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 1530 An Act to Improve the Sustainability of Emergency Medical Services in Maine

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Executive summary

Lewis & Ellis, LLC ("L&E") was engaged by the Maine Bureau of Insurance ("BOI" or "Bureau") to provide analysis related to the proposed commercial major medical health insurance coverage mandate contained in LD 1530 as amended, titled *An Act to Improve the Sustainability of Emergency Medical Services in Maine*.

The proposed mandate would require carriers in the fully insured individual, small group, and large group markets, as well as the health plan offered to state employees (SOM plan), to include coverage of non-transporting emergency medical service (NT-EMS) providers for services currently covered when provided by ambulance service providers. The bill would prohibit prior authorization requirements. LD 1530 also requires coverage for naloxone hydrochloride or other opioid overdose-reversing medications when provided by an ambulance provider or NT-EMS provider.

L&E estimates a premium impact range of $1.26 to $3.34 per member per month (PMPM) depending on carrier, benefit plan, and NT-EMS provider reimbursement levels. The resulting percentage impact to premiums is estimated to be between 0.20% and 0.51%. These estimates are based primarily on carrier data reported in aggregate to BOI and statistics published by Maine Emergency Medical Services (Maine EMS). These PMPM estimates translate to total additional paid claims of $3.8 million to $9.3 million spread across all markets and carriers.

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 text of LD 1530 as amended. Appendix E contains the letter from the Joint Standing Committee on Health Coverage, Insurance and Financial Services requesting this mandate study.

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.

Proposed mandate and analysis

Summary of proposed mandate

Title 24-A M.R.S. §4303-F(1) describes reimbursement rates for covered services provided by ambulance service providers. LD 1530 as amended modifies this subsection to include reimbursement for covered services when provided by NT-EMS providers in the same manner as if those services were provided by an ambulance service provider and changes the reimbursement threshold for both ambulance service providers and NT-EMS providers from 200% to 300% of Medicare. The provisions for reimbursement in LD 1530 as amended add NT-EMS to the subsection

on reimbursement for ambulance services[1] instead of to the subsection on non-transport services[2]. Because "non-transporting EMS provider" and "ambulance provider" are different license classes – an ambulance provider does not become a "non-transporting provider" when a patient is not transported. The subsection on non-transport services is only applicable to ambulance services when the ambulance responds to a call for emergency services but the individual refuses transport to a hospital. Other provisions of the bill include:

- a prohibition on prior authorization requirements
- a requirement for coverage for naloxone hydrochloride or other opioid overdose-reversing medications when provided by an ambulance provider or NT-EMS provider
- a specification that carriers are not required to reimburse twice for the same service when billed separately by ambulance providers and NT-EMS providers.

The full text of LD 1530 as amended is shown in Appendix D. Note that the letter from the committee directs the Bureau to only consider the amended bill, therefore this study does not consider provisions of the original bill that were subsequently amended.

Naloxone is currently a covered service under certain circumstances, such as when it is provided by a doctor's office for at-home use. LD 1530 as amended would require reimbursement when given by an ambulance service provider or NT-EMS.

Applicability to Maine population

State health insurance mandates apply only to health insurance policies in the fully insured individual, small group, and large group markets, as well as the SOM plan.

To identify the impact of LD 1530 as amended, we first identified the percentage of the population that would be impacted by this mandate. To that end, we used 1,395,722 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.

Based on reports provided by the carriers to BOI, the covered lives at year-end 2024 for the three commercial markets[3] that would be impacted by the mandate were as follows:

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

The total for these three markets represents approximately 18.6% of the total insured population of Maine. The remaining balance (over 80%) of insureds 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, and Medicaid, and other federally funded health care programs.

[1] 24-A M.R.S. 4303-F, Subsection 1
[2] 24-A M.R.S. 4304-F, Subsection 1-A
[3] As of July 1, 2025, the SOM plan covers approximately 26,224 individuals.

We asked Maine carriers about the contracting status of NT-EMS providers. Currently, no Maine carrier includes NT-EMS as eligible providers in commercial markets. Based on our research and experience, this is the case in most states.

