PROPOSED
MANDATED HEALTH INSURANCE BENEFIT
FOR
DIABETES SUPPLIES AND SELF-MANAGEMENT TRAINING

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

Prepared by the
Bureau of Insurance
March 1996

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EVALUATION BASED ON 24-A M.R.S.A. § 2752

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EXECUTIVE SUMMARY

The Joint Standing Committee on Banking and Insurance of the 117th Maine Legislature on January 31, 1996, directed the Bureau of Insurance to review LD 1702, "An Act to Require That Diabetes Supplies and Self-Management Training be Covered by Health Insurance Policies." 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 procedure covered under the proposal.

LD 1702 requires all group and individual health insurance policies to reimburse the insured for all medically appropriate and necessary equipment, supplies and out-patient self-management training and educational services for diabetes. This coverage must be provided if the physician certifies the services are necessary. The education services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist and medical-nutrition therapy provided by a licensed, registered dietitian. As currently written, this bill does not apply to Health Maintenance Organizations (HMOs) or non-profit hospital or medical service organizations (Blue Cross).

There are two draft proposed amendments to further limit benefits provided under LD 1702. One draft limits supplies to monitors, test-strips, syringes and lancets. Another draft amendment adds the requirement to nonprofit hospital and medical service organizations and HMOs. Both eliminate coverage of diabetes educators and endocrinologists and limit the out-patient self-management training to facilities certified by the Diabetes Control Project. If these amendments are adopted there would be no fiscal note because the state employee plan already provides these services and supplies.

Due to the extremely short time frame to develop this report, the review has been limited to the version of LD 1702 as revised by the two proposed

amendments. In addition, only a limited amount of information and data could be collected. Most of the information used was provided by the Diabetes Control Project, Bureau of Health. Insurance companies were also surveyed to determine what their policies covered for diabetes education and supplies.

Diabetes mellitus is a common, serious and expensive disease that affects about 1 in 20 Americans. Using 1993 population projections the number of persons in Maine with diabetes mellitus may range from 29,858 to 99,944. Of those with diabetes it is estimated that only half have been diagnosed. Diabetes is a major cause of hospitalization, disability and suffering. With its complications, diabetes is the 7th leading cause of death for both the U.S. and Maine.

The results of the National Institutes of Health's Diabetes Control and Complications Trial (DCCT) demonstrated that intensive diabetes education programs which prepare individuals with diabetes to participate more actively in their own self-care are currently the most cost-effective means to significantly improve glycemic control and reduce the risk of long-term complications.

In Maine, hospitalization data demonstrated a 32.2 percent reduction in the number of hospitalizations reported by the program participants, representing a net savings of $237,885, or $293 for each patient. 10 other states reported similar reductions in hospital admissions and savings from education programs. On the basis of these results Blue Cross and Blue Shield, Medicare, Medicaid and other third-party payers have agreed to offer the ADEF program as a permanent benefit in Maine.

The Maine Diabetes Control Project's Ambulatory Diabetes Education and Follow-up (ADEF) Program is a comprehensive ten-hour group class program designed to assist persons with diabetes in learning the skills, attitudes and behavior changes necessary to achieve and maintain good diabetes control and to prevent acute and long-term complications of diabetes. The ADEF program is delivered

at 29 hospitals, 3 home health agencies and 7 community health centers (as of 2/96).

Education or nutritional programs are usually covered by most insurance at time of diagnosis but may not be covered for follow-ups needed later. The Maine Diabetes Control Project in 1983 found that a major factor contributing to the lack of outpatient diabetic education and follow-up services in Maine is the ambiguity concerning reimbursement for this service by the major third-party payers. Some insurers do not cover supplies for type II diabetics even if they are used to control their condition.

At least five states (New York, New Jersey, Florida, Minnesota, and Wisconsin) have passed similar legislation stating that coverage shall be provided for diabetic supplies and education. Massachusetts requires coverage for test strips for type I only. Ten states including Maine have legislation pending. In a Wisconsin study of mandated benefits in 1989, insurance carriers and HMOs reported that diabetes equipment, supplies and education accounted for an average of .13% of total medical benefits paid.

Of the 15 insurers responding to our request for coverage information, all but two covered the various supplies and all but three covered some type of education. Some had different coverage for noninsulin-dependent diabetics. Most did not believe there would be an increase in premiums due to the proposed mandate or it would be insignificant because they already provide basic coverage.

However, the mandate proposal as written would require insurance policies such as medical surgical or supplemental policies to provide benefits not typically covered and therefore would increase premiums in these types of policies.

BACKGROUND

The Joint Standing Committee on Banking and Insurance of the 117th Maine Legislature on January 31, 1996, directed the Bureau of Insurance to review LD 1702, "An Act to Require That Diabetes Supplies and Self-Management Training be Covered by Health Insurance Policies." 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 procedure covered under the proposal.

LD 1702 requires group and individual health insurance policies to reimburse the insured for all medically appropriate and necessary equipment, supplies and out-patient self-management training and educational services for diabetes. This coverage must be provided if the physician certifies the services are necessary. The education services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist and medical-nutrition therapy provided by a licensed, registered dietitian. This bill as written, does not apply to Health Maintenance Organizations (HMOs) or non-profit hospital or medical service organizations (Blue Cross).

There are two draft proposed amendments to further limit benefits provided under LD 1702. One draft amendment limits supplies to monitors, test-strips, syringes and lancets. Another draft amendment adds the requirement to nonprofit hospital and medical service organizations and HMOs. Both eliminate coverage of diabetes educators and endocrinologists and limits the out-patient self-management training to facilities certified by the Diabetes Control Project. If these amendments are adopted there would be no fiscal impact on the State because the state employee plan already provides these services and supplies. No quantitative information is available on the impact health plans other than the State Plan except through estimates provided by insurance companies.

Due to the extremely short time frame to develop this report, the review has been limited to the version of LD 1702 which includes the proposed amendments. Most of the information used was provided by the Diabetes Control Project, Maine Bureau of Health. Insurance companies were also surveyed to determine what policies covered for diabetes education and supplies.

Current law does not require reimbursement for these products and services. Of the 15 insurers responding to our request for coverage information, all but two covered various diabetic supplies and all but three covered some type of education. Some had different coverage for noninsulin-dependent diabetics. Most did not believe there would be an increase to premiums due to the mandate, and if at all, it would be insignificant. One insurer that does not currently provide coverage estimated that premiums could go up $9.60 per year for an individual and another estimated 0.5% of the premium, or about $6 per member per year, depending on the benefits in the policy. John Alden and Pioneer estimated a 2% increase to premiums to provide the additional coverage required by the mandate.

The proposal as written would require policies such as medical, surgical or supplemental policies to provide benefits not typically covered and therefore increase premiums for those types of policies significantly to reflect this. No quantitative information is available for these types of policies.

