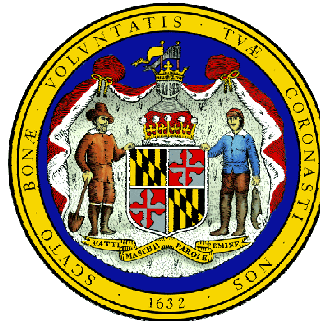
MARYLAND HEALTH CARE COMMISSION

Required Under Section 15-1501 of the Insurance Article

Annual Mandated Health Insurance Services Evaluation



December 31, 2004

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Executive Summary

In 1998, pursuant to Section 15-1501 of the Maryland Insurance Article, the Maryland Health Care Access and Cost Commission (HCACC), predecessor of the Maryland Health Care Commission (MHCC), was required to:

- Initially determine the cost of existing mandated services as a percentage of:
  - Maryland's average annual wage
  - Health insurance premiums.
- Annually assess the financial, social, and medical impact of proposed mandates.

The HCACC hired Mercer Human Resource Consulting (Mercer) to prepare a report to the General Assembly in 1998 to address these issues. Using the recommendations in the Mercer report, in 1999 the General Assembly passed SB625 "Mandated Health Insurance Services – Cost Determination" to require the Commission to continue evaluating the existing and proposed mandates annually. Since 1999, the MHCC has contracted with Mercer to perform this analysis annually.

Section 15-1501 does not affect the ability of the General Assembly to enact legislation on mandated health insurance services. Mandated services are defined as those mandates for health services contained in Title 15, Subtitle 8 of the Insurance Article.

The following report addressed the assessment and evaluation criteria defined under Section 15-1501.

We used the following resources in the assessment:

- Mercer-conducted surveys of health plans as to current practices
- Mercer-conducted surveys of collective bargaining agents and health coalitions on their level of interest in negotiating for the benefits in the proposed mandates
- Fiscal notes on proposed mandates prepared by the Department of Legislative Services
- Mercer databases on indemnity and managed care plans
- Mandate-specific research by Mercer's analysts
- Mandate-specific research by Mercer's clinical consultants.

Financial Analysis of Current Mandates

Subtitle 8 of Title 15 of Maryland's insurance law currently has 40 "required health insurance benefits for services" (Sections 15-801 through 15-840) that insured health plans must include. This report analyzes the cost of these mandates for four types of contracts:

- Group insurance plans
- Individual insurance plans
- Comprehensive Standard Health Benefit Plan for small groups
- Maryland State Employee Benefit Plan.

Executive Summary

The financial cost of mandated health insurance services could be defined as the full cost of the service, or it could be defined as the marginal cost of the mandate, where the marginal cost equals the full cost of the service minus the value of the services that would be covered in the absence of the mandate.

On a full-cost basis, the total cost for all the current mandates is about 12.6% of premium. As a percentage of Maryland's average wage, assuming the same average wage for all types of insurance contracts, the full cost averages about 1.8%.

On a marginal cost basis, for all the current mandates, the average cost is about 1.5% of premium across all insurance contracts. As a percentage of Maryland's average wage, the marginal cost averages 0.2%.

For the past two years, the Commission had Mercer adjust the cost estimates for mandates by utilization and unit cost trends. This year, Mercer was asked to perform a comprehensive update of the cost of each mandate. Because of additional sources of information that are now available, most of the estimates have been refined with this update. Primarily as a result of this update, the full cost of mandates dropped from 15% of premium to 12.6% of premium and from 2.3% of average wages to 1.8% of average wages. In addition, on a marginal cost basis, compared to data in our 2003 report to the MHCC, the cost of the mandates as a percentage of average wage increased from 1.3% to 1.5%, while, as a percentage of the average wage, it held at 0.2%.

Financial, Social, and Medical Impact of Proposed Mandates

The following proposals were reviewed for their potential financial, medical, and social impact:

- Mandated health insurance coverage for mental health services provided to children and adolescents in a wraparound mental health program.

- Mandated health insurance coverage for smoking cessation services.

- Mandated health insurance coverage of private helicopter ambulance.

This portion of the report contains background information for legislators. It does not recommend which proposals should be passed. Determining the relative importance of the financial, social, and medical impact of proposed mandates is the prerogative of the legislature.

Introduction

This report contains two sections. The first section evaluates the full cost of each existing mandated health insurance service as a percentage of the State's average annual wage and of premiums for the individual and group health insurance market. The second section provides a financial, social, and medical impact of proposed mandates. At the end of the report we provide a bibliography of sources referenced in this report.

This report uses various sources of information. As required by statute, the report refers to a survey of health plans and a survey of collective bargaining agents. Mercer surveyed the prominent health plans in the Maryland market which also participate in the Maryland small-group market. The health plans were surveyed on their coverage practices in both the small-group and large-group markets in Maryland. The surveys produced data for an overview of practices and coverage in the Maryland marketplace.

Mercer also conducted a telephone survey of Maryland collective bargaining agents. The sample included groups such as the AFL/CIO, Laborers International, AFSCME, Building and Construction Trades, and United Food and Commercial Workers. The survey assessed their level of interest in negotiating for coverage and their support for or opposition to the proposed mandates. The collective bargaining agents showed little interest in the proposed mandates. Their current concern is more with preventing employers from dropping retiree medical plans.

We have also surveyed the Maryland Department of Budget and Management, Office of Personnel Services and Benefits, on its compliance with current and proposed mandates.

This year, there were no legislative bills with accompanying Fiscal Notes containing additional information on the cost impact. All requests for a review of a proposed mandate were presented before a bill was filed.

Mercer's analysis incorporates data from our proprietary databases, which include financial information on indemnity and managed care plans. These databases were developed by purchasing data from other sources and through several comprehensive surveys. We update the databases regularly.

Another major resource for this report was the Internet. Through searches on the Internet, we collected published articles and information on the proposed mandates.

This report includes information from several sources to provide more than one perspective on each proposed mandate. Mercer's intent is to be unbiased. At times, as a result, the report contains conflicting information. Although we included only sources that we consider credible, we do not state that one source is more credible than another. The reader is advised to weigh the evidence.

The Mercer staff on this report included clinical, actuarial, and research specialists. The clinical staff reviewed the study of the medical impact and assisted on research of the financial and

social impact of the mandates. The actuarial staff coordinated the analysis of the financial impact.

Financial Analysis of Current Mandates

This section addresses the cost of existing mandated health insurance services. The requirements for this evaluation are defined under Section 15-1501(d) of the Insurance Article.

The financial cost of mandated health insurance benefits could be defined either as the full cost of the benefit or as the marginal or additional cost of the mandate. The marginal cost equals the full cost of the benefit minus the value of the services that would be covered in the absence of the mandate. For example, the full cost for requiring coverage of hospitalization for maternity equals the assumed number of maternity cases times the hospital cost per case. The vast majority of contracts would include coverage of maternity cases without the mandate; therefore, the marginal cost equals the assumed number of cases that would not be covered without the mandate times the hospital cost per case. This report shows estimates for both the full cost and the marginal cost.

To estimate the difference between the full cost and marginal cost, we surveyed carriers and self-funded employers on the rate of voluntary compliance for self-funded, because self-funded employer sponsored plans are not subject to the benefit mandates. We assume that insured plans would have the same compliance rate, if compliance were voluntary rather than mandatory. The voluntary compliance rate could vary for individual, small group, and large group plans; however, no data are available to confirm if there is a likely difference in potential voluntary compliance. We assume there would be no difference in the rate of voluntary compliance for each benefit mandate.

Exhibit 1 summarizes the cost of the "required health insurance benefits for services." The costs are summarized for four types of contracts:

- Group insurance plans
- Individual insurance plans
- Comprehensive Standard Health Benefit Plan for small groups
- Maryland State Employee Benefit Plan.

There are two types of "required health insurance benefits for services": mandated coverage of services and mandated offering of additional benefits through riders or other policies. Because the mandated offering of benefits does not require a benefit to be covered under the standard policy, we show the cost as $0 for mandated offerings.

The Mercer Survey of Employer-Sponsored Health Plans showed an average annual cost per contract of about $7,034 for Maryland employers in 2003. This is for health plans that cover medical and prescription drug benefits but excludes the cost of dental benefits. The survey covers employers with 10 or more employees.

The MHCC annual monitoring report of small group plans including enhancements to the CSHBP shows a 2003 average annual premium of $5,134 per employee. Excluding enhancements, the cost is $4,021 per employee. For small groups, our report compares the cost of mandates to the CSHBP premium rate excluding enhancements.

Financial Analysis of Current Mandates

We estimate that the average individual policy cost is almost 50% lower than an employer-sponsored contract. The primary reasons are the lower average number of members per contract, individual underwriting by the carriers to screen out individuals with preexisting health conditions, and the tendency of individuals to purchase plans with higher deductibles and lower prescription drug limits.

The MHCC report, *State Health Care Expenditures, Experience from 2002*, shows a per capita private insurance cost of $2,446 in 2002. The MHCC report, *Health Insurance Coverage in Maryland Through 2002*, showed that 73% of Maryland residents had employment based coverage while 5% had direct-purchase coverage.

Combining the MHCC data and the estimates for the individual and group market rates, our estimate of the 2003 average premium rate is $5,919 annually per contract holder.

Our estimate of the cost of mandates is the total health care dollars spent net of contract-holder out-of-pocket expenses. We assume the same portion of out-of-pocket expenses apply to the mandates as applies to other benefits.

Exhibit 1 shows the estimated 2003 cost for current mandates and the:

- Relative cost factors by type of contract
- Cost of each mandated service under a group contract
- Cost of the mandates as a percentage of the premium cost and as a percentage of the average Maryland wage.

The total costs by policy type are shown at the bottom of the page, adjusted to the cost level for the type of contract.

When expressing the cost of the mandates as a percentage of the average annual wage, we did not segregate the wage by type of delivery system; therefore, we used the same wage base for all types of contracts. The average annual wage in 2003 was $40,714, according to statistics from the Maryland Department of Labor, Licensing and Regulation (DLLR). This is 3.4% higher than the 2002 Maryland average annual wage of $39,386.

On a full-cost basis, the total cost for all the current mandates is about 12.6% of premium. As a percentage of Maryland's average wage, assuming the same average wage for all types of insurance contracts, the full cost ranges from 1.0% to 2.2% and averages about 1.8%.

