	§ 376.1200 (ind.) (group) (1995)	Shall offer coverage for dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for treatment of breast cancer. Policy may contain a provision imposing a lifetime benefit maximum of not less than $100,000 for the chemotherapy/bone marrow transplant or stem cell transplants
NH	§ 415:18-c	Must provide coverage to residents of state in group whose principal place of employment is in state, for autologous bone marrow transplants treatment for breast cancer.
RI	§ 27-18-36 § 27-19-32 (nonprofits) § 27-20-27 § 27-41-41 (HMOs)	Must cover new cancer therapies still under investigation if meet certain guidelines in statute.
VA	§ 38.2-3418.1:1	Mandated offer of coverage for treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplant or stem cell transplants.

CANCER FACTS & FIGURES-1995

AMERICAN CANCER SOCIETY®

Estimated number of new cancer cases in 1995 by state, total 1,252,000 (excluding Puerto Rico).*

*Excluding basal and squamous cell skin cancer and carcinoma in situ

REVISED 1/95

Estimated New Cancer Cases and Deaths by Sex for All Sites, United States, 1995*

	Estimated New Cases			Estimated Deaths		
	Both Sexes	Male	Female	Both Sexes	Male	Female
All sites	1,252,000	677,000	575,000	547,000	289,000	258,000
Buccal cavity & pharynx (Oral)	28,150	18,800	9,350	8,370	5,480	2,890
Lip	2,500	1,900	600	100	80	20
Tongue	5,550	3,600	1,950	1,870	1,200	670
Mouth	11,000	6,900	4,100	2,300	1,300	1,000
Pharynx	9,100	6,400	2,700	4,100	2,900	1,200
Digestive organs	223,000	118,000	105,000	124,330	66,130	58,200
Esophagus	12,100	8,800	3,300	10,900	8,200	2,700
Stomach	22,800	14,000	8,800	14,700	8,800	5,900
Small intestine	4,600	2,400	2,200	1,120	590	530
Large intestine (Colon-Rectum)	100,000	49,000	51,000	47,500	23,000	24,500
Rectum (Colon-Rectum)	38,200	21,700	16,500	7,800	4,200	3,600
Liver and biliary passages	18,500	9,800	8,700	14,200	7,700	6,500
Pancreas	24,000	11,000	13,000	27,000	13,200	13,800
Other and unspecified digestive	2,800	1,300	1,500	1,110	440	670
Respiratory system	186,300	108,400	77,900	162,950	99,470	63,480
Larynx	11,600	9,000	2,600	4,090	3,200	890
Lung	169,900	96,000	73,900	157,400	95,400	62,000
Other & unspecified respiratory	4,800	3,400	1,400	1,460	870	590
Bone	2,070	1,100	970	1,280	750	530
Connective tissue	6,000	3,300	2,700	3,600	1,800	1,800
Melanoma of skin	34,100	18,700	15,400	7,200	4,500	2,700
Breast	183,400	1,400	182,000	46,240	240	46,000
Genitol organs	333,100	252,200	80,900	67,380	40,980	26,400
Cervix uteri (Uterus)	15,800	—	15,800	4,800	—	4,800
Corpus & unspecified (Uterus)	32,800	—	32,800	5,900	—	5,900
Ovary	26,600	—	26,600	14,500	—	14,500
Other & unspecified genital, female	5,700	—	5,700	1,200	—	1,200
Prostate	244,000	244,000	—	40,400	40,400	—
Testis	7,100	7,100	—	370	370	—
Other & unspecified genital, male	1,100	1,100	—	210	210	—
Urinary organs	79,300	54,400	24,900	22,900	14,600	8,300
Bladder	50,500	37,300	13,200	11,200	7,500	3,700
Kidney & other urinary	28,800	17,100	11,700	11,700	7,100	4,600
Eye	1,870	1,000	870	240	130	110
Brain & central nervous system	17,200	9,700	7,500	13,300	7,300	6,000
Endocrine glands	15,380	3,900	11,480	1,780	760	1,020
Thyroid	13,900	3,200	10,700	1,120	440	680
Other endocrine	1,480	700	780	660	320	340
Leukemia	25,700	14,700	11,000	20,400	11,100	9,300
Lymphocytic leukemia	11,000	6,700	4,300	6,400	3,500	2,900
Granulocytic leukemia	11,100	5,900	5,200	8,400	4,600	3,800
Other & unspecified leukemia	3,600	2,100	1,500	5,600	3,000	2,600
Other blood & lymph tissues	71,200	41,100	30,100	34,450	18,120	16,330
Hodgkin's disease	7,800	4,500	3,300	1,450	820	630
Non-Hodgkin's lymphoma	50,900	29,500	21,400	22,700	12,000	10,700
Multiple myeloma	12,500	7,100	5,400	10,300	5,300	5,000
All other & unspecified sites	45,230	30,300	14,930	32,580	17,640	14,940

