



DEPARTMENT OF

**Professional &
Financial Regulation**

STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF PROF. AND OCC. REGULATION

A Report to the Joint Standing Committee on Insurance and Financial Services of the 128th Maine Legislature

Review and Evaluation of LD 1030 *An Act to Require Nondiscrimination Policies in Providing Health Insurance*

December 2017

**Prepared by:
Donna Novak, FCA, ASA, MAAA
of NovaRest, Inc.
Marti Hooper, ASA, MAAA
of the Maine Bureau of Insurance**

Contents

| | |
|---|----|
| I. Executive Summary..... | 3 |
| II. Background | 5 |
| III. Social Impact | 8 |
| IV. Financial Impact | 13 |
| V. Medical Efficacy | 17 |
| VI. Balancing the Effects | 18 |
| VII. Appendices | 19 |
| Appendix A: Cumulative Impact of Mandates | 19 |
| Appendix B: Letter from the Committee on Insurance and Financial Services with Proposed Legislation..... | 28 |
| Appendix C: LD 1030 Original Bill | 30 |
| Appendix D: LD 1030 Amendment..... | 35 |

I. Executive Summary

The Joint Standing Committee on Insurance and Financial Services (Committee) of the 128th Maine Legislature directed the Bureau of Insurance (Bureau) to review LD 1030, *An Act to Require Nondiscrimination Policies in Providing Health Insurance*. The review was conducted as required by Title 24-A, Section 2752. This document and review are a collaborative effort of NovaRest, Inc. and the Bureau.

LD 1030 as originally proposed would have significantly extended coverage and changed the in-network and out-of-network model over the current model.¹ An amendment to the bill was submitted that greatly narrowed the scope of the bill. Our report addresses only the proposed amended version of LD 1030. Below we have outlined the major differences between the bill as originally proposed and the amendment.

- Workers' compensation insurance policies, automobile liability insurance policies, and health insurance policies would all be impacted by the original language. Testimony provided by separate organizations recognized that differences in coverage models would make implementation of the bill difficult. The amended bill removed the reference to workers' compensation insurance policies and automobile liability insurance policies. Given that NovaRest does not have experience in workers' compensation insurance policies or automobile liability policies, it considers the impact of the bill on those types of insurance policies beyond the scope of this report.
- The language in the original bill would not allow for discrimination against any state licensed, registered or certified health care provider acting within the scope of the provider's license. This language could be interpreted to force health insurers to cover providers of acupuncture, massage therapy, and Chinese herbology, among others. The amendment narrowed the scope of the bill to naturopathic doctors.
- The original bill prohibited carriers from eliminating from coverage or restricting coverage of integrative or naturopathic services that are otherwise within the provider's scope of practice. This could extend coverage to many treatments and services that health insurance carriers consider experimental, investigational, or not medically necessary. The amendment removed that restrictive language. The amended language allows for reimbursement of naturopathic doctors for types of services that would be reimbursed when performed by any other type of health care provider.
- The original bill also prohibited lower reimbursement rates for certain categories of providers who are delivering the same services as other provider types according to procedural codes and there may be no differentiation between in-network and out-of-network until the deductible is met, which would mean all licensed providers would be

¹ The original LD 1030 and the amendment were provided by the Insurance and Financial Services Committee.

reimbursed at the same amount. In addition, all provider reimbursement would be applied to the deductible, whether they are in-network or out-of-network. In his testimony in opposition to LD 1030² Superintendent of Insurance Eric Cioppa mentioned the bill's potential negative consequences on network coverage. The amendment removed this language and would now only prohibit carriers from excluding naturopathic doctors from in-network participation subject to network adequacy.

The amended LD 1030 provides for the following:

- Each insurer that issues or renews any individual³ policy, plan, or contract of health insurance providing benefits for medical or hospital expenses shall provide to Maine policy holders, coverage for expenses arising from a health service performed by a doctor of naturopathic medicine licensed under Title 32 section § 12522 if that particular type of service is within the scope of practice of such doctor and if the insurer would reimburse for that type of service when performed by any other type of health care provider.
- Such coverage shall be subject to each insurer's standards and mechanisms for determining medical necessity, for credentialing pursuant to, and for contracting. Benefits provided shall not be subject to any greater co-payment, deductible, or coinsurance than any other similar benefits provided by the insurer.
- Health plans may not exclude naturopathic doctors from in-network participation, however, they are not required to include all providers who apply, only to meet network adequacy for primary care providers. Network participation must include all plan types, if offered to other providers providing similar services, within their scope of practice.

We believe the network adequacy requirement in the amendment is unclear. For example, if a carrier already has an adequate network but does not contract with naturopathic doctors (NDs), would the mandate require the carrier to add one or more NDs or does the carrier only need to include NDs when there is an opening in the network? Also, should there be a separate network adequacy standard for NDs or just the current standard for primary care providers (PCPs), with NDs not being discriminated against when applying to be network PCPs? Our interpretation of the language is that carriers will be required to add NDs to their network, although we recommend further clarification of this issue.

In order to develop our cost estimate, we performed a survey of the largest carriers in Maine to

² Cioppa, Eric. "Testimony of Eric Cioppa Superintendent of Insurance Bureau of Insurance Department of Professional and Financial Regulation in Opposition to L.D. 1030." April 4, 2017. <http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=59611>. Accessed October 30, 2017.

³ While the amendment specifies individual policies, we do not believe the intent of the bill was to exclude group policies, but rather read it to mean to a single policy rather than to the individual market.

determine the level of coverage already available and other critical information. Our survey indicated that carriers already reimburse naturopathic doctors for services that are covered by an enrollee's contract, although not for all plan types. Because some of the carriers do not currently contract with naturopathic doctors, services provided may not be covered for HMO plans without out-of-network benefits. For PPO and POS plan types that provide out-of-network benefits, the service would typically be covered at an out-of-network rate. LD 1030 would prohibit carriers from excluding naturopathic doctors from in-network participation, although it does not require carriers to include all naturopathic doctors who apply. We believe the bill will have the impact of mandating that all carriers include naturopathic doctors in-network including HMO networks, which may not currently cover services provided by naturopathic doctors. We believe this would increase the use of naturopathic doctors. We do note, however, that not all services provided under a naturopathic doctor's scope of practice are covered currently, but this would not change under the amended LD 1030. The bill would only cover NDs providing types of services that are already covered when performed by other providers within the providers' scope of practice. For this reason, we believe the cost impact will be minimal.