On a marginal cost basis, for all the current mandates, the cost averages about 1.5% of premium across all insurance contracts. As a percentage of Maryland's average annual wage, the marginal cost ranges from 0.1% to 0.3% and averages 0.2%.

The most costly mandates are:

- Mental health and substance abuse treatment (§ 15-802 of the Insurance Article); and
- Maternity care (§§ 15-811 and 15-812 of the Insurance Article).

On a full cost basis, compared to data in our 2003 report to the MHCC, the cost of the mandates as a percentage of wages decreased from 2.3% to 1.8%. The full cost as a percentage of premium decreased from about 15% to 12.6%. The full cost of most mandates, as a percentage of wages, has decreased because of a comprehensive update of the utilization and cost per service for mandates. Additional information is now available on most of the mandated services. For example, since the adoption of the mandate for morbid obesity, additional studies have been published on the cost and frequency of bariatric surgery to treat morbid obesity. In other cases, the intensity and mix of services have changed. For example, less invasive services can reduce hospital costs while new technology can increase the cost and frequency of tests.

On a marginal cost basis, compared to data in our 2003 report to the MHCC, the cost of the mandates as a percentage of average wage increased from 1.3% to 1.5%, while as a percentage of the average wage it held at 0.2%. While the overall full cost decreased, there was a reallocation toward benefits that health plans tend not to cover in the absence of a mandate and away from benefits the plans are more likely to cover in the absence of a mandate. This is why the full cost decreased while the marginal cost increased.

Proposed Mandates

This section assesses the financial, social, and medical impacts of proposed mandated health insurance services. The requirements for this assessment are defined under Section 15-1501(c).

"Wraparound" Mental Health Services for Children

We were asked to review a request to require coverage for "wraparound" mental health services for children. The model we were asked to evaluate is based upon the "Wraparound Milwaukee" program.

Wraparound Milwaukee is a system of care in Milwaukee County for children with serious emotional disturbance and their families. It operates like a health maintenance organization that manages mental health care for children institutionalized or at risk of being sent to residential treatment centers, correctional facilities or psychiatric hospitals. It pays for all services by eliminating barriers between agencies and pooling money from the juvenile justice, child welfare, mental health, and Medicaid systems. 99% of the program's funding comes from these systems.

The program's goal is to minimize out-of-home placements, support families to function as autonomously as possible, build on the families' strengths, coordinate care, and provide the families access to a variety of services and supports that wraparound the family's specific needs. Services in the Wraparound Milwaukee Benefit Plan include:

- Care Coordination
- In-Home Therapy
- Medication Management
- Outpatient—Individual Family Therapy
- Alcohol/Substance Abuse Counseling
- Psychiatric Assessment
- Psychological Evaluation
- Housing Assistance
- Mental Health Assessment/Evaluation
- Mentoring
- Parent Aide
- Group Home Care
- Respite Care
- Child Care for Parent
- Tutor
- Specialized Camps
- Emergency Food Pantry
- Crisis Home Care
- Treatment Foster Care
- Residential Treatment
- Foster Care
- Day Treatment/Alternative School
- Nursing Assessment/Management
- Job Development/Placemen

Proposed Mandates

- Kinship Care
- Transportation Services
- Supervision/Observation in Home
- After School Programming
- Recreation/Child-Oriented Activities
- Discretionary Funds/Flexible Funds
- Housekeeping/Chore Services
- Independent Living Support
- Psychiatric Inpatient Hospital

The vast majority of children in the program enter because of a juvenile court order. The program starts with an enrollment worker meeting with the child and family in the child's home or detention center to explain the wraparound program, conduct an initial screening, assess strengths, resources, and the current situation, and assign a care coordinator. The care coordinator is from one of several agencies that have contracted with Wraparound Milwaukee. Each care coordinator handles up to eight families. Care coordinators have a bachelor's degree in mental health or a related field and complete a four day certification program conducted by Wraparound Milwaukee.

The first visit of the care coordinator focuses on establishing a rapport, listening to the family's story, exploring family strengths and immediate needs, reviewing what has and has not worked and what would help, providing the family with additional program information, and establishing a crisis safety plan. Then during the first month, the coordinator works with the child and family to form a family team. The family team may include family members, relatives, church members, friends, system staff, teachers, other school personnel, probation officer, child welfare worker, clinical psychologist, and family advocates. The team then works with the family to determine the family's short term and long term vision and needs, the team's needs and expectations, and strategies to meet all those needs. The team prioritizes strategies, determines outcomes to be realized, establishes a plan, and assigns roles and tasks.

The team indicates outcomes that must be achieved, such as changes in school attendance, incidence of juvenile justice charges and adjudications, restrictiveness in living situation, and behavior functioning as measured by the Child and Adolescent Functioning Scale, the Child Behavior Checklist, and other evaluation instruments.

Using the team plan, the care coordinator will authorize payment to providers that are part of the Wraparound Milwaukee network. The plan may require approval by a clinical psychologist.

When the team goals are met and approval is granted by the Wraparound Review and Intake Team and the courts, the child and family can transfer from Wraparound Milwaukee to other less intensive services. For youths on probation, the average length of time in the program is just over 14 months.

For commercial insurance plans, it is not clear that non-medical personnel who are not covered under the Maryland Health Occupations Article will be eligible for financial reimbursement. For our review, we analyze the cost of the program but assume that the

carriers will only be required to cover the cost of providers defined under the Health Occupations Article.

The report on this proposed mandate includes information from several sources to provide more than one perspective. As a result, it contains some conflicting information. Mercer's intent is to be unbiased. While we included only sources we consider credible, we do not state that a given source is more credible than another source. The reader is advised to weigh the evidence.

A discussion of the financial, social, and medical impact of this proposal follows.

Financial

For the purpose of Mercer's financial projections, we assume that Milwaukee style wraparound programs in Maryland could support 1,000 children. There are approximately 1.4 million children under age 18 in Maryland. Therefore, approximately 0.07% of children could participate in the program. While the participation rate may differ for a commercially insured population, there is no information available to quantify this difference, so we are using the same 0.07% participation rate.

Mercer estimates that the mandate would create an extension of the current managed care mental health care limits and result in an additional 20 to 30 covered visits per year. Mercer estimates a $70 average cost per visit. Using an assumed 25 additional visits per case and $70 per visit, the additional insurance cost per child participating in the program would be about $1,750.

Based on a participation rate of 0.07% and a cost per case of $1,750, the average cost per child is $1.23 annually. Assuming 0.6 children per contract, the average annual cost per contract is about $0.74.

Carriers we surveyed do not cover State-run wraparound programs. Carriers cover mental health coverage under the mental health parity requirements and under the Insurance Article Section 15-840 mandate. Mercer views this proposal as an expansion of the Insurance Article Section 15-840 mandate. Assuming that about 10% of the services are already covered under the Insurance Article Section 15-840 mandate, the marginal cost equals the 90% of the full cost. If a similar program were already widely used, then the marginal cost would be lower.

Proposed Mandates

The full and marginal costs are summarized below:

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.0%	0.0%
Estimated cost as a percentage of average wage	0.00%	0.00%
Estimated annual per-employee cost of mandated benefits for group policies	$0.74	$0.67

Social

In this section, we address the following:

- The extent to which "wraparound" mental health services for children are generally utilized by a significant portion of the population;
- The extent to which lack of coverage of "wraparound" mental health services for children results in individuals avoiding necessary health care treatments;
- The extent to which lack of coverage of "wraparound" mental health services for children results in unreasonable financial hardship;
- The level of public demand for coverage of "wraparound" mental health services for children;
- The level of interest of collective bargaining agents in negotiating privately for inclusion of expansion of coverage of "wraparound" mental health services for children in group contracts; and
- The extent to which "wraparound" mental health services for children are covered by self-funded employers in the state who employ at least 500 employees.

In 1999, in Olmstead v. L.C., the U. S. Supreme Court upheld the decision that under the Americans with Disabilities Act (ADA), unnecessary institutionalization of people with disabilities is "unwarranted institutionalization" and discrimination. The Court stated that "…confinement in an institution severely diminishes the everyday life activities of individuals, including family relationships, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Wraparound Milwaukee is designed to provide comprehensive, individualized and cost efficient care to children with complex mental health and emotional needs. A goal has been to reduce the amount of inpatient and residential treatment while providing quality care. In 2003, Wraparound Milwaukee served 905 children. The enrollee distribution was:

- 58% Delinquent (Court Services)
- 31% CHIPS (Child Welfare referral)
- 8% Delinquent/CHIPS
- 3% Other.

Proposed Mandates

In testimony to the U.S. Senate Government Affairs Committee by Tammy Seltzer of the Bazelon Center for Mental Health Law, on a typical night, nationally nearly 2,000 children and youth remain in juvenile detention centers because they cannot access needed mental health services. A survey commissioned by Representative Henry Waxman (D-CA) and Senator Susan Collins (R-ME) revealed that over a six-month period in 2003, nearly 15,000 incarcerated youth were detained awaiting mental health services in the community. That represented 8% of all children in the centers surveyed. Also, these youths stayed in detention an average of 23.4 days compared to the average for all youths detained of 17.2 days. Also, the Surgeon General reported that about 5% to 9% of children ages 9 to 17 are affected by a serious emotional disturbance.

Tammy Seltzer explains that children are funneled into the juvenile justice system because:

- There is a lack of access because public mental health services are only available from 9 AM to 5 PM while the police department is open 24 hours per day.
- Schools are invoking zero tolerance policies and call the police to report even minor violations rather than providing positive support and proactive intervention.
- Agencies responsible for providing support to parents are instructing them to call the police when the child needs help.
- Out of desperation, parents who lack comprehensive insurance for mental health problems are calling the police when they can no longer handle their child's behavior problems.
- Lack of coordination between public agencies such as child welfare, schools, mental health, and juvenile justice results in parents being misguided.

According to the Bazelon Center for Mental Health Law, private insurance does not cover the full array of intensive, community-based rehabilitative services that children with the most severe mental or emotional disorders need. They compare it to physical health care where they claim rehabilitative services are often not covered. Many other individuals are uninsured. When coverage is unavailable or inadequate, children are forced to enter the child welfare or juvenile justice system to access treatment. When families do not satisfy the Medicaid needs test, they may be told to place their children in state custody to access the services of public programs. Other parents may be told to call the police and turn their children over to the juvenile justice system. The Federation of Families for Children's Mental Health reported that 36% of children were in the juvenile justice system because they did not have access to mental health services. In many cases, children are forced into residential placements.

