Maine Bureau of Insurance

REPORT TO THE JOINT STANDING COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES OF THE 132ND MAINE LEGISLATURE

Review and Evaluation of LD 1502 An Act to Update the Requirements for Health Insurance Coverage of Prostate Cancer Screening

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Executive summary

Lewis & Ellis, LLC (L&E) was engaged by the Maine Bureau of Insurance (BOI) to provide analysis related to the proposed commercial major medical health insurance coverage mandate contained in LD 1502, titled *An Act to Update the Requirements for Health Insurance Coverage of Prostate Cancer Screening*. The proposed mandate would require carriers in the Maine fully insured individual, small group, and large group markets, as well as the health plan offered to Maine state employees (SOM plan) to include coverage for services related to the early detection of prostate cancer when those services are "supported by medical and scientific evidence according to the most recently published nationally recognized clinical practice guideline." The proposed mandate would also prohibit the application of patient cost sharing for those services.

L&E estimates a premium impact range of $0.41 to $1.29 per member per month (PMPM) depending on the carrier and benefit plan for this expanded coverage. The resulting percentage impact to premium is 0.06% to 0.18%. This is based on 2023 carrier data reported to CMS for the individual and small group markets, nationally recognized clinical guidelines, relevant studies published by the National Institutes of Health and others, and actuarial judgment. These PMPM estimates translate to total additional paid claims of $1.2 million to $3.6 million spread across all markets and carriers.

While this particular mandate is not expected to have a material impact on premiums, it would add to the cumulative impact of all state mandates on health insurance costs in the fully insured market. The cumulative impact of mandates is a consideration for employers when weighing whether to move out of the fully insured market and into a self-funded arrangement that is not subject to state mandates. The cost of state mandates can also cause employers and individuals to shift to health plans with greater member cost-sharing as a way to lower monthly premiums.

Appendix A provides commentary on the items required of all health insurance mandate studies under Maine law. Appendix B contains disclosures required by Actuarial Standards of Practice. Appendix C contains summary information regarding existing health insurance coverage mandates under Maine law, compiled by BOI. Appendix D contains the letter from the Joint Standing Committee on Health Coverage, Insurance and Financial Services requesting this mandate study.

Proposed mandate and analysis

Summary of proposed mandate

Current Maine law requires coverage under fully insured individual and group health plans for services for the early detection of prostate cancer, including a digital rectal examination (DRE) and a prostate-specific antigen (PSA) test. The carriers must reimburse for services for the early detection of prostate cancer, if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72. LD 1502 would eliminate the age restrictions and require coverage for services related to the early detection of prostate cancer when those services are "supported by medical and scientific evidence according to the most recently published nationally recognized clinical practice guideline." The bill further prohibits the application of patient cost sharing for those services. We note that the services described by the bill include the following:

1. Methods for detecting prostate cancer, including DRE and PSA tests, as well as associated laboratory services; and,
2. Medically necessary follow-up testing as directed by a physician, including but not limited to urinary analysis, serum biomarker testing, and medical imaging.

The prohibition on patient cost sharing would not apply to policies or contracts offered for use with a health savings account (HSA) unless the Internal Revenue Service determines this requirement is permissible in an HSA-qualified high-deductible health plan (HDHP) [1].

Current Maine law requires coverage for PSA and DRE tests once annually for applicable patients aged 50 to 72 when recommended by a physician, possibly with cost sharing applied. LD 1502 would remove the cost sharing for these services and any follow-up services. It is possible that removing cost sharing will increase both appropriate and inappropriate utilization over the next five years.

Applicability to Maine population

To calculate the impact of LD 1502, we needed to identify the percentage of the population that would be affected by this mandate. We used 1,378,322 as the population of Maine and 1,296,827 for the insured population of Maine (regardless of coverage source), based on the 2023 American Community Survey 1-year estimate tables.

The requirements of LD 1502 would apply to all policies in Maine's individual, fully insured small group, and fully insured large group markets, as well as the State of Maine employee (SOM) plan. Based on reports provided by the carriers to the BOI, the total covered lives at the end of 2024 for the three commercial insurance markets were as follows:

- Individual: 65,760
- Small group: 46,263
- Large group: 128,726
- Total: 240,749

These three markets represent approximately 18.6% of the total insured population of Maine. An additional 26,224 people are covered under the SOM plan. The remaining balance (over 80%) of covered lives are in health plans that are not governed by state health insurance mandates including the Federal Employee Health Benefits Program (FEBHP), student health plans, self-insured plans, Medicare, Medicaid, and other federally funded health care programs.

The National Comprehensive Cancer Network's clinical guidelines[2] for prostate cancer generally recommend testing for men aged 45 to 75 (or beginning at age 40 if certain high-risk factors are present). Men aged 45 to 75 with some type of insurance comprise about 19% of the insured population. Based on the enrollment for the fully insured commercial markets and the SOM plan, about 52,283 people would be eligible to receive the enhanced benefit.

[1] Generally, all services offered under an HDHP/HSA must be subject to the deductible unless they are considered 'preventive' by the IRS except for individual exchange Catastrophic and Bronze plans.
[2] https://www.nccn.org/guidelines/guidelines-detail?category=2&id=1460, version 2.2025. Last updated June 2025, last accessed August 2025.

How other states treat these services

Prostate cancer screening services are covered in most commercial major medical plans nationwide, possibly with patient cost sharing. Thirty-eight states, including Maine, mandate coverage for these services in one or more commercial health insurance markets. Of these 38 states, 7 states[3] currently restrict or eliminate cost sharing for screening services. An eighth state[4] will do so effective January 1, 2026. The State of Delaware includes "associated labs" without cost sharing. The other states that restrict cost sharing appear only to do so for the screening services themselves.