How other states treat these services

Emergency services are one of the ten base categories of essential health benefits specified by the Affordable Care Act. We identified only one state, Indiana, that has passed legislation[4] addressing reimbursement terms for all providers of emergency medical services, including NT-EMS. Specific reimbursement levels are neither required nor limited. We are aware of one other state, New Hampshire[5], that commissioned a study to develop a fee schedule for ground ambulance services, including the "Treat No Transport" situation. NT-EMS providers were outside the scope of the New Hampshire report.

We identified 12 states that have enacted laws addressing coverage of naloxone hydrochloride or other opioid overdose reversal medications, which are also collectively known as "opioid antagonists." Eleven of these states[6] either directly or effectively require coverage for at least one opioid antagonist. Two states mention naloxone hydrochloride specifically. Some states limit or prohibit the application of cost sharing and prior authorization requirements. Others specify that coverage requirements exist only when the drug is prescribed and dispensed by a licensed pharmacist. None of these states appeared to address coverage specifically in an emergency setting.

Cost estimate; summary of data and analysis

Because coverage for NT-EMS providers is rare, we relied on publicly available information to construct a range we consider reasonable for the premium impact of adding such coverage.

We calculated a premium impact range of $1.26 to $3.34 per member per month depending on market and NT-EMS provider reimbursement level. The resulting percentage impact to premium is 0.20% to 0.51%.

States are required under the Affordable Care Act to pay for ("defray") the costs of all health insurance benefit mandates that are included in individual exchange plans, unless the mandate was in effect prior to December 31, 2011 and was part of the state's defined essential health benefit (EHB) package. The state must defray the cost of the mandate's premium impact on individual market plans sold on the health insurance exchange. 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. The BOI suggests amended LD 1530 requirements would be considered a provider mandate with no defrayal necessary.

[4] Indiana HB1587, took effect July 1, 2025

[5] New Hampshire Ground Ambulance Cost Study, January 2025, Public Consulting Group LLC, https://nhhp.org/wp-content/uploads/2025/01/New-Hampshire-Ground-Ambulance-Cost-Study-Final-Report-1.7.25.pdf

[6] Network for Public Health Law, May 2023
https://www.networkforphl.org/wp-content/uploads/2023/06/Naloxone-Insurance-Coverage-Mandates.pdf

For the number of encounters involving NT-EMS providers, we relied on data published by Maine EMS in its 2024 Annual Data Report.[7] In total, there were 303,701 activations of EMS services. These are broken down into total numbers of transports, refusals, patient deceased, and others. We used the 'other' category as a proxy for activations where services were provided by NT-EMS providers. There were 41,466 activations reported in this category in 2024. We assumed a 2% annual utilization increase to this data for trend to 2027, the first effective year of the mandate.

We note these counts would include activations for patients in Medicare and/or Medicaid, as well as uninsured patients. The information available was insufficient to make this adjustment; not doing so adds conservatism to our estimate. It is not possible to quantify this without additional detail.

We used the "other" count along with the population of Maine to arrive at a utilization rate per 1,000 people per month of 30.30. We then looked at a variety of cost per service calculations as follows:

- Average reimbursement per activation as given in a presentation in September 2022[8] to Maine's Blue Ribbon Commission To Study Emergency Medical Services in the State.[9] Three things should be considered:
    - The average was calculated based on assumptions as stated in the report;
    - The average likely includes Medicare and Medicaid patients, where reimbursement is typically lower than in commercial populations that would tend to cause understatement;
    - The average likely includes mileage rates for ambulance transports, whereas NT-EMS providers would presumably not be reimbursed for mileage. This would tend to cause overstatement.
- We used the Medicare rates for certain codes related to basic and advanced life support as of 2025 with 3% annual increases to state them in 2027 dollars, and assumed reimbursement of 160%, 200%, and 300% of these rates, respectively. The rates were weighted using the following attributes to produce one average reimbursement rate:
    - Regional rate separation (Cumberland and York counties versus all others)
    - Urban versus rural versus super-rural designations
    - Service mix

200% and 300% of Medicare rates were used because those are the maximum reimbursement levels in current Maine law and LD 1530, respectively. Nothing in LD 1530 requires reimbursement of NT-EMS providers at these levels for basic or advanced life support or any other service. We also looked at 160% of Medicare as that appears to approximate the average reimbursement in the individual and small group markets based on carrier data as shown in the EDGE files for 2023, which are prepared for the Centers for Medicare and Medicaid Services (CMS) to administer the risk adjustment programs in those markets.

