



DEPARTMENT OF

**Professional &  
Financial Regulation**

STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF LICENSING AND REGISTRATION

# A Report to the Joint Standing Committee on Insurance and Financial Services of the 126th Maine Legislature

*Review and Evaluation of LD 1367,  
An Act to Require Health Insurance Carriers and the MaineCare  
Program To Cover the Cost of Transition Services To Bridge the  
Gap between High School and Independence*

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## **I. Executive Summary**

The Joint Standing Committee on Insurance and Financial Services (Committee) of the 126th Maine Legislature directed the Bureau of Insurance (Bureau) to review LD 1367, An Act to Require Health Insurance Carriers and the MaineCare Program to Cover the Cost of Transition Services to Bridge the Gap between High School and Independence. The review was conducted as required by Title 24-A, Section 2752. This document and review is a collaborative effort of the Bureau and NovaRest, Inc., an actuarial consulting firm.

LD 1367 requires that all health insurance policies issued or renewed on or after January 1, 2014 provide coverage for the cost of transition services to bridge the gap between high school and age 26. The scope of services intended to be covered by LD 1367 are outreach to, and case management for, patients who are graduating from high school and who are having difficulty complying with treatment. Covered services include clinic visits to prevent and treat behavioral and mental health conditions and to avoid hospitalization.

LD 1367 requires each provider of behavioral and mental health services for children to establish or participate in “bridge teams” for the purpose of ensuring continuity of care for students receiving behavioral and mental health services who are graduating from high school.

Adolescents are often faced with challenges and additional stress upon reaching 18 years of age. This is a transition period for many young adults who may be living on their own for the first time and will be charged with tasks such as cooking and personal finances. This can be a significantly stressful time for the roughly 14.6% of children diagnosed with behavioral and mental health conditions in Maine.<sup>1</sup> The 2007 National Survey of Children’s Health reported that 42.8% of the children in Maine between the ages of 2 and 17 who have been diagnosed with a behavioral or mental health condition receive coordinated care, and that 75.5% of those children are adequately covered by public and private insurance.<sup>2</sup> The Maine Kids Count 2013 report states “95% of Maine children ages 18 years and younger have health insurance” (including MaineCare). Approximately 48% of children ages 0-18 are covered by MaineCare. What is unknown is the percentage of the target population over 18 that requires care coordination and is not receiving it due to limitations in their insurance coverage.

State Representative Anne Graham stated that “the bill attempts to address a hole in the system that allows at-risk youth to fall between the cracks, which often leads to trouble. Youth with behavioral or

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<sup>1</sup> The Child & Adolescent Health Measurement Initiative, *2007 National Survey of Children’s Health*, <http://childhealthdata.org/browse/snapshots/nsch-profiles/mental-health?geo=1&geo2=21&offset=256&offset=256>.

<sup>2</sup> The Child & Adolescent Health Measurement Initiative, *2007 National Survey of Children’s Health*, <http://childhealthdata.org/browse/snapshots/nsch-profiles/mental-health?geo=1&geo2=21&offset=256&offset=256>.

mental health difficulties often have strong support and receive treatment while in school, only to lose that support after graduation.”

Many mental health conditions will persist into adulthood. However, as adolescents transition into adults, they may not be eligible for MaineCare coverage. LD 1367 seeks to require coverage of the cost for “transitional services.” If the Committee proceeds with this bill, clarification of what is included in the term “transitional services” will be needed, to define what services or providers the mandate covers. It is possible that the mandated services are covered under the essential health benefits (EHB). The Affordable Care Act (ACA) allows young adults to stay on their parents’ insurance plans to age 26 and thereby receive behavioral and mental health coverage.

All insurance carriers will provide mental health and substance abuse coverage at parity with physical illnesses as required by Maine’s mental health parity law, as well as the essential health benefits required by the ACA, and the federal Mental Health Parity Law for new ACA-compliant coverage starting January 1, 2014. Grandfathered and renewing non-ACA plans that offer mental health benefits will be required to offer parity with physical health benefits in plans renewed on or after July 1, 2014. According to the carriers, treatment may not be provided if there is not a mental illness present or if the treatment is specifically for transition to independence care.

In addition, the federal Mental Health Parity Act requires insured or self-insured plans covering employers with 50 or more employees that provide coverage for mental health services to apply cost-sharing requirements (deductibles, co-payments, coinsurance) and treatment limitations (limitations on the frequency of treatment, number of visits, etc.) to mental health services that are no more restrictive than those applied to medical and surgical benefits.

LD 1367 does not identify specific covered services. We recommend that the Committee request the language be updated to specifically define the services to be covered and the type of providers that are required to be reimbursed. Also, it is unusual for health insurance companies to reimburse providers that are not licensed. It is possible that many of the community case managers are not licensed and therefore insurers may not be required to pay claims for these services, unless specified in LD 1367.

Most medically necessary services included in LD 1367 are currently covered by insurance, if provided by a licensed health care professional. The services not covered by insurance are primarily vocational services, home based services and community support services. Since we are unclear about the exact services to be covered by LD 1367, we cannot estimate the cost of adding currently uncovered services or the potential for unreasonable financial hardship. To estimate any cost increase to the plans, more information about the specific additional services, level of utilization and cost of services for the additional care is needed.

## **II. Background**

The Joint Standing Committee on Insurance and Financial Services of the 126th Maine Legislature directed the Bureau of Insurance to review LD 1367, An Act to Require Health Insurance Carriers and the MaineCare Program to Cover the Cost of Transition Services to Bridge the Gap between High School and Independence. The review was conducted as required by Title 24-A, Section 2752. This document and review is a collaborative effort of the Bureau and NovaRest, Inc., an actuarial consulting firm.

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

- the extent to which coverage of mental and behavioral health services are included in the State's essential health benefits package and the manner in which LD 1367 may expand this coverage;
- the extent to which existing coverage is not meeting the needs of the affected population;
- if the bill expands coverage beyond the essential health benefits package, the estimated costs to the State to defray the costs of including the coverage in qualified health plans;
- the impact of amending LD 1367 to require coverage for adults up to age 26; and
- the impact of the federal Affordable Care Act's provisions for cost-sharing in qualified health plans on existing coverage of mental and behavioral health services and the expanded coverage required by the bill.

