



Bureau of Insurance

A Report to the Joint Standing Committee on Banking and Insurance of the 123rd Maine Legislature

Review and Evaluation of LD 1667, An Act To
Require Health Insurance to Provide Coverage for
Nutritional Wellness and Prevention

October 2007

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I. Executive Summary

The Joint Standing Committee on Banking and Insurance of the 123rd Maine Legislature directed the Bureau of Insurance to review LD 1667, An Act To Require Health Insurers to Provide Coverage for Nutritional Wellness and Prevention. The review was conducted as required by 24-A M.R.S.A., § 2752. This review was a collaborative effort of NovaRest, Inc. and the Maine Bureau of Insurance (the Bureau).

LD 1667 would require all individual and group health insurance policies issued or renewed on or after January 1, 2008 to provide coverage of “nutritional wellness and prevention measures that have been shown to be beneficial to an enrollee’s health when used as directed by the manufacturer or manufacturer’s representative.” Nutritional wellness and prevention products are defined in the legislation as; “nutritional measures and products, including dietary supplements, whose primary purposes are to enhance health, improve nutritional intake, strengthen the immune system, cleanse the body of toxins, address specific health needs and aid in resisting disease”. This language is quite broad and could be interpreted to include all over-the-counter (OTC) medications. OTC medications include pain relievers, antacids, diarrhea medications, diuretics, diet treatments, allergy medications, smoking cessation, and many other products.

In 2006, the average person in the United States spent \$15.70 a year on dietary supplements. Additionally, the average person in the United States in 2000 spent approximately \$68¹ on OTC medicines per year. With inflation, this would translate to over \$95 person for OTC medications and \$16 in dietary supplements in 2007, for a total of over \$100 a year or over \$9 a month. The actual cost could increase significantly if items not included in the definition of OTC medication or dietary supplements were covered by the act. An example would be Lactaid, a product for individuals with lactose intolerance.

A survey of other states failed to discover any state with legislation similar to LD 1667.

A survey of the major health insurers in Maine indicates that none cover nutritional products or dietary supplements as proposed by LD 1667. The insurers surveyed include Aetna, Anthem Blue Cross Blue Shield of Maine, CIGNA, and Harvard Pilgrim Health Care. Most insurers were not able to estimate the cost of the mandate due to lack of information and the broad language of the

¹ *OTC Tax Deductibility*; http://www.chpa-info.org/ChpaPortal/PressRoom/PositionPapers/OTC_tax_deductibility.htm



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act. Anthem Blue Cross and Blue Shield estimated the additional premium to cover the added benefit cost to be 0.2 % using an assumption that half the population takes vitamins or supplements at ten cents a piece 3.5 times a week. Aetna estimated 2% to 5% additional premium assuming the proposed mandate would include OTC medications. Insurers expressed concern that the language was very broad, which could lead to increased utilization for the products covered by this act.

We estimate that the minimum increase in premium due to this act would be 2.8% if OTC medications were included or 0.41% if OTC medications were not included. The impact could be more if additional products were covered by the act or if there were significant increases in utilization due to the impact of insurance coverage.

The premium increase estimated for LD 1667 when combined with large renewal increases would intensify the consumer's sensitivity to health insurance costs.



II. Background

The Joint Standing Committee on Banking and Insurance of the 123rd Maine Legislature directed the Bureau of Insurance to review LD 1667, An Act To Require Health Insurers to Provide Coverage for Nutritional Wellness and Prevention. The review was conducted as required by 24-A M.R.S.A., § 2752. This review was a collaborative effort of NovaRest, Inc. and the Maine Bureau of Insurance (the Bureau).

LD 1667 would require all individual and group health insurance policies issued or renewed on or after January 1, 2008 to provide coverage of “nutritional wellness and prevention measures that have been shown to be beneficial to an enrollee's health when used as directed by the manufacturer or manufacturer's representative.” Nutritional wellness and prevention products are defined in the legislation as; “nutritional measures and products, including dietary supplements, whose primary purposes are to enhance health, improve nutritional intake, strengthen the immune system, cleanse the body of toxins, address specific health needs and aid in resisting disease”. This language is quite broad and could be interpreted to include all over-the-counter (OTC) medications. OTC medications include pain relievers, antacids, diarrhea medications, diuretics, diet treatments, allergy medications, smoking cessation, and many other products.