EVALUATION OF LD 1702 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;

Diabetes mellitus is a common, serious and expensive disease that affects about 1 in 20 Americans. Estimates vary regarding the prevalence of diabetes mellitus in Maine from 2.39% to 8.0% of the population. Using 1993 population projections the number of persons in Maine with diabetes mellitus may range from 29,858 to 99,944. Of those with diabetes it is estimated that only half have been diagnosed.

Diabetes is a major cause of hospitalization, disability and suffering. With its complications, diabetes is the 7th leading cause of death for both the U.S. and Maine. Diabetes is the most frequent cause of blindness among working-age adults, the major cause of nontraumatic lower-extremity amputation and end-stage renal disease. In addition, diabetes is an important risk factor of many chronic conditions, including stroke, ischemic heart disease, and peripheral vascular disease. See Appendix C for more detail.

Insulin-dependent (type I) diabetes occurs most often in children and young adults. People with type I must take daily injections of insulin to stay alive because the cells that make insulin have stopped working. Non-insulin-dependent (type II) diabetes occurs most often in adults. About 90% of all people with diabetes have type II. Type II can often be controlled with diet and exercise, although some people also need oral medication or insulin injections. Nearly 43% of adults with diabetes use insulin, and a similar proportion use oral medications.

Diabetics use insulin, syringes, oral blood glucose lowering drugs and other medications. They access primary care physicians and diabetes specialists. Blood glucose monitors and test strips are used for management purposes.

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

Since 1977, the Centers for Disease Control and Prevention (CDC) has supported state-based diabetes control programs (Self-Management Training and Education) to prevent and control complications of diabetes.

Maine's Diabetes Control Project, Department of Human Services developed and sponsors the Ambulatory Diabetes Education and Follow-up (ADEF) Program. The self-management training and education program is a comprehensive ten-hour group class designed to assist persons with diabetes in learning the knowledge, skills, attitudes and behavior changes necessary to achieve and maintain good diabetes control and to prevent acute and long-term complications of diabetes. The ADEF program is delivered at 29 hospitals, 3 home health agencies and 7 community health centers. The ADEF Program is the only comprehensive outpatient diabetes education program in Maine. See Appendix C for more detail.

Maine currently has 19 community-based health promotion programs scattered throughout the state and cover about 40% of the population. They form a framework through which state health programs can channel health promotion programs. These are not under the DCP but some of these programs contain ADEF sites.

For medical nutrition therapy, the Maine Dietetic Association has 300 members that include dietitians and diet technicians with 40% working in hospitals, 25% in private practice, 15% in public health, 20% in management and education. Dietitians and diet technicians work along side physicians to provide medical

nutrition therapy as part of the comprehensive treatment of the management of diabetes and other illnesses.

Diabetic supplies are generally available throughout the state at local pharmacies or mail order.

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

Diabetes education is recognized as part of the hospital's inpatient treatment plan and is an allowable cost and a covered hospital service. However organized outpatient diabetic education and follow-up is generally not recognized by insurance as an integral part of a diabetic's medical care.

Over the past several years, an increasing number of third-party payers have chosen to include diabetes outpatient education in their covered benefits. Blue Cross/Blue Shield, Healthsource and selected commercial carriers, Medicaid and Medicare have reported that they cover the ADEF Program. However, in a chart prepared by Blue Cross for the Diabetes Control Project Advisory Committee, nutritional counseling required for a medical condition was not covered for most of the Blue Cross/Blue Shield products, except HMO Maine and HMO Choice.

Of the 15 insurers responding to our request for coverage information, all but two covered the various supplies and all but three covered some type of education. Some had different coverage for noninsulin-dependent diabetics. See Appendix C.

The 1994 annual report from the National Diabetes Advisory Board stated that nationally the costs for training in self-management by nurses and dietitians are either poorly covered or not reimbursed at all.

Blue Cross' Major Medical Plans through Blue Alliance (BAMICO) reimburse for test strips, lancets and insulin based on medical necessity. Coverage for the

monitors is limited to individuals with brittle, type I, insulin-dependent diabetes and is based on medical necessity. Healthsource provides coverage for equipment and supplies when deemed medically necessary and if a supplemental rider is purchased. Some insurers do not cover supplies for type II diabetics even if they are used to control their condition.

In testimony, a family mentioned that its health plan only covered education at time of diagnosis. They were denied coverage for the education of their daughter who had been diagnosed at age 4 and was now old enough to comprehend the course.

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;

The Maine Diabetes Control Project in 1983 found that a major factor contributing to the lack of outpatient diabetes education and follow-up services in Maine is the lack of and ambiguity concerning reimbursement for this service by the major third-party payers.

Individuals unable to afford education and monitoring supplies must choose which not to access. Often individuals forgo the education and hope to manage by themselves. Going without testing for periods of time due to the cost of test strips can cause major set backs in diabetes control for the person with diabetes. Lack of "control" means high blood glucose levels which result in the short and long-term health related complications referenced earlier.

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;

Diabetes affects low-income people in disproportionate numbers. Estimates are that over 1 million of 8.3 million diabetic persons in the U.S. are poor, and

equally as many experience financial hardship. As a result of a lack of access to health and hygiene resources, low-income individuals may resort to folk treatments and seek and accept health care advice from family and friends rather than from health professionals.

The cost of a monitor ranges from $40 to $100. Testing strips are 50 cents a piece, and may be used any where from once a month up to eight times a day. One family estimated that they spend $89.90 a month for their daughter's supplies. The educational courses, usually a series of 5 classes, can cost from $50 to $450. Kennebec Valley Medical Center reported that their course costs $313. Individuals who have numerous diabetes-related expenses that are not covered, such as foot care, must decide what service or supply to cut back on or eliminate from the self-management regime.

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

The provider community and public both support and utilize the education programs to encourage understanding of their illness and support and utilize the supplies to improve their ability to manage their health.

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;

Strong support by the providers, people with diabetes and associations working with diabetes was demonstrated at the Committee's public hearings. There is also evidence of strong provider support for the Maine Diabetes Control Project in the form of letters of support recommending reimbursement of the ADEF program.

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;

At least five states (New York, New Jersey, Florida, Minnesota, and Wisconsin) have passed similar legislation stating that coverage shall be provided for diabetic supplies and education. Massachusetts requires coverage for strips for type I only. Ten states including Maine have legislation pending. See Appendix B.

In a Wisconsin study of mandated benefits in 1989, insurance carriers and HMOs reported that diabetes equipment, supplies and education accounted for an average of .13% of total medical benefits paid.

The Michigan Department of Public Health in 1983 funded a 1 year pilot program for the regulation and education of insulin-dependent diabetics in an outpatient setting as an alternative to hospitalization. Researchers found that 445 hospital stays were saved during the study period with a calculated dollar savings of more than $90,000.

