



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 347

An Act to Amend Insurance Coverage for Diagnosis of Autism Spectrum Disorders

January 2014

Updated

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Background

The Joint Standing Committee on Insurance and Financial Services of the 126th Maine Legislature directed the Bureau of Insurance to review LD 347, An Act To Amend Coverage for Diagnosis of Autism Spectrum Disorders. The review was conducted as required by Title 24-A M.R.S.A., §2752. In addition to the statutory criteria, the Committee also asked that the review provide an analysis of:

- the extent to which coverage of autism spectrum disorders is included in the State's essential benefits package and the manner in which LD 347 may expand this coverage;
- 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 the federal Affordable Care Act (ACA) on the ability of carriers to impose an annual dollar limit of \$36,000 for applied behavior analysis (ABA); and
- the impact of the ACA's provisions for cost-sharing in qualified health plans on existing coverage of autism spectrum disorders and the expanded coverage required by the bill.

LD 347 would require that all individual, group health and health maintenance organization (HMO) insurance policies issued or renewed on or after January 1, 2014 provide expanded health insurance coverage for autism spectrum disorders to persons 21 years of age and under. The effective date in the bill would need to be updated. Current law requires coverage for those 5 years of age and under.

The previous report provided by the Bureau for LD 1198 in December 2009 to require autism coverage contains information relevant for LD 347 and should be referenced. In addition to answering the Committee questions above, this report will provide updated information and estimates related to extending the current mandate to ages 21 and under.

Analysis

Autism Spectrum Disorder (ASD) encompasses a variety of related neurobiological developmental disorders with varying degrees of impairment. ASDs are on the rise in the United States and in the State of Maine. At the national level, the dramatic increase in the prevalence of autism is currently labeled as an epidemic by the U.S. Centers for Disease Control.¹ Previously, it was estimated that autism affects two to six of every 1,000 people², but more recent studies have increased that estimate to 1 in every 88³. It is currently the fastest growing developmental disability with a 10-17% annual growth rate.⁴ While the US population increased by 13% during the 1990s, autism increased by 172%.⁵

School systems in Maine have experienced a steady increase in children diagnosed and seeking treatment for Autism Spectrum Disorders. The following statistics from the U.S. Department of Education show the increase of parents seeking special assistance for their children with autism spectrum disorders.⁶

- Annual average increase of 18% in the number of children served in Maine schools under the category of autism.
- The number of transition-aged youth (ages 14-18) served in Maine schools under the autism category has doubled over a five year period.
- An increase of 95% in the number of students in the autism category in public schools from the Fall of 2003 to the Fall of 2007.

Research has shown that a diagnosis of autism at age 2 can be reliable, valid and stable.⁷ More children are being diagnosed at earlier ages—a growing number (18%) by age 3. Still, most children are not diagnosed until after they reach age 4. The average age for diagnosis is a bit earlier for children with autistic disorder (4 years) than for children with the more broadly-

¹ This is a clearly established fact. It is also stated in several of the pieces of evidence submitted such as the autism fact sheet from the National Institute for Child Health and Human Development, which states “Autism is a complex neurobiological disorder” and from Volkmar F, Pauls D, 2003. Autism. The Lancet 362:1133-1141. “Autism is a neuropsychiatric disorder.”

² Centers of Disease Control and Prevention (2001).

³ Centers for Disease Control and Prevention, *Autism Spectrum Disorders: Data & Statistics*, <http://www.cdc.gov/ncbddd/autism/data.html>.

⁴ Autism Society of America.

⁵ U.S. Department of Education’s “Twenty-First Annual Report to Congress on Implementation of Individuals with Disabilities Education Act” (1999).

⁶ Maineddc.org <<http://www.maineddc.org/pdd-systems.html>>.

⁷ Centers for Disease Control and Prevention, <http://www.cdc.gov/ncbddd/autism/data.html>, (2013).

defined autism spectrum diagnoses (4 years, 5 months), and diagnosis is much later for children with Asperger Disorder (6 years, 3 months).