It is estimated that 42%² of Americans take a dietary supplement and 77%³ use OTC medications.

Dietary supplements are believed to help provide a variety of benefits including reducing cold symptoms, reducing the symptoms of menopause, reversing the effect of aging, strengthening the immune system, increasing bone density, and many more. Dietary supplement production is a rapidly growing industry with approximately \$4.7 billion in sales in 2006⁴. In Utah alone, the Utah Natural Products Alliance says there are more than 130 dietary supplement companies with total sales between \$2.5 to \$4 billion a year.⁵ Nutritional products or dietary supplements are

² Herbal, nutritional supplements linked to side effects ranging from dry eye to retinal hemorrhages and transient visual loss; *Medical Research News*, Oct 13, 2004, <http://www.news-medical.net/?id=5569>.

³ OTC Tax Deductibility, http://www.chpa-info.org/ChpaPortal/PressRoom/PositionPapers/OTC_tax_deductibility.htm.

⁴ Reported by Mind Branch, a market research company; <http://www.mindbranch.com/Nutritional-Supplements-R567-609/>, Nov 2006.

⁵ Nutritional supplements are Utah's third largest industry; <http://deseretnews.com/dn/view/0,1249,600135508,00.html>, May 21, 2005; <http://www.newstarget.com/008034.html>



distributed through specialty nutrition stores, grocery stores, drug stores, direct distribution through multi-level distributing networks, internet web sites, etc.

The cost of nutritional products or dietary supplements varies as much as their use. Some supplements can cost pennies a day while others can cost \$100 a month or more. The cost per person in 2006, based on census data, is around \$16, but there is a wide variation from person to person in use of nutritional products or dietary supplements and therefore the amount spent on them.

In October 1994, an amendment to the Federal Food, Drug, and Cosmetic Act, created a new regulatory framework for the safety and labeling of dietary supplements⁶. Under the law, dietary supplement manufacturers are responsible for determining that the dietary supplements are safe. The FDA does not test or approve dietary supplements as it does pharmaceutical products. The only responsibility that the manufacturer has is to provide information to the FDA on safety and effectiveness testing for a product, if there is a new dietary ingredient included in the product. A dietary supplement cannot be advertised as a treatment or cure for a specific disease.

OTC medications are another category of products that could be covered by this act. In January 2001, Consumer Healthcare Products Association (CHPA)⁷ commissioned a survey of OTC product usage by Roper Starch Worldwide⁸. As reported; “this survey of 1,505 adults revealed a more empowered American public. Findings included the following:

- 59% reported they would be more likely to treat to their own health conditions now than they were a year ago.
- 73% would rather treat themselves at home than see a doctor, and six in 10 say they would like to do more of this in the future; and
- 77% of consumers used an OTC medication in the past year (compared to 43% who consulted a physician and 38% who took a prescription medication).”

OTC sales were approximately \$19 billion in 2000. CHPA points out that “Nonprescription, or OTC, medicines not only treat the symptoms of everyday ailments such as the common cold, fever, and flu, but also can manage recurring conditions such as migraine headaches, minor pain from arthritis, allergies, vaginal yeast infections, and non-ulcer dyspepsia (non-severe heartburn). The growing list of OTCs conveniently available to consumers include: formerly prescription

⁶ Overview of Dietary Supplements; <http://www.cfsan.fda.gov/~dms/supplmnt.html>

⁷ CHPA is an organization that promotes the use of OTC medicines; <http://www.chpa-info.org/ChpaPortal/AboutCHPA/>

⁸ OTC Tax Deductibility; http://www.chpa-info.org/ChpaPortal/PressRoom/PositionPapers/OTC_tax_deductibility.htm



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smoking cessation, antihistamine, proton pump inhibitor (for the prevention of frequent heartburn), antifungal, and pediatric analgesic/decongestant combination products. Aspirin with professional labeling has been shown to be effective in preventing secondary heart attacks and frequent applications of sunscreens are recommended to prevent skin cancer.”⁹

Proponents have provided anecdotal information concerning the personal benefit from some dietary supplements. Only one of the proponents commented on their inability to pay for the dietary supplements without insurance coverage.