II. Background

Naturopathic medicine is a distinct primary health care profession, emphasizing prevention, treatment, and optimal health using therapeutic methods and substances that encourage individuals' inherent self-healing process. The practice of naturopathic medicine includes modern and traditional, scientific, and empirical methods.⁴ Treatments provided by Naturopathic Doctors (NDs) include: clinical and laboratory diagnostic testing, nutritional medicine, botanical medicine, naturopathic physical medicine (including naturopathic manipulative therapy), public health measures, hygiene, counseling, minor surgery, homeopathy, acupuncture, prescription medication, intravenous and injection therapy, and naturopathic obstetrics (natural childbirth).⁵

Training for naturopathic doctors includes a four-year, in-residence, graduate level medical school program at an accredited naturopathic medical school where they are educated in the same biomedical sciences as a medical doctor (MD).⁶ States with licensure laws require at least 4,100 hours of study from a college or university recognized by the Council on Naturopathic

⁴ The American Association of Naturopathic Physicians. "Definition of Naturopathic Medicine." Amended 2011. <http://www.naturopathic.org/content.asp?contentid=59>. Accessed October 30, 2017.

⁵ Ibid.

⁶ Association of Accredited Naturopathic Medical Colleges. "Naturopathic Medicine Programs in the United States." <https://aanmc.org/resources/comparing-nd-md-curricula/>. Accessed October 29, 2017.

Medical Education (CNME).⁷ There are currently licensing or registration laws for naturopathic doctors in 20 states (including Maine), the District of Columbia, and the United States territories of Puerto Rico and the United States Virgin Islands.⁸ There are five naturopathic medicine schools in the U.S. and two in Canada. NDs are trained to be specialists in prevention and chronic care.⁹

In addition to the statutory criteria, the Committee also asked that the review provide an analysis of:

- The extent to which coverage of services provided by naturopathic doctors is already included in health plans and covered by the State's essential benefits package and the manner in which the proposed amendment may expand this coverage;
- The current participation of naturopathic doctors in carrier networks;
- If the proposed amendment expands coverage beyond the essential benefits package, the estimated costs to the State to defray the costs of including the coverage in qualified health plans.

The extent to which coverage of services provided by naturopathic doctors is already included in health plans and covered by the State's essential benefits package and the manner in which the proposed amendment may expand this coverage.

According to our survey of 6 carriers in Maine, most plans currently cover ND services but often at an out-of-network reimbursement level so long as they are a covered benefit and are within the scope of the naturopath's license. The exceptions are HMO plans where the carriers do not have naturopathic doctors in-network and no out-of-network coverage. Half of the carriers surveyed indicated they did not have any naturopathic doctors within their network. For most plans, this means that covered services provided by naturopathic doctors are covered at out-of-network rates, which can vary considerably by plan and carrier but are typically more expensive for insureds than in-network rates. As an example, Community Health Options recently raised deductibles for out-of-network care by as much as 472 percent in 2017, from \$2,500 to \$14,300, while the in-network deductibles in 2017 range from \$1,200 to \$7,150.¹⁰ For HMO plans that do not provide out-of-network coverage, naturopathic doctors would have to be in-network for

⁷ Bastyr University. "About Naturopathic Medicine." <http://bastyr.edu/academics/naturopathic-medicine/about-naturopathic-medicine#Principles>. Accessed October 30, 2017.

⁸ The American Association of Naturopathic Physicians. "Regulated States & Regulatory Authorities." <http://www.naturopathic.org/content.asp?contentid=57>. Accessed October 31, 2017.

⁹ Association of Accredited Naturopathic Medical Colleges. "Naturopathic Medicine Programs in the United States." <https://aanmc.org/resources/comparing-nd-md-curricula/>. Accessed October 30, 2017.

¹⁰ Anderson, J. Craig. "Out-of-network costs to soar for members of Maine health insurance co-op." 2016. <http://www.pressherald.com/2016/10/28/out-of-network-costs-to-soar-at-maine-health-co-op/>. Accessed November 2, 2017.

LD 1030, An Act to Require Nondiscrimination Policies in Providing Health Insurance

an insured to receive coverage. The proposed amendment would not allow carriers to exclude NDs from in-network participation, however, carriers do not need to include all providers who apply, only to prove network adequacy. Although we could not find any standard for network adequacy for naturopaths, the following information explains general network adequacy requirements in Maine.

According to Maine statute 24-A M.R.S.A. § 4303, “A carrier offering or renewing a health plan in this State must meet the following requirements:¹¹

- Demonstration of adequate access to providers. A carrier offering or renewing a managed care plan shall provide to its members reasonable access to health care services. A carrier may provide incentives to members to use designated providers based on cost or quality, but may not require members to use designated providers of health care services.
- Information about provider networks. A carrier offering a managed care plan shall prominently disclose to applicants, prospective enrollees and enrollees information about the carrier's provider network for the applicable managed care plan, including whether there are hospitals, health care facilities, physicians or other providers not included in the plan's network and any differences in an enrollee's financial responsibilities for payment of covered services to a participating provider and to a provider not included in a provider network. The superintendent may adopt rules that set forth the manner, content and required disclosure of the information in accordance with this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Harvard Pilgrim stated that the proposed amendment would mean that Harvard Pilgrim cannot exclude naturopaths from in-network participation and thus, covered services may be provided through the HMO.

Community Health Options was unclear about the network adequacy requirement and stated they “...recommend that the standard for network adequacy for qualified doctors of naturopathic medicine should be clarified to permit a carrier to understand the applicable standard.”