As an alternative to institutional care, the Bazelon Center also identifies two federal laws that give States access to funding for home and community based care:

- Tax Equity and Financial Responsibility Act of 1988 (TEFRA)
- Home and community based services (HCBS) waiver under section 1915(c) of Medicaid law.

In order to qualify under TEFRA:

- The child must satisfy the disability definition under Supplemental Security Income (SSI) or the Social Security Disability Insurance (SSDI) program. (The disability can be physical or mental).

- The child must need the level of care provided in a hospital, nursing home, or Intermediate Care Facility for Mental Retardation.
- The child must be able to be cared for at home rather than institutionalized.
- The cost of community based care must not be more than the cost of institutional care.
- Without regard to the family income, the child must not have income or assets that exceeds the state's financial eligibility standards for an institutionalized child.

If the child qualifies under TEFRA, they would become eligible for Medicaid. The Bazelon Center reported that Wisconsin had 4,302 TEFRA children (262 with primary mental diagnosis) while Maryland has not applied for a TEFRA expansion.

In order to qualify under a home and community based services waiver:

- The child must require care in a medical institution, excluding a residential treatment center.
- Home and community based services must be an appropriate option.

The exclusion of children residing in residential treatment centers creates a significant barrier to accessing the home and community based services available under the waiver. If the child does qualify under the waiver, the state has the authority to expand the array of services, which is an advantage over TEFRA.

Both TEFRA and the waiver let a child qualify without regard to family income.

The Government Accountability Office (GAO), formerly known as the General Accounting Office, estimates that, in 2001, more than 12,700 children were placed in the child welfare or juvenile justice systems in order to receive mental health treatment. However, these numbers exclude data from 32 states, including the five largest states, because the data were not available.

Currently, in Maryland, The Family League of Baltimore and Community Kids have programs modeled after the wraparound approach.

The Family League of Baltimore City currently coordinates a Wraparound Mental Health program and the Family Preservation Initiative (FPI). The Wraparound program began with the notion of bringing 850 Maryland children from out of state, most from in-patient residential treatment centers (RTC), but a few were from more substantive mental health hospitals, and returning them to their families or local RTCs. By using community-based services and treatment facilities, the Family League has been successful. By 1996, they had reached a maximum of 145 children in one year returned from out of state. In 2004, they had only 100 children still residing out of state, most with long-term care issues or legal problems. They have since shifted focus to concentrate on in-state children outside of their home geographic areas. Most recently, the Wraparound program was assisting 75 children in-state to improve their circumstances. The program is budgeted at $2 million annually and is paid for by the Governor's Office for Youth and Families.

The FPI program is designed to return kids to the home as well, both from in-state and out-of-state, but not all are mental health related cases. FPI also uses community-based services and support to help kids return to their parents and to keep them at home. To gauge the intervention

a success, the children must stay in the home for at least one year after returning. To date, they report achieving an 80% success rate with FPI children. The program helps approximately 405 families per year and is budgeted at $2.2 million, also paid by the Governor's Office for Youth and Families.

Community Kids is a Montgomery County program funded by a system of care grant from the Substance Abuse and Mental Health Service Administration under the U.S. Department of Health and Human Services. The program includes a 10-kid pilot program modeled after the initial Wraparound Milwaukee pilot. The program reports an annual budget of $50,000 per child which is significantly lower than their budget of $10,000 per month for a child in a RTC program. Community Kids has a short-term goal of expanding the pilot to 200 children in Montgomery County and Baltimore.

Under Governor Ehrlich's first Executive Order 01.01.2003.01, Standards of Conduct for Executive Branch Employees, it states, "Employees shall conduct intra-agency and interagency relations predicated upon civility, collaboration, and cooperation for the sake of budgetary concerns, dignity and to achieve the goals of the Administration." This executive order generated an informal retreat for agency heads to give them the opportunity to understand each other's agency needs and discuss how they could work together for the benefit of the State. The discussions at the retreat identified the need to examine opportunities for implementing community based services and supports via a team-driven wraparound approach as an alternative to out-of-home placement. The pilot projects in Baltimore City and Montgomery County offered the opportunity for examination of wraparound programs with the Department of Juvenile Services. The retreat also identified the need to undertake a system-level assessment for Maryland and its jurisdictions on the policy and funding requirements necessary for wraparound. This generated Maryland's support of the National Wraparound Initiative. The National Wraparound Initiative has brought together the major innovators in wraparound programs in order to fully define the wraparound model and specify standards or practice at the system, program and team levels.

In October of 2003, the Department of Juvenile Services received approval of funding through the Juvenile Justice Council for the Governor's Office of Crime Control and Prevention's Youth Strategy Initiative to further the advancements of Wraparound in Maryland. This was combined with the Maryland Community Based Treatment Alternatives for Children Real Choices Systems Change Grant awarded to the Department of Health and Mental Hygiene under the President's New Freedom Initiative. The combined funding is being used to assess the wraparound system in Maryland and create a wraparound model definition tailored to Maryland in conjunction with the National Wraparound Model. This is being coordinated through the University of Maryland.
Maryland's mental health parity mandate, enacted in 1994, requires a carrier (health insurer, nonprofit health services plan, or HMO) to provide coverage for mental health services on the same terms as physical illness. Carriers must cover a minimum of 60 days of partial hospitalization for mental illness. Also, as to inpatient coverage of services provided in a licensed or certified facility including a hospital, the total number of days covered and the terms of coverage must be at least equal to those that apply to the benefits available under the policy for physical illness. Benefits may be provided through a carrier's managed care system.

Proposed Mandates

Before the mental health parity mandate, benefit costs were managed through limited benefit maximums. Since implementation of the mental health parity mandate, carriers have turned to managed care systems to control costs. These managed care systems, along with more effective diagnosis and treatment, have reduced the use of mental health care services. The Maryland Health Resources Planning Commission reported a decrease in inpatient stays in psychiatric units of general hospitals one year after the passage of Maryland's parity law. In 1995, 11 people were hospitalized for more than 60 days, which is significantly lower than the 21 people in 1993. In 1995, 18% of cases in private psychiatric hospitals were stays of longer than 24 days, which is significantly lower than the 24% of cases in 1993.

As of October 1, 2002, under Maryland's health insurance mandates, Section 15-840 of the Insurance Article, carriers are required to cover residential crisis services defined as intensive mental health and support services:

- provided to a child or adult with a mental illness at risk of a psychiatric crisis
- designed to prevent or provide an alternative to a psychiatric inpatient admission or shorten the length of stay
- provided at the residence on a short-term basis
- provided by DHMH-licensed entities.

This mandate already includes some residence based services on a short term basis.

According to Lori Doyle of Mosaic Community Services, which offers an array of behavioral health care services throughout the Baltimore Metropolitan area,

> "Private carriers tend to reimburse only for "medically necessary" services rendered by providers covered under the Maryland Health Occupations Article. Many of the wraparound services, including rehabilitation, housing assistance, respite care, mentoring, transportation, etc. are provided by non-licensed personnel or are considered non-medical services.
>
> Despite Maryland's mental health parity law, private carriers have been steadily reducing services for kids. They usually do so not by eliminating benefits, which might be a violation of law, but by creating massive hoops to accessing those benefits. These "hoops" take the form of arbitrary and inappropriate denials of authorization, "phantom" panels (mental health providers listed as being in the carrier's network who do not accept that insurance or who have capped their participation), and downstream risk contracts that prove confusing and difficult to access for families trying to get mental health services for their child.
>
> Under current practice, private carriers are off the financial hook when a kid enters an RTC (at least in 99% of the cases). There is, therefore, no incentive for them to provide the services and supports that will keep a kid out of the RTC.
>
> Private carriers are already failing to comply with the mandate, passed a few years ago by the Maryland General Assembly, requiring them to pay for community-based mental health crisis services. The Task Force on Access to Private Insurance (also created by the General Assembly to examine barriers to accessing mental health services for persons with private insurance) has targeted this as one area of concern but, so far, this practice has not changed."

Proposed Mandates

Overall, the level of public demand for coverage of wraparound programs is low because of the relative newness and lack of Milwaukee type programs. Also, the demand is low because of the relatively low incidence rate among the general population. However, for those who need the service, the demand for either residential treatment center or in-home care is often urgent.

The responses from our survey of collective bargaining agents show little interest in this proposed mandate.

Mercer does not know of any health plans that cover wraparound programs.

The State of Maryland, Department of Budget and Management, Employee Benefits Division told Mercer that mental health coverage for state employees is administered by a managed behavioral health care vendor. The vendor does cover hospitalization, partial hospitalization (4 to 10 hours a day), intensive outpatient care, occasional overnight partial hospitalization, and outpatient services.

When an employer selects a carrier as its administrator, it is unusual to address definitions of covered providers at this level of detail. The issue is more likely to arise when a claim is denied for an employee's covered dependent and the employee files an appeal with the sponsoring employer.

While benefit limits may create a barrier to some mental health care services, it was not the barrier that was eliminated to create Wraparound Milwaukee. For that program, the barrier that was eliminated was the lack of communication between agencies and the misdirection of child welfare, juvenile justice, and Medicaid funds to residential treatment centers and psychiatric hospitals rather than to community based services. Wisconsin does not have a benefits mandate requiring commercial health insurance plans to cover Wraparound Milwaukee.

Medical

In this section we answer the following questions related to "wraparound" mental health services for children:

- Are wraparound services recognized by the medical community as being effective and efficacious in the treatment of patients?
- Are wraparound services recognized by the medical community as demonstrated by a review of scientific and peer review literature?
- Are wraparound services available and utilized by treating physicians?

The amount of studies focusing on "wraparound" mental health services for children is limited.

The New Freedom Initiative was created by President George W. Bush in February 2001. The initiative promotes increased access to education and employment opportunities for the disabled and includes initiatives to increase access to community life. On April 29, 2002, the President identified three obstacles to treatment for mental health care:

- The stigma surrounding mental illness

- Unfair treatment limitations and financial requirements that private health insurance imposes on mental health benefits
- The fragmented mental health service delivery system.

