

# 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 non-HMO employee group 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 other 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 then decreased, reaching 2.90% in 2005. In 2006, it increased to 3.23%. For 2006, this broke down as 3.11% for HMOs and 3.51% for other plans. The decrease in 2005 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 a delayed 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 2006 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 non-HMO 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 other 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 0.65% for 2002 through 2006 despite implementation of the parity requirement. The long-term decrease for HMOs 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 to 49% in 2006. Claims for substance abuse were 0.65% of total group claims for 2006. This broke down as 0.57% for HMOs and .84% for other 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
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- **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. It was 1.40% in 2006. The level varies significantly between group and individual. For 2006, the percentages for group plans were 1.48% for HMO plans, 1.20% for other plans, and an aggregate of 1.40%. For individual plans, it was 0.13% for HMO plans, 0.87% for other plans, and an aggregate of 0.87%. We estimate 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.
  - **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 0.63% in 2006, which may reflect increasing utilization of this service followed by a leveling off. This figure broke down as 0.62% for HMO plans, 0.64% for other plans. We estimate 0.63% 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.
  - **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
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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 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%.
  - ♦ ***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 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 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.
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- ♦ *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.
- ♦ 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 is phased-in by requiring coverage from birth to age 5 effective 1/08, age 6-13 effective 1/09 and age 14-18 effective 1/10. Our report estimated a cost of 0.1% of premium once fully implemented.

These costs are summarized in the following table.

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## COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Non-HMO	HMO
1975	Maternity benefits provided to married women must also be provided to unmarried women.	All Contracts	0 <sup>1</sup>	0 <sup>1</sup>
1975	Must include benefits for <b>dentists'</b> services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.10%	--
1975	Family Coverage must cover any <b>children</b> born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0 <sup>1</sup>	--
1983	Benefits must be included for treatment of <b>alcoholism and drug dependency</b> .	Groups of more than 20	.84%	0.57%
1975 1983 1995 2003	Benefits must be included for <b>Mental Health Services</b> , including psychologists and social workers.	Groups of more than 20	3.51%	3.11%
		Groups of 20 or fewer	--	1.55%
1986 1994 1995 1997	Benefits must be included for the services of <b>chiropractors</b> to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	Group	1.20%	1.48%
		Individual	0.13%	0.87%
1990 1997	Benefits must be made available for screening <b>mammography</b> .	Group	0.63%	0.63%
		Individual	0.63%	0.63%
1995	Must provide coverage for <b>reconstruction of both breasts</b> to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for <b>metabolic formula</b> and up to \$3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for <b>maternity (length of stay)</b> 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 <b>diabetes</b> and approved self-management and education training.	All Contracts	0.20%	0.20%
1996	Benefits must be provided for <b>screening Pap tests</b> .	Group, HMOs	0.01%	0
1996	Benefits must be provided for <b>annual gynecological exam</b> without prior approval of primary care physician.	Group managed care	--	0.10%
1997	Benefits provided for <b>breast cancer treatment</b> for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%	0.07%
1998	Coverage required for <b>off-label use of prescription drugs</b> for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%	0.30%
1998	Coverage required for <b>prostrate cancer screening</b> .	All Contracts	0.07%	0

1999	Coverage of nurse <b>practitioners and nurse midwives</b> and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts	--	0.16%
1999	Prescription drug must include <b>contraceptives</b> .	All Contracts	0.80%	0.80%
1999	Coverage for <b>registered nurse first assistants</b> .	All Contracts	0	0
2000	Access to <b>clinical trials</b> .	All Contracts	0.46%	0.46%
2000	Access to <b>prescription drugs</b> .	All Managed Care Contracts	0	0
2001	Coverage of <b>hospice care services</b> for terminally ill.	All Contracts	0	0
2001	Access to <b>eye care</b> .	Plans with participating eye care professionals	0	0.04%
2001	Coverage of <b>anesthesia</b> and facility charges for certain <b>dental</b> procedures.	All Contracts	0.05%	0.05%
2003	Coverage for <b>prosthetic devices</b> 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 and marriage & family therapists	All Contracts	0	0
2007	Coverage of hearing aids for children	All Contracts	0.1%	0.1%
	<b>Total cost for groups larger than 20:</b>		<b>8.30%</b>	<b>8.03%</b>
	<b>Total cost for groups of 20 or fewer:</b>		<b>4.00%</b>	<b>5.96%</b>
	<b>Total cost for individual contracts:</b>		<b>3.66%</b>	<b>2.95%</b>