Opponents of LD 1667 are concerned about the lack of FDA oversight and the potential large increase in utilization if the supplements are covered by insurance.

⁹ *OTC Tax Deductibility*; http://www.chpa-info.org/ChpaPortal/PressRoom/PositionPapers/OTC_tax_deductibility.htm



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.*

In general, it is estimated that 42%¹⁰ of Americans take a dietary supplement and 77%¹¹ use OTC medications, but the language of this act is very broad. As written, almost every household in the state could use some type of product that is “intended to supplement the diet and contains one or more dietary ingredients, including, but not limited to, vitamins, minerals, herbs, botanicals, amino acids, concentrates, metabolites, extracts and other substances and their constituents”. These products are expected to “be beneficial to an enrollee’s health when used as directed by the manufacturer or manufacturer’s representative”.

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

The covered products are readily available to the population.

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

None of the insurers surveyed currently cover nutritional products or dietary supplements.

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.*

One of the proponents commented on their inability to pay for the dietary supplements without insurance coverage. No other information is available.

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

¹⁰ Herbal, nutritional supplements linked to side effects ranging from dry eye to retinal hemorrhages and transient visual loss; <http://www.news-medical.net/?id=5569>

¹¹ OTC Tax Deductibility; http://www.chpa-info.org/ChpaPortal/PressRoom/PositionPapers/OTC_tax_deductibility.htm



unreasonable financial hardship.

Based on the estimate of the current spending on nutritional products or dietary supplements and OTC drugs, the average cost per person on average would be more than \$100 per year or \$9 a month, but cost varies significantly depending on the product and the utilization. If an individual wanted to purchase some of the more expensive dietary supplements, the cost could exceed \$100 a month.

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

Nationally, it is estimated that 42% of the population uses a dietary supplement¹² and 77% use OTC medications.

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

It is unclear what the level of demand for insurance coverage of nutritional products or dietary supplements is. Three individuals from the public provided testimony describing the health benefits from taking a dietary supplement.

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.*

A survey of other states failed to discover any state that had legislation similar to LD 1667.

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.*

¹² Herbal, nutritional supplements linked to side effects ranging from dry eye to retinal hemorrhages and transient visual loss; <http://www.news->



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

11. *Alternatives to meeting the identified need.*

No alternatives to meeting the need have been identified.

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

The requirements of LD 1667 are inconsistent with the role of health insurance as it is typically provided. Typically, health insurance only covers procedures or products that have been proven effective. Most procedures and products covered by insurance must be recommended or approved by the medical community. This would include being tested and approved by the FDA or recommended by a professional organization specializing in the treatment of specific medical conditions. Although many OTC medications have medical endorsements, and may have previously been approved by the FDA, many dietary supplements lack the evidence usually required for medical recommendation.

Managed care is generally provided through contracts with providers and pharmacies and that could be problematic with the variety of distribution methods for supplements and OTC drugs.

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

There is little or no social stigma attached to having coverage for nutritional products or dietary supplements.

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

There is anecdotal evidence that nutritional products or dietary supplements can have a positive impact on some conditions that typically require much more intensive treatment. From the opposite perspective, it is reported that some nutritional products or dietary supplements can cause severe medical problems or



side effects, which would increase the use of other medical benefits.¹³

In one study, for 12 ailments analyzed, every dollar spent on OTCs yielded \$2.47 in healthcare value, taking into account savings versus the cost of a doctor visit, lost time from work, and the cost of prescription drugs (Kline & Company 1997).¹⁴

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.*

There is no evidence that this benefit is currently being offered by employers with self-insured plans.

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

Based on Anthem Blue Cross and Blue Shield of Maine's response, the state employee plan does not currently provide coverage for nutritional and dietary supplements for the purpose of nutritional wellness and prevention. Anthem Blue Cross Blue Shield of Maine estimates the impact on the Maine State Employees Health Insurance Program to be 0.2% similar to their other plans.