The current participation of naturopathic doctors in carrier networks

Aetna

Aetna currently has four participating naturopaths in network for their commercial, fully insured plans in Maine. Aetna has approached additional naturopaths about joining its network and will continue to do so. Aetna welcomes naturopaths who wish to join their network and has an open panel for the same.

¹¹ National Conference of State Legislatures. “Insurance Carriers and Access to Healthcare Providers | Network Adequacy”. 2015. <http://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx>. Accessed November 2, 2017.

Anthem

Anthem currently has nine naturopathic doctors who are participating providers for their plans in Maine; seven have offices located in Maine and two are located in New Hampshire.

Cigna

Naturopathic doctors are not covered in-network.

Community Health Options

Community Health Options has 12 licensed doctors of naturopathic medicine in their network.

Harvard Pilgrim Health Care

Harvard Pilgrim does not credential, enroll, or contract with naturopaths.

United Healthcare Insurance Company

UHIC does not currently have any participating naturopathic doctors in their direct network, although they are willing to accept them upon request.

If the proposed amendment expands coverage beyond the essential benefits package, the estimated costs to the State to defray the costs of including the coverage in qualified health plans

Aetna and Anthem estimated the expansion of coverage under the amended bill to be cost neutral. Community Health Options and Harvard Pilgrim Health Care were not able to provide cost implications although Harvard Pilgrim Health Care stated that any cost increase would be insignificant. United Healthcare Insurance Company estimated a 0.1% increase to costs.

We believe that any increases in costs due to the amended bill would be insignificant as the services that would be provided by NDs are a substitute for those provided by MDs. The Affordable Care Act does not require states to defray the cost of provider mandates such as this one. The requirement to defray the cost of a mandate is when a new benefit that was not required to be covered previously is established.

III. Social Impact

A. Social Impact of Mandating the Benefit

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

LD 1030, An Act to Require Nondiscrimination Policies in Providing Health Insurance

A study of 3 major carriers in Washington State showed that 1.6% of 600,000 enrollees filed claims for naturopathic services in 2002.¹² The National Health Statistics Report estimated 0.2% of claims for naturopathic services in 2002 and 0.3% of claims for naturopathic services in 2007.¹³ We note, however, that these utilization statistics show claims for naturopathic services, which may not be covered by the bill. Although the bill would require coverage for covered services provided by NDs, it is our understanding that naturopathic services that are not currently covered by carriers would still not be reimbursed. We use these statistics simply to show that a small percentage of the population is opting for services provided by NDs.

We did not find similar statistics for Maine.

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

According to the Maine licensing website, there are currently 51 registered NDs in Maine.¹⁴

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

Our survey of carriers indicated they currently reimburse covered services provided by NDs. Some carriers do not contract with NDs and therefore insureds may be subject to higher out-of-network copays.

Aetna, Anthem Blue Cross and Blue Shield, and Community Health Options all have naturopathic doctors in-network. United Healthcare Insurance Company does not have any naturopathic doctors in their network but is willing to accept them upon request. Cigna and Harvard Pilgrim Health Care indicated they would pay providers according to the out-of-network coverage provided to the insured.

4. If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.

If ND services are not covered by insurance, medical doctors (MDs) can provide health care treatment, which would be covered by insurance. Some testimonials indicated that NDs were able to help patients when conventional medicine did not. However, it is likely in these cases the NDs provided additional naturopathic services that are outside the scope of this bill and would still not be covered if the bill passes.

¹² Fleming, Sara A., and Nancy C. Gutknecht. "Naturopathy and the Primary Care Practice." 2010. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2883816/>. Accessed October 26, 2017.

¹³ Ibid.

¹⁴ Maine.gov. Regulatory Licensing and Permitting. <https://www.pfr.maine.gov/ALMSOnline/Welcome.aspx>. Accessed October 31, 2017.

LD 1030, An Act to Require Nondiscrimination Policies in Providing Health Insurance

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

For NDs not included in a provider network, insureds would have to pay out-of-network cost sharing which can vary considerably by carrier and plan but would typically be a higher amount than if it were in-network. However, services for the same health problems are currently provided by medical doctors who are within carriers' networks and so the insured would pay the in-network cost sharing. For patients who feel that an ND can help them when conventional medicine has not, there could be substantial additional cost, but this could still be the case if the bill passes because alternative treatments would still not be covered.

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

The use of complementary and alternative medicine has been gaining popularity in recent years, with one study showing 36% of adults used some sort of complementary and alternative medicine in 2002 and 38% in 2008.¹⁵ Although this definition includes practitioners of many types of medicine in addition to NDs, it shows that people are beginning to request alternative forms of medicine.

USNews.com published an article stating that medical schools are adding integrative medicine courses, which "blend conventional treatments such as surgery and prescription drugs with complementary and alternative medicine like biofeedback, homeopathy and mindfulness."¹⁶ In addition, alternative therapy has been introduced for many as an alternative to opioids,¹⁷ which the Department of Health and Human Services now recognizes as a serious health epidemic.¹⁸

Through the public testimony provided in support of LD 1030, there were several common themes, one of which is that patients desire more choice in their health care. The testimonials expressed that people desire health care providers who focus on overall wellness or who align more closely with a patient's health philosophy. For some people, conventional treatment methods for chronic conditions were not successful so they pursued treatment from naturopathic doctors and had more positive results leading to a

¹⁵ Ventola, C. Lee. "Current Issues Regarding Complementary and Alternative Medicine (CAM) in the United States: Part 1: The Widespread Use of CAM and the Need for Better-Informed Health Care Professionals to Provide Patient Counseling." 2010. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2935644/>. Accessed October 27, 2017.

¹⁶ Kowarski, Illana. "Med Schools Adding Integrative Medicine Courses." 2017. <https://www.usnews.com/education/best-graduate-schools/top-medical-schools/articles/2017-09-05/integrative-medicine-courses-increase-at-medical-schools>. Accessed October 30, 2017.

¹⁷ Andrews, Michelle. "Holistic Therapy Programs May Help Pain Sufferers Ditch Opioids." 2017. <http://www.npr.org/sections/health-shots/2017/08/29/546145817/holistic-therapy-programs-may-help-pain-sufferers-ditch-opioids>. Accessed October 30, 2017.