*Excludes basal and squamous cell skin cancers and in situ carcinomas except bladder. Carcinoma in situ of the uterine cervix accounts for about 65,000 new cases annually, carcinoma in situ of the female breast accounts for about 25,000 new cases annually, and melanoma carcinoma in situ accounts for about 10,000 new cases annually. Overall, about 120,000 new cases of carcinoma in situ of all sites of cancer are diagnosed each year.

Basal cell and squamous cell skin cancers account for more than 800,000 new cases annually. About 2,100 nonmelanoma skin cancer deaths will occur in 1995.

Incidence estimates are based on rates from NCI SEER program 1989-91.

Estimated New Cancer Cases, by State, 1995*

State	All Sites	Female Breast	Colon & Rectum	Lung	Oral	Uterus	Prostate	Skin Melanoma	Bladder	Leukemia
Alabama	21,400	3,000	2,000	3,100	320	810	3,900	530	640	460
Alaska	1,200	130	140	170	70	30	180	70	60	10
Arizona	18,500	2,500	1,800	2,500	390	540	4,000	590	830	430
Arkansas	14,100	1,800	1,600	2,300	200	600	3,000	360	550	290
California	120,000	17,600	12,200	15,600	3,000	4,800	23,100	4,500	4,900	2,600
Colorado	13,300	2,100	1,500	1,500	330	560	3,100	510	570	280
Connecticut	16,200	2,300	2,000	2,100	420	630	3,000	410	800	360
Delaware	3,800	570	480	560	110	190	520	150	210	70
Dist. of Columbia	3,500	620	440	360	90	100	780	20	130	60
Florida	88,700	11,800	9,300	13,000	2,300	3,300	19,000	2,300	4,300	1,700
Georgia	28,400	3,900	2,600	4,200	680	850	5,700	730	900	590
Hawaii	4,200	440	470	520	140	110	790	50	110	80
Idaho	4,400	700	470	500	90	80	1,100	140	110	110
Illinois	58,500	9,200	6,900	7,400	1,400	2,400	11,500	1,400	2,100	1,300
Indiana	28,600	4,100	3,300	4,200	550	1,100	4,800	670	1,200	530
Iowa	14,700	2,200	1,800	1,900	240	500	3,200	490	660	320
Kansas	12,800	1,800	1,500	1,700	330	600	2,600	430	330	300
Kentucky	21,300	2,400	2,400	3,600	440	910	3,500	520	700	440
Louisiana	21,200	3,200	2,000	3,200	550	610	4,200	350	430	430
Maine	7,100	910	790	1,000	160	160	1,400	200	370	110
Maryland	24,100	3,500	2,900	3,300	590	980	4,900	580	930	440
Massachusetts	32,300	5,000	4,200	3,900	710	980	5,900	940	1,700	550
Michigan	46,100	6,800	5,300	6,100	860	1,700	8,700	1,000	1,900	1,000
Minnesota	20,200	3,100	2,400	2,300	430	680	4,800	550	840	510
Mississippi	13,600	1,700	1,400	1,900	370	440	3,000	300	370	270
Missouri	28,500	4,200	3,300	4,200	500	1,200	4,700	810	1,000	640
Montana	4,100	560	410	540	50	100	780	140	130	90
Nebraska	7,700	1,200	860	940	180	360	1,600	180	250	150
Nevada	6,400	780	560	1,000	130	220	1,100	230	360	120
New Hampshire	5,200	880	460	700	140	180	980	180	230	90
New Jersey	43,300	7,000	5,300	5,300	990	1,700	8,100	1,100	2,100	750
New Mexico	6,000	800	560	700	160	330	1,100	210	330	150
New York	88,100	14,500	10,700	11,200	2,000	3,900	16,100	2,100	3,900	1,700
North Carolina	34,500	4,600	3,500	4,900	930	1,400	7,500	1,100	1,300	680
North Dakota	3,400	480	500	360	70	140	1,000	40	120	70
Ohio	57,600	8,400	6,600	8,100	1,100	2,200	10,500	1,400	2,400	1,200
Oklahoma	16,400	2,100	1,700	2,500	280	630	3,100	530	670	320
Oregon	15,500	2,000	1,500	2,200	370	460	3,200	460	600	340
Pennsylvania	71,500	11,200	8,300	9,200	1,300	3,100	13,800	1,700	3,000	1,400
Rhode Island	5,700	880	690	710	80	100	950	180	280	130
South Carolina	17,600	2,700	1,900	2,500	490	760	3,700	430	710	290
South Dakota	3,400	420	430	380	30	140	840	100	200	80
Tennessee	26,300	3,600	2,800	4,000	540	950	5,000	750	920	530
Texas	74,600	9,800	7,900	10,800	2,000	3,200	13,000	1,800	2,700	1,600
Utah	5,000	850	530	410	40	200	1,500	300	180	130
Vermont	2,700	390	310	320	40	70	570	110	170	60
Virginia	29,200	4,500	2,900	4,000	630	1,100	5,800	810	1,000	590
Washington	23,000	3,400	2,200	3,200	540	820	4,600	680	930	510
West Virginia	10,900	1,300	1,300	1,700	240	420	1,700	280	470	200
Wisconsin	25,300	3,800	2,900	2,900	530	1,200	5,700	650	1,100	600
Wyoming	1,900	290	200	230	20	60	410	40	60	40
United States	1,252,000	182,000	138,200	169,900	28,150	48,600	244,000	34,100	50,500	25,700
Puerto Rico	10,600	1,100	1,000	790	380	550	2,700	75	240	220