¹³ Herbal, nutritional supplements linked to side effects ranging from dry eye to retinal hemorrhages and transient visual loss; <http://www.news-medical.net/?id=5569>

¹⁴ OTC Tax Deductibility; http://www.chpa-info.org/ChpaPortal/PressRoom/PositionPapers/OTC_tax_deductibility.htm



IV. Financial Impact

B. Financial Impact of Mandating Benefits.

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

The impact on the cost of products from having nutritional products or dietary supplements covered by insurance is not known at this time, but in general when medical services are covered by insurance it increases demand and reduces price sensitivity, resulting in an increase in the cost of the service.

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.*

It is likely that LD 1667 would increase the use of nutritional products or dietary supplements since the cost to the consumer would become much smaller. With nutritional products or dietary supplements, there is also a possibility that they would be used as a replacement for traditional medical services. It is difficult to judge whether such use is appropriate or inappropriate due to the scarcity of reliable studies.

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

It is possible that mandated nutritional products or dietary supplements would serve as an alternative for more expensive alternatives, but possible complications from the use of nutritional products or dietary supplements may result in the need for additional medical services to treat the side effects.

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

LD 1667 does not specifically prohibit health plans from requiring prior



authorization for coverage of nutritional products or dietary supplements in the same manner that prior authorization is required for prescription medications through the use of prescriptions, but it is possible that health plans would not require a doctor visit for the prior authorization of this benefit.

The act does not preclude copays or other types of cost-sharing that may decrease the over-utilization of the benefit.

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

It is unlikely that this LD 1667 would affect the number or types of providers of nutritional products or dietary supplements, but it may increase the number of distributors. Besides increasing the number of specialty stores, it may increase the interest in multi-level marketing mechanisms currently used to market a number of nutritional products or dietary supplements. If the product being distributed were covered by insurance, more individuals might be interested in starting a business marketing these nutritional products or dietary supplements.

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.*

Most insurers surveyed were not able to estimate the cost of the mandate due to lack of information and the broad language of the act. Anthem Blue Cross and Blue Shield estimated the additional premium to cover the added benefit cost to be 0.2 % using an assumption that half the population takes vitamins or supplements at ten cents a piece 3.5 times a week. Aetna estimated 2% to 5% additional premium assuming the proposed mandate would include OTC medications. Insurers expressed concern that the language was very broad, which could lead to increased utilization for the products covered by this act.

In 2006, the average person in the United States spent \$15.70 a year on dietary supplements. Additionally, the average person in the United States in 2000 spent



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approximately \$6815 on OTC medicines per year. With inflation, this would translate to over \$95 per person for OTC medications and \$16 in dietary supplements in 2007, for a total of over \$100 a year or over \$9 a month. The actual cost could increase significantly if items not included in the definition of OTC medication or dietary supplements were covered by the act. An example would be Lactaid, a product for individuals with lactose intolerance.

The premium increase would depend on the interpretation as to what is included as a covered product, the cost sharing assigned to these products, and any resulting increase in utilization or price of products resulting from them being covered by insurance. Until these factors are known, we can only estimate the impact on premiums. Using an estimated average product cost of \$9.29 PMPM, an average premium of \$316 PMPM and a 20% cost sharing, the premium increase is estimated to be at least 2.8% of premium for the OTC medications and dietary supplements before any utilization increase. If additional supplemental food products were included or if the price of covered products is driven up, the impact on premiums would be significantly higher. The premium impact without the OTC medications is estimated to be at least 0.4%.

These estimates do not include the effect of increased utilization, which we cannot quantify but which would almost certainly occur unless carriers imposed strict utilization review standards. Strict utilization review standards might reduce the estimated claims but would also increase administrative expenses. Utilization increases would be most pronounced for the more expensive supplements since these are most likely to have current utilization levels suppressed due to their cost.

The insurers surveyed did not anticipate a large increase in administrative costs, but we believe that the processing of receipts from grocery stores, drug stores, internet purchases, etc. is outside of the current insurer claims process. The vast majority of products and services processed by health insurance claim payments systems have standard codes associated with them that allow the systems to

¹⁵ *OTC Tax Deductibility*; http://www.chpa-info.org/ChpaPortal/PressRoom/PositionPapers/OTC_tax_deductibility.htm



automatically determine if the product or service is covered by the insured's benefit package. Claims for the products covered by LD 1667 would have to be manually reviewed to verify that the products included in the claim were covered. Unfamiliar products, such as those purchased over the internet or from multi-level distributors, would have to be researched to verify that they were dietary supplements and not topical treatments (creams, gels etc.) or other non-covered treatments.