Thirty-five states, including Maine, have specific autism mandates requiring certain insurers to provide coverage for autism spectrum disorder: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia, and Wisconsin.⁸

Coverage in Maine:

As mandated by state and federal mental health parity with regards to Autism Spectrum Disorders, group insurance plans provide coverage for diagnosis and treatment of autism the same as any other illness or disorder subject to medical necessity. Maine's benchmark plan used to set the Essential Health Benefits for ACA compliant plans included mental health parity coverage. All new individual and small group plans will cover benefits at least equal to those for physical illnesses for a person receiving medical treatment for any of the categories of mental illness as defined in the Diagnostic and Statistical Manual (DSM), including ASD. Grandfathered and non-grandfathered plans with mental health benefits will cover them at parity for renewals on or after July 1, 2014 as required by federal law.

The ACA eliminated the ability of carriers to impose an annual dollar limit of \$36,000 for applied behavior analysis for individual and small group plans. Carriers have substituted the dollar cap with equivalent visit limits. Large group plans may continue the annual dollar limit under the mandate.

Some insurance companies will not cover services related to applied behavior analysis (ABA) unless specifically mandated. The ABA treatment may be denied for reasons such as *not a provided service* if there isn't a comparable physical illness modality or *not provided by a licensed or participating provider*. We understand that LD 347 would require coverage of ABA and other support services, if determined to be medically necessary. There are 77 qualified ABA providers in Maine. Appendix B lists the providers and their licensure. (The list includes psychologists, social workers, mental health and substance abuse counselors and speech therapists.)

⁸ <http://www.asha.org/Advocacy/state/States-Specific-Autism-Mandates/>.

Discussion of ABA Treatment and Providers:

According to the Center for Autism Related Disorders, ABA is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree. Behavior analysts have been applying ABA since the 1960s to help children with autism and related developmental disorders.⁹ ABA has been endorsed by a number of state and federal agencies, including the U.S. Surgeon General and the New York State Department of Health, as a safe and effective treatment for autism.

Quality ABA programs are overseen by a qualified behavior analyst who customizes the program to each person receiving treatment through a variety of behavioral analytic procedures. These qualified analysts should be either licensed clinical psychologists with training in applied behavior analysis or behavior analysts, who are board certified (through the Behavior Analyst Certification Board or the Association of Professional Behavior Analysts) with supervised experience providing ABA treatment for autism or those who can clearly document that they have equivalent training and experience.¹⁰ Maine law currently does not require ABA therapists to be licensed.

In traditional ABA, the behavior analyst spends 20 to 40 hours per week working one-on-one with a child. Often, though, an analyst will use a version of the therapy known as “modified ABA.” With modified ABA, 10-15 hours per week are spent with the child, to allow the child time for other treatments, such as speech and occupational therapy.¹¹ The Lovaas Method developed by Dr. Ivar Lovaas (Lovaas, 1987) showed the highest effectiveness when at least 30 to 40 hours of tutoring per week were provided in about 2 or 3 hour sessions.¹²

ABA programs can be provided in a variety of ways, and can be costly. Children can be involved in schools that specialize in ABA treatment, however, the cost of tuition may range between \$16,000 and \$25,000 per year.¹³ ABA can take place at home using analysts in training, or undergraduates who have taken workshops in the ABA program, at a cost of \$5,000 to \$20,000 per year. An in-home full-time professional ABA therapy team can cost \$50,000 or more per year.

⁹ Autismspeaks.org, *Applied Behavior Analysis (ABA)*, <http://www.autismspeaks.org/what-autism/treatment/applied-behavior-analysis-aba>.

¹⁰ Autismspeaks.org, *Applied Behavior Analysis (ABA)*, <http://www.autismspeaks.org/what-autism/treatment/applied-behavior-analysis-aba>.

¹¹ WebMD, *Autism Therapies: ABA, RDI, and Sensory Therapies*, <http://www.webmd.com/brain/autism/autism-therapies-aba-rdi-and-sensory-therapies>.

¹² Special Learning, *Cost of ABA Therapy*, http://www.special-learning.com/article/Cost_of_ABA_Therapy.

¹³ Special Learning, *Cost of ABA Therapy*, http://www.special-learning.com/article/Cost_of_ABA_Therapy.