[7] Maine EMS 2024 Annual Data Report, https://www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/2024-MEMS-Annual-Data-Report.pdf
[8] https://legislature.maine.gov/ems-study-meeting-9152022
[9] Maine Blue Ribbon Commission to Study EMS report, https://www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report-On-EMS-final.pdf, January 2023

We assumed loss ratios and cost sharing percentages by market as shown in the table below. For the loss ratio assumptions, we used the Minimum Loss Ratio thresholds for each market established under the Affordable Care Act. Assumed cost sharing for the individual and small group markets reflects the numbers shown on the 2025 Unified Rate Review Template (URRT) public use file published by CMS, which was submitted by carriers in 2024. Typically large group plans are more generous than the individual and small group markets.

Market	Loss ratio	Cost sharing
Individual	80%	70%
Small Group	80%	70%
Large Group	85%	80%

The premium impact PMPM by reimbursement rate scenario is shown below.

Premium impact PMPM	**Rate Scenario**			
Market	**100% of Medicare**	**160% of Medicare**	**200% of Medicare**	**300% of Medicare**
Individual	$1.27	$1.67	$2.09	$3.12
Small Group	$1.27	$1.67	$2.09	$3.12
Large Group	$1.37	$1.80	$2.24	$3.36

The following table shows the impact in terms of total additional paid claims dollars:

Total paid claims (in millions)	**Rate Scenario**			
Market	**100% of Medicare**	**160% of Medicare**	**200% of Medicare**	**300% of Medicare**
Individual	$0.9	$1.2	$1.5	$2.2
Small Group	$0.7	$1.0	$1.2	$1.8
Large Group	$2.1	$2.8	$3.5	$5.2
Total	$3.8	$5.0	$6.2	$9.3

The above figures include an additional $0.02 PMPM for naloxone administration by an EMS provider, based on the total number of administrations and dispensations in the Maine EMS report and an average price per administration of $50.

Anthem Health of Maine, the benefits administrator for the SOM plan, provided an estimate of LD 1530's impact on the SOM plan, which was $1.86 PMPM, or 0.23% of premium. L&E did not review the development of this estimate, but it is consistent with the overall analysis.

We note that nothing in LD 1530 requires carriers to increase reimbursement to 200% or 300% of Medicare for in-network ambulance claims. We did not estimate a rate impact associated with this increased reimbursement. This calculation method only addresses the addition of NT-EMS providers as eligible providers. This calculation also does not consider the possibility that some of these

claims will be found to duplicate services performed by ambulance providers and would thus not be paid, which adds a small amount of conservatism.

We also note that it will take some time for the claims experience to develop to its ultimate level. NT-EMS providers will likely need to develop processes for submitting claims. It will also take time for carriers to complete contracting and credentialling efforts and develop processes for detecting duplicate claims.

Conclusion

L&E estimates the premium impact of adding NT-EMS providers as eligible providers as described in LD 1530 as amended to be between $1.26 and $3.34 PMPM, depending on coverage, population, and provider contracting. This amounts to 0.20% to 0.51% of premium. The impact to the SOM plan was estimated by Anthem Health to be $1.86 PMPM, or about 0.23% of premium.

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

Maine EMS[10] reported that there were 303,701 activations of EMS services in 2024. The exact proportion of these activations directly attributable to NT-EMS providers was not reported and is unknown. The Maine EMS report states that of these activations, 208,622 resulted in transport, and another 52,020 resulted in refusal of transport. 1,593 activations were for a patient who was deceased. The remaining 41,466 were otherwise uncategorized.

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

The amended LD 1530 specifies that reimbursement to NT-EMS providers would be for services that are already covered. Therefore, such services are generally already available to enrollees through other providers.

Maine EMS also reported that EMS providers (both ambulance and non-transporting) administered 1,775 doses of naloxone. The breakdown of these among insurance populations (commercial, Medicare, Medicaid, uninsured) is not known. In addition, Maine EMS reported about 300 doses were administered prior to EMS arrival.