*Does not include carcinoma in situ or basal and squamous cell skin cancers.

These estimates are offered as a rough guide and should be interpreted with caution. They are calculated according to the distribution of estimated 1995 cancer deaths by state.

Cancer Mortality, by State, 1995

State	Reported Death Rate per 100,000*	Estimated Number of Deaths									
		All Sites	Female Breast	Colon & Rectum	Lung	Oral	Uterus	Prostate	Skin Melanoma	Bladder	Leukemia
Alabama	180	9,100	710	800	2,800	110	160	590	140	140	360
Alaska	173	500	40	50	170	10	10	30	10	10	10
Arizona	157	8,300	630	710	2,400	100	110	680	140	180	360
Arkansas	178	6,100	480	630	2,100	80	130	530	70	120	250
California	165	51,200	4,400	4,900	14,000	830	1,000	3,700	950	1,100	2,000
Colorado	148	6,000	560	630	1,400	110	130	530	100	150	230
Connecticut	169	7,000	580	760	2,000	130	130	520	90	170	260
Delaware	196	1,700	150	190	540	50	30	90	30	60	50
Dist. of Columbia	227	1,600	160	200	360	20	40	120	10	30	50
Florida	167	39,100	2,900	3,600	12,200	680	750	3,100	490	900	1,400
Georgia	176	12,200	970	980	3,800	200	200	920	150	190	490
Hawaii	137	1,800	110	190	510	30	30	140	10	20	50
Idaho	148	1,900	190	190	440	30	20	170	20	30	80
Illinois	180	25,900	2,400	2,800	6,900	450	550	1,900	300	460	1,100
Indiana	178	12,500	1,000	1,200	4,000	160	210	790	130	270	450
Iowa	159	6,500	590	780	1,800	70	120	520	100	160	270
Kansas	159	5,600	480	610	1,600	90	110	410	110	70	230
Kentucky	191	9,300	610	950	3,300	130	190	570	130	150	350
Louisiana	193	9,200	810	960	2,900	160	120	710	90	110	350
Maine	185	3,200	250	300	1,000	60	30	220	40	70	100
Maryland	192	10,500	870	1,100	3,100	150	220	830	110	210	340
Massachusetts	179	13,800	1,200	1,700	3,600	250	200	970	180	380	430
Michigan	177	20,200	1,600	2,300	5,500	270	430	1,500	210	460	820
Minnesota	157	8,800	780	950	2,100	120	150	770	110	160	430
Mississippi	180	6,100	470	620	1,700	120	90	490	70	60	210
Missouri	176	12,600	1,000	1,300	4,000	140	280	800	180	230	500
Montana	161	1,800	130	180	520	10	20	130	20	40	70
Nebraska	158	3,400	320	350	880	60	60	260	30	50	120
Nevada	183	2,900	190	210	1,000	30	40	200	50	20	90
New Hampshire	179	2,400	230	230	650	40	50	190	40	70	70
New Jersey	185	18,700	1,800	2,300	4,800	290	340	1,300	210	490	600
New Mexico	146	2,600	210	220	670	60	70	180	50	40	120
New York	175	38,500	3,700	4,200	10,500	580	880	2,600	450	850	1,300
North Carolina	174	15,300	1,200	1,500	4,600	270	300	1,300	220	300	550