ABA treatment is most effective if it begins when children are younger than 5, although older children with autism can also benefit.¹⁴ There have been more than 100 research articles documenting the use of applied behavior analysis principles to teach new skills to children with autism over the age of five.¹⁵ Most of these studies were not comprehensive programs, but rather focused on one issue (e.g., one skill to develop or one behavior to change). Research shows that applied behavior analysis procedures have been used effectively in many intervention programs to address the needs of a variety of populations and diagnoses (e.g., teaching children to read, helping adults quit smoking, increasing productivity of a business, etc.). The National Research Council's 2001 book *Educating Children with Autism* addresses interventions for adolescents and adults. The book points out, "A number of interventions have demonstrated that adolescents or adults with autism can be taught purchasing skills and other community living skills, such as ordering food in a restaurant."

Carrier Responses:

According to responses received from Maine insurance carriers, they cover the following services for the treatment of autism spectrum disorders to the extent required by Maine law:

- Any assessments, evaluations or tests by a licensed physician or psychologist to diagnose whether a covered individual has an autism spectrum disorder.
- Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary, to develop, maintain and restore the functioning of an individual to the extent possible. To be covered by the insurance plan, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts.
- Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker.
- Therapy services provided by a licensed speech therapist, occupational therapist or physical therapist.
- Prescription drugs in the same manner as provided for the treatment of any other illness or condition if the insurance plan includes outpatient prescription drug coverage.

Consumer complaints received by the Bureau regarding denial of treatment for autism spectrum conditions have all related to self-insured plans and are not subject to the current mandate or LD 347.

¹⁴ WebMD, *Autism Therapies: ABA, RDI, and Sensory Therapies*, <http://www.webmd.com/brain/autism/autism-therapies-aba-rdi-and-sensory-therapies?page=2>.

¹⁵ Rudy, Lisa J, *Can Applied Behavioral Analysis (ABA) Improve Adolescent and Adult Autism?* <http://autism.about.com/od/allaboutaba/f/ABAadults.htm>.

CIGNA stated that they do not apply age, dollar, or visit limits on ABA therapy, nor on speech/ physical/ occupational therapy in Maine because they believe it is prohibited under the federal mental health parity regulations. Of 4,218 claims billed at \$1.7 million, \$463,571 was paid in 2012.

Anthem replaced the \$36,000 annual limit with a quantitative visit limit of 360 hourly sessions in the group market and 1,450 15-minute sessions or 360 hourly sessions in the individual market.

Aetna stated ABA is covered up to the mandated calendar year dollar maximum up to the mandated age, when precertified as medically necessary. When federal mental health parity applies, ABA services are not limited to the calendar year maximum, but require precertification and medical necessity review. There were a total of 2,187 claims processed by Aetna for diagnosis and/or treatment for autism spectrum disorders during 2012 in Maine. There were 634 claims that were not paid. Denials were due to out-of-network providers, lack of medical necessity, experimental or investigational service and hours for ABA exceeding those preauthorized.

Harvard Pilgrim stated that in accordance with the ACA, they removed dollar limits on ABA and replaced them with a standard number of visits allowed per plan.

MEGA noted that ABA must be provided by a person who is professionally certified by a national board of behavior analysts, or preformed under the supervision of a provider professionally certified by a national board of behavioral analysts.

Financial Impact:

Carriers were requested to provide an estimate of the cost of extending the coverage of autism from age 5 to age 21. The following table summarizes the survey results (the amounts included assume no restriction in costs for ABA).

Estimated Premium Increase PMPM			Percent of Premium
Carrier	Individual	Group	
Anthem	\$3.00	\$3.00	
Aetna		\$1.60	
Cigna		\$0.74	0.2%
Harvard Pilgrim	\$0.30-0.50	\$0.30-0.50	0.1%
UnitedHealth		\$0.00	

NovaRest, Inc. estimates that the approximate premium increase resulting from LD 347 would be \$1.48 per member per month (PMPM), or 0.4% of premium.

The ACA requires states to subsidize the cost of mandated benefits not included in the Essential Health Benefits (EHB). Since the EHB plan currently covers this benefit to age 5, the benefit not covered by the EHB plan would be for individuals over age 5. The EHB plan in Maine required at least 60 visits for habilitative or rehabilitative services, which could be interpreted to include ABA services.

Maine will be required to pay both a portion of the premium for consumers eligible for federal premium subsidies and the cost of reduced cost-sharing for federally subsidized individuals for any additional mandates. It is estimated that there will be 38,000 federally subsidized individuals in Maine.¹⁶ The cost to the state includes the reduced cost-sharing as well as premium. The cost-sharing varies by income level so we used an estimate of 10% of allowed claims cost-sharing. Using these assumptions, the approximate cost to the state for all subsidized members could be up to \$742,000 per year. Guidance after 2015 has not been released and it is possible that HHS will broaden the definition of what benefits have to be subsidized even if they are in the EHB plan.