Prostate cancer screening services are explicitly included in the Essential Health Benefits (EHB) packages of most states, including Maine. Some states do not specifically mention these services but include coverage for 'diagnostic tests' generally. Other states do not specifically mention these services but require coverage for biomarker testing, which is likely to include them.

The Affordable Care Act (ACA) requires that any service given a grade of "A" or "B" by the United States Preventive Services Task Force (USPSTF) must be covered with no patient cost sharing applied in the ACA-compliant individual and small group markets. PSA tests have had a grade of "C" or "D" since the passage of the ACA, so carriers are permitted to impose cost sharing for the test in the absence of state mandates. The follow-up services included under LD 1502 are covered today but likely subject to patient cost sharing.

The State of Kentucky passed but did not implement[5] a related mandate to take effect January 1, 2025. The proposed mandate referenced the National Comprehensive Cancer Network (NCCN) guidelines among others. The mandate intended to "require coverage for screenings, tests, and procedures performed for the purpose of detecting cancer that occur prior to diagnosis." The types of cancer screenings included but were not limited to: lung, breast, cervical, prostate, and colorectal. Regarding prostate cancer, we believe this mandate is materially similar to LD 1502.

We note the Kentucky Insurance Department determined the mandate was in addition to that state's EHB package and required the associated defrayal payments specified by the ACA and associated regulations, which resulted in suspending implementation pending the outcome of a State Innovation Waiver application submission to CMS.

Cost estimate; summary of data and analysis

The premium impact estimate associated with the requirements of LD 1502 is $0.41 to $1.29 PMPM in the individual and group markets. Of this amount, we estimate less than $0.10 is attributed to the PSA and DRE tests alone with the remaining costs related to the follow-up services. This results in premium impacts that range between 0.06% and 0.18%. The premium impacts experienced by a given carrier or covered individual will vary according to market populations, plan designs offered, and contracted rates for the services contemplated. These PMPM estimates translate to total additional paid claims of $1.2 million to $3.6 million spread across all markets and carriers. Table 1

[3] DC, Delaware, Illinois, Maryland, New York, Rhode Island, Oklahoma, Arkansas
[4] Virginia
[5] https://apps.legislature.ky.gov/record/24rs/hb52.html

shows the cost distribution for each market segment based on low, middle, and high utilization estimates:

Table 1. Total paid claims (millions)

	Utilization Estimates		
Market	**Low**	**Middle**	**High**
Individual	$0.3	$0.6	$0.9
Small Group	$0.3	$0.5	$0.8
Large Group	$0.6	$1.2	$1.9
Total	$1.2	$2.2	$3.6

States are required to pay for ("defray") the costs of all health insurance benefit mandates that are included in individual Qualified Health Plans (QHPs), unless the mandate was in effect prior to December 31, 2011 and is part of the state's EHB package. The state must defray the cost of the mandate's premium impact on individual exchange/QHP plans. The ACA permits certain narrow exceptions to the defrayal requirements for mandates that are: an expansion of an existing mandate, required by federal law, a cost sharing requirement, or a provider mandate. Maine's prostate mandate became effective in 1997. The BOI suggests that LD 1502 requirements could be considered an expansion of an existing mandate with no defrayal necessary.

Key data and assumptions included in the cost estimate:

- 2023 EDGE files provided by Maine carriers for the individual and small group markets, produced for the purpose of administering the individual and small group market risk adjustment programs
- Annualized trend of 8%
- Loss ratio of 85% for the large group market and 80% for the individual and small group markets
- The "most recently published nationally recognized clinical guideline" for prostate cancer early detection as stated below
- A 2018 study published by the National Institute of Health regarding the uptake of cancer screening tests[6]
- Assumptions regarding the proportion of persons receiving follow-up services after a PSA test – we tested a range of 15% to 22% based on various studies[7,8]

[6] Hall IJ, Tangka FKL, Sabatino SA, Thompson TD, Graubard BI, Breen N. Patterns and Trends in Cancer Screening in the United States. Prev Chronic Dis. 2018 Jul 26;15:E97. doi: 10.5888/pcd15.170465. PMID: 30048233; PMCID: PMC6093265. https://pmc.ncbi.nlm.nih.gov/articles/PMC6093265/

[7] Espaldon R, Kirby KA, Fung KZ, Hoffman RM, Powell AA, Freedland SJ, Walter LC. Probability of an abnormal screening prostate-specific antigen result based on age, race, and prostate-specific antigen threshold. Urology. 2014 Mar;83(3):599-605. doi: 10.1016/j.urology.2013.10.051. Epub 2014 Jan 16. PMID: 24439009; PMCID: PMC3943595. https://pmc.ncbi.nlm.nih.gov/articles/PMC3943595/

[8] Zeliadt SB, Buist DS, Reid RJ, Grossman DC, Ma J, Etzioni R. Biopsy follow-up of prostate-specific antigen tests. Am J Prev Med. 2012 Jan;42(1):37-43. doi: 10.1016/j.amepre.2011.08.024. PMID: 22176844; PMCID: PMC3556898. https://pmc.ncbi.nlm.nih.gov/articles/PMC3556898/

- Insurer data reported on the Rule 945 reports
- Population data from the American Community Survey, 2023 1-year estimates
- Impact of current cost sharing of 20% for the large group market and 30% for the individual and small group markets

For the "most recently published nationally recognized clinical guideline", we used the NCCN Prostate Cancer Early Detection guideline[9], last updated in June 2025. The guideline recommends PSA tests for individuals meeting the criteria listed below, after discussion of the potential benefits and harms of early detection.