LD 1367 requires that all individual, group health and health maintenance organization (HMO) insurance policies issued or renewed on or after January 1, 2014 provide health insurance coverage for the cost of transition services to bridge the gap between high school and age 26. The scope of service intended to be covered by LD 1367 are outreach to, and case management for, patients who are graduating from high school or have recently graduated from high school and who are having difficulty complying with treatment. Covered services include clinic visits to prevent and treat behavioral and mental health conditions and to avoid hospitalization.

LD 1367 requires each provider of behavioral and mental health services for children to establish or participate in bridge teams for the purpose of ensuring continuity of care for students graduating from high school. The bridge teams shall: (1) conduct outreach and identify students prior to graduation who are likely to be in need of behavioral and mental health services after graduation; (2) develop plans to meet those students' needs after graduation; (3) facilitate access to services and; (4) coordinate the continuance of care for those students after graduation. When developing plans for students, the bridge teams shall focus on prevention, continuity of treatment and avoidance of hospitalization.

The requirements of LD 1367 would bridge the gap in behavioral and mental health services provided

between high school and 26 years of age, through contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014. The effective date in the bill would need to be updated.

There are a number of items that are not well-defined in LD 1367, including:

1. the services required to be provided;
2. the provider types to be included; and
3. whether the providers must be licensed to be reimbursed.

The bill's sponsor, Representative Anne Graham, suggested that the following scope of services be covered under LD 1367 for individuals ages 12 -26 with Axis I Psychiatric Disorders or high utilization of mental health services:

- intensive community-based treatment program (intent is to re-establish the Anchor program);
- a team approach to treatment (psychiatrist, social workers, clinical nurse specialist, community support workers, vocational specialist);
- three to six months of treatment followed by six months of case management;
- services that include medication management, case management, community support and vocational services, in addition to intensive individual and family counseling and treatment; and
- a target population of ages 3 to 18 years (goal is to extend the treatment age to 26 years).

It is estimated that 4.5 to 6.3 million children in the U.S. are severely emotionally disturbed; the average age is 12 years old; 66% are male; 61% are below the poverty line vs. 20% of all children; and 54% are in single-parent homes.<sup>3</sup>

Major insurance companies operating in Maine were sent a copy of the proposed scope of services found in Appendix B and asked to provide information about their current coverage and the effect of the proposed mandate on premiums.

Dr. Douglas Robbins, Director of the Division of Child and Adolescent Psychiatry at Maine Medical Center, Chair of The Glickman Family Center of Child and Adolescent Psychiatry at Spring Harbor Hospital, and Clinical Professor of Psychiatry at Tufts University School of Medicine provided testimony in support of LD1367. Dr. Robbins stated that:

“...an active collaboration between mental health providers and primary care providers is an important component of LD 1367. This means that all primary care practices, pediatric, family

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<sup>3</sup> PowerPoint on Anchor program from Surgeon General's Conference on Children's Mental Health-2000.

medicine, and others get involved. This is particularly important in rural areas where other providers are less available. There are two active programs of such collaborative or 'integrated' services in Maine, which are currently funded by grants, not MaineCare or commercial insurance - the Child Psychiatry Access Program and the Maine Health Mental Health Integration initiative."

**The extent to which coverage of mental and behavioral health services are included in the State's essential benefits (EHB) package and the manner in which the bill may expand this coverage**

Beginning in 2014, the federal ACA requires non-grandfathered individual and small group health plans to cover essential health benefits (EHB), which include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. The essential health benefits should be equal in scope to the State of Maine's benchmark plan, which is Anthem's small group BlueChoice plan.

The current mental health parity mandate in Maine requires group contracts, other than those covering employers with 20 or fewer employees, to provide benefits at least equal to those for physical illnesses for a person receiving medical treatment for eleven categories of mental illness as defined in the Diagnostic and Statistical Manual (DSM).

In addition, the federal Mental Health Parity Act requires insured or self-insured plans covering employers with 50 or more employees that provide coverage for mental health services, to apply cost-sharing requirements (deductibles, co-payments, coinsurance) and treatment limitations (limitations on the frequency of treatment, number of visits, etc.) to mental health services that are no more restrictive than those applied to medical and surgical benefits.

**If the bill 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**

Since we are unclear about the exact services to be covered by LD 1367, we cannot estimate the costs to the State to defray the costs of including the coverage in qualified health plans. To estimate any cost increase to the plans, more information about the specific additional services, level of utilization and cost of services for the additional care is needed.

**The impact of amending LD 1367 to require coverage for adults up to age 26.**

LD 1367 is intended to extend the coverage to age 26, so there will be no change to the analysis.

**The extent to which existing coverage is not meeting the needs of the affected population**

It is estimated that 75.5% of the mental health needs of Maine children ages 2 to 17 are covered by public and private insurance and that insurance is adequate.<sup>4</sup> The 2007 National Survey of Children's Health reported that 42.8% of Maine children ages 2 to 17 who are diagnosed with behavioral or mental health conditions receive coordinated care.<sup>5</sup> The Maine Kids Count 2013 report states "95% of Maine children ages 18 years and younger have health insurance" (including MaineCare). Approximately 48% of children ages 0-18 are covered by MaineCare. What is unknown is the percentage of the target population over 18 years old that requires care coordination and is not receiving it due to limitations in their insurance coverage.

Existing health insurance does not cover outreach services to young adults who are not currently under the care of a health care professional. Many children with mental disorders fail to be identified and therefore lack access to treatment or support, causing a lower quality of life. When children with untreated mental disorders become adults they often use more health care services and incur higher health care costs than other adults. Left untreated, childhood disorders are likely to persist and may lead to school failure, limited or non-existent employment opportunities and poverty in adulthood.<sup>6</sup> An untreated mental disorder can lead to a more severe, more difficult to treat illness and to the development of co-occurring mental illnesses.<sup>7</sup>

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<sup>4</sup> The Child & Adolescent Health Measurement Initiative, *2007 National Survey of Children's Health*, <http://childhealthdata.org/browse/snapshots/nsch-profiles/mental-health?geo=1&geo2=21&offset=256&offset=256>.