¹⁸ U.S. Department of Health & Human Services. "The U.S. Opioid Epidemic." <https://www.hhs.gov/opioids/about-the-epidemic/index.html>. Accessed October 30, 2017.

higher quality of life.

Providers stated in testimony that chronic conditions often cannot be cured and must be managed through a combination of therapies and approaches. Providers such as naturopathic doctors provide a more integrative approach to medicine that may improve the quality of life for patients.

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

Beverly Cowan provided testimony that she was denied insurance coverage for an office visit that would have been covered by a medical doctor.¹⁹

Mary Dolan provided testimony that reimbursement for a naturopath is at the “out-of-network” level and is significantly less than if the provider accepted insurance.²⁰

Another sign of the public support for alternative medicine was addressed in the Affordable Care Act (ACA) section 2706, which states that a “group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable state law.”²¹ We note that the ACA does not require that the health care provider be in the carrier’s network.

8. The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.

No information is available.

9. The likelihood of meeting a consumer need as evidenced by the experience in other states.

New Hampshire has a similar law HB 351 (2011), which requires carriers to provide coverage for services delivered by naturopathic doctors if those services would be covered when provided by other

¹⁹ Cowan, Beverly. “Testimony on LD 1030.” <http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=59602>. Accessed October 27, 2017.

²⁰ Dolan, Mary. “Testimony on LD 1030.” <http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=59605>. Accessed October 27, 2017.

²¹ Centers for Medicare and Medicaid Services. “Affordable Care Act Implementation FAQs - Set 15.” https://www.cms.gov/CCIIO/Resources/FACT-Sheets-and-FAQs/aca_implementation_faqs15.html. Accessed October 27, 2017.

LD 1030, An Act to Require Nondiscrimination Policies in Providing Health Insurance

primary care physicians.²² New Hampshire concluded that the addition of coverage would increase the cost of health insurance by an indeterminable amount.²³

Vermont 8 V.S.A. § 4088d provides that “A health insurance plan shall provide coverage for medically necessary health care services covered by the plan when provided by a naturopathic physician licensed in this state for treatment within the scope of practice described in 26 V.S.A. chapter 81 and shall recognize naturopathic physicians who practice primary care to be primary care physicians.”²⁴

In addition, Oregon, Vermont, and Washington are three states that cover naturopathic doctors in the Medicaid system.²⁵

No information is currently available on the impact of these mandates.

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

State agencies did not provide findings pertaining to the proposed legislation.

11. The alternatives to meeting the identified need.

We do not believe there are alternatives and the carriers noted that they do not have any alternatives to suggest.

12. Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.

The bill is consistent with the role of insurance to cover medical services to correct a health condition. Under the amended bill, carriers could use managed care methodologies to ensure that the services provided were for the appropriate level of care.

²² LegiScan. “HB 351-FN – As Amended by the House.” 2011. <https://legiscan.com/NH/text/HB351/id/569398>. Accessed October 29, 2017.

²³ New Hampshire Liberty Alliance. “HB351 (2011)”, <https://www.nhliberty.org/bills/view/2011/HB351>. Accessed October 29, 2017.

²⁴ JUSTIA. “2012 Vermont Statutes Title 08 Banking and Insurance Chapter 107 HEALTH INSURANCE § 4088d Coverage for covered services provided by naturopathic physicians.” <https://law.justia.com/codes/vermont/2012/title08/chapter107/section4088d/>. Accessed October 29, 2017.

²⁵ La Corte, Rachel. “State’s Medicaid program now covers naturopaths.” 2014. <https://www.seattletimes.com/seattle-news/statersquos-medicaid-program-now-covers-naturopaths/>. Accessed October 30, 2017.

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

We do not believe there would be a stigma attached to the benefit.

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

The amended bill would not provide for additional benefits that are not currently covered, but would mandate carriers reimburse NDs for covered benefits that would be reimbursed to any other type of health care provider and would prohibit carriers from excluding NDs from in-network participation. All carriers we surveyed would reimburse NDs for covered benefits and 3 of the 6 carriers already have NDs in-network.

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

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

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

Anthem stated, “the proposed amendment does not appear to expand covered services and, as a result, they do not expect any significant cost implications to the State Employee Health Plan as a result of the proposed amendment. However, as also noted above, this pertains only to the proposed amendment; there would be significant costs associated with the bill as originally proposed.”

IV. Financial Impact

B. Financial Impact of Mandating Benefits

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

Demand for naturopathic doctors could increase due to (1) being included in carriers’ networks and (2) being reimbursed for treatments and services typically reimbursed by other health providers. Due to the limited supply of naturopathic doctors (51) in Maine, if demand did increase, we would expect the cost of

LD 1030, An Act to Require Nondiscrimination Policies in Providing Health Insurance

ND services to increase. For comparison, there are 6,058 active medical doctors licensed in Maine.²⁶

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

LD 1030 would likely have the effect of increasing the use of naturopathic doctors over the next five years. We do not believe the proposed coverage would increase inappropriate use.

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

In general, naturopathic services cost less than traditional medical services for the same conditions.

A study was performed where a naturopathic doctor conducted biometric screenings and sent out individual health reports and created a monthly wellness letter for the 1182 employees at the Vermont Automobile Dealers Association (VADA).²⁷ The naturopathic doctor also created a pedometer challenge with prizes and incentives. After one-year, another health screening was held which showed decreased incidence of high blood pressure, risk of cardiovascular disease, high risk stress, physical inactivity, high cholesterol, and obesity.²⁸ They estimated the combined direct and indirect financial savings to be nearly \$1.5 million dollars.²⁹

A study in Washington state was also performed to compare health care expenditures for insured patients with back pain, fibromyalgia syndrome, or menopause symptoms for those who use complementary and alternative medical (CAM) versus those who do not.³⁰ The results showed that those who use complementary and alternative medicine had lower average expenditures, \$3,797 versus \$4,153 per person.³¹ CAM users had more outpatient expenditures, but lower inpatient and imaging expenditures.³²

²⁶ Maine.gov. Regulatory Licensing and Permitting. <https://www.pfr.maine.gov/ALMSOnline/Welcome.aspx>. Accessed October 31, 2017.