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

Based on the responses to our carrier survey, NT-EMS providers are generally not included as eligible providers in commercial major medical plans.

Coverage for "Treat No Transport" is already required under Maine law and became effective January 1, 2024. MaineCare also covers this situation, reimbursing a flat rate regardless of the urban / rural distinctions. Medicare does not cover Treat No Transport, although Medicare did have a limited pilot program to cover Treat No Transport under certain conditions which ended December 31, 2023.

Naloxone is a covered service currently under certain circumstances, such as when it is provided by a doctor's office for at-home use. Patient cost-sharing may apply. Naloxone in the nasal spray form is available over the counter for purchase in any Maine pharmacy, at a price of $40 to $60 for a two-dose carton. Injectable naloxone may also be available from certain county organizations and from some health care providers at no charge to patients.

(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

[10] Maine EMS, 2024 Annual Data Report, https://www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/2024-MEMS-Annual-Data-Report.pdf

Obtaining services from non-covered providers will likely result in the out-of-pocket cost being borne entirely by the patient, which the patient may find to be a burden. The Maine Blue Ribbon Commission to Study Emergency Medical Services in the State received a presentation on September 13, 2023 which gave the current average reimbursement per transport at $491.99. We believe a significant portion of the population would consider this financially burdensome.

(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

This is discussed in the section above.

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

The level of demand from the public for EMS is stated above based on reporting from Maine EMS. A breakdown of this data by insured population or EMS license is not available and likely cannot be ascertained from claims data.

Seven pieces of testimony were submitted during the hearings for LD 1530. These were prior to the amended version of LD 1530 and thus may address points related to community paramedicine and other items which were not applicable to the amendment. One was from the Bureau and was neither for nor against. Another was from the Director of the Office of MaineCare Services which was also neither for nor against.

Of the five remaining testimonies, two were opposed to the original LD 1530 and three were in favor. The two opponents, carrier representatives, cited cost and administrative concerns related to duplicate claims when transporting EMS and NT-EMS respond to the same scene as well as contracting with NT-EMS, which no Maine carrier currently does in the commercial markets. The concern regarding duplicate claims appears to have been addressed by the amended legislation, but carriers will need to put procedures in place to ensure multiple claims for the same service are not paid.

Three proponents testified in favor of the original LD 1530. The Maine Ambulance Association and Maine Municipal Association each cited financial strain on non-transporting EMS organizations and costs to taxpayers and patients. A third testimony was submitted by a member of the public, which cited patient cost.

(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 addressed in the previous section.

(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

We identified one state (Indiana) which requires reimbursement for NT-EMS. The Indiana mandate only recently took effect and there was no public-facing report available. In our experience, it is rare that NT-EMS providers are included as stand-alone eligible providers in commercial major medical plans. We discuss the treatment of naloxone in other states above beginning on Page **Error! Bookmark not defined.**.

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

No State agencies provided commentary on social impacts related to LD 1530.

(11) The alternatives to meeting the identified need

In response to our survey of Maine carriers, none offered alternatives to the coverage as specified in amended LD 1530.

(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

The services contemplated by LD 1530 are currently covered by most health insurance plans when provided by ambulance services or in other settings. As such they are consistent with the role of health insurance and the concept of managed care.

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

There is unlikely to be a social stigma associated with the 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.

(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

We would expect similar premium impacts to those outlined above.

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

LD 1530 as amended does not specify the reimbursement for NT-EMS providers. The bill only states that reimbursement can be no more than 300% of Medicare rates for in-network providers and may only increase by, at most, 5% each year. The previous maximum (for ambulance services) was 200% of Medicare.

As NT-EMS providers are not eligible today, LD 1530 as amended is likely to result in a premium increase as described in Section **Error! Reference source not found.** above. The ultimate cost of the mandated coverage will depend on the outcome of contracting with NT-EMS providers. It is likely the contracting process will take some time to complete. The full effect of amended LD 1530 may not be known for some time.

We discussed the mandated treatment of naloxone and other opioid antagonists in other states in Section **Error! Reference source not found.** above. A table providing additional detail is found in the report tables on the *Naloxone* tab.

(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

We do not believe the proposed mandate would materially affect the appropriate or inappropriate use of emergency services.