<sup>5</sup> The Child & Adolescent Health Measurement Initiative, *2007 National Survey of Children's Health*, <http://childhealthdata.org/browse/snapshots/nsch-profiles/mental-health?geo=1&geo2=21&offset=256&offset=256>.

<sup>6</sup> National Alliance on Mental Illness, Child & Adolescent Action Center, [http://www.nami.org/Template.cfm?Section=federal\\_and\\_state\\_policy\\_legislation&template=/ContentManagement/ContentDisplay.cfm&ContentID=43804](http://www.nami.org/Template.cfm?Section=federal_and_state_policy_legislation&template=/ContentManagement/ContentDisplay.cfm&ContentID=43804).

<sup>7</sup> National Institute of Mental Health Release of landmark and collaborative study conducted by Harvard University, the University of Michigan and the NIMH Intramural Research Program (release dated June 6, 2005 and accessed at [www.nimh.nih.gov](http://www.nimh.nih.gov)).

### 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.*

Mental illness is not uncommon among children and adolescents. Approximately 12 million children under the age of 18 in the U.S. have mental disorders.<sup>8</sup> The National Mental Health Association has compiled some statistics about mental illness in children and adolescents. They are listed below.

- Mental health problems affect one in every five young people at any given time.
- As many as 1 in every 33 children may be depressed. Depression in adolescents may be as high as 1 in 8.
- Suicide is the third leading cause of death for 15- to 24-years-olds and the sixth leading cause of death for 5- to 15-year-olds.
- Schizophrenia is rare in children under age 12, but it occurs in about 3 of every 1,000 adolescents.
- Between 118,700 and 186,600 youths in the juvenile justice system have at least one mental illness.
- Of the 100,000 teenagers in juvenile detention, an estimated 60 percent have behavioral, cognitive, or emotional problems.

Approximately 50% of students in the U.S. aged 14 and older who are living with a mental illness drop out of high school.<sup>9</sup> This is the highest dropout rate of any disability group. Research shows that early identification and intervention can minimize the long-term disability of mental disorders.<sup>10</sup>

Treatment can involve both medications and psychotherapy, depending on the condition and its severity. Slightly more than 6% of U.S. teens take prescription medications for a mental health

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<sup>8</sup> The Science of Mental Illness, *Information about Mental Illness and the Brain*, [science.education.nih.gov/supplements/nih5/Mental/guide/info-mental-a.htm](http://science.education.nih.gov/supplements/nih5/Mental/guide/info-mental-a.htm).

<sup>9</sup> U.S. Department of Education, *Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Education Act*, Washington, D.C., 2001.

<sup>10</sup> New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-0303832. Rockville, MD: 2003.

condition.<sup>11</sup> Teens aged 12 to 19 typically took drugs to treat depression or ADHD, the two most common mental health disorders in that age group. About 4% of children aged 12 to 17 have experienced a period of depression, the study found. Meanwhile, 9% of children aged 5 to 17 have been diagnosed with ADHD, a disorder marked by a difficulty in paying attention and impulsive behavior.

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

Widespread growing awareness of the prevalence of mental health disorders in children and adolescents has spurred the search for therapeutic and pharmacological approaches that are safe and effective for youth.

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

Mental health is a category of Essential Health Benefits under ACA. Beginning January 1, 2014, individual and small group policies are required to cover mental health services at parity with other medical services, with no annual or lifetime dollar limits. Since we are unclear about the exact services to be covered by LD 1367, it is unclear the extent to which insurance coverage for the treatments intended by the bill are already available.

UnitedHealth Care stated that it provides transitional services to age 26.

Coverage for Aetna's group plans follows the state and federal mental health parity requirements. Mental health and substance abuse services are covered the same as any other medical expense, subject to medical necessity. For Aetna's renewing HMO Pay/Play individual plans, the annual limitations for inpatient coverage is 30 calendar days for the standard plans and 15 calendar days for the basic plan. Aetna's renewing individual conversion plans cover mental health and substance abuse services the same as any other medical expense.

As a general rule, Harvard Pilgrim provides the services included in the request for information, attached in Appendix B. However, the following services are not covered: Targeted Case Management, Home and Community Treatment (children and adolescents <18), Assertive Community Treatment, Child-Assertive Community Treatment, Vocational services, Telepsychiatry evaluation and treatment, and collaboration between clinicians or between clinicians and schools and other community services and programs.

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<sup>11</sup> Mann, Denise, More Than 6 percent of U.S. Teens Take Psychiatric Meds: Survey, Slightly more than 6 percent of U.S. teens take prescription medications for a mental health condition such as depression or attention-deficit/hyperactivity disorder (ADHD).

The transition, screening and triage services (described in the summary of services attached to this request), which are proposed to be included under LD 1367, are not themselves separate benefits that are subject to billing and reimbursement. Therefore there is no claims data for these services because they are part of all services for which benefits are provided under a carrier's plan. For example, if a covered individual requests inpatient treatment for bipolar disorder, the screening and triage services (as described in the summary), are conducted and provided as part of that carrier's benefit for inpatient services. They are not separate services/benefits for which billing and reimbursement occurs. In general, this is true for all health policies.

Finally, Harvard Pilgrim notes the need for these services for individuals between high school and independence. These individuals may be covered by commercial insurance policies through age 26 pursuant to federal law under the Affordable Care Act. Nothing in a commercial policy delineates coverage to cease upon completion of high school.

Cigna reported a total of 188 denials of claims, the majority of which were due to lack of timeliness of the claim or lack of documentation.

Aetna did not provide a number of denied claims; however, the company did report that services considered to be of an educational, vocational or community-based nature are not covered.