In his speech announcing the New Freedom Commission on Mental Health, the President expanded on "…our fragmented mental health service delivery system. Mental health centers and hospitals, homeless shelters, the justice system, and our schools all have contact with individuals suffering from mental disorders."

Under Executive Order 13263, the Commission was charged to study the problems and gaps in the mental health system and make concrete recommendations for immediate improvements the Federal government, State governments, local agencies, and public and private health care providers can implement.

In its interim report to the President, the Commission described the current mental health system as fragmentary and in disarray. It noted that this was leading to unnecessary and costly disability, homelessness, school failure, and incarceration. It pointed out the fragmentation and gaps in care for children.

In their final report, the Commission states:

> "Successfully transforming the mental health service delivery system rests on two principles:
> - First, services and treatments must be consumer and family centered, geared to giving consumers real and meaningful choices about treatment options and providers – not oriented to the requirements of bureaucracies.
> - Second, care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not on managing symptoms."

The Commission report advises that providers should develop individualized plans of care in full partnership with consumers. It then follows up with:

> "An exemplary program that expressly targets children with serious emotional disturbances and their families, Wraparound Milwaukee strives to integrate services and funding for the most seriously affected children and adolescents…Wraparound Milwaukee demonstrates that the seemingly impossible can be made possible: children's care can be seamlessly integrated. The services provided to children not only produce better clinical results, reduce delinquency, and result in fewer hospitalizations, but are cost-effective."

The Commission recognizes that psychiatric residential treatment facilities have become the primary provider for children needing institutional level care and the Medicaid program provides Federal matching funds for children receiving inpatient psychiatric services. It also acknowledges that the HCBS waiver should allow alternatives to residential treatment facilities so that children can receive treatment in their own homes, surrounded by their family, with a lower treatment cost than institutional care. The Commission report urges "rebalancing" which is a reallocation of funds from institutional services to community based services.

The website Paper Boat, which provides support for human service agencies in transition to a comprehensive or wraparound approach, acknowledges that implementing a wraparound program is not easy. The most significant barriers are:

- Accepting a false consensus – Rather than using the teams in a collaborative effort to create a common purpose among people with diverse perspectives, teams are used to simply communicate information.
- Relying on slot-based solutions – This is when the team or some of its key members lock in on a strategy too soon and then use a complex analytical process to justify decisions they have already made.
- Operating competing collaboratives – This can result when there are multiple initiatives from various team members or agencies.
- Succumbing to the myth of beneficence – The willingness to operate with the untested assumption that because we are acting with good intentions, we will produce good results.
- Getting trapped in the crisis cycle – The wraparound program should have an action plan to avoid crises and a plan to deal with the crises that will still occur.
- Substituting process for action – This can happen when considerable energy is expanded on convening the team and developing and implementing an action plan. With the success of the first steps, it may be unsettling to deal with unmet needs.

When a wraparound plan is successful, its effects may be long lasting. In "Common Ground, developing Strength-Based Community Care Alliances," John Franz writes:

> "A positive outcome for an individual and family doesn't just mean a reduction of symptoms or the resolution of a crisis. It also means creating an ongoing circle of natural support which will sustain the person and family after formal services have been reduced or ended. It is because of this value that at least 50% of the membership of teams should be people who will retain an ongoing commitment to the person and family. It also means that proposed plans of care are reviewed not just for their short term impact, but to see whether they include a strategic plan for increasing individual and family autonomy."

In "Promising Practices in Wraparound for Children with Serious Emotional Disturbance and Their Families" from the National Technical Assistance Center for Children's Mental Health at Georgetown University, they define wraparound as "a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes." The report also identifies the right to individualized treatment formulated by an interdisciplinary team. This right was confirmed by the court case of Brewster v. Dukakis where the court ruled that an interdisciplinary team must look at a broad base of client's needs instead of a narrow, categorical set of needs. The report includes Wraparound Milwaukee as one of three promising wraparound models. It states:

> "Wraparound Milwaukee has proven to be a successful implementation for the wraparound approach and has grown relatively quickly over a 4-year period from a demonstration project of 25 youth to approximately 600 youth who are seriously emotionally disturbed and at risk of out-of-home placement. This growth has occurred because wraparound has demonstrated that it can be both cost effective as well as an effective way of serving youth with complex needs and their families, gaining the acceptance of wraparound from the courts, the child welfare system, and families. The wraparound approach also is compatible with managed care and its goal to ensure that the right services are delivered in the right amount at the right time, maximizing flexibility to allocate resources most efficiently and effectively. The strong and competent leadership of Wraparound Milwaukee has clearly been an important factor in generating the confidence that the community has shown in the initiative."

The other two model programs are in La Grange, Illinois and Santa Clara County, California. The report also includes case studies of other programs such as the Baltimore City Wraparound project, Family Preservation Initiative (FPI). FPI is a youth and family centered intervention program that targeted job placement and training in addition to both child and family therapy and one-on-one mentoring programs. The program returned children from out-of-state placements and diverted children from being placed out-of-state. The average per diem cost for a FPI youth was $216 compared to $269 for a youth in out-of-state treatment. In a satisfaction survey where 1 equaled very dissatisfied and 5 equaled very satisfied, parents gave the services a 3.54 rating and youth gave the services a 3.89 rating. Parents rated the program 3.78 while youth gave the program a 3.47 rating.

In the American Youth Policy Forum report "Less Cost, More Safety: Guiding Lights for Reform in Juvenile Justice," Richard Mendel states that there has been an over reliance on out-of-home treatment. He quotes U.S. Surgeon General Dr. David Satcher as saying:

> "In the past, admission to [residential treatment centers] has been justified on the basis of community protection, child protection, and benefits of residential treatment per se. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings."

Of the money spent on mental health treatment for children, 50% goes for inpatient hospitalization and 25% goes for residential treatment centers and group homes. A six-state study of children discharged from residential treatment centers showed that 75% were readmitted to a mental health facility or incarcerated within seven years. Mendel states that there has been an underinvestment in high quality community based care and that there has been a lack of coordination between concerned agencies.

He then presents Wraparound Milwaukee as a model program that has reduced the average length of stay in residential treatment centers from 14 months to 3.5 months. He recognizes that under the program, the residential treatment program daily population has fallen from 360 with a waiting list down to 135; in addition, psychiatric hospitalization of adolescents has declined 80%. At the same time, there has been a reduction in delinquency and an improvement in clinical outcomes as measured by the Child Behavioral Check List and the Child and Adolescent Function Assessment Scale.

New York State has also been looking at Wraparound Milwaukee as a model. The Mental Health Association in New York State presents Wraparound Milwaukee as an evidence-based practice. In the New York Journal health series, "Throwaway Kids," they explore the problems with residential treatment centers and the potential of wraparound programs. In a three-month investigation, The Journal found that, "children in residential treatment centers are routinely given powerful and dangerous psychiatric medications with inadequate oversight, little accountability and no consensus that they work... Most of the medications are not approved for children, and others were approved without new clinical trials or sufficient proof that they are effective."

Proposed Mandates

The Journal reports that a report on the 2000 national conference on children's mental health says, "Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them."

The Journal also studied the affect of Wraparound Milwaukee on residential treatment centers. When the program was introduced, residential treatment centers tried to show that their residents could not survive on the outside. Cathy Connolly, president of St. Charles Youth and Family Services, which operates Milwaukee's largest institution said, "I remember meeting with groups of people and folks saying 'Let's get some reports out that show (Wraparound) is going to start hurting kids now. Well, nobody could ever bring the reports to the meetings, 'cause there were none that existed that said we were doing anything all that great." Wraparound cut the number of children in residential treatment centers by 90%, dramatically shortened their stays, reunited hundreds of families, reduced the incidence of crime and saved millions of dollars in treatment. Residential treatment centers are now only used as a temporary fix or to stabilize children while a longer term treatment plan is developed. Some centers have closed while others have established programs for children in the community.

The National Mental Health Association (NMHA) also recognizes that "community-based treatment programs are superior to institutional-based programs…Although some youth may need treatment in institutions, many more can be appropriately served in the community, where youth behavior can be addressed in its social context. It is extremely important for justice authorities to involve family members in the treatment and rehabilitation of their children." NMHA also presents Wraparound Milwaukee as an effective model.

The National Psychologist also states "there are programs that appear to be working, including the Milwaukee program…"

The Wraparound Milwaukee 2002 annual report states:

- The average monthly cost to serve a youth enrolled in Wraparound Milwaukee was only $4,350 per month compared to over $7,300 per month in a residential treatment center or $6,000 per month in a juvenile correctional facility.
- Placements in residential treatment centers continue to drop.
- Re-offense rates for youth continue to drop even three years after leaving Wraparound Milwaukee.
- The funding distribution was 60% from CHIPS & Delinquent (Child Welfare and Juvenile Justice), 29% from Medicaid, 10% from Medicaid crisis funds, and 1% from other.

According to Lori Doyle of Mosaic Community Services, which offers an array of behavioral health care services throughout the Baltimore Metropolitan area,

> "Wraparound services have been shown to be highly effective in reducing expensive RTC admissions. However, this has taken place (to my knowledge) only in the public sector. The private insurance sector has been steadily reducing services for kids. As a result, the public sector has been picking up the slack at great expense since the kids come in sicker and needing a higher level of intervention. This "flood" of kids (including private insurance kids and MCHP kids) has ultimately caused the Mental Hygiene Administration to drastically reduce (or eliminate) in-

school, after-school, and in-home mental health supports and rehabilitation for kids, the very services that the Bazelon Center identifies as needed to keep kids out of the criminal justice system and other institutional placements."

Proposed Mandates

Treatment for Smoking Cessation

This proposed mandate would require a health insurer, nonprofit health service plan, or HMO (carrier) to provide coverage for smoking cessation treatments. Coverage would be required for: (1) two 90-day courses of nicotine replacement therapy and pharmacotherapy approved by the U.S. Food and Drug Administration as a cessation aid and obtained by prescription within a 12-month period, (2) two office visits within a calendar year to a physician or other health care professional for evaluation or treatment to assist in ceasing tobacco use, and (3) two more office visits within a calendar year for the management and evaluation of a course of therapy.