²⁷ Green Mountain Wellness. "Vermont Car Dealers Help to Quantify the Benefits of Naturopathic Care." 2006. <http://www.greenmountainwellness.com/PressReleases/pressrelease080906.htm> . Accessed October 31, 2017.

²⁸ Ibid.

²⁹ Ibid.

³⁰ Lind, BK et al. "Comparison of health care expenditures among insured users and nonusers of complementary and alternative medicine in Washington State: a cost minimization analysis." 2010. <https://www.ncbi.nlm.nih.gov/pubmed/20423210> . Accessed October 31, 2017.

³¹ Ibid.

³² Ibid.

LD 1030, An Act to Require Nondiscrimination Policies in Providing Health Insurance

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

There is no language in the amended bill that prohibits medical management. According to our interpretation, carriers will be able to limit services to those that would be considered medically necessary by the physician. If treatment were not having an impact, medical management could be used to discontinue treatment.

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

LD 1030 (original or as amended) can be reasonably expected to increase the number of naturopathic doctors and other licensed or certified providers of complementary and alternative medicine in Maine over the next five years.

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

Aetna

Because Aetna already covers services provided by naturopaths, there would be no cost implications for Aetna if the current proposal went into effect. There would be an additional cost if additional services, not currently covered, became a requirement.

Anthem Blue Cross and Blue Shield

The proposed amendment does not appear to expand covered services and, as a result, Anthem does not expect any significant cost implications to result from the proposed amendment. However, this pertains only to the proposed amendment; there would be significant costs associated with the bill as originally proposed.

Cigna

It would be challenging to estimate the cost implications of including these providers, as Cigna is unsure of both the cost and potential utilization of these providers.

Harvard Pilgrim Health Care

Harvard Pilgrim does not have enough information to determine the possible cost implications but would anticipate that any cost increase would be insignificant.

United Healthcare Insurance Company

UHIC expects a 0.1% increase in costs if naturopaths are covered. This amount is consistent across all group sizes. All increases are due to an increase in claim costs – they are not expecting an increase in administrative expenses.

Our Estimate

We believe any increase in costs due to LD 1030 would be minimal and if the services are a substitute for MD services, there may be a decrease in cost for some patients.

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

There will not be any additional cost effect beyond benefit and administrative costs.

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

Harvard Pilgrim Health Care indicated there could be potential savings in health care costs specific to certain conditions, particularly with regard to control of hypertension, obesity, and select chronic pain.

The other carriers indicated they do not anticipate any potential benefits or savings and are not aware of any comparative research studies.

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.

We believe the impact will be minimal.

10. The effect of the proposed mandates on cost-shifting between private and public payers of health care coverage and on the overall cost of the health care delivery system in this State.

These additional services are not currently covered by MaineCare and will be paid for by private insurance after the mandate is implemented, therefore there should be no cost-shifting.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit

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

Under the bill, NDs would only be reimbursed for services and treatments that would be covered by any other health provider, so the overall quality of care would likely not change. Medical doctors are able to perform additional treatments including extensive surgery and imagery, but may specialize in particular disciplines, while NDs focus on primary care.³³ NDs training is focused on treating and preventing illness and they draw from a variety of health disciplines when creating personalized treatment plans for patients which may include changes in diet, nutritional supplementation, plant medicine, and physical therapy.³⁴

Studies have shown that naturopathic doctors have longer interaction times with patients and are more likely to recommend medications (usually natural health products); however, quantitative data has shown that patients perceived no differences in patient centered care between family practitioners and naturopathic doctors.³⁵

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

LD 1030 mandates that carriers cannot exclude NDs from in-network participation. Naturopaths are covered today due to ACA, but not necessarily in-network.

³³ Mahaya Forest Hill Integrative Health. "When to See a Medical Doctor Vs. a Naturopathic Doctor." <http://www.mahayaforesthill.com/medical-doctor-vs-naturopathic-doctor/>. Accessed October 31, 2017.

³⁴ Holistic Health Clinic. "Focus." <http://www.theholistichealthclinic.com/Understand.html>. Accessed October 31, 2017.

³⁵ Boon, Heather et al. "Visiting Family Physicians and Naturopathic Practitioners. Comparing Patient-Practitioner Interactions." 2003. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2214143/>. Accessed October 31, 2017.

VI. Balancing the Effects

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

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

Our survey shows that insurance carriers currently reimburse naturopathic doctors for benefits covered under a contract. Some carriers have naturopathic doctors in-network, while others reimburse naturopathic doctors at out-of-network rates. Not all services provided under a naturopathic doctor's scope of practice are covered currently, but this would not change under the amended LD 1030.

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

Several of the public hearing testimonies stated their frustration with being mandated to pay for an insurance policy that they cannot use for their naturopathic doctor. By mandating availability of coverage those who would prefer to use an ND for covered treatments and services could do so. However, the services that would be provided by the NDs would be the same as what would be provided by other health care providers in-network.

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

We anticipate that LD 1030 as proposed will ultimately have a minimal increase or even no increase on costs.

VII. Appendices

Appendix A: Cumulative Impact of Mandates

Bureau of Insurance Cumulative Impact of Mandates in Maine Report for the Year 2016

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

- ♦ **Mental Health** (Enacted 1983)

Mental health parity for group plans in Maine became effective July 1, 1996, and was expanded in 2003. The percentage of mental health group claims paid has been tracked since 1984 and has historically been between 3% - 4% of total group health claims and was reported as 3.8% in 2016. Mental health claims stayed in this range despite the fact that an expansion of the list of conditions for which parity is required was fully implemented in 2005.

Mental health parity was only a mandated offer for individual plans until it was included in the essential health benefits for ACA (Affordable Care Act) individual and small group plans beginning 2014. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) amended the PHS Act, ERISA, and the Code to provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits and extended parity to all individual plans. As expected, mental health claims have stabilized back to a lower level of 2.6% in 2016 after meeting pent-up demand of 9.4% in 2015.