Anthem did not provide a response to a request for information sent on August 9, 2013. Follow-up requests were sent October 30, 2013 and November 19, 2013. At the time this report was submitted, no response had been received.

General outreach services to a group of individuals who are not under the care of a health care professional are currently not included in insurance coverage.

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.*

Broad outreach efforts to school-aged children are not available, except as provided by the school systems in regular testing programs. These fall outside typical insurance benefit coverage.

Below is a list of the numbers of mental health professionals by county in Maine.

County	Licensed Clinical Professional Counselor (LCPC)	Licensed Master Social Worker (LMSW)	Licensed Clinical Social Worker (LCSW)	Psychiatrist	Psychologist
Androscoggin	41	41	170	17	24
Aroostock	10	24	90	8	9
Cumberland	297	247	962	122	196
Franklin	24	10	34	1	8
Hancock	33	22	96	7	18
Kennebec	86	57	191	34	78
Knox	33	19	91	12	23
Lincoln	10	14	53	1	6
Oxford	28	15	61	1	4
Penobscot	120	70	228	37	76
Piscataquis	10	3	16	3	1
Sagadahoc	30	21	84	2	9
Somerset	14	18	34	1	4
Waldo	28	20	72	6	13
Washington	17	11	31	2	7
York	99	84	305	12	38
Total	880	676	2518	266	514

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

Most medically necessary services included in LD 1367 are currently covered by insurance if provided by a licensed health care professional. The services not covered by insurance are primarily vocational services, home-based services and community support services. Since we are unclear about the exact services to be covered by LD 1367, we cannot estimate the cost of uncovered services and the potential for unreasonable financial hardship.

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

During the public hearing for LD 1367, some testimony noted that recent tragedies have raised awareness of mental health issues and public demand for treatment. There are many advocacy groups for youth with mental health issues across the nation that support community services.

Proponents of the bill stated that proactive treatment can reduce the higher health care costs associated with mental health crises and related hospitalization.

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

The sponsors of LD 1367 believe mandated coverage should include outreach and case management services and providers should be required to provide these services through bridge teams.

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.*

Similar transition planning in other states is limited. The main goal in many states is to identify and provide students with opportunities and necessary supports while they are in school that will lead the student to achieve his/her post-secondary goals for lifelong learning, community participation, and work for pay. There are many resources that school officials can access for more information on individualized education programs. As an example, the Special Education Services in the Alabama Department of Education has a number of initiatives aimed at transitional services.<sup>12</sup>

The mandate in LD 1367 seems to reach far beyond what other states have in place, by requiring insurance coverage – rather than services provided by public programs – to fill the transitional gap of students graduating from high school.

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.

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<sup>12</sup> <http://alex.state.al.us/specialed/transition.html>.

11. *The alternatives to meeting the identified need.*

The following are the responses from commercial insurance carriers to the Bureau's request for information. We are not opining on the validity of the following assumptions or conclusions, but rather are repeating them as provided.

***UnitedHealthcare***

The implementation of the federal Mental Health Parity Addiction Equity Act (MHPAEA) in conjunction with the Affordable Care Act (ACA) have done much to help ensure that persons suffering from a mental health and/or substance abuse condition receive adequate coverage and appropriate care.

***Harvard Pilgrim Health Care***

The purpose of the Mandate appears to be to address a challenge that exists with respect to the provision of mental health services in the MaineCare system which does not have an analog in the commercial insurance system. We recommend that the scope of the mandate be limited to the MaineCare system and not applied to the commercial insurance system for the reasons articulated in response to these questions.

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.*

Some of the benefits of LD 1367 would address a medical need due to a mental health condition. As a result, coverage required by the bill is not inconsistent with the role of insurance to provide medically necessary services for a condition. However, the bill's mandate may be outside the role of insurance in that it requires providers to establish or participate in bridge teams for the purpose of ensuring continuity of care for students receiving behavioral and mental health services who graduate from high school, until age 26.

LD 1367 also does not identify specific services that would be covered. We recommend that the Committee request updated language to specifically define the services to be covered and the type of providers who would be eligible for reimbursement.

It is also unusual for health insurance companies to reimburse providers who are not licensed. It is possible that many of the community support providers contemplated by this bill are not licensed and therefore carriers may not be required to pay claims for services obtained from those providers, unless specified in LD 1367.

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

A recent article on the stigma of mental illness quoted Tipper Gore, wife of former Vice President Al Gore, as stating that “The last great stigma of the twentieth century is the stigma of mental illness.” There may be some stigma attached to receiving these services or to being diagnosed with a mental condition.

A stigma of this kind can prevent some individuals and their families from reaching out and getting the care they need. The Interim Executive Director of the Maine NAMI (National Alliance on Mental Illness) affiliate, Carrie Worthington, observed, “Fortunately, the more that it is talked about, the more that is learned and the less ‘shameful’ it becomes. Once mental illness is treated as a ‘real’ illness, more people should have better access to treatment, as well as insurance coverage and research dollars to find not only better treatment options, but also cures for these brain disorders.”<sup>13</sup>

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

LD 1367 would require bridge teams to perform outreach services to identify mental health problems in students prior to high school graduation. This outreach, if successful, would likely increase the use of mental health services for students after graduation.

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 they provide to employees and to control the cost of premiums. Since we are unclear about the exact services to be covered by LD 1367, we cannot estimate the impact on premiums, so are unable to predict any shifting to self-insured plans.

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

Aetna responded that “There is no cost impact because we do not limit benefit coverage.”

## IV. Financial Impact

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<sup>13</sup> Morris Daily News, ‘Great stigma’ still a barrier, [http://www.morrisdailyherald.com/2012/06/15/great-stigma-still-a-barrier/ai6jrrf/?\\_\\_xsl=/print.xsl](http://www.morrisdailyherald.com/2012/06/15/great-stigma-still-a-barrier/ai6jrrf/?__xsl=/print.xsl).

## 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.*

Mental health treatments are currently covered by insurance, so it is unlikely that the cost of these services will increase. To estimate any cost increase to insurance plans, due to the other services under LD 1367, more information about the specific additional services and anticipated level of utilization is required.