North Dakota	158	1,500	130	130	340	20	40	170	20	30	50
Ohio	181	25,000	2,100	2,600	7,400	320	550	1,800	240	520	970
Oklahoma	169	6,900	500	650	2,200	70	140	520	100	120	230
Oregon	168	6,900	480	590	2,100	110	90	540	110	120	280
Pennsylvania	180	31,200	2,800	3,500	8,500	380	720	2,400	340	680	1,100
Rhode Island	179	2,400	240	290	650	30	30	130	40	60	90
South Carolina	177	7,800	690	770	2,400	140	160	640	90	190	210
South Dakota	151	1,500	120	150	350	10	20	130	20	60	60
Tennessee	179	11,400	880	1,200	3,700	140	180	780	180	190	410
Texas	166	33,100	2,600	3,300	10,200	630	720	2,200	390	560	1,300
Utah	125	2,200	220	230	410	20	40	240	80	40	80
Vermont	174	1,100	110	120	310	10	10	80	20	30	40
Virginia	180	12,800	1,200	1,200	3,600	180	250	950	170	220	470
Washington	164	10,300	850	870	3,000	160	170	790	150	220	410
West Virginia	182	4,700	330	500	1,600	80	90	280	50	120	150
Wisconsin	165	11,100	950	1,100	2,600	170	280	930	150	280	430
Wyoming	155	800	80	80	200	10	10	60	10	10	30
United States	173	547,000	46,000	55,300	157,400	8,370	10,700	40,400	7,200	11,200	20,400
Puerto Rico	128	4,800	330	490	610	170	110	610	25	80	160

*Average annual mortality rate for 1987-1991, adjusted to the age distribution of the 1970 US census population.

APPENDIX C

List of Blue Cross OB/Gyns that practice as PCPs

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

Monday, December 11, 1995

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

Region/Grp ID	Prov_ID	First Name	Middle	Last Name	MD/DO	Grp Practice Name	City	HMO Prac Type	SB Prac Type
622-1079	014459	J.	Donald	Burgess	M.D.	Mere Point OB/GYN Associates	Brunswick	B	B
446-0663	000267	Arlene	J.	Cenedella	M.D.	Cenedella, M.D., P.A.	Presque Isle	B	B
622-1080	014462	Gregory	L.	Gimbel	M.D.	Mere Point OB/GYN Associates	Brunswick	S	B
529-0942	016924	Robert	K.	Greene	M.D.	State Street OB/GYN, P.A.	Portland	B	B
525-0935	016782	Richard	L.	Littlefield	D.O.		Skowhegan	B	B
529-0943	016923	Thomas	J.	Sunshine	M.D.	State Street OB/GYN, P.A.	Portland	B	B
196-0293	002447	James		Wilberg	M.D.	Southern Maine OB/GYN	Portland	B	B
138-0213	001837	William	T.	Yates	M.D.		Farmington	B	B

APPENDIX C

List of Blue Cross OB/Gyns that practice as PCPs

Brian K. Atchinson
Superintendent

Nancy H. Johnson
Deputy Superintendent

Alessandro A. Iuppa
Deputy Superintendent

State House Station 34
Augusta, Maine 04333
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DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