UPDATE: A recent email from CMS/CIIO (Centers for Medicare and Medicaid Services/Center for Consumer Information & Insurance Oversight) stated that amending a law that was initially enacted prior to 2012 to expand the applicable age would not be enacting a law that establishes a new requirement (a new mandate) to offer a new benefit. Therefore, Maine would not be required to pay the additional premium due to expanding the current mandate.

Some states have already reacted to reduce costs required under the ACA for mandated benefits by:

- 1) not requiring mandated benefits above the EHB benefits for plans on the insurance exchange;
- 2) determining that autism is covered under the mental health parity that is part of EHB;
- 3) only requiring the mandate for large groups; or
- 4) finding outside funding such as new insurer fees.

The ACA eliminated the ability of carriers to impose an annual dollar limit of \$36,000 for applied behavior analysis under Maine's mandate for individual and small group plans. A state can still permit an insurer to put limits on the number of actuarially equivalent services provided, according to the Silver State exchange legislative analysts.¹⁷ Also, carriers can limit the number of services based on medical opinion of the number of services that are medically necessary. We believe the additional cost would be less because LD 347 would only impact individuals ages

¹⁶ Gorman report, "The Impact of the ACA on Maine's Health Insurance Markets."

¹⁷ Bell, *Nevada exchange eyes autism mandate bill*, <http://www.lifehealthpro.com/2013/03/26/nevada-exchange-eyes-autism-mandate-bill?page=2>, (2013).

6 to 21, who typically would not use the maximum number of treatment hours due to time in school and other activities.

The ACA contains provisions for individuals with pre-existing conditions including autism. New individual health insurance plans are no longer allowed to deny, limit, or exclude anyone based on a pre-existing condition, including children on the autism spectrum.¹⁸

Alternatives:

Anthem indicated its view that the efficacy of ABA therapy beyond age 5 has not been established.

Two carriers pointed out that the federal Individuals with Disabilities in Education Act (IDEA) requires school districts to provide disabled students with a “free appropriate public education.” School-age autistic children up to age 21 receive services in schools, as required by IDEA, to help them learn in an appropriate fashion despite their developmental disability. The implication of the carriers is that the mandate is not needed because the schools are required to provide the services. We do not believe schools provide all services covered by LD 347.

Cost Shift:

MaineCare provided 2012 claims data for an autism spectrum diagnosis for those age 21 or under. Of the claims with a CPT (Current Procedural Terminology) code that indicated the individual also had third party coverage (other health coverage) the claims totaled just under \$180,000. Of the total, about \$30,000 were for ages 1-5 and would not be affected by the proposed mandate. Coverage for many of the services listed could be required by the mental health parity or habilitative benefits in new ACA plans. None of the claims coded as ABA treatment indicated that the individual also had private insurance. There were a number of claims for speech and occupational therapy totaling \$14,400 that could result in some claims shift if the autism mandate were expanded to age 21 and under. It is impossible to determine an individual’s eligibility for private insurance from the claims data unless the claims are coded with third party coverage. The third party indicator includes self-insured plans that are not subject to state mandates. We would estimate a minimal (less than \$108,000) cost shift, based on an assumption that only 60% of coverage would be affected by the proposed mandate (with 40% self-insured).

This review was a collaborative effort of NovaRest, Inc., an actuarial consulting firm, and the Maine Bureau of Insurance.

¹⁸ U.S. Department of Health & Human Services, *The Affordable Care Act and Autism and Related Conditions*, www.hhs.gov/autism/factsheet-aca-autism.html#UgPC2dbn-_Y (2001).

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

LD 347, 126th Maine State Legislature
An Act to Reform Insurance Coverage to Include Diagnosis for Autism Spectrum Disorders

SENATE

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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 347, An Act to Amend Insurance Coverage for Diagnosis of Autism Spectrum Disorders.**

A copy of the bill 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 autism spectrum disorders is included in the State's essential benefits package and the manner in which the bill may expand this coverage;
- 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 the federal Affordable Care Act on the ability of carriers to impose an annual dollar limit of \$36,000 for applied behavior analysis; and
- The impact of the federal Affordable Care Act's provisions for cost-sharing in qualified health plans on existing coverage of autism spectrum disorders and the expanded coverage required by the bill.