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

The outreach efforts may increase the appropriate use of the treatments. It may increase inappropriate use as well, until protocols are developed concerning the type and amount of services that are useful.

Although it is reasonable to expect that the proposed mandate in LD 1367 would likely increase the number of young adults receiving appropriate care, the magnitude of this potential increase is unclear. Premium and cost sharing for the insurance coverage may be unaffordable for some and there will still be an issue of the stigma attached to getting care.

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

One goal of LD 1367 is to reduce hospitalization by providing appropriate lower-cost care earlier, before the condition escalates.

This additional care provided to young adults could result in fewer health care costs in future years due to appropriate early care. According to NAMI (National Alliance on Mental Illness) testimony at the public hearing, young adults with serious behavior or mental illness who do not receive effective intervention are at higher risk of substance abuse, criminal activity, other disorders or suicide.

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

LD 1367 does not prohibit health plans from covering the services with the same medical management used for other services.

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

Currently, there are 4,854 licensed mental health professionals in Maine. If the mandate in LD 1367 requires the bridge team members to be licensed, it is likely that the number of licensed therapists will increase to meet the utilization.

If the mandate requires payment to non-licensed community support providers, it may result in an increase in non-licensed community support providers.

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.*

Cigna responded that they currently cover the standard behavioral health benefits up to age of 26, so this bill should not result in additional cost implication for large group policies. However, Cigna stated their mental health and substance abuse claim costs did increase when coverage for dependents up to age 26 was first required under federal healthcare reform.

Harvard Pilgrim Health Care indicated that the majority of the services identified in the summary of services in LD 1367 are already inherently covered benefits included in commercial insurance policies. The company said there would, therefore, be no additional cost for coverage to age 21, or to age 26, for individual, small group, or large group policies.

Aetna does not believe there will be any cost impact because they do not limit benefit coverage.

MEGA does not provide benefits without a specific mental illness diagnosis. If an illness is diagnosed, benefits are covered under mental health parity, if applicable. MEGA does not cover benefits specifically for transition to independence.

We do not have sufficient information concerning the services and providers that would be covered to make a professional estimate of the impact on premium or administrative costs.

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.*

It could be reasonably expected that the proposed mandate in LD 1367 would result in an increase in young adults receiving appropriate care. This additional care could result in fewer health care costs in future years, if hospitalizations or other costly services are avoided due to early intervention.

As previously noted, NAMI testimony at the public hearing indicated that young adults with serious behavior or mental illness who do not receive effective intervention are at higher risk of substance abuse, criminal activity, other disorders or suicide.

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.*

Since we are unclear about the exact services covered by LD 1367, we cannot estimate the impact on cost.

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.*

To the extent services contemplated by LD 1367 are currently covered by MaineCare and would be paid for by private insurance after the mandate is implemented, the cost may be shifted from public payers to private payers. MaineCare is the secondary form of payment when individuals also have private insurance.

## 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.*

With most children achieving some level of improvement after treatment, it is clear that there is a benefit to society. The cost of educating and caring for these children will go down, and some children will be able to enter mainstream society as fully functioning citizens. The additional care early in life could result in overall lower health care costs in future years. Also, with appropriate care this group may be less of a risk to themselves and the public.

Researchers at North Carolina State University, the Research Triangle Institute and the University of South Florida identified 4,056 people who had been hospitalized for mental illness between 2004 and 2005 and began to track them based on a number of outcomes. After seven years, researchers found that people receiving care were significantly less likely to be arrested than those who did not have access to low-cost or free mental health services.<sup>14</sup>

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

We are unclear if only a certain class of practitioners will be mandated and if they will have to be licensed.

## 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.*

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<sup>14</sup> McDonough, Katie, *Study: Treating mental illness prevents crime, saves taxpayers money*, [www.salon.com/2013/06/10/study\\_treating\\_mental\\_illness\\_prevents\\_crime\\_saves\\_taxpayers\\_money/](http://www.salon.com/2013/06/10/study_treating_mental_illness_prevents_crime_saves_taxpayers_money/).

Experts agree that it is important to treat mental health conditions as early as possible to increase the likelihood of successful outcomes. However, insurance carriers are already providing coverage due to the ACA and mental health parity laws.

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

It is likely that only those who would benefit from the services would purchase the coverage. This would result in an alternative coverage that would cost more than the additional cost of services because of the administrative charges added to benefit costs. This cost would be reduced if the option was only available when the coverage was initially purchased, but it would then be less effective because many individuals would not anticipate needing the coverage and, therefore, would not purchase it.

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

Since we are unclear about the exact services to be covered by LD 1367, we cannot estimate the cumulative impact on cost and availability of mandating this benefit in combination with existing mandates.

The estimated cost of current Maine mandates is detailed in Appendix C. For most of these mandates, our estimate is based on the net impact on premiums as estimated at the time the mandate was enacted. Four of the mandates – mental health, substance abuse, chiropractic, and screening mammograms – require carriers to report annually the amount of claims paid for these benefits and the estimates are based on that data. The true cost for the Maine mandates are impacted by the fact that:

1. some services would be provided and reimbursed in the absence of a mandate;
2. certain services or providers will reduce claims in other areas; and
3. some mandates are required by Federal law.

## **VII. Appendices**

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

SENATE

GEOFFREY M. GRATWICK, District 32, Chair  
RICHARD G. WOODBURY, District 11  
RODNEY L. WHITTEMORE, District 26

COLLEEN MCCARTHY REID, Legislative Analyst  
MOLLY GALLANT, Committee Clerk



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PETER DOAK, Columbia Falls

State of Maine  
ONE HUNDRED AND TWENTY-SIXTH LEGISLATURE  
COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

May 23, 2013

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 1367, An Act to Require Health Insurance Carriers and the MaineCare Program To Cover the Cost of Transition Services To Bridge the Gap between High School and Independence.**

A copy of the bill is enclosed. Based on further information provided by the bill's sponsor, Rep. Graham, the scope of services intended to be covered by the bill are intensive community-based treatment services, including, but not limited to, medical medication management, case management, community support, and vocational services, in addition to intensive individual and family counseling and treatment. The intended population is those individuals in need of treatment under age 26. We will also forward copies of reports provided by the sponsor for your consideration.