The report on this proposed mandate includes information from several sources to provide more than one perspective. As a result, it contains some conflicting information. Mercer's intent is to be unbiased. While we included only sources we consider credible, we do not state that a given source is more credible than another source. The reader is advised to weigh the evidence.

The financial, social and medical impacts of this proposal follow.

Financial

According to 2004 data highlights from the Centers for Disease Control (CDC), 23.1% of US adults and 22.9% of 9th to 12th grade students are smokers. In Maryland, the smoking rate is slightly lower at 22% of adults and 19% of public school 9th through 12th graders. The CDC puts the 2004 average national rate of attempted quits at 52% of adult smokers and Maryland adult smoker quit attempts are reported at that same percent. There are no data on quit attempts for high school students in Maryland, but the national median quit attempt rate for this teen group is 60%. No data are available on their success rates. Not all smokers who attempt to quit use a smoking cessation program.

Mercer assumes that, with coverage, 20% of Maryland smokers attempting to quit would use smoking cessation services (individual counseling, prescription drugs, over-the-counter medications, and self-help programs). Mercer also assumes that 52% of smokers will attempt to quit; therefore, 2.2% (or 20% x 22% x 52%) of the adult and teen members are expected to use the benefit. Mercer assumes that up to two attempts per year would be covered and the program would be defined to include the following per attempt:

- Counseling:
  - Mercer estimates a cost of $100 per smoking cessation course (which includes counseling and fees for quit smoking aids)
  - office visits per attempt (Mercer estimates an average cost of about $60 per visit)
    - up to two for evaluation
    - up to two for treatment/management

- Pharmacotherapy:

- Prescription drugs including non-nicotine medication as well as nicotine replacement therapy. Mercer estimates an average wholesale price of about $400 per prescription (3 month supply); requires inclusion in drug formulary
- Over-the-counter medication (Mercer assumes this is covered only if included as part of the course fee for a smoking cessation course)

Mercer assumes that the average participant using the benefit will use one attempt using a course (average cost of $100), one attempt using three individual counseling visits (total cost of $180 for 3 visits), and one 3-month prescription nicotine replacement (average cost of $400); therefore, the average cost per adult or teen using the services will be $680 annually. Assuming 2.2% of adults and teens use the benefit, and assuming 1.6 adult or teen members per contract, the full cost would be about $24 per contract per year (2.2% x 1.6 x $680) or 0.4% of premium. Based on the 2001 Mercer survey, about 75% of the cost is currently covered, primarily for prescription drugs, so the marginal costs would be about $6 per contract per year or 0.1% of premium. The full and marginal costs are summarized below:

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.4%	0.1%
Estimated cost as a percentage of average wage	0.06%	0.01%
Estimated annual per employee cost of mandated benefits for group policies	$24	$6

Because the focus of this report is on first year costs only, it does not take into account any offsetting savings from decreasing the health risk factors of smokers who succeed in quitting. Also, a significant portion of the potential offsetting savings occur at later ages where health care costs are paid by Medicare. There are still potential savings in health care costs for the under-65 population as well. The 2004 Surgeon General Report, The Health Consequences of Smoking, and a 2004 article published in Employee Benefits Journal both claim that some of the more serious smoking-induced diseases (such as cancers, cardiovascular disease, stroke) can onset earlier in middle age or in people in their 40s and 50s. The Surgeon General Report further finds that even young smokers have poorer health status, take more time off work, and use medical care services at higher rates than their non-smoking peers. A study cited in the report puts medical expenses incurred at 25% higher for smokers than non-smokers under the age of 65. The Surgeon General reports have noted that quitting smoking immediately reduces rates of respiratory symptoms (such as coughing and wheezing) and respiratory infections (such as bronchitis and pneumonia). CDC reports that employers offering the benefit see cost savings in reduced absenteeism, increased on-the-job productivity, reduced life insurance costs, and a reduction in smoking-attributed neonatal costs. In addition to the savings to the health care system, the ex-smoker incurs a monetary savings from the money that would have been spent on cigarettes.

Proposed Mandates

Although the cessation program definitions above can include over-the-counter drugs, only 8% of employer sponsored health plans cover over-the-counter smoking cessation drugs. While there are still some nicotine replacements that require a prescription, many are available without a prescription.

The premium impact for this benefit expansion may seem small, but if this mandate were enacted, it could lead to similar bills that expand other types of coverage. For example, similar reasoning can be used to mandate coverage of weight loss programs for obese individuals. This concern should be weighed against the preponderance of evidence that smoking cessation treatments improve quit rates and are cost-effective health measures. A recent study (cited below in the medical section) found that lifetime medical savings to quitters is 15 times the cost of an effective cessation program. The CDC also reports it costs between only 10 and 40 cents per member per month to provide a comprehensive tobacco cessation benefit (costs vary based on utilization and dependent coverage), whereas, the annual cost of tobacco use is about $3,400 per smoker. The CDC further reports that men who smoke incur $15,800 (in 2002 dollars) more in lifetime medical expenses than non-smoking men, and women who smoke incur $17,500 (in 2002 dollars) more than non-smoking women.

Social

- What is the extent to which the service is generally utilized by a significant portion of the population?
- What is the extent to which the insurance coverage is already generally available?
- What is the extent to which lack of coverage results in individuals avoiding necessary health care treatments?
- What is the extent to which lack of coverage results in unreasonable financial hardship?
- What is the level of public demand for the services?
- What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts?
- What is the extent to which the mandated health insurance service is covered by self-funded employers in the state who employ at least 500 employees?

According to the American Lung Association (ALA) and the American Legacy Foundation, nearly 70% of current adult smokers want to quit smoking completely each year. About half of those (35 - 45% of total) attempt to quit and only 3-5% succeed. Assuming that 20% of the Maryland adult smokers trying to quit would participate in a smoking cessation program, and 11% of Maryland adult smokers try to quit, then 2.2% of the adult and teen members are expected to use the benefit. The high rate of relapse is a consequence of the effect of nicotine dependence.

In 2000, the total percent of adults who ever smoked but quit (prevalence of cessation) was 48.8%. There is no information available on how many of these people used a cessation program to quit.

Smoking cessation treatments (both pharmacotherapy and counseling) are not consistently provided as covered services of health insurance packages.

Proposed Mandates

The national health promotion and disease prevention objectives for the year 2010 as set forth in the CDC's Healthy People 2010, propose to increase insurance coverage of evaluation-based treatments for nicotine dependency to 100%. Examples of such treatments are tobacco-use cessation counseling by health care providers, tobacco-use cessation classes, and prescriptions for nicotine replacement therapies.

The U.S. Department of Health and Human Services (HHS) launched a national Quitline initiative in November 2004. The toll-free number connects smokers with state hotlines (or the National Cancer Institute hotline) that provide free cessation support in the form of telephone counseling, self-help information, referrals for clinics and programs, and smoking cessation aides. The Maryland Quitline offers counseling and referrals but does not provide smoking cessation medication. It does, however, refer smokers to local programs that do.

Of the carriers Mercer surveyed, few covered smoking cessation programs. One covered the program only if justified by a medical condition. However, most carriers covered the prescription drugs related to smoking cessation.

According to the Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2001, 23% of employers with less than 500 employees and 31% of employers with more than 500 employees cover smoking cessation services. Of those employers that cover the service, 61% cover individual counseling, 88% cover prescription drugs, 33% cover over-the-counter medications, and 49% cover self-help programs.

In a 2002 American Association of Health Plans (AAHP) survey, it was determined that 30% of Managed Care Organizations (MCOs) have no smoking cessation guidelines, 89% cover prescription drugs, and 42% will not cover behavioral therapy for smoking cessation efforts.

According to the Henry J. Kaiser Family Foundation, *"State Medicaid Coverage of Tobacco Dependence Treatments, 2003,"* only seven State Medicaid programs covered comprehensive smoking cessation efforts in 2003.

The ALA and the American Cancer Society offer smoking cessation materials and programs at a low or no cost to people wishing to quit. The Maryland chapter of the ALA offers materials and resources such as a Quit Kit and clinic and program referrals. Their *Freedom from Smoking* classes include nicotine replacement therapy at no cost to residents. The classes are also available through the Internet. The Maryland Department of Health and Mental Hygiene (DHMH) identifies more than 100 different resources, by county, in Maryland's Smoking Cessation Resource Directory 2004. Most of these resources – which vary from self-help, information, classes, counseling, nicotine replacement therapy, and even alternative therapies such as acupuncture – are available at no cost to county residents. There are also special programs to service different smoking populations such as teens, over-50, gay and lesbian, pregnant women, and Hispanics. Courses with individual counseling tend to have a greater cost associated with them, and program availability varies by county.

Smoking cessation programs are also provided for the public at Maryland hospitals, universities, schools, and health departments. Many of these programs are free or will work with low-income residents to provide treatment.

Even without insurance coverage, cessation programs have become more accessible in Maryland because of the Tobacco Master Settlement Agreement. To direct the use of these funds, SB896/HB1425 (2000) created the Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening, and Treatment Program under the DHMH. For fiscal year 2001, $18.1 million was earmarked for the Tobacco Use Prevention and Cessation Program. A portion of these funds support and implement local and statewide cessation and prevention programs. The funds are also allocated for tobacco law enforcement, countermarketing, and surveillance and evaluation. Through this program, smoking cessation programs have become more available to those who currently are not insured for this benefit.

However, it is worth noting that states have reduced funds for anti-smoking programs by 28% since 2001 according to a recent report by the Campaign for Tobacco-Free Kids, American Heart Association, American Cancer Society and ALA. The report finds that all but three states failed to meet minimum funding guidelines recommended by the CDC for 2004 and that the funding in 2005 for all states combined is only a third of what CDC recommends. There is concern that not enough tobacco settlement money is being used for the establishment and support of smoking cessation and prevention programs. Maryland's state ranking by the ALA went from an A in 2002 to an F in 2003 due to substantial funding cuts. For 2005, its tobacco cessation and prevention spending is only 31% of what the CDC recommends. Fiscal year 2005 budgets for both DHMH and the Cigarette Restitution Fund Program (CRFP) reflect a steady decrease in state funds available for smoking cessation since 2003. CRFP's operating budget for the Tobacco Use Prevention and Cessation Program went from $19.6M in 2003 to $14.3M in 2004 to $9.5M in 2005. The 2005 DHMH budget reduces funds for statewide tobacco use cessation activities by $662,000 and reduces grants to local health departments for cancer and tobacco programs by $2.5M. Maryland state law requires the Governor to include $21M for tobacco prevention activities, but a 2003 Budget Reconciliation Act (BRA) lowered it to $18M and a 2004 BRA threatens to permanently lower this amount to $12M. Despite the current prevalence of free programs in Maryland, these budget cuts pose substantial challenges to organizations providing free programs and nicotine replacement therapies.