- For patients with average risk aged 45 to 75
- For patients with higher-than-average risk aged 40 to 75
- For patients over age 75 in select circumstances
- Patients with higher-than-average risk include those with family history of cancers or other prostate disease, Black / African American identity, or exposure to certain medications and chemicals. Widespread screening in patients over 75 is not recommended; the guideline states that testing should be done in "very healthy people with little or no comorbidity." We note the age range in the NCCN guideline is an expansion of the age range from 72 to 75[10] for PSA and DRE testing required by current Maine law.[11]

The guideline includes consideration of DRE but states DRE should not be used as a stand-alone test. The guideline also does not recommend a single regular interval for testing; instead, testing intervals vary by test result and population as listed above.

When PSA and DRE testing results in need for further evaluation, LD 1502 would require that no cost sharing also apply to medically necessary follow-up services as directed by a physician.

According to the NCCN guideline, follow-up services can include:

- Repeated PSA or DRE tests
- Magnetic resonance imaging (MRI)
- Certain biomarker tests or urinalysis
- Biopsy, possibly with MRI targeting

Conclusion

L&E estimates the premium impact of removing cost sharing on PSA tests, DRE tests, and any follow-up services resulting from such tests as $0.41 to $1.29 PMPM, depending on market, population, and provider contracting outcomes. This amounts to 0.06% to 0.18% of premium. The impact to the

[9] https://www.nccn.org/guidelines/guidelines-detail?category=2&id=1460. National Comprehensive Cancer Network (login required).

[10] §2745-G, §2837-H, §4244 Digital rectal examinations and prostate-specific antigen tests covered if recommended by a physician, at least once a year for men 50 years of age or older until age 72.

[11] 24 M.R.S. Section 2325-C and 24-A M.R.S. Sections 2745_G, 2837-H, and 4244

State of Maine's (SOM) employee benefits plan was estimated by Anthem Health Plans of Maine, the SOM plan administrator, to be $0.34 PMPM.

Appendix A – Information required by Maine law

Maine Insurance Code Title 24-A, Chapter 33, Section 2752 requires BOI to conduct a review and evaluation of proposed health insurance benefit mandates upon request, which includes the items listed below.

Social impact

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

The services contemplated by LD 1502 are currently covered in the fully insured individual[12] and group[13] markets. Coverage for PSA tests and DREs at least once annually are currently required by Maine law for men between the ages of 50 and 72. Current law does not prohibit the application of cost sharing.

LD 1502 would replace the existing age recommendation with the most recently published nationally recognized clinical practice guidelines discussed above. LD 1502 would also eliminate cost sharing for PSA tests and DREs as well as any necessary follow-up services.

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

These services are currently available to residents of Maine, as Maine law currently requires coverage for the prostate cancer screening procedures listed in LD 1502.

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

Maine law currently requires coverage for the prostate cancer screening procedures listed in LD 1502. We believe the follow-up services contemplated in the bill are also widely covered across all segments. The bill would require all such services to be covered with no patient cost sharing.

(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;

These services are covered currently in the market, possibly subject to patient cost-sharing, which is discussed immediately below.

(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;

Proponents of the bill testified that even low cost-sharing for these services creates financial barriers to seeking them. PSA tests are typically $40 to $60. Follow-up services can include biopsies and MRIs and can exceed $2,000 for in-network services. Typical cost sharing provisions can result in patients paying a significant portion of that amount.

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

The Joint Standing Committee on Health Coverage, Insurance, and Financial Services received 10 testimonies regarding LD 1502 – 7 in favor, 2 against, and 1 neither for nor against. None of these

[12] 24-A M.R.S. §2745-E
[13] 24-A M.R.S. §2837-H

testimonies were provided by provider organizations directly. Six of the 7 testimonies were provided by patients or patient advocacy groups. Much of the testimony centered around the out-of-pocket costs to individuals and families, which may be reduced by implementation of LD 1502.

(7) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

This is covered in the above item.

(8) The level of interest in and the extent to which collective bargaining organizations are negotiating privately for inclusion of this coverage in group contracts;

No additional information regarding collective bargaining organizations was available.

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

PSA tests, DREs, and medically necessary follow up services are covered in most commercial major medical plans nationwide, possibly with patient cost sharing. Thirty-eight states (including Maine) mandate coverage for PSA tests or DREs in one or more commercial health insurance markets. Of these 38 states, we identified 7 states[14] which currently restrict or eliminate cost sharing for PSA and DRE tests. An eighth state[15] will do so effective January 1, 2026. Regarding the ACA-compliant individual and small group markets specifically, we believe these benefits are covered in the EHB package of most if not all states (including Maine), possibly with applicable cost sharing.

Of the 8 states identified with no or reduced cost sharing, we identified only one state (Delaware) that included associated follow-up laboratory tests.

(10) The relevant findings of the appropriate health system agency relating to the social impact of the mandated benefit;

State agencies did not provide findings or other information pertaining to the social impact of LD 1502.

(11) The alternatives to meeting the identified need;

Carrier responses generally tended to oppose the mandate, citing cost and concerns about potentially inappropriate use or overuse. One carrier suggested the mandate be limited solely to the PSA and DRE tests themselves and not the follow-up services, which are generally subject to cost sharing in other similar situations relating to cancer diagnoses. Another carrier suggested that language relating to medical necessity and clinical appropriateness be added.

(12) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

[14] DC, Delaware, Illinois, Maryland, New York, Rhode Island, Oklahoma, Arkansas
[15] Virginia

The services contemplated by LD 1502 are currently covered by most health insurance plans when medically necessary and as such are not inconsistent with either the role of health insurance or the concept of managed care.

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

These services are currently available and there is unlikely to be a social stigma associated with receiving this additional benefit.

(14) The impact of this benefit on the availability of other benefits currently being offered;

We do not expect the availability of this benefit to impact the availability of other benefits currently being offered. It is possible that a reduction in cost sharing for PSA tests and DREs could cause an increase in utilization of these services, which may result in increased usage of the higher-cost follow-up services.