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 would 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.*

The total cost of health care would be increased as utilization of OTC medications and dietary supplements is increased. This increase in utilization would almost certainly happen to some extent due to the reduced cost of the products to the insured and price increases may also result.

It is possible that mandated nutritional products or dietary supplements would prevent diseases or illnesses resulting in a net decrease in health care costs. In one study, for 12 ailments analyzed, every dollar spent on OTC medications yielded \$2.47 in healthcare value, taking into account savings versus the cost of a doctor visit, lost time from work, and the cost of prescription drugs (Kline & Company 1997).¹⁶ On a more macro level, it is not currently possible to estimate the net impact on health care costs alone. Also, to the extent OTC medications and dietary supplements are already used, insurance coverage would not produce any new savings. Any potential savings would come from increased utilization of

¹⁶ *OTC Tax Deductibility*; http://www.chpa-info.org/ChpaPortal/PressRoom/PositionPapers/OTC_tax_deductibility.htm



these products.

9. *The effects 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.*

It is estimated that LD 1667 would, on average, increase premiums for health plans that do not currently comply with LD 1667, by at least 2.4% or 0.35% without the coverage of OTC medications. Employers would pay this additional premium, as would employees to the extent the cost is passed on through the employee's contribution to the premiums. There is no reason that the estimated percentage premium increase would vary for small employers, medium-sized employers and large employers.

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.*

Primarily, the products covered by this mandate are not currently covered by MaineCare. Therefore, it is unlikely that there would be a shift of cost from the public to the private sector.



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.*

Since there is no requirement to prove effectiveness of nutritional products or dietary supplements, there is little research demonstrating the medical efficacy of nutritional products or dietary supplements. Some research is being done by independent organizations, but none that we found compared the efficacy of the nutritional products or dietary supplements to that of current medical treatments, which would indicate a potential improvement of the quality of care.

Some OTC drugs once required a prescription and therefore these products have medical evidence demonstrating their efficacy and the improved patient health from their use.

2. *If the legislation seeks to mandate coverage of an additional class of practitioners:*
 - a. *The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.*

LD 1667 would not require an additional class of practitioners.

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

LD 1667 would not require an additional class of practitioners.



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.*

Many of these products are elective and their medical efficacy is not proven. If premiums were increased to cover these products, the additional cost might force individuals and employers to drop coverage. This would result in an increase in the uninsured and the inability of those uninsured to access needed medical care.

Minimally, mandating the insurance coverage of these products would result in shifting the cost of high users of higher cost dietary supplements to the rest of the insured population.

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 not practical to offer this coverage as an option for individual policyholders since only the policyholders purchasing large amounts of nutritional products or dietary supplements would purchase the optional coverage. The result would be that the premium for the optional coverage would be higher than the average cost of the products when administrative costs were added.

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

The Bureau's estimates of the premium increases due to existing mandates and the proposed mandate are displayed in Table B.



TABLE B MAXIMUM MEDICAL PREMIUM INCREASES			
	Group (more than 20 employees)	Group (20 or fewer employees)	Individuals
CURRENT MANDATES			
▪ Indemnity Plans	8.64%	4.27%	3.55%
▪ Managed Care Plans	7.51%	5.70%	3.58%
LD 1667			
▪ Fee-for-Service Plans	2.8%	2.8%	2.8%
▪ Managed Care Plans	2.8%	2.8%	2.8%
CUMULATIVE IMPACT			
▪ Fee-for-Service Plans	11.44%	7.07%	6.35%
▪ Managed Care Plans	10.31%	8.50%	6.38%

If OTC drugs and dietary supplements were covered with no increase in utilization, the premium impact could be as low as 2.8% or 0.41% without the OTC medications. If the scope also includes supplemental foods such as Lactaid or if utilization and price are driven up, the cost could be significantly more.

The increases due to existing mandates for mental health, substance abuse, chiropractic, and screening mammography are based on the estimated portion of claim costs that the mandated benefits represent, as detailed in Appendix B. The true cost impact is less than this for two reasons:

1. Some of these services would likely be provided even in the absence of a mandate.
2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering surgical treatments may fix a problem earlier and reduce the ongoing use of other treatments that could be used, if surgery was not an option. The cost impact is the net result of the cost of the more expensive treatment and the reduction in the utilization of less expensive treatments.