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

Some carriers cited the possibility that use of NT-EMS providers may result in avoidance of costly ambulance transports and trips to the emergency room.

We believe naloxone is generally the least expensive, most readily available opioid overdose reversal drug. It is on the generic medication lists of most formularies which means it usually gets the lowest copays available in copay-based drug plans. It is also the only one available without a prescription.

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

LD 1530 expressly prohibits the application of pre-authorization requirements to NT-EMS providers prior to initiating transport, if used. Maine law already prohibits pre-authorization for ambulance service providers prior to initiating transport. To the extent any other methods are used for ambulance services, we presume they will likewise be used for NT-EMS.

(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 do not expect that amended LD 1530 will have a material impact on the types of providers that provide EMS.

(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 1530 is discussed in Section **Error! Reference source not found.** above. We would not expect a material change in carrier administrative expense due to LD 1530 as a percentage of premium.

(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 under the amended LD 1530.

(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

Carrier responses to our questions indicated minimal or no savings resulting from LD 1530. Those that commented on possible savings cited avoidance of the emergency room or ambulance transports. There did not appear to be any attempts to quantify such savings.

(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

Estimated costs of this mandate range from $1.26 PMPM to $3.34 PMPM. 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 would expect to see some cost-shifting from the taxpayer base supporting NT-EMS agencies (and the patients that use these services) to the insurance carriers. It is likely the carriers will impose cost sharing, which will reduce this cost-shift to some extent. It is not possible to further quantify without additional information.

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. The CPI-U for

medical care only for the same time periods was 2.48% and 3.07%, respectively. The CPI-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

This bill mandates payment for services currently provided. It does not add requirements for additional covered services. We do not believe it would have any meaningful effect on the quality of care or the health status of the population.

(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. It does add an existing class of practitioners defined in Maine law to the class of providers reimbursed by commercial major medical insurance plans for covered services.

Balancing considerations

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

The services contemplated are already covered when provided by ambulance service providers. LD 1530 would require reimbursement for NT-EMS providers when such services are provided, which is rare in commercial major medical plans. Current law may result in patient bills for such services which patients may find financially burdensome. The proposed mandate is likely to increase premiums in the commercial markets for all purchasers but would not apply to Medicare, Medicaid, or self-insured health plans as noted previously.

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

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 Section II, D. There would likely be administrative expenses associated with the requirement to contract with NT-EMS providers. 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. Finally, this bill does not expand the universe of covered services; rather, it adds to the list of providers eligible to receive reimbursement for services that are covered when performed by other types of providers.

(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 1530 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*:

- 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 1530

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

Sec. 1. 24-A MRSA §4303-F, as amended by PL 2023, c. 468, §2 and c. 591, §§3 and 4, is further amended by amending the section headnote to read:

§4303-F. Reimbursement for ambulance services and nontransporting emergency medical services; participation of ambulance and nontransporting emergency medical service providers in carrier networks

Sec. 2. 24-A MRSA §4303-F, sub-§1, as amended by PL 2023, c. 591, §3, is further amended to read:

1. Reimbursement for ambulance and nontransporting emergency medical services. With respect to a bill for covered services rendered by an ambulance service or nontransporting emergency medical service provider, a carrier shall reimburse the ambulance service or nontransporting emergency medical service provider or enrollee, as applicable, as follows.

A. If the ambulance service or nontransporting emergency medical service provider participates in the carrier's network, the carrier shall reimburse at the ambulance service provider's or nontransporting emergency medical service provider's rate or 200% of the Medicare rate for that service, whichever is less, plus any adjustment required by paragraph C.

B. If the ambulance service or nontransporting emergency medical service provider is an out-of-network provider, the carrier shall reimburse at the ambulance service provider's or nontransporting emergency medical services provider's rate or 180% of the Medicare rate for that service, whichever is less, plus any adjustment required by paragraph C.

C. If the ambulance service or nontransporting emergency medical service provider is located in a rural or super rural area as designated by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services and eligible for additional Medicare reimbursement for services that were provided to a Medicare enrollee, the carrier shall increase the reimbursement to that ambulance service provider or nontransporting emergency medical service provider in the same amount as the additional Medicare reimbursement.