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

While this particular mandate is not expected to have a material impact on premiums, it would add to the cumulative impact of all state mandates on health insurance costs in the fully insured market. The cumulative impact of mandates is a consideration for employers when weighing whether to move out of the fully insured market and into a self-funded arrangement that is not subject to state mandates. The cost of state mandates can also cause employers and individuals to shift to health plans with greater member cost-sharing to lower monthly premiums.

Since BOI does not regulate self-insured plans that do not fit into the governmental exception under ERISA, we do not have data about specific benefits offered by self-insured plans.

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

According to the SOM Health Plan Benefit Summaries for plan years 2024 and 2025, PSA tests and DREs are covered with no member cost sharing at in-network providers. The SOM plan also covers laboratory tests and certain imaging procedures with no cost sharing when performed at an independent lab or imaging center. Based on this, we expect the cost impact on the State plan to be less than the impact on the commercial markets, because a subset of the services contemplated by LD 1502 already have no cost sharing. Anthem Health Plans of Maine provided an estimated premium impact of $0.34 to the SOM plan. Based on SOM plan enrollment of 26,224 people, the total additional cost to the SOM plan is estimated to be $107,000.

Financial impact

(1) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;

It is likely that removing patient cost sharing from the applicable services and expanding the population eligible to receive them with no cost sharing will increase utilization of these services and therefore increase the associated claims cost. We did not attempt to quantify the magnitude of such an increase.

(2) The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;

Current Maine law requires coverage for PSA and DRE tests once annually for applicable patients aged 50 to 72 when recommended by a physician, possibly with cost sharing applied. LD 1502 would remove the cost sharing for these services and any follow-up services. It is possible that removing cost sharing barriers will increase both appropriate and inappropriate utilization over the next five years. Current medical guidelines recommend discussion of the benefits and drawbacks of testing with patients and nothing in LD 1502 overrides this, which we expect would mitigate at least some of the possible overuse.

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

The services contemplated by LD 1502 are widely available and aligned with current standards of care.

Proponents of LD 1502 say that removing cost sharing barriers will increase utilization of the services and improve early detection of prostate cancer, thereby mitigating future adverse effects and their associated costs.

(4) The methods that will be instituted to manage the utilization and costs of the proposed mandate;

LD 1502 would effectively expand the population eligible to receive the mandated services by eliminating the age range of patients eligible to receive them. Nothing in LD 1502 appears to prohibit the use of medical management techniques to manage the utilization and costs of necessary follow-up services, and these techniques likely exist already.

(5) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years;

We would not expect the mandate to materially impact the number or types of providers of the mandated services over the next 5 years.

(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;

The expected increase in premium due to LD 1502 is discussed in the Cost Estimate section of this report. We would not expect a material change in carrier administrative expense due to LD 1502.

(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.

We expect no additional costs beyond benefit or administrative costs due to LD 1502.

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

Some proponents of the bill mentioned the possibility of avoiding more costly care in the future. In practice this is very difficult to quantify, and may not benefit the member's current carrier as people and employers may switch carriers. This is not to say there is no beneficial effect on the total cost of care over time – only that the effects are difficult to quantify and are very rarely captured in pricing exercises, which typically apply only to a 12-to-18-month time horizon.

Several studies have found that PSA or combined PSA/DRE screening are cost-effective for men under the age of 70. "The combined PSA and DRE strategy of screening is cost-effective, yields up to $3 saving in costs per case and emerges as the dominant strategy over PSA alone. Screening for men aged 70 and above does not meet economic justification, indicated by a negative Net Cost-Benefit Index (NCBI). The 40–49 age group exhibits the highest net benefit, $13.81 based on basic information. Sensitivity analysis strongly supports the cost-effectiveness of the combined screening approach."[16]

Another study found that "PSA screening prevented one death for every 11-14 men diagnosed with the disease. Among black men, who are at higher risk of dying from prostate cancer than men in general, the benefits of PSA screening were even greater. Prevention of death isn't the only benefit of PSA screening, because advanced prostate cancer that does not lead to death can still negatively affect a man's quality of life by causing pain and other unwanted side effects."[17]

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

While this particular mandate is not expected to have a material impact on premiums, it would add to the cumulative impact of all state mandates on health insurance costs in the fully insured market. The cumulative impact of mandates is a consideration for employers when weighing whether to move out of the fully insured market and into a self-funded arrangement that is not subject to state mandates. The cost of state mandates can also cause employers and individuals to shift to health plans with greater member cost-sharing to lower monthly premiums.

(10) The effect of the proposed mandate on cost shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this State.

We do not expect material impacts related to cost shifting due to LD 1502.

In order to enable the committee to assess the financial impact of the benefit, the report must include a comparison of the rate of increase in the Consumer Price Index for medical care services to the rate of increase in the Consumer Price Index for the previous year and the current year as reported by the United States Department of Labor, Bureau of Labor Statistics;

Using data through May 2025, the Consumer Price Index for All Urban Consumers (CPI-U) was 2.35% for the 12 months ending May 2025 and 3.27% for the 12 months ending May 2024 respectively. The CPI-U for medical care only for the same time periods was 2.48% and 3.07% respectively. The CPI-

[16] https://pmc.ncbi.nlm.nih.gov/articles/PMC11071254/
[17] https://www.uhhospitals.org/blog/articles/2023/01/psa-screening-is-more-beneficial-than-previously-thought

U for medical care includes consumer out-of-pocket costs and premiums and does not take utilization levels into account.

Medical efficacy

(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 clinical guidelines recommend that PSA or DRE tests be performed after discussion with the patient regarding benefits and drawbacks of the testing and consideration of the patient's history. According to the NCCN guideline, it is possible that increased frequency of testing could result both in additional early detection of cancers as well as additional overtreatment.

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

This bill does not create new classes of practitioners and does not address the scope of practice of any existing class of practitioners.