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

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

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

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

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

Respectfully Submitted,

Brian K. Atchinson

BRIAN K. ATCHINSON
Superintendent

			SCREENING MAMMOGRAPHY REPORT 1994						# Screening		# Diagnostic	
	TOTAL		Screening Mammograms		Diagnostic Mammograms		Breast Cancer Treatment		Mammograms		Mammograms	
COMPANY	Individual	Group	Individual	Group	Individual	Group	Individual	Group	Individual	Group	Individual	Group
AETNA LIFE INS. CO.	$26,700	$16,688,186		$22,901		$17,855		$91,572		631		519
AETNA LIFE & ANNUITY	$2,377				$125		$332		0		1	
AID ASSOC. FOR LUTHERANS	$991		$0		$12		$0		0		1	
AMER CAS OF R PA	$2,000	$0	$0	$0	$0	$0	$0	$0	0	0	0	0
AMERICAN FAMILY LIFE	$1,299,240	$0	$0	$0	$0	$0	$0	$0	0	0	0	0
AMER REPUBLIC	$950,614	$26,802	$1,968	$0	$393	$0	$49,957	$0	28	0	45	0
BLUE ALLIANCE MUT	$2,373,100	$36,800,225	$1	$11	$0	$0	$10,330	$170,034	1	0	0	3
BCBS	$98,242,049	$281,428,068	$161,268	$461,970	$149,545	$428,392	$705,252	$2,192,170	3499	10025	3184	9122
CENTRAL STATES	$58,483		$0		$74		$0		0		1	
COMBINED	$184,746		$1,058		$0		$0		40		0	
CONN GEN LIFE	$0	$20,484,948	$0	$10,077	$0	$16,753	$0	$4,352,045	0	498	0	386
CONTINENTAL ASSURANCE	$2,241	$37,246	$0	$4,699	$0	$4,360	$0	$26,615	0	37	0	35
CONTINENTAL CASUALTY	$8,734	$120,458	$0	$0	$28	$0	$0	$0	0	0	1	0
CUNA MUTUAL	$0	$433,222	$0	$146	$0	$744	$0	$0	0	6	0	26
EMPLOYERS HEALTH	$190	$19,269	$0	$26	$0	$0	$0	$0	0	1	0	0
FIDEL SEC PAY POWER	$0	$10,987,608	$0	$15,380	$0	$22,130	$0	$84,105	0	630	0	701
FORTIS	$0	$114,932	$0	$64	$0	$106	$0	$0	0	2	0	2
GUARDIAN LIFE	$0	$3,158,493	$0	$3,428	$0	$2,916	$0	$76,281	0	99	0	98
HORACE MANN	$0	$34,393	$0	$0	$0	$0	$0	$0	0	0	0	0
JOHN ALDEN		$9,432,450		$9,596		$8,759		$215,616		182		
LINCOLN NATIONAL	$0	$74,653	$0	$0	$0	$26	$0	$0	0	0	0	1
METRAHEALTH	$49,234	$20,170,947	$0	$40,382	$0	$39,400	$548	$26,216	0	833	0	783
MUTUAL OF OMAHA	$0	$174,469	$618	$4,096	$1,121	$1,017	$262,771	$715	13	104	21	23
NEW YORK LIFE	$0	$15,663,279	$16	$42,086	$229	$37,398	$5,721	$266,767	0	1086	0	905
NORTHWESTERN NATIONAL		$1,270,037		$175		$280		$16,805		6		7
PIONEER	$607,140	$23,279	$0	$0	$0	$0	$0	$0	0	0	0	0
PRINCIPAL MUTUAL	$0	$13,395,842	$0	$17,234	$0	$23,253	$0	$71,962	$0.00	277	0	341
PROVIDENT L & A		$3,413,979	$0	$1,399	$0	$7,390	$0	$56,781	0	31	0	158
PRUDENTIAL	$946,721	$4,793,088	$51	$12,252	$288	$1,158	$1,947	$1,947	1	399	4	152
STATE MUTUAL	$0	$15,269,688	$0	$36,158	$0	$34,162	$0	$310,127	0	872	0	814
TRANSPORT LIFE	$19,551	$215,523	$0	$45	$0	$0	$0	$0	0	1	0	0
TRUSTMARK	$246,632	$0	$209	$0	$585	$0	$31,228	$0	2	NOT DETER	7	0
UNION BANKERS	$167,407	NA	$0	NA	$0	NA	$0	NA	0	NA	0	NA
UNITED OF OMAHA	$0	$31,512	$0	$198	$0	$0	$0	$0	0	2	0	0
TOTALS	$105,188,210	$454,262,596	$165,189	$682,329	$152,400	$646,099	$1,134,086	$7,969,358	3584	15728	3265	14076
BCBS/BAMICO	$100,615,209	$318,228,293	$161,269	$461,987	$149,545	$428,392	$781,582	$2,371,804	3500	10031	3184	9125
All Other	$4,573,001	$136,034,303	$3,920	$220,342	$2,855	$217,707	$352,504	$5,597,554	84	5697	81	4951
%BC			0.16%	0.15%	0.15%	0.13%	0.78%	0.75%				
% All Other			0.09%	0.16%	0.06%	0.16%	1.71%	4.11%				
% TOTAL			0.16%	0.15%	0.14%	0.14%	1.08%	1.75%				