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 mental and behavioral health services are included in the State's essential benefits package and the manner in which the bill may expand this coverage;
- The extent to which existing coverage is not meeting needs of the affected population;
- If the bill 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 impact of amending LD 1367 to require coverage for adults up to age 26; and
- The impact of the federal Affordable Care Act's provisions for cost-sharing in qualified health plans on existing coverage of mental and behavioral health services and the expanded coverage required by the bill.

*LD 1367, 126<sup>th</sup> Maine State Legislature*  
*An Act to Require Health Insurance Coverage for Transition Services To Bridge the Gap between High School and Independence*

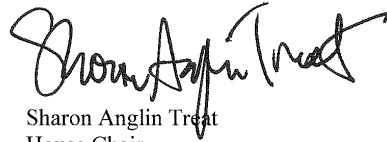
LD 1367 Letter  
Page 2

Please submit the report to the committee before January 1, 2014. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,



Geoffrey M. Gratwick  
Senate Chair



Sharon Anglin Treat  
House Chair

cc: Rep. Anne Graham

**126th MAINE LEGISLATURE**

**FIRST REGULAR SESSION-2013**

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**Legislative Document**

**No. 1367**

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H.P. 975

House of Representatives, April 9, 2013

**An Act To Require Health Insurance Carriers and the MaineCare Program To Cover the Cost of Transition Services To Bridge the Gap between High School and Independence**

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

*Millicent M. MacFarland*

MILLICENT M. MacFARLAND

Clerk

Presented by Representative GRAHAM of North Yarmouth. Cosponsored by President ALFOND of Cumberland and

Representatives: BEAUDOIN of Biddeford, BEAVERS of South Berwick, BRIGGS of Mexico, CASSIDY of Lubec, CHIPMAN of Portland, COOPER of Yarmouth, DAUGHTRY of Brunswick, EVANGELOS of Friendship, FARNSWORTH of Portland, GATTINE of Westbrook, GILBERT of Jay, GRANT of Gardiner, KORNFIELD of Bangor, LONGSTAFF of Waterville, MASTRACCIO of Sanford, McLEAN of Gorham, MONAGHAN-DERRIG of Cape Elizabeth, PEASE of Morrill, PRINGLE of Windham, RYKERSON of Kittery, SCHNECK of Bangor, TREAT of Hallowell, Senators: CRAVEN of Androscoggin, KATZ of Kennebec.

Printed on recycled paper

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

2       **Sec. 1. 22 MRSA §3174-WW** is enacted to read:

3       **§3174-WW. Transitional behavioral and mental health services for students after**  
4       **graduation**

5       For the purpose of easing the transition to independence of children receiving  
6       behavioral and mental health services in high school after graduation, the department  
7       shall provide reimbursement under the MaineCare program for outreach to and case  
8       management for patients who are graduating from high school or have recently graduated  
9       from high school and who are having difficulty complying with treatment, including  
10       coverage for clinic visits and for behavioral and mental health services for prevention of  
11       and continuation of treatment for mental health conditions and the avoidance of  
12       hospitalization.

13       **Sec. 2. 24-A MRSA §4320-I** is enacted to read:

14       **§4320-I. Transitional behavioral and mental health services for students after**  
15       **graduation**

16       For the purpose of easing the transition to independence of children receiving  
17       behavioral and mental health services in high school after graduation, a carrier shall  
18       provide coverage for outreach to and case management for patients who are graduating  
19       from high school or have recently graduated from high school and who are having  
20       difficulty complying with treatment, including coverage for clinic visits and for  
21       behavioral and mental health services for prevention of and continuation of treatment for  
22       mental health conditions and the avoidance of hospitalization.

23       **Sec. 3. Transition services.** The Department of Health and Human Services shall  
24       require each provider of behavioral and mental health services for children to establish or  
25       participate in so-called bridge teams for the purpose of ensuring continuity of care for  
26       students receiving behavioral and mental health services who graduate from high school.  
27       The bridge teams shall conduct outreach and identify students prior to graduation who are  
28       likely to be in need of behavioral and mental health services after graduation, develop  
29       plans to meet those students' needs after graduation, facilitate access to services and  
30       coordinate the continuance of care for those students after graduation. When developing  
31       plans for students, the bridge teams shall focus on prevention, continuity of treatment and  
32       avoidance of hospitalization.

33        **SUMMARY**

34        This bill requires the Department of Health and Human Services to require providers  
35        of behavioral and mental health services for children to establish or participate in so-  
36        called bridge teams for the purpose of ensuring continuity of care for students receiving  
37        behavioral and mental health services who graduate from high school and are likely to be  
38        in need of such services following graduation. The bill also requires MaineCare and  
39        private health insurance carriers to provide coverage for such services.

## Appendix B: LD 1367 – Program Description and Services Included

### An Act to Require Health Insurance Carriers and the MaineCare Program to Cover the Cost of Transition Services to Bridge the Gap between High School and Independence

#### Population Treated

1. Ages 12-26
2. Persons with Axis I Psychiatric Disorders (DSM-IV) likely to persist into adulthood and to become Severe and Persistent Mental Illness (SPMI)
  - a. Bipolar I Disorder
  - b. Major Depressive Disorder
  - c. Schizophrenia
  - d. Schizoaffective Disorder
3. High-Utilization of Mental Health Services – Any diagnosis. Includes:
  - e. Psychiatric hospitalization within the previous year.
  - f. Two or more contacts with ED or Crisis services due to mental illness in the past 6 months.
4. Persons at very High-Risk for Axis I disorders likely to persist into adulthood and to become SPMI
  - a. Mood disorders
  - b. Psychotic disorder
  - c. Does not include Autism Spectrum Disorders and other Developmental Disorders

#### Screening and Triage

Phone review of information relevant to Population Treated (above)

1. Imminent risk of harm to self or others  
Referral to Crisis services or to an ED for consideration psychiatric hospital admission.  
Police transport if needed.
2. Sufficiently safe for outpatient treatment  
Referred for assessment

#### Assessment

1. Initial Assessment
  - a. Clinician licensed for mental health treatment of children and adolescents. E.g.
    - i. Social Worker with Child & Adolescent Psychiatrist review
    - ii. Psychologist with Child & Adolescent Psychiatrist review
    - iii. Child & Adolescent Psychiatrist – Resident plus attending or Attending
  - b. Review of prior evaluations and reports from primary care, school and others
  - c. Interview with child individually and with parent(s)/caregiver(s).