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;

The results of the Diabetes Control and Complications Trial (DCCT) demonstrated that intensive diabetes education programs which prepare individuals with diabetes to participate more actively in their own self-care are currently the most cost-effective means to significantly improve glycemic control and reduce the risk of long-term complications. Over the past five years, the Diabetes Control Project (DCP) has supported registered dietitians efforts to secure third-party reimbursement for medical nutrition therapy.

Maine hospitalization data demonstrated a 32.2 percent reduction in the number of hospitalizations reported by the program participants, representing a net savings of $237,885, or $293 for each patient. On the basis of these results Blue Cross and Blue Shield, Medicare, Medicaid and other third-party payers have agreed to offer the ADEF program as a permanent benefit since 1983.

11. The alternatives to meeting the identified need;

More funding for public health programs has been suggested by the Health Care Reform Commission in their final report. Such programs could educate, inform and train people with diabetes, health care professionals and the public about the self-care, clinical and community strategies.

Coverage of medical nutrition therapy would allow those individuals not interested in a comprehensive course like the ADEF program to receive individualized instruction at $35 - 45 an hour from a licensed, registered dietitian.

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

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

A pro-active plan, which deals with health maintenance, would find education and supplies consistent with its policy within the scope of insurance coverage. The National Diabetes Advisory Board in its 1994 annual report recommended that our health care system be reformed to encourage and support the delivery of cost-effective, preventive services for chronic diseases such as diabetes.

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

There is no apparent social stigma for these benefits.

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

No information.

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

A Wisconsin study on mandated benefits found that while self-insured plans are not required to cover mandated benefits, these plans spent an average of .20% of total medical costs on diabetes supplies and education compared to .13% for insured plans. Their study found no support for the theory that mandated benefits are not included in self-funded plans which are administered by insurers. This may be because insurers encourage self-funded plans to include benefits similar to those provided by insured plans or more preventive benefits to reduce overall costs.

FINANCIAL IMPACT

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

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

No information.

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

The proposal requires the treating physician to certify the services are necessary, limiting the extent they may be misused. Requiring reimbursement for educational classes may act as an incentive for more people with diabetes to attend and learn how to better manage their diabetes.

The Maine ADEF Program has tracked enrollment since 1980 when it was first introduced. In 1983, Blue Cross, Medicare and Medicaid made reimbursement for the Program a matter of policy. The enrollment change from 637 in 1980 to 1490 in 1994 shows a steady but not significant increase after reimbursement was provided. See Appendix C.

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

Researchers have found that diabetic patients were 22 times more likely to be admitted for skin ulcers and gangrene, 15 times more likely due to peripheral vascular disease and 10 times more likely due to atherosclerosis. Diabetic complications accounted for 2 percent of total hospital admissions in the U.S. in 1987. In 1990, 2.8 million hospitalizations were associated with diabetes - representing 24.5 million hospital days.

Modern therapies can reduce hospitalizations for uncontrolled diabetes. Better diabetes management retards the development of long-term complications. People

with diabetes must understand their disease and know how to perform optimal care. A record audit of 78 consecutive community hospital admissions for diabetic complications found that 27 percent were due to a specific educational deficit. Inpatient education may add significantly to the cost and duration of hospital stay. See Appendix C for Maine hospital cost information for people with diabetes.

An example was given during testimony of an individual admitted to the hospital with diabetic ketoacidosis (DKA, excessively high blood sugar, a life-threatening condition). After attending an education program, the patient's blood glucose level had dropped to the almost acceptable range and had prevented a possible rehospitalization for DKA - a cost savings of $6,956.

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

The National Diabetes Advisory Board has developed a set of National Standards for Diabetes Patient Education Programs. These consist of 10 carefully defined institutional and programmatic standards by which programs may be judged, and criteria used to assess the programs. The American Association of Diabetes Educators offers a certification examination for educators (Certified Diabetes Educator - CDE). It may be used to assure the up-to-date knowledge base of individual providers.

The Maine Diabetes Educators Task Force in 1980 set up general guidelines for outpatient diabetic education and follow-up to assure high quality programs. These guidelines are periodically reviewed and updated by the Diabetes Control Project. The ADEF Program guidelines are consistent with the referenced National Standards.

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;

Of the 15 insurers responding to our request for coverage information, most did not believe there would be an increase or significant increase to premiums due to the mandate because they already provide coverage. One insurer that provides no coverage estimated that premiums could go up $9.60 per year for an individual and another insurer estimated 0.5% of the premium or about $6 per member per year depending on existing benefits in the policy. John Alden provides supplies and equipment but limits the education to initial diagnosis and estimated a 2% increase to premiums to increase benefits due to the mandate.

Initial increases in claims due to paying for additional services is expected but over the long term claims due to complications may be reduced. The proposal as written requires policies such as medical surgical or supplemental policies to provide benefits not typically covered and therefore would increase premiums to reflect this.

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;

Indirect costs relate to the loss of productive output caused by absenteeism, early retirement and premature death. In addition, the costs of increased enrollment in the Medicaid program due to diabetes complications must be considered. People with diabetes face not only a shortened life span, but also suffer from many preventable diabetes-related complications each year.

A study in Minnesota to estimate the magnitude of the economic impact of diabetes found that the total cost of diabetes in the state during 1988 was $301,527,681; direct costs were $189,357,088 of this total and indirect costs were $112,170,593. Hospitalizations due to chronic complications of diabetes account for 25.8 percent of the total costs; more than 50 percent of these complications are currently preventable using appropriate and timely interventions. Using similar methodology, the Centers for Disease Control and Prevention (CDC) estimates the cost of diabetes (both medical and lost productivity) in Maine to be $393 million annually.

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

Third-party reimbursement for outpatient education services for patients with diabetes is viewed by those in the field as a promising means of reducing the staggering costs associated with diabetes. If fewer financial barriers are present to obtaining health services and if more people learn about the complications of diabetes, it is possible that although direct costs will continue to rise, indirect costs due to morbidity may decrease and there may be a lower total cost to health care.

A Wisconsin study of mandated benefits including a current diabetic mandate found that it does not appear that costs for mandates are showing consistent increases nor do mandates, as a class, appear to be increasing at a faster rate than nonmandated benefits.

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.

There may be a small increase in utilization of services and resulting increase in premiums if enacted. The proposed mandate results in an expansion of coverage for those carriers not already providing this coverage but would only be utilized by a small portion of the population.

Small business representatives contend that government health care mandates are discriminatory because they do not apply to large companies that self-insure, or to Medicaid and Medicare. They feel that the burden of cost-sharing for this mandate would fall squarely on the shoulders of small businesses and their employees. Opponents of the proposal claim that it has the potential of becoming one of the most expensive mandates ever enacted by legislature because of the lifetime care required for diabetes. For this particular mandate, Medicare and Medicaid do cover the educational program as noted earlier.