Balancing considerations

(1) The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders;

Proponents of LD 1502 contend that removing cost-sharing will increase utilization of the services and improve early detection of prostate cancer, which can improve treatment outcomes and mitigate their associated costs. Clinical guidelines suggest that increased early detection has resulted in lower mortality from prostate cancer. The NCCN guidelines also cite possible risks related to over-detection or over-treatment of disease with a low probability of clinical benefit, false-positive results which cause patient anxiety, as well as complications (such as infection) associated with biopsies performed after false-positive tests.

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

Coverage for the services contemplated in LD 1502 is already available in all Maine health insurance markets, subject to applicable medical management methods and patient cost sharing. The bill addresses only the level of patient cost sharing to be applied in commercial major medical plans.

Having separate riders for certain benefits for ACA individual and small group plans is prohibited. For any other plans, we would expect the option to be more expensive per covered member than the added cost outlined in the Cost Estimate section of this report. There would likely be administrative expenses associated with the increased complexity. In addition, it is likely that only those expecting to use the benefit would purchase it, distributing the increased total cost over a smaller pool of insured members.

(3) The cumulative impact of mandating this benefit in combination with existing mandates on the costs and availability of coverage. [PL 1997, c. 616, §5 (AMD).]

The estimated cumulative cost of all benefits mandated by current Maine law is shown in Appendix C.

Appendix B – Actuarial Disclosures

This appendix contains the disclosures required by applicable Actuarial Standards of Practice (ASOP).

Identification of responsible actuaries

I, Jason R. Dunavin, FSA, MAAA, Vice President and Senior Consulting Actuary, am associated with the firm of Lewis & Ellis, LLC. I am a member in good standing of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I have been retained by the Maine Bureau of Insurance to conduct the analysis shown in this report. I meet the Academy qualification standards for completing the analysis described in this report.

Identification of actuarial documents

This file *LD 1502 BOI Mandate Analysis.docx* comprises the entire report. The date of this report is September 12, 2025.

Latest information date

The latest date through which data or other information has been considered in performing this analysis is September 12, 2025.

Disclosures

The following disclosures are required by ASOP #41, *Actuarial Communications*:

- The contents of this report are intended for the use of the Maine Bureau of Insurance. The authors of this report are aware that it may be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claims, or action against L&E, under any theory of law, related in any way to this material.
- L&E is financially and organizationally independent from the health insurers and providers involved in this analysis. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Maine Bureau of Insurance in assessing the medical, social, and financial impacts of expanding coverage related to prostate cancer screening. It is not intended to advocate for or against any policy position.
- It is likely that premium impacts on a specific carrier's rates will differ from those presented here, based on the carrier's own population, currently covered benefits, and medical management practices, among other things.
- L&E reviewed the data provided by the insurers and by BOI and others for reasonableness. L&E did not audit the data. Neither L&E nor the responsible actuaries assume responsibility for these items which may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- Several assumptions made in this analysis are subject to significant uncertainty. It is expected that actual results will differ from the calculated estimates.

- L&E is not aware of any subsequent events that may have a material effect on the findings contained in this report.

Reliance

The items relied upon are referenced in the body of the report, with footnotes and links where applicable. We reviewed each item for reasonableness but did not audit any item. Neither L&E nor the responsible actuaries assume responsibility for these items which may have a material impact on the analysis. To the extent that there are material inaccuracies, misrepresentations, or lack of adequate disclosure in each item, the results may be accordingly affected.

Appendix C – Cumulative Impact of Maine mandates

This report provides data for medical insurance coverage of mandates as required by 24-A M.R.S.A. §2752 and compiled by the Bureau of Insurance. While some data was provided through annual mandate reports by insurers, other figures were estimated as a part of the proposed mandates study. The following provides a brief description of each state mandate and if the cost is not negligible, the estimated claim cost as a percentage of premium. Many of these mandates are now required by the federal Affordable Care Act (ACA). In addition, the ACA requires benefits covered by the benchmark plan which includes all state mandates to be covered by all individual and small group plans effective January 1, 2014. A summary chart is provided at the end of this report.

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

Mental health parity for group plans in Maine became effective July 1,1996 and was expanded in 2003. The percentage of mental health group claims paid has been tracked since 1984 and has historically been between 3% - 4% of total group health claims.

Maine mental health parity is included in the essential health benefits for ACA individual and small group plans beginning 2014. At the federal level, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) amended the PHS Act, ERISA, and the Code to provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits and extended parity to all individual plans.

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

Maine's mandate for substance abuse was added to the list of mental health conditions for which parity is required, and the federal Affordable Care Act requires substance abuse treatment benefits for individual and small group plans as part of the essential health benefits. The percentage of claims paid for group plans has been tracked since 1984. For the past 5 years, substance abuse claims paid have remained flat at 1-1.2% average of the total health claims. For 2024, group claims for substance abuse were reported as 1.08% and for individual claims 1.13% of total medical claims.

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

This mandate requires coverage for the services of chiropractors to the extent that the same services would be covered if performed by a physician. Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1986 and, in 2024, was 0.46% of total health claims.

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

This mandate requires that benefits be provided for screening mammography. Coverage is required by the ACA through preventive services. For total health claims, we estimate the current 2024 levels

of 0.6% for group and 1.08% for individual going forward.

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

This mandate requires coverage for dentists' services to the extent that the same services would be covered if performed by a physician. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate.

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

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

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

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

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

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

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

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

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

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

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

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

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

This mandate requires that benefits for breast cancer treatment be provided for a medically appropriate period of time as determined by the physician in consultation with the patient. Group claims in 2024 were 1.45% compared to individual claims at 1.39%. This creates a combined 1.43% of total medical claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This mandate affects plans that use participating eye care professionals. Coverage is required without prior approval of the enrollee's primary care provider for a maximum of 2 visits, one initial visit and one follow-up visit, for each occurrence requiring urgent care. Our report estimated a cost of 0.04% of premium.