Year 1994 SCREENING MAMMOGRAPHY

TOTAL OF 35 COMPANIES	INDIVIDUAL	GROUP	TOTAL
TOTAL MEDICAL CLAIMS IN ME	$105,188,210	$454,262,596	$559,450,806
SCREENING MAMMOGRAMS CLAIMS	$165,189	$682,329	$847,518
PERCENT OF TOTAL	0.16%	0.15%	0.15%
DIAGNOSTIC MAMMOGRAMS CLAIMS	$152,400	$646,099	$798,729
PERCENT OF TOTAL	0.14%	0.14%	0.14%
BREAST CANCER TREATMENT CLAIMS	$1,134,086	$7,969,358	$9,103,444
PERCENT OF TOTAL	1.08%	1.75%	1.63%
BLUE CROSS/BLUE SHIELD OF MAINE AND BAMICO			
TOTAL MEDICAL CLAIMS IN ME	$100,615,209	$318,228,293	$418,843,502
SCREENING MAMMOGRAMS CLAIMS	$161,269	$461,987	$623,256
PERCENT OF TOTAL	0.16%	0.15%	0.15%
DIAGNOSTIC MAMMOGRAMS CLAIMS	$149,545	$428,392	$577,937
PERCENT OF TOTAL	0.15%	0.13%	0.14%
BREAST CANCER TREATMENT CLAIMS	$781,582	$2,371,804	$3,153,386
PERCENT OF TOTAL	0.78%	0.75%	0.75%
ALL OTHER COMPANIES			
TOTAL MEDICAL CLAIMS IN ME	$4,573,001	$136,034,303	$140,607,304
SCREENING MAMMOGRAMS CLAIMS	$3,920	$220,342	$224,262
PERCENT OF TOTAL	0.09%	0.16%	0.16%
DIAGNOSTIC MAMMOGRAMS CLAIMS	$2,855	$217,707	$220,562
PERCENT OF TOTAL	0.06%	0.16%	0.16%
BREAST CANCER TREATMENT CLAIMS	$352,504	$5,597,554	$5,950,058
PERCENT OF TOTAL	7.71%	4.11%	4.23%

BIBLIOGRAPHY

"Breast-Cancer Patients Seeking New Therapy Face Tough Obstacles," The Wall Street Journal, February 17, 1993.

Cancer Facts & Figures - 1995, American Cancer Society.

"EEOC probing denial of coverage for cancer treatments," Business Insurance, August 1, 1994.

"Eighth Circuit Tells Company To Certify Woman's Participation In Cancer Program," BNA's Health Law Reporter, October 12, 1995.

"High-Quality Mammography: Information for Referring Providers," Quick Reference Guide for Clinicians, U.S. Department of Health and Human Services, October 1994.

"Mandated Benefits Advisory Commission Reports on Screening Mammograms and PAP Tests," February 1990.

"Patients' Lawyers Lead Insurers To Pay for Unproven Treatments," New York Times, March 28, 1994.

"PDQ Cancer Screening/Prevention Summary," Screening for Breast Cancer for Patients, National Cancer Institute, May 1995.

"Public Hearing Transcript, Experimental Treatments/Autologous Bone Marrow Transplants," National Association of Insurance Commissioners, January 1995.

"Study of Insurers Sees Decisions as 'Arbitrary'," New York Times, February 17, 1994.

"Things to Know About Quality Mammograms," Consumer Version, Clinical Practice Guideline Number 13, U.S. Department of Health and Human Services, October 1994.

"When Insurers Refuse To Pay," Best's Review, April 1993.

The ReliaStar State Health Rankings, 1995 Edition, ReliaStar Employee Benefits, Minneapolis, Minnesota.

"Relieving Insurance Pain For Patients and Courts," NY Times, November 5, 1995.