D. If, on the effective date of this subsection in the case of an ambulance service provider or on October 1, 2025 in the case of a nontransporting emergency medical service provider, an ambulance service provider's or a nontransporting emergency medical service provider's charge for ambulance services is below 200% of the Medicare rate for that service, the ambulance service provider or nontransporting emergency medical service provider may not increase the charge for that service by more than 5% annually.

E. A carrier may not require a ground ambulance service provider or nontransporting emergency medical service provider to obtain prior authorization before transporting an enrollee to a hospital, between hospitals or from a hospital to a nursing home, hospice care facility or other health care facility, as defined in Title 22, section 328, subsection 8. A carrier may not require an air ambulance service provider to obtain

prior authorization before transporting an enrollee to a hospital or between hospitals for urgent care.

Notwithstanding this subsection, a carrier is ~~not~~ required to reimburse an ambulance service provider at the reimbursement rates required in this subsection for covered services delivered through community paramedicine in accordance with Title 32, section 84, subsection 4 and a carrier may require an ambulance service provider to obtain prior authorization before providing services through community paramedicine.

As used in this subsection, "nontransporting emergency medical service" has the same meaning as in Title 32, section 83, subsection 14.

Sec. 3. 32 MRSA §86, sub-§2-A, as amended by PL 2019, c. 627, Pt. B, §9, is further amended to read:

2-A. Treatment. When an ambulance service or nontransporting emergency medical service is present at an accident or other situation in which a person or persons require emergency medical treatment, the medical treatment of the patients must be carried out in accordance with any rules adopted under this chapter, any protocols as defined in section 83, subsection 19 and any orders given by online medical control~~;~~ and is reimbursable care under Title 24-A, section 4303-F when provided on scene regardless of transport to another facility, except that:

A. When a patient is already under the supervision of a personal physician or physician assistant or a nurse practitioner supervised by the physician and the physician, physician assistant or nurse practitioner assumes the care of the patient, then for as long as the physician, physician assistant or nurse practitioner remains with the patient, the patient must be cared for as the physician, physician assistant or nurse practitioner directs. The emergency medical services persons shall assist to the extent that their licenses and protocol allow; and

B. A patient is not required to accept treatment to which the patient does not consent.

Sec. 4. 32 MRSA §86, sub-§4, as amended by PL 2023, c. 161, §6, is further amended to read:

4. Naloxone hydrochloride or another opioid overdose-reversing medication. An ambulance service or a nontransporting emergency medical service licensed under this chapter may dispense naloxone hydrochloride or another opioid overdose-reversing medication as reimbursable care under Title 24-A, section 4303-F in accordance with Title 22, section 2353, subsection 2-A and the rules adopted and protocols developed for ambulance services and nontransporting emergency medical services under this chapter. An opioid overdose-reversing medication referenced in this subsection must be approved by the federal Food and Drug Administration.

SUMMARY

This bill provides that care that is provided at the scene of an emergency medical services event by an ambulance service or nontransporting emergency medical service is reimbursable care regardless of whether a patient is transported to another facility. This includes the administration of overdose-reversing medications that do not result in patient transport to a facility. Additionally, the bill requires reimbursement for certain services provided through community paramedicine.

Appendix E – Letter from Committee

SENATE

DONNA BAILEY, DISTRICT 31, CHAIR
JOSEPH M. BALDACCI, DISTRICT 9
DAVID G. HAGGAN, DISTRICT 10

COLLEEN MCCARTHY REID, PRINCIPAL LEGISLATIVE ANALYST
EDNA CAYFORD, COMMITTEE CLERK

HOUSE

KRISTI MICHELE MATHIESON, KITTERY, CHAIR
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ROBERT A. FOLEY, WELLS *
JOSHUA MORRIS, TURNER
ROLF A. OLSEN, JR., RAYMOND
PAUL R. FLYNN, ALBION
MARYGRACE CAROLINE CIMINO, BRIDGTON

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 1530, An Act to Improve the Sustainability of Emergency Medical Services in Maine.** During the committee's deliberations, the members proposed changes to the bill and developed a draft proposed amendment.

A copy of the draft committee amendment replacing the bill is enclosed. Please prepare a review of the proposed mandate for coverage outlined in the draft committee amendment 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 1530 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: Sen. Chip Curry

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