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While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time.



III. Appendices



Appendix A: Letter from the Committee on Banking and Insurance with Proposed Legislation



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NANCY B. SULLIVAN, DISTRICT 4, CHAIR
PETER B. BOWMAN, DISTRICT 1
LOIS A. SNOWE-MELLO, DISTRICT 15



COLLEEN MCCARTHY REID, LEGISLATIVE ANALYST
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DAVID C. SAVAGE, FALMOUTH

STATE OF MAINE

ONE HUNDRED AND TWENTY-THIRD LEGISLATURE

COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

July 31, 2007


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 the Bureau of Insurance prepare a review and evaluation of **LD 1667, An Act to Require Health Insurers to Provide Coverage for Nutritional Wellness and Prevention**. A copy of the bill is enclosed.

Please prepare the evaluation using the guidelines set out in Title 24-A § 2752 and submit the report to the committee by October 26, 2007 so the committee can take final action on LD 1667 before the December 7, 2007 deadline set by the presiding officers. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,


Nancy B. Sullivan
Senate Chair


John R. Brautigam House Chair

cc: Members, Insurance and Financial Services Committee

1 **123nd MAINE LEGISLATURE**

2 **First Regular Session**

3

Legislative Document

No. 1667

4

H.P. 1176

5
6 **An Act To Require Health Insurers To Provide Coverage for Nutritional**
7 **Wellness and Prevention**

8

Referred to the Committee on Insurance and Financial Services .

9
10 Presented by Representative TUTTLE of Sanford.

1
2
3 **An Act To Require Health Insurers To Provide Coverage for Nutritional**
4 **Wellness and Prevention**

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

6 **Sec. 1. 24-A MRSA §4316** is enacted to read:

7 **§ 4316. Coverage for nutritional wellness and prevention**

8
9 **1. Definitions.** As used in this section, unless the context otherwise indicates, the
10 following terms have the following meanings.

11
12 A. "Dietary supplement" has the same meaning as in the federal Dietary Supplement Health
13 and Education Act of 1994 and means a product, other than tobacco, that:

14
15 (1) Is intended to supplement the diet and contains one or more dietary ingredients,
16 including, but not limited to, vitamins, minerals, herbs, botanicals, amino acids,
17 concentrates, metabolites, extracts and other substances and their constituents;

18
19 (2) Is intended for ingestion in pill, capsule, tablet or liquid form;

20
21 (3) Is not represented for use as a conventional food or the sole item of a meal or diet;
22 and

23
24 (4) Is labeled as a dietary supplement.

25
26 B. "Nutritional wellness and prevention" means nutritional measures and products,
27 including dietary supplements, whose primary purposes are to enhance health, improve
28 nutritional intake, strengthen the immune system, cleanse the body of toxins, address
29 specific health needs and aid in resisting disease.

30
31 **2. Required coverage.** A carrier shall provide coverage and reimburse for nutritional
32 wellness and prevention measures that have been shown to be beneficial to an enrollee's health
33 when used as directed by the manufacturer or manufacturer's representative.

34
35 **3. Application.** The requirements of this section apply to all policies, contracts and
36 certificates executed, delivered, issued for delivery, continued or renewed in this State. For
37 purposes of this section, all contracts are deemed to be renewed no later than the next yearly
38 anniversary of the contract date.

39 **Sec. 2. Application.** The requirements of this Act apply to all policies, contracts and

1 certificates executed, delivered, issued for delivery, continued or renewed in this State on or after
2 January 1, 2008. For purposes of this Act, all contracts are deemed to be renewed no later than
3 the next yearly anniversary of the contract date.

4
5

SUMMARY

6 The purpose of this bill is to improve health, reduce health care usage and costs and help
7 prevent disease through nutritional wellness and prevention measures and allow for
8 nonpharmacological alternatives to enrollees who choose them. The bill requires that health
9 insurance policies provide coverage for nutritional wellness and prevention that is shown to be
10 beneficial to the enrollee. The bill applies to all individual and group policies issued or renewed
11 on or after January 1, 2008.