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

Existing scientific information clearly and convincingly establishes that the burden of diabetes can be both controlled and prevented. Recent scientific evidence suggests that rigorous blood sugar control can delay the onset and slow the progression of diabetic complications. Seventeen articles in a report of selected annotations related to economic aspects of diabetes discuss reduced hospitalization associated with diabetes education studies. Their findings suggest that a comprehensive diabetes management program consisting of medical treatment, education and psychological support services has a positive influence on patient outcome.

Diabetes has been a model for chronic disease intervention programs and the diabetes community has made important strides in implementing these interventions. Research funded by the American Nurses' Foundation in 1988

pooled 47 studies in meta-analysis and concluded the results clearly support the notion that patient education has positive outcomes in diabetic adults.

The results of the National Diabetes Control and Complications Trial (DCCT) sponsored by the National Institutes of Health demonstrated that intensive diabetes education programs which prepare individuals with diabetes to participate more actively in their own self-care are currently the most cost-effective means to significantly improve glycemic control and reduce the risk of long-term complications.

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

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

The Maine Dietetic Association compiled data that demonstrated that medical nutrition therapy provided by Registered Dietitians is a cost-effective approach to promoting health, preventing disease and treating illness. The report gives several case studies describing the patient diagnosis, cost of care received and estimated cost savings.

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

Dietitians are required to pass state licensing standards before becoming licensed. The law (Title 32, Chapter 105) which establishes the licensing procedure gives the board which oversees licensing the authority to establish continuing education and supervision requirements. Additionally, the board has the authority to suspend, revoke, or refuse to renew a license for several reasons such as incompetence or unprofessional conduct.

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

According to the 1994 annual report from the National Diabetes Advisory Board, the immediate costs of providing education and supplies would be offset by future savings that would result if the following complications were prevented: kidney failure $40,000 per patient, amputations $16,000 per patient and blindness due to retinopathy 24,000 new cases per year.

In 1980, a pilot study of diabetes outpatient education was implemented by the Maine Diabetes Control Project with support from the CDC in more than 30 hospitals and health centers. There was a 32 percent reduction in hospital admissions for 1,488 patients over a three-year period, with a savings of $293 per participant. 10 other states reported similar reductions in hospital admissions and savings from education programs.

Because both education and supplies are important in controlling diabetes, coverage of one without the other may not be as effective.

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

Traditionally, group policyholders do not view mandated offerings as desirable unless they are pressured by their certificate holders. Therefore, 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.

For individual coverage, it would seem that severe antiselection would make the premiums for this coverage excessively high: that is, only those who are likely to need the service would purchase coverage.

APPENDIX A

LD 1702

Draft Amendment to LD 1702

Charge to the Bureau

117th MAINE LEGISLATURE

SECOND REGULAR SESSION-1996

Legislative Document No. 1702

H.P. 1242 House of Representatives, January 11, 1996

An Act to Require That Diabetes Supplies and Self-management Training be Covered by Health Insurance Policies.

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 26. Reference to the Committee on Banking and Insurance suggested and ordered printed.

Joseph W. Mayo

JOSEPH W. MAYO, Clerk

Presented by Representative JONES of Pittsfield.
Cosponsored by Representatives: AIKMAN of Poland, AULT of Wayne, BARTH of Bethel, BOUFFARD of Lewiston, CHASE of China, CHICK of Lebanon, CROSS of Dover-Foxcroft, DEXTER of Kingfield, GATES of Rockport, GERRY of Auburn, JOY of Crystal, LIBBY of Kennebunk, LOOK of Jonesboro, MADORE of Augusta, McELROY of Unity, MITCHELL of Vassalboro, MITCHELL of Portland, NICKERSON of Turner, PAUL of Sanford, PENDLETON of Scarborough, POIRIER of Saco, REED of Dexter, RICHARD of Madison, SAXL of Portland, SIROIS of Caribou, STEDMAN of Hartland, TRUE of Fryeburg, TYLER of Windham, Senators: BENOIT of Franklin, CAREY of Kennebec, CIANCHETTE of Somerset, LORD of York.

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

Sec. 1. 24-A MRSA §2754 is enacted to read:

§2754. Coverage for diabetes supplies

An insurer that issues or issues for delivery in this State individual health policies shall provide coverage for all medically appropriate and necessary equipment, supplies and out-patient self-management training and educational services used to treat diabetes, if:

1. Certification of medical necessity. The insured's treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary; and

2. Provision of medical services. Those diabetes out-patient self-management training and educational services are provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist and medical-nutrition therapy is provided by a licensed, registered dietitian.

Sec. 2. 24-A MRSA §2847-E is enacted to read:

§2847-E. Coverage for diabetes supplies

An insurer that issues or issues for delivery in this State group health policies shall provide coverage for all medically appropriate and necessary equipment, supplies and out-patient self-management training and educational services used to treat diabetes, if:

1. Certification of medical necessity. The insured's treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary; and

2. Provision of medical services. Those diabetes out-patient self-management training and educational services are provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist and medical-nutrition therapy is provided by a licensed, registered dietitian.

STATEMENT OF FACT

This bill requires that individual and group health insurers provide coverage for all medically appropriate and necessary equipment, supplies and out-patient self-management training and educational services used to treat diabetes.

SENATE

I. JOEL ABROMSON, DISTRICT 27, CHAIR
MARY E. SMALL, DISTRICT 19
DALE MCCORMICK, DISTRICT 18

COLLEEN MCCARTHY, LEGISLATIVE ANALYST
MARIANNE MACMASTER, COMMITTEE CLERK

HOUSE

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LISA LUMBRA, BANGOR
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STATE OF MAINE

ONE HUNDRED AND SEVENTEENTH LEGISLATURE

COMMITTEE ON BANKING AND INSURANCE

January 31, 1996

Brian K. Atchinson, Superintendent
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Brian:

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. While we understand that the Bureau feels a review can not be completed before the end of the session, the Joint Rules prohibit bills from being carried over in the Second Regular Session. Because of that prohibition, the committee would like to take final action on the bill during this session. We hope that the Bureau will be able to accommodate our request.