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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 Treadwell
House Chair

cc: Sen. Colleen Lachowicz

An Act To Amend Insurance Coverage for Diagnosis of Autism Spectrum Disorders

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

Sec. 1. 24-A MRSA §2768, sub-§2, as reallocated by PL 2011, c. 420, Pt. A, §24, is amended to read:

2. Required coverage. All individual health insurance policies and contracts must provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is §21 years of age or under in accordance with the following.

A. The policy or contract must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder.

B. The policy or contract must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually.

C. The policy or contract may not include any limits on the number of visits.

D. The policy or contract may limit coverage for applied behavior analysis to \$36,000 per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy or contract. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy or contract.

Sec. 2. 24-A MRSA §2847-T, sub-§2, as reallocated by PL 2011, c. 420, Pt. A, §26, is amended to read:

2. Required coverage. All group health insurance policies, contracts and certificates must provide coverage for autism spectrum disorders for an individual covered under a policy, contract or certificate who is §21 years of age or under in accordance with the following.

A. The policy, contract or certificate must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder.

B. The policy, contract or certificate must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to

demonstrate ongoing medical necessity for coverage provided under this section at least annually.

C. The policy, contract or certificate may not include any limits on the number of visits.

D. Notwithstanding section 2843 and to the extent allowed by federal law, the policy, contract or certificate may limit coverage for applied behavior analysis to \$36,000 per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy, contract or certificate. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy, contract or certificate.

Sec. 3. 24-A MRSA §4259, sub-§2, as reallocated by PL 2011, c. 420, Pt. A, §27, is amended to read:

2. Required coverage. All individual and group health maintenance organization contracts must provide coverage for autism spectrum disorders for an individual covered under a contract who is 521 years of age or under in accordance with the following.

A. The contract must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder.

B. The contract must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually.

C. The contract may not include any limits on the number of visits.

D. Notwithstanding section 4234-A and to the extent allowed by federal law for group contracts, the contract may limit coverage for applied behavior analysis to \$36,000 per year. A health maintenance organization may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the contract. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the contract.

Sec. 4. Application. The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014. For purposes of this Act, all contracts are deemed to be renewed no later than

the next yearly anniversary of the contract date.

SUMMARY

This bill expands health insurance coverage for autism spectrum disorders to persons 21 years of age and under. Current law requires coverage for only those 5 years of age and under. The bill applies to individual, group health and group health maintenance organization insurance policies, contracts and certificates issued or renewed on or after January 1, 2014.

Appendix B: Maine Applied Behavior Analysis Providers

Name	City	Certification	Maine License Type
Barnes, Susan	Gray	BCBA	
Beardsley, Erin	Windham	BCBA	
Bentley, Mary	New Gloucester	BCBA	
Boivin, Nicole	Limerick	BCBA	Speech
Bowie, Pamela	Mount Desert	BCBA	
Brophy, Laurie	Waterville	BCBA	Social Work
Brown, Russell	Waterford	BCBA	Social Work & pending Alcohol & Drug counselor
Cameron, Elizabeth	Cape Elizabeth	BCBA-D	
Campbell, Eric	Portland	BCBA	
Close, Jillian	Auburn	BCBA	
Conley, Erin	South Portland	BCBA	
Conley, Jill	Bangor	BCaBA	
Constantine, Amy	Auburn	BCBA	
Cote, Catherine	Lewiston	BCBA	
Couture, Nicole	Gray	BCBA	
Crowder, Helki	Lisbon Falls	BCaBA	
Dana, Terese	Fryeburg	BCaBA	
English, Larrie	Old Orchard Beach	BCBA	
Ferretti, Marcy	Kennebunk	BCBA	
Foley-Ingersoll, Colleen	North Yarmouth	BCBA	
Fredericks, Kelly	Cape Elizabeth	BCBA	
Funk Schliestett, Kristina	Eliot	BCBA	
Geren, Mark	Yarmouth	BCBA	
Gilliam, Colleen	Wiscasset	BCaBA	Social Work
Goguen, Olivia	Limington	BCBA	
Golonka, Adam	Yarmouth	BCBA	
Grebouski, Thomas	Berwick	BCBA-D	Counselors--pending
Grindle, Shayna	Trenton	BCBA	
Grondin, Betsy	Falmouth	BCBA	
Guimond, Iris	Fort Kent	BCBA	
Guptill, Derek	Denmark	BCaBA	
Hamlin, Nicole	Kennebunk	BCBA	
Haskell-Lehigh, Tiffany	Windham	BCBA	
Hathaway, Michelle	Leeds	BCBA	
Hauber Wall, Lynda	Richmond	BCaBA	
Hinton, Nichole	Bath	BCaBA	