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

Maine's mandate only applied to group coverage. Effective October 1, 2003, substance abuse was added to the list of mental health conditions for which parity is required. Effective on

January 1, 2014 the federal Affordable Care Act requires substance abuse treatment benefits for individual and small group plans as part of the essential health benefits. The percentage of claims paid for group plans has been tracked since 1984. Substance abuse claims paid decreased from 0.7% in 2015 to 0.4% in 2016 of the total group health claims. Individual substance abuse health claims decreased from 5.8% in 2015 to 2.5% in 2016. As expected, substance abuse claims have leveled out as pent-up demand is met and carriers manage utilization.

- ♦ ***Chiropractic*** (Enacted 1986)

This mandate requires coverage for the services of chiropractors to the extent that the same services would be covered if performed by a physician. Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1986 and, in 2016, was 1.01% of total health claims. Prior to 2014, the level has typically been lower for individual than for group. Individual claims at 1.42% continue to exceed group 0.87% in 2016. We estimate the current combined levels going forward. Although it is likely that some of these costs would have been covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

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

This mandate requires that benefits be provided for screening mammography. We estimate the current combined levels of 0.70% going forward. Coverage is required by ACA for preventive services.

- ♦ ***Dentists*** (Enacted 1975)

This mandate requires coverage for dentists' services to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

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

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

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

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

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

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

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

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

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

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

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

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

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

This mandate requires that benefits for breast cancer treatment be provided for a medically appropriate period of time as determined by the physician in consultation with the patient. Group claims in 2016 were 1.58% compared to individual claims at 1.32% with the combined impact remaining level with past years at 1.5%.

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

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

♦ ***Prostate Cancer*** (Enacted 1998)

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

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

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

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

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

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

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

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

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

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

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

♦ ***Hospice Care*** (Enacted 2001)

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

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

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

♦ ***Dental Anesthesia*** (Enacted 2001)

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

♦ ***Prosthetics*** (Enacted 2003)

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

♦ ***LCPCs*** (Enacted 2003)

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

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

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

♦ ***Hearing Aids*** (Enacted 2007)

This mandate requires coverage for a hearing aid for each ear every 36 months for children age 18 and under. The mandate was phased-in between 2008 and 2010, and our report estimated a cost of 0.1% of premium.

♦ ***Infant Formulas*** (Enacted 2008)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


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 | 0.40% |
| | | Individual | 2.50% |
| 1975 1983 1995 2003 | Benefits must be included for Mental Health Services , including psychologists and social workers. | Groups | 3.80% |
| | | Individual | 2.60% |
| 1986 1994 1995 1997 | Benefits must be included for the services of chiropractors to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. | Group | 0.87% |
| | | Individual | 1.42% |
| 1990 1997 | Benefits must be made available for screening mammography . | Group | 0.68% |
| | | Individual | 0.76% |
| 1995 | Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes. | All Contracts | 0.02% |
| 1995 | Must provide coverage for metabolic formula and up to \$3,000 per year for prescribed modified low-protein food products. | All Contracts | 0.01% |
| 1996 | If policies provide maternity benefits, the maternity (length of stay) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care." | All Contracts | 0 |
| 1996 | Benefits must be provided for medically necessary equipment and supplies used to treat diabetes and approved self-management and education training. | All Contracts | 0.20% |
| 1996 | Benefits must be provided for screening Pap tests . | All | 0.01% |
| 1996 | Benefits must be provided for annual gynecological exam without prior approval of primary care physician. | Group managed care | 0.10% |
| 1997 | Benefits provided for breast cancer treatment for a medically appropriate period of time determined by the physician in consultation with the patient. | All Contracts | 1.51% |
| 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% |

LD 1030, An Act to Require Nondiscrimination Policies in Providing Health Insurance

| | | | |
|------|--|---|---------------|
| 1999 | Coverage of nurse practitioners and nurse midwives and allows nurse practitioners to serve as primary care providers. | All Managed Care Contracts | 0.16% |
| 1999 | Prescription drug must include contraceptives . | All Contracts | 0.80% |
| 1999 | Coverage for registered nurse first assistants . | All Contracts | 0 |
| 2000 | Access to clinical trials . | All Contracts | 0.19% |
| 2000 | Access to prescription drugs . | All Managed Care Contracts | 0 |
| 2001 | Coverage of hospice care services for terminally ill. | All Contracts | 0 |
| 2001 | Access to eye care . | Plans with participating eye care professionals | 0.04% |
| 2001 | Coverage of anesthesia and facility charges for certain dental procedures. | All Contracts | 0.05% |
| 2003 | Coverage for prosthetic devices to replace an arm or leg | Groups >20 | 0.03% |
| | | All other | 0.08% |
| 2003 | Coverage of licensed clinical professional counselors | All Contracts | 0 |
| 2005 | Coverage of licensed pastoral counselors and marriage & family therapists | All Contracts | 0 |
| 2007 | Coverage of hearing aids for children | All Contracts | 0.1% |
| 2008 | Coverage for amino acid-based elemental infant formulas | All Contracts | 0.1% |
| 2008 | Coverage for colorectal cancer screening | All Contracts | 0 |
| 2009 | Coverage for independent dental hygienist | All Contracts | 0 |
| 2010 | Coverage for autism spectrum | All Contracts | 0.3% |
| 2010 | Coverage for children's early intervention services | All Contracts | 0.05% |
| 2014 | Coverage for chemotherapy oral medications | All Contracts | 0 |
| 2014 | Coverage for human leukocyte antigen testing | All Contracts | 0 |
| 2014 | Coverage for dental hygienist | All Contracts | 0 |
| 2015 | Coverage for abuse-deterrent opioid analgesic medications | All Contracts | 0 |
| | Total cost for groups larger than 20: | | 9.89% |
| | Total cost for groups of 20 or fewer: | | 9.94% |
| | Total cost for individual contracts: | | 11.47% |