Pursuant to § 2752, we request the Bureau prepare a review and evaluation of the following proposal:

LD 1702 - An Act to Require that Diabetes Supplies and Self-Management Training be Covered by Health Insurance Policies

A copy of the bill is enclosed. Please prepare the evaluation using the guidelines set out in 24-A MRSA § 2752 and submit the report to the committee on or before March 15, 1996. For more information, you may want to contact Maryann Zaremba, Project Director of the Diabetes Control Project at the Bureau of Health. 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

cc: Nancy Johnson, Deputy Superintendent
Marti Hooper, Senior Insurance Analyst
Banking and Insurance Committee members

115 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0115 TELEPHONE: 207-287-1314

Committee: BAN
LA: C.McCarthy
LR (item)#: 2532()
WPP Doc. #:
New Title?: n
Add Emergency?: n
Date: 01/18/96

PRESENTED BY THE SPONSOR
REPRESENTATIVE JONES

COMMITTEE AMENDMENT "." TO L.D. 1702, An Act to Require That Diabetes Supplies and Self-Management Training be Covered by Health Insurance Policies.

Amend the bill by inserting after the title and before section 1 the following:

Sec. 1. 24 MRSA §2333 is enacted to read:

§2333. Coverage for diabetes supplies

A nonprofit hospital and medical service organization that issues or issues for delivery in this State individual and group health policies shall provide coverage for all medically appropriate and necessary equipment, supplies and out-patient self-management training and educational services used to treat diabetes, if:

1. Certification of medical necessity. The subscriber's treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary; and

2. Provision of medical services. Those diabetes out-patient self-management training and educational services are provided under the direct supervision of a provider enrolled with the Maine Diabetes Control Project and medical-nutrition therapy is provided by a licensed, registered dietitian.

Amend the bill in section 1, line 20-21 by striking out the phrase: "~~a certified diabetes educator or a board certified endocrinologist~~" and inserting in its place the following: "a provider enrolled with the Maine Diabetes Control Project".

Amend the bill in section 2, line 42-43 by striking out the phrase: "~~a certified diabetes educator or a board certified endocrinologist~~" and inserting in its place the following: "a provider enrolled with the Maine Diabetes Control Project".

Further amend the bill by inserting at the end before the statement of fact the following:

Sec. 3. 24-A §4241 is enacted to read:

§4241. Coverage for diabetes supplies

An health maintenance organization that issues or issues for delivery in this State individual and group health policies shall provide coverage for all medically appropriate and necessary equipment, supplies and out-patient self-management training and educational services used to treat diabetes, if:

1. Certification of medical necessity. The enrollee's treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary; and

2. Provision of medical services. Those diabetes out-patient self-management training and educational services are provided under the direct supervision of a provider enrolled with the Maine Diabetes Control Project and medical-nutrition therapy is provided by a licensed, registered dietitian.

Further amend the bill by renumbering the sections to read consecutively.

STATEMENT OF FACT

This amendment requires that nonprofit hospital and medical service organizations and health maintenance organizations provide coverage in individual and group contracts for all medically appropriate and necessary equipment, supplies, and out-patient self-management training and educational services used to treat diabetes.

The amendment also clarifies that coverage must be provided for self-management training and educational services if the services are provided by a person enrolled in the Maine Diabetes Control Project.

DRAFT - February 5, 1996 Amendment to L.D. 1702
An Act to Require that Diabetes Supplies and Self-management Training be Covered by Health Insurance Policies.

Please note: Additionally, language needs to be included to amend to include Title 24 if the expectation is that BCBS will be included.

Sec. 1. **24-A MRSA section 2754** is enacted to read:

Section 2754. **Coverage for diabetes supplies**

An insurer that issues or issues for delivery in this State individual policies shall provide coverage for ~~all~~ medically appropriate and necessary equipment, limited to monitors, test-strips, syringes and lancets, ~~supplies~~ and out-patient self-management training and educational services used to treat diabetes, if:

1. Certification of medical necessity. The insured's treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary; and

2. Provision of medical services. Those diabetes out-patient self-management training and educational services are provided ~~under the direct supervision of a certified diabetes educator or a board certified endocrinologist and medical nutrition therapy is provided by a licensed, registered dietician~~ through ambulatory diabetes education facilities certified by the Diabetes Control Project.

Sec. 2. **24-A MRSA section 2847-E** is enacted to read:

Section 2847-E. **Coverage for diabetes supplies**

An insurer that issues or issues for delivery in this State group health policies shall provide coverage for ~~all~~ medically appropriate and necessary equipment, limited to monitors, test-strips, syringes and lancets, ~~supplies~~ and out-patient self-management training and educational services used to treat diabetes, if:

1. Certification of medical necessity. The insured's treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary; and

2. Provision of medical services. Those diabetes out-patient self-management training and educational services are provided ~~under the direct supervision of a certified diabetes educator or a board certified endocrinologist and medical nutrition therapy is provided by a licensed,~~

~~registered dietician~~ through ambulatory diabetes education facilities certified by the Diabetes Control Project.

APPENDIX B

States With Mandates

Summary of Legislative Initiatives to Provide Coverage for Diabetes Equipment, Supplies and Self-Management Education and Training

State	Covered Items: Equipment; Supplies; Education	Current Status in Legislature	Signed by Governor	Comments
CA	E,S,Ed (?)	pending	no	
FL	E,S,Ed by CDE	passed	yes	ADA recognized program or ADA eligible; applies to insurance companies only: not HMO's
FL	E,S,Ed by CDE	pending	no	Extending mandates to all HMO's
GA	E,S,Ed	pending	no	
IN	E,S,Ed	pending	no	
MA	S (limited)	passed	yes	Strips only for IDDM
MD	E,S,Ed	in committee	no	
ME	E,S,Ed	pending	no	
MI	E,S,Ed	in committee	no	
MN	E,S	passed	yes	Also applies to Medi-Gap
NJ	E,S,Ed	passed	yes	Gov. signed 1/9/96
NY	E,S,Ed by CDE	passed	yes	Contains limitations on plans affected
OH	E,S,Ed by CDE	pending	no	
OK	E,S,Ed	pending	no	
WI	E,S,Ed	passed	yes	
WV	E,S,Ed	pending	no	