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

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

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

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

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

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

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

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

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

The prior mandate required coverage for a hearing aid for each ear every 36 months for children age 18 and under. For 2020 the hearing aid mandate was expanded to require coverage of adult hearing aids. Based on rate filings and a proposed mandate study we estimate 0.2% addition impact to rates to provide hearing aids to adults.

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

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

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

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

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

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

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

This mandate requires all contracts to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals who are 10 years of age or under. A report estimated a cost of 0.3% of premium once the mandate is fully implemented. Based on that estimate and recently reported experience we are estimating this going forward.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- ***Certified Registered Nurse Anesthetists (CRNA)*** (Enacted 2021)

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

- ***Certified Midwives*** (Enacted 2021)

This mandate requires coverage under those contracts for services performed by a certified nurse midwife to a patient who is referred to the certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the certified nurse midwife.

- ***HIV Prevention Drugs*** (Enacted Federal 2021)

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

estimate of 0.26% increase to premium was provided in our report.

- ***Mental Health Parity for Individuals 21 Years of Age or Younger*** (Enacted 2022)

This mandate requires health insurance carriers to provide coverage for mental health services that use evidence-based practices and are determined to be medically necessary health care for individuals 21 years of age or younger.

- ***Contraceptives Without Cost-sharing*** (Enacted 2022)

This mandate requires health insurance carriers to provide coverage for all prescription contraceptives without cost-sharing.

- ***Postpartum Care*** (Enacted 2022)

Health insurance carriers must provide coverage to include recommendations in the "Optimizing Postpartum Care" opinion published May 2018 by the American College of Obstetricians and Gynecologists including pelvic floor surgery. An estimate of 0.15% increase to premium was provided in our report.

- ***Fertility Care*** (Enacted 2022 and effective 2024)

This mandate requires health insurance carriers to provide coverage for fertility diagnostic care, fertility treatment if the enrollee is a fertility patient, and fertility preservation services. Actual experience for individual coverage was $669,149, or approximately 0.25% of premium in 2024 but we expect cost and utilization to increase as the benefit becomes known and treatments get scheduled. Recent estimates place the impact of this coverage at 0.69% of premium. Individual on-exchange plans do not reflect the increased premium due to the ACA requirement for that increase to be defrayed by state funds.

- ***Prosthetic Needs of Children for Recreational Purposes*** (Enacted 2022)

This mandate requires health insurance carriers to provide coverage for prosthetic devices of those under 18 years of age to meet the recreational needs of an enrollee in addition to their medical needs. Our report estimated a negligible increase to premiums.

- ***Medically Necessary Dental Procedures for Cancer Patients*** (Enacted 2022)

This mandate requires health insurance carriers to provide coverage for dental procedures that are medically necessary to reduce the risk of infection, eliminate infection, or to treat tooth loss or decay in an enrollee prior to beginning cancer treatment or that are the direct or indirect result of cancer treatment. Recent estimates place the impact of this coverage at 0.2% of premium.

- ***Donor Breast Milk for Infants*** (Enacted 2023)

This mandate requires health insurance carriers to provide coverage for donor breast milk for infants when medically necessary. Recent estimates place the impact of this coverage at 0.02% of premium.

- ***First Dollar Coverage for Diagnostic Breast Exams*** (Enacted 2023)

Health insurance carriers are prohibited from imposing cost-sharing on diagnostic breast examinations, including mammography, MRI, or ultrasound.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts	0.10%
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups	1.08%
		Individual	1.13%
1975 1983 1995 2003	Benefits must be included for **mental health services**, including psychologists and social workers.	All Contracts	5.34%
1986 1994 1995 1997	Benefits for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services.	Group	0.52%
		Individual	0.31%
1990 1997	Benefits must be made available for screening **mammography**.	Group	0.60%
		Individual	1.08%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%
1996	If policies provide maternity benefits, the **maternity (length of stay)** and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care."	All Contracts	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.20%
1996	Benefits must be provided for **screening Pap tests**.	All	0.01%

1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	0
1997	Benefits provided for **breast cancer treatment** length of stay.	All Contracts	1.43%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%
1998	Coverage required for **prostate cancer screening**.	All Contracts	0.07%
1999	Coverage of **nurse practitioners and nurse midwives** and allows nurse practitioners to serve as primary care providers.	All Managed Care Contracts	0
1999	Prescription drug must include **contraceptives**.	All Contracts	0.80%
1999	Coverage for **registered nurse first assistants**.	All Contracts	0
2000	Access to **clinical trials**.	All Contracts	0.19%
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0
2001	Access to **eye care**.	Plans with participating eye care professionals	0
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg.	Groups >20	0.03%
		All other	0.08%
2003	Coverage of **licensed clinical professional counselors**.	All Contracts	0
2005	Coverage of **licensed pastoral counselors and marriage & family therapists**.	All Contracts	0
2007	Coverage of **hearing aids** for children.	All Contracts	0.1%
2008	Coverage for amino acid-based elemental **infant formulas**.	All Contracts	0.1%
2008	Coverage for **colorectal cancer screening**.	All Contracts	0
2009	Coverage for **independent dental hygienist**.	All Contracts	0
2010	Coverage for **autism spectrum**.	All Contracts	0.3%
2010	Coverage for **children's early intervention services**.	All Contracts	0.05%
2014	Coverage for **chemotherapy oral medications**.	All Contracts	0
2014	Coverage for **human leukocyte antigen testing**.	All Contracts	0
2014	Coverage for **dental hygienist**.	All Contracts	0
2015	Coverage for **abuse-deterrent opioid analgesic medications**.	All Contracts	0
2018	Coverage for **naturopath**.	All Contracts	0
2018	Coverage for **preventive services**.	All Contracts	0
2019	Coverage for **adult hearing aids**.	All Contracts	0.20%
2019	Coverage for **abortion services**.	Individual	0.14%
		Group	0.19%
2021	Coverage for **certified registered nurse anesthetists**.	All Contracts	0
2021	Coverage for **certified midwives**.	All Contracts	0
2021	Coverage for **HIV prevention drugs**.	All Contracts	0.26%