- d. Family assessment.
    - i. Family contributing factors
    - ii. Assessment of parents' needs, burden of illness
  - e. Assess for co-occurring disorders.
  - f. Behavior Assessment Schedule for Children – II (BASC-II) completed by parent, teacher, child
  - g. Review medical history and risk factors
  - h. Assess for risk of severe maladaptive outcomes including
    - i. Suicide risk.
    - ii. Aggression or other antisocial behavior. May include legal involvement
    - iii. Non-suicidal self-injury
    - iv. Unwanted pregnancy
    - v. Substance abuse
    - vi. School drop-out
    - vii. Other
2. Risk Stratification based on above:
- a. Low risk
  - b. Moderate
  - c. High
    - i. Imminent risk of outcome with lasting consequences
    - ii. Active outreach if needed to engage or retain in treatment

### **Treatment:**

1. Level of service intensity:
  - a. Severity Level 1.
    - a. Outpatient Psychiatry Clinic – Psychotherapies, Medication Management
    - b. Collaboration with Primary Care, school, other
  - b. Severity Level 2.
    - a. Case management
    - b. Intensive outpatient treatment. Outpatient Clinic services. Increased frequency as needed.
    - c. Home and Community Treatment (HCT) as needed
  - c. Severity Level 3.
    - a. Assertive Community Treatment. Currently not available for those under 18.
    - b. Clinic + case management + Home and Community Treatment (HCT)
    - c. Psychiatric hospital if needed
2. Intervention modalities:
  - A. Safety Plan - See American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter\* [Suicidal Behavior](#)

B. AACAP Practice Parameters for diagnostic subgroups \*

\*AACAP Practice Parameters

[http://www.aacap.org/cs/root/member\\_information/practice\\_information/practice\\_parameters/practice\\_parameters](http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters)

Include Individual psychotherapy (CBT, other), Family psychoeducation and Family therapy, Collaboration with primary care, schools and vocational services, and community resources, Psychotropic medication.

- i. Bipolar Disorder
- ii. Depressive Disorders
- iii. Schizophrenia
- iv. Substance Abuse Disorders
- v. Post Traumatic Stress Disorder
- vi. ADHD
- vii. Conduct Disorder
- viii. Anxiety Disorders

C. Family

- i. AACAP Practice Parameters\*
  1. Assessment of the Family
  2. Family Interventions
- ii. Family Psychoeducation
  1. NAMI Family-to-Family
  2. Multi-family psychoeducation group

D. Community-based treatment

- i. Anchor Treatment Fidelity Manual (Maine CBHS / DHHS Intensive Outpatient Treatment for Children and Adolescents)
- ii. AACAP Practice Parameter \*  
Community Systems of Care

E. Assessment regarding need for psychotropic medication

- i. Consistent with AACAP Practice Parameters \*
  1. [Prescribing Psychotropic Medication to Children](#)
  2. [Depressive Disorders](#)
  3. [Bipolar Disorder](#)
  4. Schizophrenia
  5. Guidelines – Atypical Antipsychotic Medication

**Outcome monitoring**

3. Every 90 days :

A. Clinical outcomes:

- i. Function:
  1. CGAS/GAF
  2. Family Burden Assessment

ii. Symptom:

All patients: BASIS-24, BPRS, BPRS-C – Consider other instruments, e.g. OQ, YOQ, CANS

As indicated:

1. Depression - Center for Epidemiologic Studies – Depression (CES-D)
2. Mania - Young Mania Rating Scale (YMRS)
3. Psychosis - Structured Interview for Prodromal Symptoms (SIPS)
4. Psychosis - Positive and Negative Syndrome Scale (PANSS)
5. Substance Abuse - CRAFFT Screening Tool

B. Cost outcomes

- i. Health care service use - Child & Adolescent Service Intensity Instrument (CASII)
- ii. Maine Health Data Organization – Commercial insurance
- iii. MaineCare - DHHS

**Summary of services to be included:**

**1. Services with known CPT codes**

- Initial evaluation by a licensed mental health professional - LCSW, LCPC, Psychologist, Psychiatrist  
CPT Code 90791, 90792
- Individual Psychotherapy  
90832, 90834, 90837
- Individual psychotherapy with E&M  
90805, 90817, 90807, 90810, 90809, 90822
- Interactive psychotherapy with E/M  
E/M code plus 908333, 90836, or 90838
- Psychotherapy for Crisis  
90839, 90840
- Family Psychotherapy  
90846, 90847, 90849
- Group Psychotherapy  
90853
- Pharmacologic Management  
E/M codes – Established and New Patient
- Multifamily Psychoeducation CPT code not known

**2. Other services currently included in MaineCare and commercial insurance coverage**

- Psychotropic medications
- Psychiatric Hospitalization
- Psychiatric Partial Hospitalization
- Psychiatric Intensive Outpatient Program (IOP) treatment, includes DDIOP

**3. Services for which I am not aware of CPT codes – covered currently by MaineCare but not by commercial insurance carriers:**

- Targeted Case Management
- Home and Community Treatment (children and adolescents, <18)
- Assertive Community Treatment
- Child-Assertive Community Treatment
- Vocational services
- Telepsychiatry evaluation and treatment

**4. Services not currently covered by MaineCare or most commercial insurance**

- Collaboration between clinicians or between clinicians and schools and other community services and programs. Includes when patient or family not present.
  - Face – to – face
  - Telephone
- Care Coordination. This can be considered Case Management (Targeted Case Management), which is covered by MaineCare, but would need to be available for those who might not currently meet the current criteria of illness severity (Global Assessment of Function (GAF) less than 50). It is not covered by commercial insurance carriers currently.