February 2, 1996-

APPENDIX C

Current Insurance Coverage

Maine Data

Table 1: Insurance Coverage of Diabetes Supplies, Equipment and Education

Insurance Company	Supplies	Education	Premium Increase
Aetna	testing and treatment devices	educational services and self-care training; refresher when necessary; providers include dietitian upon referral	no additional premium charge as already provide coverage
John Alden	any medically necessary medications and/or equipment used in the direct treatment of Type 1 and Type 2 diabetes	Initial orientation charged through a doctor's office only	estimate not more than a 2% increase
First Allmerica	insulin, syringes, chemstrips, lancets and glucometers	none	impact would be small so no additional rating
Blue Cross - Maine State Select	Supplies: Insulin, lancets and Chemstrips covered by MEDCO prescription drug program Equipment: monitors if insulin dependent otherwise based on individuals medical necessity	approved facilities only, no coverage for nutritional counseling	None if education is only through ADEF programs
Colonial Life	Comprehensive coverage of supplies for insulin-dependent. For non-insulin dependent only cover test-tape and urine sugar test material.	Only the initial educational consultation.	No increase in premium to add proposed mandated coverage.
Connecticut General Life	Alcohol Swabs, Insulin, lancets, syringes and test strips and/or tablets. Noninsulin-dependent: Oral blood sugar control medication	3 to 4 day outpatient program	estimated premium increase of 0.25%
CUNA Mutual	insulin, syringes, swabs, chem-sticks, glucometer	nutritional counseling once unless found medically necessary	additional cost may be insignificant
Fidelity Security	glucometers, insulin pumps, autolets, disposable syringes, disposable needles, lancets, chemstrips and tablets for measuring levels.	Related to self-care of diabetes, exclude charges for printed material, review for courses over $300 is required	do not foresee that there would be an increase in premium for the proposed coverage
Home Life	insulin, syringes, test strips, and monitors	Insulin-dependent diabetics with no restriction on frequency for in-patient, out-patient or home health care agency. Noninsulin-dependent not covered, handled by the treating physician	Increase would vary depending on benefit in policy approx. .5% of total premium or about $6 per member per year.
PFL Life	none - do not have prescription or other drug benefit coverage	Provided in New York because it is mandated.	$0.80 per month, per individual
Pioneer	do not specifically provide for the mandated supplies	do not specifically cover training	estimate 2% increase
Principal Mutual	acetone testing, alcohol swabs, Clinistix, Clinitest, insulin, isopropyl alcohol, syringes and test tape	up to a 5 day course for person w/ diabetes and/or family members	no increase in premium because already covered
Prudential	Comprehensive coverage for group policies, some what limited for non-insulin dependent diabetic. Individual policies only cover insulin, test strips and other supplies & equipment when charges are incurred in a hospital.	Comprehensively covered by group policies, individual policies limited to hospital or hospital sponsored facility	would not require a premium increase
The Guardian	insulin, syringes, cotton balls, alcohol, needles, test tapes, lancets, and blood/urine/acetone styx Equipment: insulin pump if individual meets specific criteria	one time only educational training	no significant effect on rates
Time	insulin, syringes, alcohol wipes, lancets, glucose test strips, glucometers, insulin pumps , insulin infusion devices, autojet and autoinjectible syringe system **noninsulin-dependent**: oral prescription drugs, glucometer, autojet, lancets, wipes and test strips	Nutritional counseling and self-management training courses as frequently as determined usual and reasonable	No increase in premium as already covering the proposed services.
Trustmark	insulin, insulin pumps (for insulin-dependent only), glucometers, lucostix, clinitest tablets, diastix strips, syringes & needles	Not covered. Several policies no longer marketed do have coverage.	No estimate, would depend on several variables.

Blue Cross and Blue Cross and Blue Shield of Maine
HMO Maine

Summary of Services/Supplies All Lines of Business - Type 1 and Type 2 DM

Product Line	Eye Exams	Nutritional Counseling When Required for a Medical Condition	Medical Equipment
HMO Maine	Routine eye exams for vision correction. No limit up to age 19. After end of calendar year in which member reaches age 19, routine eye exams are limited to one every two years. No referral needed from Primary Care Physician As needed to diagnose condition, regardless of age Referral needed	Limited to three visits per condition but may be extended if authorized by Primary Care Physician.	Durable medical equipment benefit - Covered in full up to $3,000 per member per calendar year
HMO Choice	Routine eye exams for vision correction. No limit up to age 19. After end of calendar year in which member reaches age 19, routine eye exams are limited to one every two years. No referral needed from Primary Care Physician As needed to diagnose condition, regardless of age Referral needed Subject to possible deductible and coinsurance depending on choice of group and if self-referred	Limited to three visits per condition but may be extended if authorized by Primary Care Physician.	Durable medical equipment benefit - Benefit of $3,000 per member per calendar year Subject to possible deductible and coinsurance depending on choice of group and if self-referred

Select Blue	Routine eye exams for vision correction. No limit up to age 19. After end of calendar year in which member reaches age 19, routine eye exams are limited to one every two years. No referral needed from Primary Care Physician As needed to diagnose condition, regardless of age Referral needed Subject to possible deductible and coinsurance depending on choice of group and if self-referred	No benefits available	Durable medical equipment benefit - Covered in full up to $3,000 per member per calendar year Subject to possible deductible and coinsurance depending on choice of group and if self-referred
Maine State Select	One routine eye exam per calendar year up to age 19 one every two years thereafter No referral needed by SELECT Physician As needed to diagnose condition, regardless of age Referral needed Subject to deductible and coinsurance if self-referred	No benefits available	Durable medical equipment benefit - Not limited when pre-authorized by SELECT Physician. Benefits limited to 60 consecutive days per calendar year, per medical condition when self-referred. Self-referred benefits are subject to deductible and coinsurance
Blue Alliance	Optional amendment available - one routine eye exam pair calendar year, one pair of glasses per calendar year. Very low usage.	No benefits available	Durable medical equipment benefit - Covered subject to medical review guidelines. Subject to deductible and coinsurance
Nongroup BA	No benefits available	No benefits available	Durable medical equipment benefit - Covered subject to medical review guidelines. Subject to deductible and coinsurance
HealthChoice	No benefits available	No benefits available	Durable medical equipment benefit - Covered subject to medical review guidelines. Subject to deductible and coinsurance

COMP-CARE (Matrix)	No benefits available	No benefits available	Durable medical equipment benefit - Covered subject to medical review guidelines. Subject to deductible and coinsurance
COMP-CARE Preferred	No benefits available	No benefits available	Durable medical equipment benefit - Covered subject to medical review guidelines. Subject to deductible and coinsurance
HMO Maine Basic and Standard Plans	No benefits available	No benefits available	Durable medical equipment benefit - Covered subject to medical review guidelines. Subject to deductible and coinsurance
COMP-CARE Basic and Standard Plans	No benefits available	No benefits available	Durable medical equipment benefit - Covered subject to medical review guidelines. Subject to deductible and coinsurance
Federal Employees Program	Limited benefits available Subject to medical review	No benefits available	Durable medical equipment benefit - covered for type 1 diabetics Subject to medical review Subject to deductible and coinsurance

HEALTHSOURCE MAINE, INC.