Appendix B: Cumulative Impact of Mandates Cumulative Impact of Mandates in Maine

Following are the estimated claim costs for the existing mandates:

- ♦ ***Mental Health*** (Enacted 1983) – The mandate applies only to group plans. It applies to all group HMO plans but does not apply to employee group indemnity plans covering 20 or fewer employees. Mental health parity for listed conditions was effective 7/1/96 but does not apply to any employer with 20 or fewer employees, whether under HMO or indemnity coverage. The list of conditions for which parity is required was expanded effective 10/1/03. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. The percentage had remained in the 3.27% to 3.47% range from 1998 to 2002 but has decreased since then, reaching 2.90% in 2005. For 2005, this broke down as 2.62% for HMOs and 3.49% for indemnity plans. This decrease occurred despite the fact that an expansion of the list of conditions for which parity is required was fully implemented in 2005. Either the expansion has had no impact or the impact was offset by other factors such as the continuing shift from inpatient care to outpatient care. We estimate a continuation of 2005 levels going forward. For HMO plans covering employers with 20 or fewer employees, we use half the value for larger groups to reflect the fact that parity does not apply. Although it is likely that some of these costs would be 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. However, this overstatement is offset by the fact that the data is an aggregate of all groups, while groups of 20 or fewer are exempt from the parity requirement in the case of HMO coverage and from the entire mandate in the case of indemnity coverage.
- ♦ ***Substance Abuse*** (Enacted 1983) – The mandate applies only to groups of more than 20 and originally did not apply to HMOs. Effective 10/1/03, substance abuse was added to the list of mental health conditions for which parity is required. This applies to HMOs as well as indemnity carriers. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage showed a downward trend from 1989 to 2000 when it reached 0.31%. It then increased and leveled off at a range of 0.59% to 0.67% for 2002 through 2005 despite implementation of the parity requirement. The long-term decrease was probably due to utilization review, which sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 and leveled off at about 55% for 1999-2005. The 0.67% for 2005 broke down as 0.55% for HMOs and 0.93% for indemnity plans. We estimate substance abuse benefits to



remain at the current levels going forward. Although it is likely that some of these costs would be 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. However, this overstatement is offset by the fact that the data is an aggregate of all groups, while the mandate applies only to groups larger than 20.

- ***Chiropractic*** (Enacted 1986) – The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the percentage increased from 0.84% in 1994 to a high of 1.51% in 2000. Since then, it has decreased slightly to between 1.32% and 1.46% during 2001 to 2005. The level varies significantly between group and individual. The variation between HMOs and indemnity plans has decreased to an insignificant level. For 2005, the percentages for group plans were 1.46% for HMO plans and 1.30% for indemnity plans with an aggregate of 1.41%. For individual plans, it was 0.33% for HMO plans, and 0.71% for indemnity plans with an aggregate of 0.70%. We estimate the aggregate levels going forward. Although it is likely that some of these costs would be 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) – The amount of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.7% in 2002, decreasing slightly to 0.69% in 2005, which may reflect increasing utilization of this service followed by a leveling off. This figure broke down as 0.70% for HMO plans, 0.67% for indemnity plans. We estimate 0.69% in all categories going forward. Although it is likely that some of these costs would be 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.
- ♦ ***Dentists*** (Enacted 1975) – This mandate requires coverage 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) – At the time this mandate was being considered in 1995, Blue Cross and Blue Shield of Maine estimated the cost at \$0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.



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- ♦ ***Errors of Metabolism*** (Enacted 1995) – At the time this mandate was being considered in 1995, Blue Cross estimated the cost at \$0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.
- ♦ ***Diabetic Supplies*** (Enacted 1996) – Our report on this mandate indicated that most of the 15 carriers surveyed in 1996 said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost \$.08 per month for an individual. Another said .5% of premium (\$.50 per member per month) and a third said 2%. We include 0.2% in our estimate.
- ♦ ***Minimum Maternity Stay*** (Enacted 1996) – Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.
- ♦ ***Pap Smear Tests*** (Enacted 1996) – No cost estimate is available. HMOs would typically cover these anyway. For indemnity 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%.
- ♦ ***Annual GYN Exam Without Referral*** (managed care plans) (Enacted 1996) – This only affects HMO plans and similar plans. No cost estimate is available. To the extent the 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. We include 0.1%.
- ♦ ***Breast Cancer Length of Stay*** (Enacted 1997) – Our report estimated a cost of 0.07% of premium.
- ♦ ***Off-label Use Prescription Drugs*** (Enacted 1998) – The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our 1998 report did not resolve this conflict but 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. We include half this amount, or 0.3%.
- ♦ ***Prostate Cancer*** (Enacted 1998) – 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 indemnity plans would approximate \$0.10 per member per month. With the inclusion of administrative expenses, we would