A study published by The New England Journal of Medicine in September 1998 continues to be widely cited as evidence that smokers are more likely to try smoking cessation programs if they have full health insurance coverage. Despite the quitting rate being lower for covered smoker participants (smokers who are covered to participate in programs are actually less likely to quit than those who have to pay for the programs), their increased participation rate more than offsets their decreased success rate. Overall, the highest rates of smokers who successfully kick the habit occur in those with full coverage plans because of the higher participation rate.

In this study, the researchers looked at 90,005 health plan enrollees at seven different companies. The subjects had four different types of insurance:

- Standard coverage (smokers paid half the fee of a behavioral program, $42.50, and $5 for a nicotine replacement product)
- Reduced coverage group ($42.50 for the behavioral program, $85 for nicotine replacement)
- Flipped coverage group ($85 for the nicotine replacement, $0 for a behavioral program)
- Full coverage group (both were free).

They found that 2.4% of smokers with reduced coverage used the smoking cessation services compared with 10% of smokers with full coverage. Of the smokers who participated, the quitting rate by coverage level was:

- 38% with standard coverage
- 31% with reduced coverage
- 33% with flipped coverage
- 28% with full coverage

Taking both use rates and success rates into account, the percentage of smokers who would quit smoking under each program is estimated to be:

- 1.3% with standard coverage
- 0.7% with reduced coverage
- 1.7% with flipped coverage
- 2.8% with full coverage

This shows that more generous coverage is more effective in getting smokers to quit, primarily because of the higher participation rates. As reported in the 2001 American Journal of Health Promotion, enrollees offered full coverage were four times as likely to use cessation services and four times as likely to quit as those offered 50% coverage.

An article recently published by the International Foundation of Employee Benefit Plans confirmed these findings by examining the use of copays and coinsurance in the benefit design of three different employer-sponsored cessation programs. It found that suspending the copayment and pharmacotherapy coinsurance appeared to have a "strong, positive" influence on enrollment in the programs. Participation in one plan fluctuated ten-fold month to month when copays were suspended and reinstated. A 2003 field report by the Commonwealth Fund found that even a $45 copayment deterred smokers from participating in a telephone-counseling plan with pharmacotherapy. To be successful, they determined the program needed to be offered as a fully covered benefit. A 2001 report in Tobacco Control concludes that "full health insurance coverage with no patient cost sharing for nicotine patch and gum and group smoking cessation classes increases quit attempts, use of nicotine replacement therapy, and quit rates among smokers in HMOs."

The updated 2000 clinical guidelines from Public Health Service (PHS) as well as AAHP's 2001 Resource Guide concur on the importance of removing any financial barriers to access for smoking cessation programs.

According to the Agency for Healthcare Research and Quality's (AHRQ) 1996 clinical guidelines, the average cost per smoker for effective cessation treatment is $165.61. These data were not updated by the 2000 PHS guidelines.

The following table shows the average cost for each smoking cessation intervention, assuming that the entire U.S. population of smokers over the age of 18 years would be willing to undergo an intervention to quit smoking. The cost is the total average cost per smoker and includes the

costs of screening, advising, motivation, and direct intervention, with and without nicotine replacement for the interventions indicated. Across all types of interventions, the estimated cost per smoker is $165.61 per attempt. The cost of each intervention varies according to the amount of provider counseling, the provision of nicotine replacement therapy and the effectiveness of the treatment.

	Without nicotine intervention	**With transdermal nicotine replacement**	**With nicotine gum**
Minimal counseling (< 3 min duration)	$33.20	$167.11	$172.18
Brief counseling (> 3 min to < 10 min)	$56.48	$185.57	$192.40
Full counseling	$94.24	$231.30	$246.34
Individual intensive counseling	$123.19	$255.01	$271.01
Group intensive counseling	$71.83	$203.65	$219.65

The level of public demand for smoking cessation treatment access is not high, probably because of the relatively low cost of these programs and the somewhat low rates of intervention by clinicians. According to a 2003 article in The Annual Review of Public Health, there is no real demand for cessation services on the part of covered populations or their employers. However, there are a number of considerations that could drive demand higher. Rising health care costs are causing everyone to look at the drivers, and addressing and preventing smoking-related illnesses may be appealing to many employers. National media campaigns such as American Legacy Foundation's truth.com are aimed at preventing the next generation of smokers and helping current smokers to quit. HHS recently announced one of the most comprehensive anti-smoking initiatives in the Federal government and established a central national Quitline to help smokers reach local state resources. HHS and AAHP are actively promoting their guidelines to encourage clinicians to increase their rates of intervention with smoker patients. The CDC's Healthy People 2010 objectives include raising the "attempt quit rate" among adults to 75% (43% in 1997) and raising the average national tobacco tax to $2 per pack. At the polls earlier this year, three states voted to substantially raise tobacco tax bringing the total to 38 states that have raised tobacco tax since 2002. The average tobacco tax for all states has risen from 44 cents per pack to almost twice that at 84 cents per pack in the last 3 years. Other CDC Healthy People 2010 objectives aim to increase tobacco-free school, public area and workplace environments. Voters also overwhelmingly upheld smoke-free ordinances for the workplace in the latest election and indicate receptivity to expanding these ordinances to restaurants and other public spaces.

As reported by the ALA and the Center for Tobacco Regulation, Litigation & Advocacy at University of Maryland School of Law, seven (out of 24) Maryland counties now have tobacco product placement laws that require the intervention of a clerk and five counties have county youth access laws that allow the health departments or other county agencies (other than law enforcement) to do enforcement checks and issue fines. In July 2003, Montgomery County passed a bill to ban smoking in all bars and restaurants, which went into effect October 9, 2003. Two other counties, Talbot and Howard, have clean indoor air laws that are stronger than the

state regulation, and Talbot recently strengthened its laws to also ban smoking in bars and restaurants. Together these factors could all contribute to increased future demand for tobacco cessation programs.

The responses from our survey of collective bargaining agents show little interest in this proposed mandate.

In general, few self-funded employers cover the programs, and when it is offered, it is outside the health insurance plan. Prescription drugs required for smoking cessation are generally covered, but not over-the-counter drugs.

Medical

- Is it recognized by the medical community as being effective and efficacious in the treatment of patients?
- Is it recognized by the medical communities demonstrated by a review of scientific and peer review literature?
- Is it available and utilized by treating physicians?

The Tobacco Use and Dependence Guideline Panel, along with consortium representatives, consultants, and staff, created "Treating Tobacco Use and Dependence," a PHS-sponsored Clinical Practice Guideline. Updated in 2000 from the 1996 Agency for Health Care Policy and Research (AHCPR), now AHRQ, sponsored Smoking Cessation Clinical Practice Guideline No. 18, the new guideline reflects current, effective clinical treatments for tobacco dependence since 1994. The following seven Federal Government and nonprofit organizations sponsored the updated guideline: AHRQ, CDC, National Cancer Institute (NCI), National Heart, Lung, and Blood Institute (NHLBI), National Institute on Drug Abuse (NIDA), Robert Wood Johnson Foundation (RWJF), and University of Wisconsin Medical School's Center for Tobacco Research and Intervention (CTRI). The update was needed because new counseling strategies and medication have become available as well as new evidence supporting the cost-effectiveness of cessation treatments.

The key recommendations of the updated Clinical Practice Guideline are as follows:

1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.

2. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments:
    - Patients willing to try to quit tobacco use should be provided with treatments identified as effective in this guideline.
    - Patients unwilling to try to quit tobacco use should be provided with a brief intervention designed to increase their motivation to quit.

3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user seen in a health care setting.

4. Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment.

5. There is a strong dose-response relation between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).

6. Three types of counseling and behavioral therapies were found to be especially effective and should be used with all patients attempting tobacco cessation:

- Provision of practical counseling (problem solving/skills training);
- Provision of social support as part of treatment (intra-treatment social support); and
- Help in securing social support outside of treatment (extra-treatment social support).

7. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit smoking.

- Five first-line pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:
  - Bupropion SR
  - Nicotine gum
  - Nicotine inhaler
  - Nicotine nasal spray
  - Nicotine patch
- Two second-line pharmacotherapies were identified as efficacious and may be considered by clinicians if first-line pharmacotherapies are not effective:
  - Clonidine
  - Nortriptyline
- Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

8. Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should ensure that:

- All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments identified as effective in this guideline; and
- Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

The 5 A's were developed from these guidelines to assist clinicians in treating patients willing to quit smoking:

- Ask: systematically identify all smokers at each visit
- Advise: urge all smokers to quit
- Assess: determine the client's willingness to make a quit attempt
- Assist: aid the client in quitting
- Arrange: schedule follow-up contact

According to the guidelines, even brief physician intervention effectively increases a smoker's chances of quitting. Counseling and pharmacology each independently boost quit success rates further but optimal rates of success may combine the treatments. The clinician must decide a course of treatment in light of available resources and circumstances presented by the patient. Using these scientifically proven effective treatments can double or even triple a patient's chance of successful quitting.

There are numerous documented studies and field reports that either based their program foundations on the guidelines or the 5 A's, or supported the guideline findings with regard to what methods are successful and how the programs are cost-effective. The following are some of the studies and reports that support the guidelines and findings.

The 5 A's are the foundation for the smoking cessation toolkit created by the California Tobacco Control Alliance's managed care working group. The toolkits are designed to provide primary care physicians the opportunity to encourage patients to quit smoking.

Built on the framework of the 5 A's, Group Health Cooperative (GHC), a Seattle based integrated health system and health plan, created the Free and Clear program, a telephone-based behavioral counseling program which includes pharmacotherapy. At first, the program had a $45 co-payment; however, due to evidence proving that it was a financial barrier to many, it was later abandoned. Used by a record number of smokers each year, Free and Clear's quit rate is astounding, running from 25 to even 30 percent. Research and findings were provided by The Commonwealth Fund in their April 2003 field report "The Business Case for Tobacco Cessation Programs: A Case Study of Group Health Cooperative in Seattle."