**Appendix C: Cumulative Impact of Mandates in Maine**

**Bureau of Insurance**  
**Cumulative Impact of Mandates in Maine**  
 Report for the Year 2012

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*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 in Maine for listed conditions became effective July 1, 1996, and was expanded effective October 1, 2003. The percentage of mental health claims paid has been tracked since 1984 and has historically been between 3% and 4% of total group health claims and was reported as 3.3% in 2012. Mental health claims stayed below 3.5%, despite the fact that an expansion of the list of conditions for which parity is required was fully implemented in 2005. Mental health coverage is included in the essential health benefits for individual and small group plans beginning 2014. This report includes claims as paid under the law requirements for 2012. Individual mental health claims were only 1.9% in 2012 as a mandated offer. We have assumed that individual mental health claims will increase under ACA and will be similar to group claims in 2014.

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

The state mandate required the provision of benefits for alcoholism and drug dependency and applied only to groups of more than 20. 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 has been tracked since 1984. For 2012, substance abuse claims paid were 0.7% of the total group health claims. Despite implementation of the parity requirement, there was a long-term decrease in the percentage, likely due to utilization review, which sharply reduced the incidence of inpatient care. We estimate substance abuse claims will remain at the current levels going forward.

- ♦ **Chiropractic** (Enacted 1986)

This mandate generally 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 2012, was 1.0% of total health claims. The level has typically

been lower for individual than for group. We estimate the current 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. The U.S. Preventive Services Task force has recommended that screening mammograms begin at a later age and be done less frequently. While it is possible this will lead to reduced utilization, the American Cancer Society, The American College of Obstetricians and Gynecologists, and many oncologists have not accepted these recommendations. We, therefore, estimate the current level of 0.71% in all categories 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 up to \$3,000 per year for 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. Our report estimated a cost of 0.07% of premium.

- ♦ ***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 if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72. No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for non-HMO plans 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.

- ♦ ***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 \$1,400 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 for persons fifty years of age or older, or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. This mandate is effective January 2009. No carriers stated they denied coverage prior to this mandate; therefore, our report estimated no impact on premium.

- ♦ ***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 five years of age or under. Coverage may be limited for applied behavior analysis to \$36,000 per year. This mandate is effective January 2011, and our 2009 report estimated a cost of 0.7% of premium once the mandate is fully implemented if it included those under age 21. Because the current mandate only applies to those up to age five, the estimate was reduced to 0.3% of premium.

- ♦ ***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. Benefits may be limited to \$3,200 per year. This mandate is effective January 2011, and our report estimated a cost of 0.05% of premium.

*LD 1367, 126<sup>th</sup> Maine State Legislature*  
*An Act to Require Health Insurance Coverage for Transition Services To Bridge the Gap between High School and Independence*

**COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS**

<b>Year Enacted</b>	<b>Benefit</b>	<b>Type of Contract Affected</b>	<b>Est. Maximum Cost as % of Premium</b>
1975	Must include benefits for <b>dentists'</b> 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 <b>alcoholism and drug dependency</b> .	All Contracts	0.70%
1975 1983 1995 2003	Benefits must be included for <b>Mental Health Services</b> , including psychologists and social workers.	Groups	3.30%
		Individual	3.30%
1986 1994 1995 1997	Benefits must be included for the services of <b>chiropractors</b> to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self-referred for chiropractic benefits.	Group	1.0%
		Individual	0.50%
1990 1997	Benefits must be made available for screening <b>mammography</b> .	Group	0.71%
		Individual	0.71%
1995	Must provide coverage for <b>reconstruction of both breasts</b> to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%
1995	Must provide coverage for <b>metabolic formula</b> 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 <b>maternity (length of stay)</b> 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 <b>diabetes</b> and approved self-management and education training.	All Contracts	0.20%
1996	Benefits must be provided for <b>screening Pap tests</b> .	All	0.01%
1996	Benefits must be provided for <b>annual gynecological exam</b> without prior approval of primary care physician.	Group managed care	--
1997	Benefits provided for <b>breast cancer treatment</b> for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%
1998	Coverage required for <b>off-label use of prescription drugs</b> for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%
1998	Coverage required for <b>prostate cancer screening</b> .	All Contracts	0.07%

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1999	Coverage of nurse <b>practitioners and nurse midwives</b> and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts	--
1999	Prescription drug must include <b>contraceptives</b> .	All Contracts	0.80%
1999	Coverage for <b>registered nurse first assistants</b> .	All Contracts	0
2000	Access to <b>clinical trials</b> .	All Contracts	0.19%
2000	Access to <b>prescription drugs</b> .	All Managed Care Contracts	0
2001	Coverage of <b>hospice care services</b> for terminally ill.	All Contracts	0
2001	Access to <b>eye care</b> .	Plans with participating eye care professionals	0
2001	Coverage of <b>anesthesia</b> and facility charges for certain <b>dental</b> procedures.	All Contracts	0.05%
2003	Coverage for <b>prosthetic devices</b> 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 <b>infant formulas</b>	All Contracts	0.1%
2008	Coverage for <b>colorectal cancer screening</b>	All Contracts	0
2009	Coverage for <b>independent dental hygienist</b>	All Contracts	0
2010	Coverage for <b>autism spectrum</b>	All Contracts	0.3%
2010	Coverage for <b>children's early intervention services</b>	All Contracts	0.05%
	<b>Total cost for groups larger than 20:</b>		<b>8.11%</b>
	<b>Total cost for groups of 20 or fewer:</b>		<b>8.16%</b>
	<b>Total cost for individual contracts:</b>		<b>7.66%</b>