SUMMARY OF SERVICES/SUPPLIES ALL LINES OF BUSINESS - TYPE 1 AND TYPE 2 DM

Product line	Eye Exams	Education	Medical Equipment
Health Maintenance Organization (HMO)	Subject to office visit copayment, covered as needed	Nutritional counseling - up to 3 visits annually Self-care classes - covered in full ADEF health education classes - covered in full	Covered items include glucose monitors, lancets, autolets under DME riders. Chem strips, insulin are covered under the Rx rider
Fully Funded Point-of-Service (POS)	Subject to office visit copayment, covered as needed	Nutritional counseling - up to 3 visits annually Self-care classes - covered in full ADEF health education classes - covered in full	Covered items include glucose monitors, lancets, autolets under DME riders. Chem strips, insulin are covered under the Rx rider
Self Funded Point-of-Service (POS)	Varies by groups - normally covered the same as fully funded POS	Varies by group	Varies by group
Self Funded Preferred Provider Organization (PPO)	Varies by group	Varies by group	Varies by group

TABLE 8: DISTRIBUTION OF DIABETICS BY PAY SOURCE--1975

	AGE GROUP			
	0-44	45-64	65+	TOTAL
Maine Population	727,918	204,709	125,328	1,057,955
No. of Diabetics*	3,674	8,301	9,062	21,037
No. Insured By:				
BC/BS	1,286	3,071	181	4,538
Medicaid	802	1,162	91	2,055
Medicare	195	1,245	8,518	9,958
Commercial Insurance	737	1,826	91	2,654
Others	654	997	181	1,832

*Estimated from National Commission on Diabetes Data.

Source: Diabetes Control Project, 1979.

BLUE CROSS/BLUE SHIELD COSTS OF DIABETIC HOSPITALIZATIONS:

Multiplying the number of diabetic patient days for Blue Cross/Blue Shield members by the Blue Cross/Blue Shield per diem rates allows an accurate estimate of the yearly costs to Blue Cross for diabetic hospitalizations.

Since 1971 the number of patient days per 1,000 Blue Cross members has decreased steadily from 874 to 607 in 1978. The rate is expected to level off at around 585 days per 1,000 members by 1982 (Crowley, personal communication, 1979). It is estimated the number of patient days per 1,000 diabetics will follow the trend presented in TABLE 9. For hospitalizations with a primary diagnosis of diabetes, the number of patient days is projected to remain constant for the period 1977 to 1982. For hospitalizations of persons with a secondary diagnosis of diabetes, a decreasing number of patient days is projected. The rate of change is projected to be the same as the rate of change for all Blue Cross members. The net effect is that by 1982 the patient days rate will be 4.7 times greater than the patient day rate for general Blue Cross members (2,371 days per 1,000 diabetics versus 585 days per 1,000 members).

The costs of diabetic hospitalizations for Blue Cross subscribers projected through 1982 are shown in TABLE 10.

By 1982 Blue Cross will be spending $4.9 million on diabetic hospitalizations.

TABLE 10: PROJECTED COSTS OF DIABETIC HOSPITALIZATIONS FOR BLUE CROSS MEMBERS

YEAR	PER DIEM HOSPITALIZATION RATES		COSTS OF DIABETIC HOSPITALIZATIONS		TOTAL
	PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	
1974	89.95	112.44	$304,841	$1,608,004	$1,912,845
1975	116.24	137.89	379,640	1,617,863	1,997,503
1976	133.08	165.73	416,407	1,868,440	2,284,847
1977	161.47	203.11	526,554	2,261,224	2,787,778
1978	188.35	235.44	614,209	2,590,546	3,204,755
1979	216.61	270.76	706,365	2,876,013	3,582,378
1980	248.94	311.17	811,793	3,276,309	4,088,102
1981	273.83	342.29	892,960	3,603,971	4,496,931
1982	301.22	376.52	982,278	3,964,379	4,946,657

Sources: Blue Cross/Blue Shield of Maine, 1979.
Diabetes Control Project, 1979.

PROJECTED COST SAVINGS:

If the projected goal of 30% reduction in patient days could be attained by 1982, an expected savings of $10.6 million would be realized, and the savings for Blue Cross alone would be $1.48 million. It is recognized that these cost savings would be realized in expenditures for a disease category and are not the savings realized by third-party payers and hospitals. Certain hospital costs are fixed and will continue whether a bed is filled or not. These fixed costs are estimated at between 60% and 80%. Thus, the realized direct savings would be between 20% and 40% ($2.1 million to $4.2 million) Statewide. However, the savings in expenditures for diabetes would be the full $10.6 million Statewide. It is further recognized, however, that a 30% reduction in patient days is a long-term goal and will most likely not be realized in the short-term. There are certain categories of hospitalizations that may be expected to show program effectiveness more rapidly than others. Some of these categories include

Angus S. King, Jr.
Governor

Kevin W. Concannon
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

MAINE DIABETES CONTROL PROJECT

The Maine Diabetes Control Project (DCP) is a program of the Maine Department of Human Services, Bureau of Health, Division of Community and Family Health. In 1977 Maine became one of ten states initially awarded a grant by the Centers for Disease Control and Prevention for a state-based diabetes control program. Since its inception, the Maine DCP has successfully competed for continued federal assistance under the Cooperative Agreement for State-Based Diabetes Control Programs through June 1994. In July 1994, the Maine DCP successfully competed and was awarded a five-year grant award under the Cooperative Agreement for State-Based Programs to Reduce the Burdens of Diabetes: A Health Systems Approach. In Fiscal Year July 1995- June 1995, the federal grant award was $276,237 and in FY 1995-96, the federal grant award was $283,972. The Maine DCP is currently composed of four full-time employees: Data Analyst, Nursing Education Consultant, Nutrition Consultant, Project Director and Clerk/Typist III. The salary and benefits for the DCP Data Analyst are support by State of Maine appropriations.

The DCP is responsible for the maintenance and implementation of the statewide **Ambulatory Diabetes Education and Follow-up (ADEF) Program**. Created in 1979, the ADEF Program is a comprehensive ten-hour program designed to assist person with diabetes in learning the knowledge, skills, attitudes and behavior changes necessary to achieve and maintain good diabetes control, and to prevent acute and long-term complications of diabetes. The ADEF Program is structurally consistent with the National Standards for Diabetes Education, and all program standards and policies are outlined in the ADEF Program Manual. In 1983, the DCP secured reimbursement of the ADEF Program by Maine Blue Cross and Blue Shield, Medicaid and Medicare after the completion of a pilot phase and evaluation study which documented a 32% reduction in hospitalizations among 813 person going through the program and receiving follow-up one year later.

Currently the ADEF Program is delivered at 29 hospitals, 7 community health centers and 3 home health agencies. Each ADEF Program site is responsible for identifying a primary instructor, dietary instructor, physical advisor and Advisory Committee to coordinate and deliver the program locally. Each site annually completes a Letter of Understanding with the DCP; has a written institutional ADEF Program policy; offers the Program four times annually; has a DCP Annual Site Visit; completes and submits ADEF Program Data Forms and One-Year Follow-up Data Forms to the DCP and has a standing Advisory Committee to assist the instructors and physician advisors in the overall management and evaluation of the ADEF Program. Each education site is financially independent from the DCP and encouraged to individualize the format of the program (within the guidelines) to meet the needs of the local community and health care providers. Since 1980, a total of 16,000 individuals with diabetes have been physician referred to the ADEF Program, with referrals now averaging 1500 annually. Accordingly, 46% of Maine's diabetic population is currently estimated to have received formal patient education through the ADEF Program. (Over)

The **DCP's Ambulatory Diabetes Education and Follow-up (ADEF) Program** services consists of:

1. A preassessment interview to determine the recipient's knowledge, skills and attitudes about diabetes management and to develop an individualized education plan and behavior change goals.