Published in 2002 in the American Journal of Industrial Medicine, Taft Hartley Funds initiated a pilot program in the Carpenters Health and Security Trust of Western Washington based on the Federal Clinical Guidelines for Smoking Cessation. In 1998, GHC's Free and Clear program was implemented, where participants were able to choose a 1-call or more intensive 5-call counseling plan. Roughly 75% of the participants opted to use pharmacotherapy, which, in this case, was limited to only the nicotine patch, nicotine gum, and/or Bupropion. Quit rates for this program were 27.5% the first year and a projected 35% per year thereafter. The program cost was $1,025.28 per smoker who quit, which equated to $11.78 per full-time equivalent employee covered by the Fund per year. For the participants who quit, the compounded savings in reduced lifetime smoking-related medical costs are calculated to be 15 times the cost of the program, yielding an annual return on investment of 27.6%.

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According to the Director of Chemical Services for New York City Health and Hospital Corporation's North Brooklyn Health Network in the July 2004 issue of Managed Healthcare, implementing a basic tobacco-reduction intervention, i.e., counseling sessions that incorporate PHS's Five A's, would cost about $0.22 per member per year (PMPY). After five years, the return equals $4.08. Providing pharmacotherapy increases the PMPY to $0.68, with a return of $4.31. Better yet, employers may observe returns of $5.04 to $6.48 from fewer sick days, an increase in productivity, and a decrease in additional expenses, i.e. designated smoking areas.

In 2001, AAHP released "Addressing Tobacco in Managed Care" to serve as a research guide for health plans. The guide endorses and supports the PHS's Clinical Practice Guideline. In Portland, Oregon, Kaiser Permanente Northwest developed TRAC (Tobacco, Reduction, Assessment and Care), which was based on the foundations of the 4 A's (now the 5 A's). In addition to 30-second clinician counseling, nurses were available to show educational videos and address concerns. By including the nurse-assisted component, the long-term quit rate nearly doubled. In Waltham, Massachusetts, Tufts Health Plan, along with the Massachusetts Department of Public Health, integrated Quitting for You 2, now known as "Tufts Health Plan's Smoking Cessation Program for Pregnant Women." As with TRAC, this program is also based on the 4 A's (now the 5 A's). Quit rates were reported at 30.3% for participants two weeks before giving birth, and an overall 35.5% for participants who met their self-defined quit date.

The March 2004 issue of Employee Benefits Journal presents another case to support smoking cessation programs as a covered benefit. Uniform Medical Plan (UMP) is a self-insured preferred provider health insurance plan available to Washington State active and retired public employees and their dependents. In January 2000, UMP implemented a telephone-based tobacco cessation program. Over 1300 members enrolled. The next year, UMP evaluated the impact of the program registration copayment ($17.50) and standard pharmacotherapy coinsurance. From November 1 until December 31, 2001, UMP suspended the copayment and coinsurance requirements. November and December 2001 boasted 341 and 270 participants, respectively, compared to November and December the previous year with 31 and 10 participants, respectively. The copayment was reinstated in January 2002, and enrollment dropped from 270 in December, 2001, to 23 at the end of January, 2002. Similar promotions in 2002 and 2003 displayed similar results. In short, eliminating the copayment and coinsurance proved to increase enrollment drastically.

The CDC report "Reducing Tobacco Use: A Report of the Surgeon General," published in 2000, discusses the efficacy of several nicotine and non-nicotine based pharmacotherapy, including the following:

- Bupropion
- Nicotine gum
- Nicotine inhaler
- Nicotine nasal spray
- Transdermal nicotine
- Clonidine
- Nortriptyline

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The report looks at previous studies and from these studies determines that all these pharmacological interventions are effective in increasing smoking abstinence rates. The report presents a meta-analysis of previous studies. The analysis, published in 2000, compares the smoking abstinence rate for the pharmacological compared to the abstinence rate for a placebo. The rates are shown in the following table.

	Abstinence rate for pharmacological	Abstinence rate for placebo
Bupropion	30.5%	17.3%
Nicotine gum	23.7%	17.1%
Nicotine inhaler	22.8%	10.5%
Nicotine nasal spray	30.5%	13.9%
Transdermal nicotine	17.7%	10.0%
Clonidine	25.6%	13.9%
Nortriptyline	30.1%	11.7%

For the pharmacologicals, the abstinence rate is significantly higher than the abstinence rate for the placebo.

It also states in the CDC report that by implementing the PHS-sponsored Clinical Practice Guideline, the cost per quality-adjusted life year saved (QALYS) ranges from $1,108 to $4,524. Compared to the cost per QALYS of annual mammography for women at $61,744 or hypertension screening for men at $23,335, smoking cessation is considered extremely cost effective. An article in a 2001 issue of American Journal of Preventive Medicine puts adult and adolescent tobacco assessment and cessation treatment near the very top of cost-effective and recommended clinical preventive services. While it is behind child vaccinations, it is recommended ahead of cervical, colorectal, and breast cancer screening, hypertension, cholesterol, and alcoholism screening as well as dietary counseling.

In 1997 the National Committee for Quality Assurance (NCQA) added a measure to its Health Plan Employer Data Information Set (HEDIS) to track what percentage of clinicians intervened with smoker patients. In 1996, 61% of smokers were advised by their MCO clinicians to quit in a routine office visit. By 2001, that percent rose to 66% and the average for 2003 – 2004 was 68%. In 2003 HEDIS added measures to track the provision of medications and strategies that follow the intervention. The mean average for 2003 and 2004 shows that cessation medications and strategies were subsequently only likely to be discussed 37% and 36% of the time, respectively. Efforts are underway to increase these percentages. The 2001 AAHP resource guide claims that its member plans all pledged to promote their guidelines among participating clinicians.

In 2002, Maryland Health Care Commission's Maryland Hospital Performance Evaluation Guide and the Joint Commission on Accreditation of Healthcare Organizations (JACHO) added smoking cessation advice and counseling as a quality of care core measure in the discharge of adult patients with heart failure or pneumonia and a history of smoking in the last 12 months. JCAHO data from 2003 found that 39% of smokers with heart failure and 35% of smokers with pneumonia were advised to quit upon their discharge.

A 2003 national study of 1,587 physician organizations (with 20 or more physicians) found that 70% of physician organizations offered their physicians some support in smoking cessation interventions: 17% require physicians to provide interventions, 15% evaluate interventions, 39% of physician organizations offer smoking health promotion programs, 25% provide nicotine replacement therapy starter kits, and materials are provided on pharmacotherapy (39%), counseling (37%), and self-help (58%). Among others, external financial incentives and public recognition for quality measures were noted as positive factors for intervention, as were awareness of the clinical guidelines and organizational size and ownership. HHS worked with the popular Internet site WebMD to help promote clinician awareness of its guidelines and its latest Quitline initiative. HHS also made the free training on its guidelines for intervention count towards clinicians' Continuing Medical Education (CME) credit. NCI recently developed a Handheld Computer Smoking Intervention Tool to assist physicians with patient interventions at the point-of-care. The tool guides the clinician through assessment of dependency, intervention, and recommended course of treatment. The tool has common prescription information as well as the PHS Guidelines. The tool is free and can be downloaded from the HHS website http://www.smokefree.gov/hp-hcsit.html.

Proposed Mandates

Privatization of Helicopter Ambulance Services

Currently, private helicopters perform most inter-hospital air ambulance transports while the Maryland State Police helicopters perform almost all scene transports. Private helicopter services are supported through health insurance reimbursement while State Police helicopter transports are supported by a surcharge on motor vehicle registrations. Private helicopter services have expressed interest in doing scene transports when appropriate. The State Police helicopters are nearing the end of their useful life and the source of funds for their replacement has yet to be determined. The proposed mandate would require carriers to cover the services that would transfer to private air ambulance companies.

The report on this proposed mandate includes information from several sources to provide more than one perspective. As a result, it contains some conflicting information. Mercer's intent is to be unbiased. While we included only sources we consider credible, we do not state that a given source is more credible than another source. The reader is advised to weigh the evidence.

The financial, social and medical impacts of this proposal follow.

Financial

Mercer was provided with a Maryland State Police, Aviation Division Fiscal 2004 Budget Request that showed total estimated annual expenses of $20.6 million. Approximately 84% of flights are for emergency medical services. Assuming the State EMS flights have the same cost as the State search & rescue and law enforcement flights, the State EMS cost is $17.3 million.

While this budget did include $1.1 million for the third year payment of a new aircraft, it does not include the cost of replacing the current equipment. Assuming an average cost of $6 million per helicopter and that, on average, one helicopter is purchased every 2 years, the annual cost for replacing helicopters would be $3 million rather than $1.1 million. This brings the State EMS helicopter budget up to $19.2 million.

The Maryland Health Care Commission report, *State Health Care Expenditures, Experience from 2002* shows total health care expenditures of $22.6 billion. Assuming that fiscal year 2004 health expenses will be about 20% higher, the projected expenses are $27.1 billion.

In fiscal year 2003, commercial services had 2,875 inter-hospital transfers while the State had 6,766 EMS flights in 2002. Even if the State stops the service, private companies will need to purchase additional equipment to fill the gap.

Assuming that private companies can operate under a similar EMS budget, and that these costs are billed to the patients, the additional patient charges are about 0.07% of the projected health expenditures. This translates to about a $4.50 increase in the annual group insurance policy rate. Because these expenses are currently covered by the State rather than charged to insurance companies, the marginal cost equals the full cost.

The full and marginal costs are summarized below:

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.07%	0.07%
Estimated cost as a percentage of average wage	0.01%	0.01%
Estimated annual per employee cost of mandated benefits for group policies	$4.50	$4.50

Social

- What is the extent to which the service is generally utilized by a significant portion of the population?
- What is the extent to which the insurance coverage is already generally available?
- What is the extent to which lack of coverage results in individuals avoiding necessary health care treatments?
- What is the extent to which lack of coverage results in unreasonable financial hardship?
- What is the level of public demand for the services?
- What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts?
- What is the extent to which the mandated health insurance service is covered by self-funded employers in the state who employ at least 500 employees?