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- expect a total cost of approximately \$0.11 per member per month, or about 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) – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.
 - ♦ ***Registered Nurse First Assistants*** (Enacted 1999) – Health plans that cover surgical first assisting are mandated 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) – Our report estimated a cost of 0.46% 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. Since carriers generally cover hospice care already, 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 0.08% 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.



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- 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.

These costs are summarized in the following table.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1975	Maternity benefits provided to married women must also be provided to unmarried women.	All Contracts	0 ¹	0 ¹
1975	Must include benefits for dentists' services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.10%	--
1975	Family Coverage must cover any children born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0 ¹	--
1983	Benefits must be included for treatment of alcoholism and drug dependency .	Groups of more than 20	0.93%	0.55%
1975 1983 1995 2003	Benefits must be included for Mental Health Services , including psychologists and social workers.	Groups of more than 20	3.49%	2.62%
		Groups of 20 or fewer	--	1.31%
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	1.41%	1.41%
		Individual	0.70%	0.70%
1990 1997	Benefits must be made available for screening mammography .	All Contracts	0.69%	0.69%
1995	Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	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%	0.01%



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Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1996	Benefits must be provided for maternity (length of stay) and newborn care, in accordance with "Guidelines for Prenatal Care."	All Contracts	0	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%	0.20%
1996	Benefits must be provided for screening Pap tests.	Group, HMOs	0.01%	0
1996	Benefits must be provided for annual gynecological exam without prior approval of primary care physician.	Group managed care	--	0.10%
1997	Benefits provided for breast cancer treatment for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%	0.07%
1998	Coverage required for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%	0.30%
1998	Coverage required for prostate cancer screening.	All Contracts	0.07%	0
1999	Coverage of nurse practitioners and nurse midwives and allows nurse practitioners to serve as primary care providers.	All Managed Care Contracts	--	0.16%
1999	Prescription drug must include contraceptives.	All Contracts	0.80%	0.80%
1999	Coverage for registered nurse first assistants.	All Contracts	0	0
2000	Access to clinical trials.	All Contracts	0.46%	0.46%
2000	Access to prescription drugs.	All Managed Care Contracts	0	0
2001	Coverage of hospice care services for terminally ill.	All Contracts	0	0
2001	Access to eye care.	Plans with participating eye care professionals	0	0.04%
2001	Coverage of anesthesia and facility charges for certain dental procedures.	All Contracts	0.05%	0.05%
2003	Coverage for prosthetic devices to replace an arm or leg	Groups >20	0.03%	0.03%
		All other	0.08%	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0	0
2005	Coverage of licensed pastoral counselors	All Contracts	0	0



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Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
	and marriage & family therapists			
	Total cost for groups larger than 20:		8.64%	7.51%
	Total cost for groups of 20 or fewer:		4.27%	5.70%
	Total cost for individual contracts:		3.55%	3.58%



Appendix C: References

1. CHPA is an organization that promotes the use of OTC medicines; <http://www.chpa-info.org/ChpaPortal/AboutCHPA/>; June 2007
2. OTC Tax Deductibility http://www.chpa-info.org/ChpaPortal/PressRoom/PositionPapers/OTC_tax_deductibility.htm; July 2005
3. Herbal, nutritional supplements linked to side effects ranging from dry eye to retinal hemorrhages and transient visual loss; <http://www.news-medical.net/?id=5569>; October 13, 2004
4. Nutritional supplements are Utah's third largest industry; <http://www.newstarget.com/008034.html>; May 21, 2005
5. [Overview of Dietary Supplements; http://www.cfsan.fda.gov/~dms/supplmnt.html](http://www.cfsan.fda.gov/~dms/supplmnt.html); August 2007