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

| | | |
|---|---|---|
| SENATE |  | HOUSE |
| RODNEY L. WHITTEMORE, DISTRICT 20, CHAIR DANA L. DOW, DISTRICT 13 EVERETT BROWNIE CARSON, DISTRICT 24 | | MARK LAWRENCE, SOUTH BERRY, CHAIR HEIDI E. BROOKS, LEWISTON GINA M. MELARAGNO, AUBURN BENJAMIN T. COLLINGS, PORTLAND HEATHER B. SANBORN, PORTLAND RAYMOND A. WALLACE, DISTRICT JOHN JOSEPH PICCHOTTI, FARMING ROBERT A. FOLEY, BELL DWAYNE W. PRESCOTT, WATTSVILLE GARREL ROBERT CRAIG, BREWER |
| STATE OF MAINE ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE COMMITTEE ON INSURANCE AND FINANCIAL SERVICES | | |

June 9, 2017

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

Dear Ms. Hooper:

Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on 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 1030, An Act to Require Nondiscrimination Policies in Providing Health Insurance**

As you know, the bill's sponsor proposed an amendment to replace the bill which would require coverage for services provided by licensed naturopathic doctors if those services are within the scope of the license and would be reimbursed if the services were provided by other licensed providers. The proposed amendment would also prohibit carriers from excluding naturopathic doctors from their networks subject to network adequacy standards. A copy of the proposed amendment is enclosed. Please prepare the evaluation using the guidelines set out in Title 24-A § 2752. In addition, we ask that the Bureau provide an analysis of the following issues:

- The extent to which coverage of services provided by naturopathic doctors is already included in health plans and covered by the State's essential benefits package and the manner in which the proposed amendment may expand this coverage;
- The current participation of naturopathic doctors in carrier networks;
- If the proposed amendment expands coverage beyond the essential benefits package, the estimated costs to the State to defray the costs of including the coverage in qualified health plans.

LD 1030 Letter
Page 2
June 9, 2017

Please submit the report to the committee before January 1, 2018. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,



Sen. Rodney L. Whittemore
Senate Chair



Rep. Mark W. Lawrence
House Chair

cc: Sen. Justin Chenette
Members, Joint Standing Committee on Insurance and Financial Services

Appendix C: LD 1030 Original Bill

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

2 **Sec. 1. 24-A MRSA §2385-G is enacted to read:**

3 **§2385-G. Nondiscrimination; prohibited practices**

4 **1. Covered providers.** An insurer may not discriminate against a health care
5 provider who is licensed, registered or certified by the State in providing covered services
6 under a workers' compensation insurance policy or contract as long as the provider is
7 acting within the scope of the provider's license, registration or certification.

8 **2. Prohibited practices.** An insurer offering a workers' compensation insurance
9 policy or contract in this State may not engage in the following practices in order to limit
10 the implementation of nondiscrimination policies:

11 A. Lower reimbursement rates for certain categories of providers who are delivering
12 the same services as other provider types, as defined by procedural codes;

13 B. Apply limits to the number of allowable visits to some types of providers and not
14 others;

15 C. Limit the amount of payment for a service provided by a licensed, registered or
16 certified provider acting within the provider's scope of practice;

17 D. Limit the number of providers in the insurer's network;

18 E. Eliminate or restrict integrative or naturopathic services that are otherwise within
19 the provider's scope of practice;

20 F. Restrict current procedural terminology codes, commonly referred to as "CPT
21 codes," by provider type;

22 G. Exclude coverage for diagnosis and treatment of a condition or illness by a
23 licensed, registered or certified provider who is acting within the provider's scope of
24 practice if the insurer covers diagnosis and treatment of the condition or illness by a
25 licensed physician or osteopathic physician;

26 H. Make access to providers difficult by implementing cumbersome approval
27 processes; or

28 I. Implement exclusionary language in provider contracts that references "not
29 medically necessary," "not clinically efficacious" or "experimental" solely to deny
30 coverage for services.

31 **3. Variable reimbursement methods.** The provisions in subsection 2 do not
32 prohibit an insurer from offering variable reimbursement methods based on quality and
33 performance measures as long as the standard measures used are applied uniformly across
34 provider types.

35 **4. Deductible.** Prior to meeting any deductible threshold, if applicable, the expense
36 of any service paid by the policyholder that is rendered by a licensed provider must be
37 applied to the deductible. When attributing the expense of services paid for by the

1 policyholder to the deductible, there may not be any differentiation between in-network
2 and out-of-network providers until the point at which the deductible is met.

3 **5. Conformity with federal law.** An insurer shall comply with:

4 A. The federal Affordable Care Act, Sections 1251, 1252 and 1304;

5 B. 42 United States Code, Section 300gg et seq.;

6 C. 42 United States Code, Section 300gg-11 et seq.; and

7 D. 42 United States Code, Section 300gg-94.

8 **Sec. 2. 24-A MRSA §2910-B** is enacted to read:

9 **§2910-B. Nondiscrimination; prohibited practices**

10 **1. Covered providers.** An insurer may not discriminate against a health care
11 provider who is licensed, registered or certified by the State in providing covered services
12 under an automobile liability insurance policy or contract as long as the provider is acting
13 within the scope of the provider's license, registration or certification.

14 **2. Prohibited practices.** An insurer offering an automobile liability insurance
15 policy or contract in this State may not engage in the following practices in order to limit
16 the implementation of nondiscrimination policies:

17 A. Lower reimbursement rates for certain categories of providers who are delivering
18 the same services as other provider types, as defined by procedural codes;

19 B. Apply limits to the number of allowable visits to some types of providers and not
20 others;

21 C. Limit the amount of payment for a service provided by a licensed, registered or
22 certified provider acting within the provider's scope of practice;

23 D. Limit the number of providers in the insurer's network;

24 E. Eliminate or restrict integrative or naturopathic services that are otherwise within
25 the provider's scope of practice;

26 F. Restrict current procedural terminology codes, commonly referred to as "CPT
27 codes," by provider type;

28 G. Exclude coverage for diagnosis and treatment of a condition or illness by a
29 licensed, registered or certified provider who is acting within the provider's scope of
30 practice if the insurer covers diagnosis and treatment of the condition or illness by a
31 licensed physician or osteopathic physician;

32 H. Make access to providers difficult by implementing cumbersome approval
33 processes; or

34 I. Implement exclusionary language in provider contracts that references "not
35 medically necessary," "not clinically efficacious" or "experimental" solely to deny
36 coverage for services.