2. Group class instruction covering the comprehensive curriculum outline by the Maine Diabetes Control Project and based on the individualized education plan.

3. A meal planning interview to determine the recipient's knowledge, skills and attitudes about meal planning and to develop an individualized meal plan and behavior change goals.

4. A postassessment interview to assess and document what the recipient has learned during the program, and to develop a plan for follow-up sessions to address the component areas not learned in the class series, and finalized behavioral goals.

5. Follow-up contacts to reassess and reinforce self-care skills, evaluate learning retention and progress toward achieving the recipient's behavior change goals. At a minimum, a follow-up visit one year after the last class is required to complete the recipient's participation in the program.

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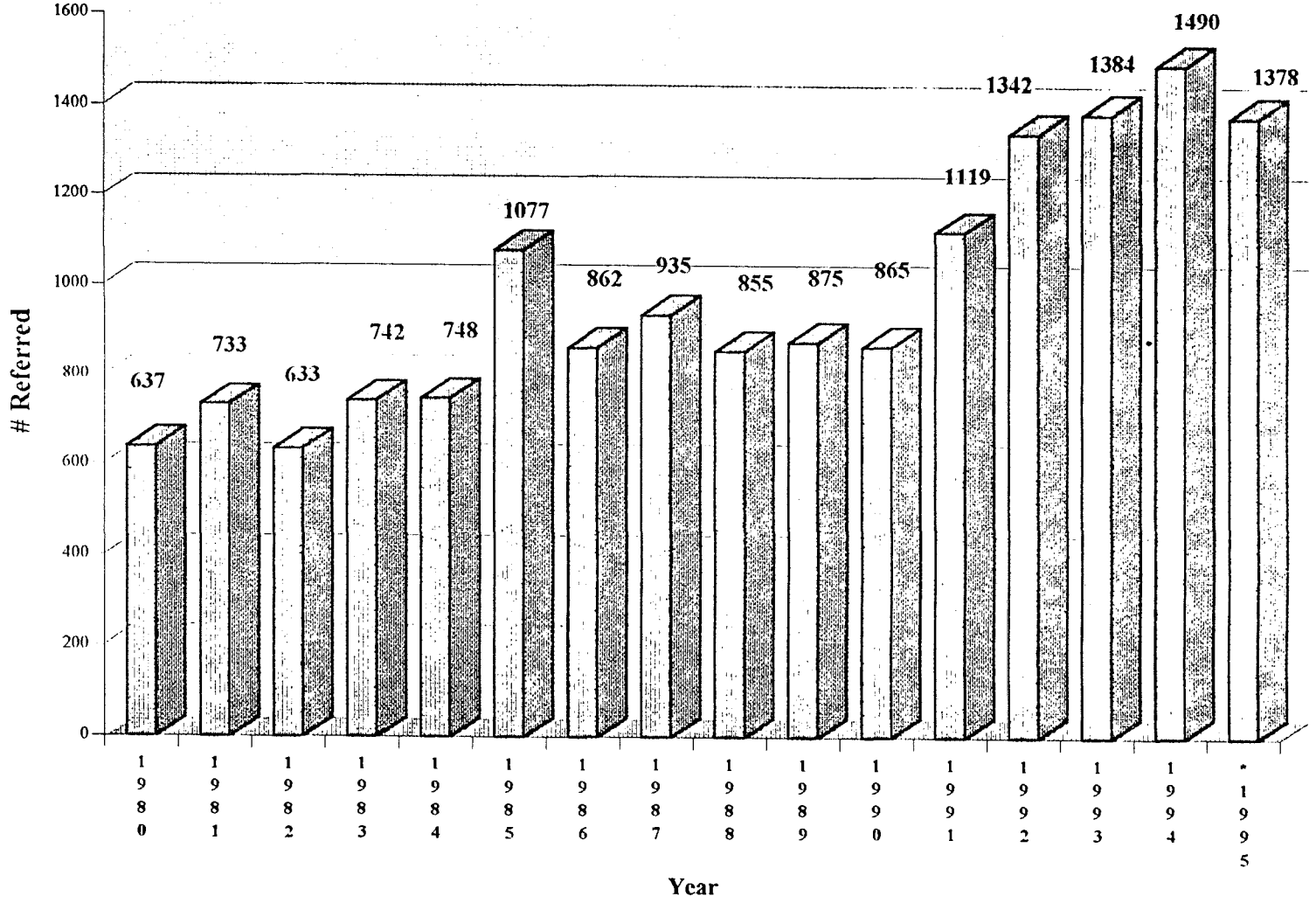
EXHIBIT 4

ESTIMATED COST OF AMBULATORY DIABETIC EDUCATION AND FOLLOW-UP PROGRAM

(One program unit includes preassessment and follow-up of five diabetics plus family members.)

	Estimated Time	Estimated Cost
PREASSESSMENT INTERVIEW: (Nurse Educator)	5 hrs.	$ 35.00
CLASSROOM SESSIONS: (Nurse Educator/Dietitian)	10 hrs.	$ 70.00
1. Diabetes Introduction 2. Diet and Meals 3. Hyperglycemia and Hypoglycemia 4. Medication and Urine Testing 5. General Factors		
6. Dietary Instruction (one-to-one, one hour each)	5 hrs.	$ 35.00
POSTASSESSMENT INTERVIEW: (Nurse Educator)	5 hrs.	$ 35.00
FOLLOW-UP VISITS: (Nurse Educator/Dietitian) Two Scheduled Within Three Months After Course Completion	10 hrs.	$ 70.00
OFFICE FUNCTIONS: (Secretary--40% FTE) Data Forms Record-Keeping Requirements Protocols (Intake/History Forms) Pre- and Posttest Instruments Skills Assessment Instruments Physician Referral Cards Follow-Up Letters to Diabetics and Physicians	16 hrs.	$ 72.00
TEACHING MATERIALS, SUPPLIES, POSTAGE, OFFICE SUPPLIES, FILES, AND TELEPHONE:		$ 30.00
DIRECT COSTS PER UNIT:		$347.00
INDIRECT COSTS: (12% of Direct Costs)		$ 42.00
TOTAL		$389.00

Maine Diabetes Control Project
Participants Referred to the ADEF Program
1980 - 1995



*1995 data is not complete

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