2022	**Mental health parity** for those 21 and younger.	All Contracts	0
2022	Expanded coverage for **contraceptives without cost-sharing**.	All Contracts	0
2022	Expanded coverage for **postpartum care**.	All Contracts	0.15%
2022	Coverage for **fertility care**.	All Contracts	0.69%
2022	**Prosthetics** for the recreational needs of children.	All Contracts	0.01%
2022	Medically necessary **dental procedures** for cancer patients.	All Contracts	0.20%
2023	Coverage for **donor breast milk** for infants.	All Contracts	0.02%
2023	First dollar coverage for **diagnostic breast exams**.	All Contracts	0
2025	Over the counter **oral contraceptives**.	All Contracts	0
	Total cost for groups larger than 20:		**11.78%**
	Total cost for groups of 20 or fewer:		**11.83%**
	Total cost for individual contracts:		**13.04%**

Appendix D – Text of LD 1502

132nd MAINE LEGISLATURE

FIRST SPECIAL SESSION-2025

Legislative Document **No. 1502**

H.P. 986 House of Representatives, April 8, 2025

An Act to Update the Requirements for Health Insurance Coverage of Prostate Cancer Screening

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

ROBERT B. HUNT
Clerk

Presented by Representative MOONEN of Portland.
Cosponsored by Representatives: BOYER of Cape Elizabeth, FLYNN of Albion, FOLEY of Wells, MASTRACCIO of Sanford, MATHIESON of Kittery, Senator: BAILEY of York.

Printed on recycled paper

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

Sec. 1. 24 MRSA §2325-C, as enacted by PL 1997, c. 754, §1, is amended to read:

§2325-C. Coverage for prostate cancer screening

~~**1. Definition.** As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:~~

~~A. A digital rectal examination; and~~

~~B. A prostate-specific antigen test.~~

1-A. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline:

(1) Developed by an independent organization or medical professional society using a transparent methodology and reporting structure and with a conflict of interest policy;

(2) That establishes a standard of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options; and

(3) That includes recommendations intended to optimize patient care.

B. "Services for the early detection of prostate cancer" means medically viable methods for the purpose of early detection and diagnosis of prostate cancer, including a digital rectal examination and prostate-specific antigen test and associated laboratory services. "Services for the early detection of prostate cancer" includes medically necessary follow-up testing as directed by a physician, including, but not limited to, urinary analysis; serum biomarker testing; and medical imaging such as magnetic resonance imaging.

2. Required coverage for prostate cancer screening. All individual and group nonprofit hospital and medical services plan contracts must provide coverage for services for the early detection of prostate cancer. The contracts must reimburse for services for the early detection of prostate cancer, if recommended by a physician, ~~at least once a year for men 50 years of age or older until a man reaches the age of 72~~ when supported by medical and scientific evidence according to the most recently published nationally recognized clinical practice guideline.

~~**3. Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after September 1, 1998. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.~~

4. Cost sharing prohibited. An individual or group nonprofit hospital and medical services plan contract may not impose any deductible, copayment, coinsurance or other cost-sharing requirement for the costs of services for the early detection of prostate cancer required to be covered under subsection 2. This subsection does not apply to a contract offered for use with a health savings account unless the United States Internal Revenue Service determines that the requirements in this subsection are permissible in a high

deductible health plan as defined in the United States Internal Revenue Code of 1986, Section 223(c)(2).

Sec. 2. 24-A MRSA §2745-G, as enacted by PL 1997, c. 754, §2 and reallocated by RR 1997, c. 2, §51, is amended to read:

§2745-G. Coverage for prostate cancer screening

~~**1. Definition.** As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:~~

~~A. A digital rectal examination; and~~

~~B. A prostate-specific antigen test.~~

1-A. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline:

(1) Developed by an independent organization or medical professional society using a transparent methodology and reporting structure and with a conflict of interest policy;

(2) That establishes a standard of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options; and

(3) That includes recommendations intended to optimize patient care.

B. "Services for the early detection of prostate cancer" means medically viable methods for the purpose of early detection and diagnosis of prostate cancer, including a digital rectal examination and prostate-specific antigen test and associated laboratory services. "Services for the early detection of prostate cancer" includes medically necessary follow-up testing as directed by a physician, including, but not limited to, urinary analysis; serum biomarker testing; and medical imaging such as magnetic resonance imaging.

2. Required coverage for prostate cancer screening. All individual insurance policies and contracts except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts must provide coverage for services for the early detection of prostate cancer. The contracts must reimburse for services for the early detection of prostate cancer, if recommended by a physician, ~~at least once a year for men 50 years of age or older until a man reaches the age of 72~~ when supported by medical and scientific evidence according to the most recently published nationally recognized clinical practice guideline.

~~**3. Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after September 1, 1998. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.~~

4. Cost sharing prohibited. An individual insurance policy or contract may not impose any deductible, copayment, coinsurance or other cost-sharing requirement for the costs of services for the early detection of prostate cancer required to be covered under

subsection 2. This subsection does not apply to a policy or contract offered for use with a health savings account unless the United States Internal Revenue Service determines that the requirements in this subsection are permissible in a high deductible health plan as defined in the United States Internal Revenue Code of 1986, Section 223(c)(2).