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Hurst, Cheri	Brunswick	BCBA	
Jefferson, Gretchen	Portland	BCBA-D	Psychology--pending
Johnson, Paul	Fort Fairfield	BCBA-D	Psychology
Jones, Aaron	Bath	BCBA	
Keyser, Lisa	Levant	BCBA	
Kimball, Jonathan	Georgetown	BCBA-D	
Kinney, Elisabeth	Hallowell	BCBA	
LaFlamme, Cheryl	Lewiston	BCBA	
McAvoy, Matthew	Lewiston	BCBA	
Moran, David	South China	BCBA	
Mozzoni, Michael	Fryeburg	BCBA-D	
Nau, Paul	Brunswick	BCBA-D	
Nazaroff, Christine	Minot	BCBA	Speech
Newcomb, Erin	Bowdoin	BCaBA	
ORLANDO, LINDA	BREWER	BCBA	Social Work
Pacholski, Courtney	China	BCBA	
Parent, Janet	South Berwick	BCBA	
Payeur, Lindsay	Saco	BCBA	
Pelletier, Kelly	Portland	BCBA	
Perry, Lora	Georgetown	BCBA	
Perry, Ariana	Hiram	BCaBA	
Poulsen, April	Orono	BCBA	
Prager, Kevin	Bath	BCBA	
Pratt, Jamie	Yarmouth	BCBA-D	Psychology
Rabe, Marian	Bridgton	BCBA	
Richard, Megghan	Windham	BCBA	
Sanborn, Tami	Blue Hill	BCBA	
Sastre, Sheri	Saco	BCBA	
Scamman, Mary	Scarborough	BCBA	Psychology
Schwalm, Jedediah	Rockland	BCBA	
Small, Cathleen	South Portland	BCBA-D	Psychology
Soucy-Camire, Johanne	Old Orchard Beach	BCBA	
Steege, Lisa	Gorham	BCBA	
Steege, Mark	Gorham	BCBA-D	Psychology
Teske, Sarah	Eliot	BCBA	
Thibadeau, Susan	Carrabassett Valley	BCBA-D	Psychology
Tomasello, Allen	Bremen	BCaBA	
Treworgy, Jamie	Hampden	BCBA	
Vincent, Seth	Auburn	BCBA	

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Appendix C: Cumulative Impact of Mandates

Bureau of Insurance

Cumulative Impact of Mandates in Maine

Report for the Year 2012

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.

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 .	All Contracts	0.70%
1975 1983 1995 2003	Benefits must be included for Mental Health Services , including psychologists and social workers.	Groups	3.30%
		Individual	3.30%
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. HMOs must allow limited self-referred for chiropractic benefits.	Group	1.0%
		Individual	0.50%
1990 1997	Benefits must be made available for screening mammography .	Group	0.71%
		Individual	0.71%
1995	Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%
1995	Must provide coverage for metabolic formula and up to \$3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%
1996	If policies provide maternity benefits, the maternity (length of stay) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care."	All Contracts	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat diabetes and approved self-management and education training.	All Contracts	0.20%
1996	Benefits must be provided for screening Pap tests .	All	0.01%
1996	Benefits must be provided for annual gynecological exam without prior approval of primary care physician.	Group managed care	0
1997	Benefits provided for breast cancer treatment for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%
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%

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1999	Coverage of nurse practitioners and nurse midwives and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts	0
1999	Prescription drug must include contraceptives .	All Contracts	0.80%
1999	Coverage for registered nurse first assistants .	All Contracts	0
2000	Access to clinical trials .	All Contracts	0.19%
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
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%
	Total cost for groups larger than 20:		8.11%
	Total cost for groups of 20 or fewer:		8.16%
	Total cost for individual contracts:		7.66%