1 **3. Variable reimbursement methods.** The provisions in subsection 2 do not
2 prohibit an insurer from offering variable reimbursement methods based on quality and
3 performance measures as long as the standard measures used are applied uniformly across
4 provider types.

5 **4. Deductible.** Prior to meeting any deductible threshold, if applicable, the expense
6 of any service paid by the policyholder that is rendered by a licensed provider must be
7 applied to the deductible. When attributing the expense of services paid for by the
8 policyholder to the deductible, there may not be any differentiation between in-network
9 and out-of-network providers until the point at which the deductible is met.

10 **5. Conformity with federal law.** An insurer shall comply with:

11 A. The federal Affordable Care Act, Sections 1251, 1252 and 1304;

12 B. 42 United States Code, Section 300gg et seq.;

13 C. 42 United States Code, Section 300gg-11 et seq.; and

14 D. 42 United States Code, Section 300gg-94.

15 **Sec. 3. 24-A MRSA §4320-K** is enacted to read:

16 **§4320-K. Nondiscrimination; prohibited practices**

17 **1. Covered providers.** A carrier may not discriminate against a health care provider
18 who is licensed, registered or certified by the State in providing covered services to plan
19 enrollees as long as the provider is acting within the scope of the provider's license,
20 registration or certification. A carrier shall maintain network adequacy by ensuring a
21 sufficient number of health care providers to serve the number of enrollees. Copayments,
22 deductibles, conversion factors and covered essential health benefits under health plans
23 must apply equally to all covered providers and not differ based solely on category or
24 professional title of the provider or by licensure, registration or certification of the
25 provider.

26 **2. Prohibited practices.** A carrier offering a health plan in this State may not
27 engage in the following practices in order to limit the implementation of
28 nondiscrimination policies:

29 A. Lower reimbursement rates for certain categories of providers who are delivering
30 the same services as other provider types, as defined by procedural codes;

31 B. Apply limits to the number of allowable visits to some types of providers and not
32 others;

33 C. Limit the amount of payment for a service provided by a licensed, registered or
34 certified provider acting within the provider's scope of practice;

35 D. Limit the number of providers in the health plan's network;

36 E. Eliminate or restrict integrative or naturopathic services that are otherwise within
37 the provider's scope of practice;

1 F. Restrict current procedural terminology codes, commonly referred to as "CPT
2 codes," by provider type;

3 G. Exclude coverage for diagnosis and treatment of a condition or illness by a
4 licensed, registered or certified provider who is acting within the provider's scope of
5 practice if the health plan covers diagnosis and treatment of the condition or illness
6 by a licensed physician or osteopathic physician;

7 H. Make access to providers difficult by implementing cumbersome approval
8 processes; or

9 I. Implement exclusionary language in provider contracts that references "not
10 medically necessary," "not clinically efficacious" or "experimental" solely to deny
11 coverage for services.

12 **3. Variable reimbursement methods.** The provisions in subsection 2 do not
13 prohibit a carrier from offering variable reimbursement methods based on quality and
14 performance measures as long as the standard measures used are applied uniformly across
15 provider types.

16 **4. Deductible.** Prior to meeting any deductible threshold, if applicable, the expense
17 of any service paid by the policyholder that is rendered by a licensed provider must be
18 applied to the deductible. When attributing the expense of services paid for by the
19 policyholder to the deductible, there may not be any differentiation between in-network
20 and out-of-network providers until the point at which the deductible is met.

21 **5. Requirements if service determined experimental or not medically necessary.**
22 A carrier that limits coverage of experimental treatment or treatment determined to be not
23 medically necessary shall:

24 A. Define the limitation and disclose the limits in any agreement, policy or
25 certificate of coverage. The disclosure must include the following:

26 (1) Who is authorized to make the determination on limiting coverage; and

27 (2) The criteria the plan uses to determine whether a treatment, procedure, drug
28 or device is experimental; and

29 B. If the carrier includes in the disclosure under paragraph A all of the information
30 required to make a decision, issue, within 5 business days after receiving a request for
31 coverage, a coverage decision. If coverage is denied, the carrier shall provide the
32 insured a denial letter that includes:

33 (1) A statement of the specific medical and scientific factors considered in
34 making a decision; and

35 (2) A notice of the insured's right to appeal and an explanation of the appeal
36 process.

37 **6. Conformity with federal law.** A carrier shall comply with:

38 A. The federal Affordable Care Act, Sections 1251, 1252 and 1304;

39 B. 42 United States Code, Section 300gg et seq.;

Appendix D: LD 1030 Amendment

LD1030:

An Act to Require Non-Discrimination in Providing Health Care Services

Naturopathy Providers; Payment for Equivalent Types of Service; Individual Insurance Plans.

Each insurer that issues or renews any individual policy, plan, or contract of health insurance providing benefits for medical or hospital expenses shall provide to persons covered by such insurance, who are residents of this state, coverage for expenses arising from a health service performed by a doctor of naturopathic medicine licensed under **Title 32 section §12522** if that particular type of service is within the scope of practice of such doctor and if the insurer would reimburse for that type of service when performed by any other type of health care provider.

Such coverage shall be subject to each insurer's standards and mechanisms for determining medical necessity, for credentialing pursuant to, and for contracting. Benefits provided shall not be subject to any greater co-payment, deductible, or coinsurance than any other similar benefits provided by the insurer. Health plans may not exclude naturopathic **doctors** from in-network participation, however they do not need to include all providers who apply, only to prove network adequacy. Network participation must include all plan types, if offered to other providers providing similar services, within their scope of practice.