Sec. 3. 24-A MRSA §2837-H, as enacted by PL 1997, c. 754, §3 and reallocated by RR 1997, c. 2, §52, is amended to read:

§2837-H. Coverage for prostate cancer screening

~~**1. Definition.** As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:~~

~~A. A digital rectal examination; and~~

~~B. A prostate-specific antigen test.~~

1-A. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline:

(1) Developed by an independent organization or medical professional society using a transparent methodology and reporting structure and with a conflict of interest policy;

(2) That establishes a standard of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options; and

(3) That includes recommendations intended to optimize patient care.

B. "Services for the early detection of prostate cancer" means medically viable methods for the purpose of early detection and diagnosis of prostate cancer, including a digital rectal examination and prostate-specific antigen test and associated laboratory services. "Services for the early detection of prostate cancer" includes medically necessary follow-up testing as directed by a physician, including, but not limited to, urinary analysis; serum biomarker testing; and medical imaging such as magnetic resonance imaging.

2. Required coverage for prostate cancer screening. All group insurance policies and contracts except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts must provide coverage for services for the early detection of prostate cancer. The contracts must reimburse for services for the early detection of prostate cancer, if recommended by a physician, ~~at least once a year for men 50 years of age or older until a man reaches the age of 72~~ when supported by medical and scientific evidence according to the most recently published nationally recognized clinical practice guideline.

~~**3. Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after September 1, 1998. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.~~

4. Cost sharing prohibited. A group insurance policy or contract may not impose any deductible, copayment, coinsurance or other cost-sharing requirement for the costs of services for the early detection of prostate cancer required to be covered under subsection 2. This subsection does not apply to a policy or contract offered for use with a health savings account unless the United States Internal Revenue Service determines that the requirements in this subsection are permissible in a high deductible health plan as defined in the United States Internal Revenue Code of 1986, Section 223(c)(2).

Sec. 4. 24-A MRSA §4244, as enacted by PL 1997, c. 754, §4 and reallocated by RR 1997, c. 2, §53, is amended to read:

§4244. Coverage for prostate cancer screening

~~**1. Definition.** As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:~~

~~A. A digital rectal examination; and~~

~~B. A prostate-specific antigen test.~~

1-A. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline:

(1) Developed by an independent organization or medical professional society using a transparent methodology and reporting structure and with a conflict of interest policy;

(2) That establishes a standard of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options; and

(3) That includes recommendations intended to optimize patient care.

B. "Services for the early detection of prostate cancer" means medically viable methods for the purpose of early detection and diagnosis of prostate cancer, including a digital rectal examination and prostate-specific antigen test and associated laboratory services. "Services for the early detection of prostate cancer" includes medically necessary follow-up testing as directed by a physician, including, but not limited to, urinary analysis; serum biomarker testing; and medical imaging such as magnetic resonance imaging.

2. Required coverage for prostate cancer screening. All health maintenance organization individual and group contracts must provide coverage for services for the early detection of prostate cancer. The contracts must reimburse for services for the early detection of prostate cancer, if recommended by a physician, ~~at least once a year for men 50 years of age or older until a man reaches the age of 72~~ when supported by medical and scientific evidence according to the most recently published nationally recognized clinical practice guideline.

~~**3. Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on~~

~~or after September 1, 1998. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.~~

4. Cost sharing prohibited. An individual or group contract may not impose any deductible, copayment, coinsurance or other cost-sharing requirement for the costs of services for the early detection of prostate cancer required to be covered under subsection 2. This subsection does not apply to a contract offered for use with a health savings account unless the United States Internal Revenue Service determines that the requirements in this subsection are permissible in a high deductible health plan as defined in the United States Internal Revenue Code of 1986, Section 223(c)(2).

Sec. 5. Application. This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2026. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

SUMMARY

Under current law, health insurance coverage must be provided for annual prostate cancer screening, if recommended by a physician, to men 50 years of age or older until attaining 72 years of age. This bill updates the required coverage by doing the following.

1. It expands the scope of the required screening services to include medically necessary follow-up testing as directed by a physician, including, but not limited to, urinary analysis; serum biomarker testing; and medical imaging. It retains the provision in current law that requires coverage of a digital rectal examination and a prostate-specific antigen test and provides that associated laboratory fees for those tests are also covered.

2. It requires the coverage of services for the early detection of prostate cancer, if recommended by a physician, when supported by medical and scientific evidence according to the most recently published nationally recognized clinical practice guideline.

3. It prohibits the use of any deductible, copayment, coinsurance or other cost-sharing requirement for the costs of services for the early detection of prostate cancer.

The requirements of the bill apply to health plans issued or renewed on or after January 1, 2026.

Appendix E – Letter from Committee

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

June 10, 2025

Robert Carey
Superintendent
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Superintendent Carey,

Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on Health Coverage, Insurance and Financial Services to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing on the proposed legislation. Pursuant to that statute, we request that the Bureau of Insurance prepare a review and evaluation of **LD 1502, An Act to Update the Requirements for Health Insurance Coverage of Prostate Cancer Screening.**

As you know, current law already mandates health insurance coverage for services for the early detection of prostate cancer, which are defined in law as a digital rectal examination and a prostate-specific antigen test, at least once a year for men 50 years of age or older until age 72. LD 1502 proposes changes to current law. A copy of the bill is enclosed. Please prepare a review of the proposed changes to the existing mandate for coverage using the guidelines set out in Title 24-A § 2752. In addition, we ask that the Bureau provide an analysis of the extent to which the bill expands coverage beyond the State's essential benefits package and, if so, the estimated costs to the State to defray the costs of including the coverage in qualified health plans.

Please submit the report to the committee no later than January 1, 2026 so the committee can take final action on LD 1502 before the end of the Second Regular Session. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,

Sen. Donna Bailey
Senate Chair

Rep. Kristi Michele Mathieson
House Chair

cc: Rep. Matt Moonen

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