In 2002, the Maryland State Police Aviation Division had 6,766 flights. The 2003 population estimate for Maryland is 5.5 million. The annual use rate is then 1.2 EMS flights per thousand.

The average cost per flight is about $2,800 but the cost will vary. Two of the private companies that provide inter-hospital transfers are MedSTAR and STAT MedEvac. For the transfer services, MedSTAR reported a fiscal year average charge of $4,200 and an average reimbursement of $2,646. STAT MedEvac reported, for EMS, an average charge of $8,000 and an average reimbursement of $4,000. The inter-hospital transfers include a nurse/paramedic crew while the EMS flights do not. This would explain much of the cost difference.

According to their website, STAT MedEvac is a non-profit 501(c)3 organization. They transport patients regardless of their ability to pay and never attach a person's wages or property to collect payment. In fiscal year 2002, they absorbed $2.5 million in uncompensated care.

The responses from our survey of collective bargaining agents show little interest in this proposed mandate.

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Insurance plans include these services as an eligible expense, if charged. Currently, the plans are not charged and are not sure how much premiums will increase if they are charged.

Medical

- Is it recognized by the medical community as being effective and efficacious in the treatment of patients?
- Is it recognized by the medical communities demonstrated by a review of scientific and peer review literature?
- Is it available and utilized by treating physicians?

According to the National Association of EMS Physicians (NAEMSP) in their position paper "Guidelines for Air Medical Dispatch," the usage of air medical transport has increased in part because of the perception it benefits the patient. One benefit is that air EMS crew are generally trained to provide a higher level of care than ground EMS providers. The other benefit is the speed afforded by air transport. However, there is still debate on the use of air transport. The position paper acknowledges that there are cases where ground EMS may be more appropriate, such as in urban areas and that, in most cases, air EMS may not change the outcome. The position paper presents guidelines to avoid the inappropriate use of air EMS. The position paper is endorsed by the Air Medical Physician Association (AMPA).

The NAEMSP general guidelines recommend air ambulance use for:

a. Patients requiring critical interventions should be provided those interventions in the most expeditious manner possible.

b. Patients who are stable should be transported in a manner that best addresses the needs of the patient and the system.

c. Patients with critical injuries or illnesses resulting in unstable vital signs require transport by the fastest available modality, and with a transport team that has the appropriate level of care capabilities, to a center capable of providing definitive care.

d. Patients with critical injuries or illnesses should be transported by a team that can provide intratransport critical care services.

e. Patients who require high-level care during transport, but do not have time-critical illness or injury, may be candidates for ground critical care transport (i.e., by a specialized ground critical care transport vehicle with level of care exceeding that of local EMS) if such service is available and logistically feasible.

The advantages and disadvantages of helicopters are:

a. Advantages

   i. In general, decreased response time to the patient (up to approximately 100 miles distance depending on logistics such as duration of ground transfer leg)

   ii. Decreased out-of-hospital transport time

   iii. Availability of highly trained medical crews and specialized equipment

b. Disadvantages

i. Weather considerations (e.g., icing conditions, weather minimums)

ii. Limited availability as compared with ground EMS

Many times there are logistical issues that make air transport more advantageous:

a. Access and time/distance factors

i. Patients who are in topographically hard-to-reach areas may be best served by air transport.

1. In some cases patients may be in terrain (e.g., mountainside) not easily accessible to surface transport.

2. Other cases may involve the need for transfer of patients from island environs, for whom surface water transport is not appropriate.

ii. Patients in some areas (e.g., in the western United States) may be accessible to ground vehicles, but transport distances are sufficiently long that air transport (by rotor-wing or fixed-wing) is preferable.

b. Systems considerations

i. In some EMS regions, the air medical crew is the only rapidly available asset that can bring a high level of training to critically ill/injured patients. In these systems, there may be a lower threshold for air medical dispatch.

ii. Systems in which there is widespread advanced life support (ALS) coverage, but such coverage is sparse, may see an area left "uncovered" for extended periods if its sole ALS unit is occupied providing an extended transport. Air medical dispatch may be the best means to provide patient care and simultaneously avoid deprivation of a geographic region of timely ALS emergency response.

iii. Disaster and mass casualty incidents offer important opportunities for air medical participation. These roles, too complex for detailed discussion here, are outlined elsewhere.

Based on supporting evidence, the guidelines define the type of trauma scenes that would best be served by a helicopter:

a. General and mechanism considerations

i. Trauma Score <12

ii. Unstable vital signs (e.g., hypotension or tachypnea)

iii. Significant trauma in patients <12 years old, >55 years old, or pregnant patients

iv. Multisystem injuries (e.g., long-bone fractures in different extremities; injury to more than two body regions)

v. Ejection from vehicle

vi. Pedestrian or cyclist struck by motor vehicle

vii. Death in same passenger compartment as patient

viii. Ground provider perception of significant damage to patient's passenger compartment

ix. Penetrating trauma to the abdomen, pelvis, chest, neck, or head

x. Crush injury to the abdomen, chest, or head

xi. Fall from significant height

b. Neurologic considerations

i. Glasgow Coma Scale score <10

ii. Deteriorating mental status

iii. Skull fracture

iv. Neurologic presentation suggestive of spinal cord injury

c. Thoracic considerations

i. Major chest wall injury (e.g., flail chest)

ii. Pneumothorax/hemothorax

iii. Suspected cardiac injury

d. Abdominal/pelvic considerations

i. Significant abdominal pain after blunt trauma

ii. Presence of a "seatbelt" sign or other abdominal wall contusion

iii. Obvious rib fracture below the nipple line

iv. Major pelvic fracture (e.g., unstable pelvic ring disruption, open pelvic fracture, or pelvic fracture with hypotension)

e. Orthopedic/extremity considerations

i. Partial or total amputation of a limb (exclusive of digits)

ii. Finger/thumb amputation when emergent surgical evaluation (i.e., for replantation consideration) is indicated and rapid surface transport is not available

iii. Fracture or dislocation with vascular compromise

iv. Extremity ischemia

v. Open long-bone fractures

vi. Two or more long-bone fractures

f. Major burns

i. >20% body surface area

ii. Involvement of face, head, hands, feet, or genitalia

iii. Inhalational injury

iv. Electrical or chemical burns

v. Burns with associated injuries

g. Patients with near drowning injuries

The paper also recognizes that conditions are continuously changing. There are a growing number of specialized ground critical care vehicles that are good candidates for high-level-of-care ground transport in place of air ambulance.

A study at Pennsylvania State University College of Medicine found that about 95% of helicopter EMS patients would have faced the same chance of survival if they had been transported by ground rather than air; however, the other 5% would not have survived. The cost of the helicopter EMS program per life saved was about $60,000. The study also shows that it would take six ground EMS units to cover the same area as one helicopter EMS unit; therefore the overall cost of a helicopter EMS program is lower. They estimate the per capita cost of the program to be $1 per year.

The American College of Emergency Physicians considers helicopter EMS a crucial component of a tiered response system. They say, "The air ambulance should be recognized as a regional resource that is available to every person needing care, at any time (weather permitting), regardless of the ability to pay."

In a study where air ambulance was discontinued in 1997, data were compared for the 12 months before and 24 months following discontinuation of the helicopter ambulance service. The conclusion was that for the facility, termination of air ambulance service did not have a measurable negative effect on outcomes for trauma patients.

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Exhibit 1 – Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Current Mandates														
Alzheimer's	15-801	RO		1.0	1.0		-	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Mental illness, emotional disorders, drug & alcohol abuse	15-802	M		1.0	1.0	0.5	0.6	1.0	$310	$31	4.8%	0.5%	0.76%	0.08%
Payment for blood products	15-803	M	1.0	1.0	1.0	0.5	0.6	1.0	$13	$0	0.2%	0.0%	0.03%	0.00%
Coverage for off-label use of drugs	15-804	M	1.0	1.0	1.0	0.5	-	1.0	$15	$2	0.2%	0.0%	0.04%	0.00%
Reimbursement for pharmaceutical products	15-805	M		1.0	1.0	0.5	-	1.0	$10	$5	0.2%	0.1%	0.02%	0.01%
Choice of pharmacy	15-806	M		1.0			-		$114	$17	1.8%	0.3%	0.28%	0.04%
Medical foods & modified food products	15-807	M		1.0	1.0	0.5	0.6	1.0	$3	$0	0.0%	0.0%	0.01%	0.00%
Home health care	15-808	M		1.0	1.0	0.5	0.6	1.0	$18	$0	0.3%	0.0%	0.04%	0.00%
Hospice care	15-809	RO		1.0	1.0	0.5	0.6	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
In vitro fertilization	15-810	M	1.0	1.0	1.0	0.5	-	1.0	$47	$40	0.7%	0.6%	0.12%	0.10%
Hospitalization benefits. for childbirth	15-811	M		1.0	1.0	0.5	0.6	1.0	$63	$0	1.0%	0.0%	0.15%	0.00%

Exhibit 1 – Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
IP hosp. coverage for mothers of newborn children (minimum length of stay)	15-812	M	1.0	1.0	1.0	0.5	0.6	1.0	$58	$0	0.9%	0.0%	0.14%	0.00%
Benefits for disability caused by pregnancy or childbirth	15-813	RO			1.0		-	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage for mammograms	15-814	M		1.0	1.0	0.5	0.6	1.0	$32	$1	0.5%	0.0%	0.08%	0.00%
Coverage for reconstructive breast surgery	15-815	M	1.0	1.0	1.0	0.5	0.6	1.0	$3	$0	0.0%	0.0%	0.01%	0.00%
Benefits for routine gynecological care	15-816	M	1.0	1.0	1.0	0.5	0.6	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage for child wellness	15-817	M		1.0	1.0	0.5	0.6	1.0	$47	$0	0.7%	0.0%	0.12%	0.00%
Benefits for treatment of cleft lip and cleft palate	15-818	M		1.0	1.0	0.5	0.6	1.0	$2	$0	0.0%	0.0%	0.00%	0.00%
Coverage for OP services and second opinions	15-819	M		1.0	1.0	0.5	-	1.0	$1	$0	0.0%	0.0%	0.00%	0.00%

Exhibit 1 – Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Benefits for prosthetic devices and orthopedic braces	15-820	M		1.0			0.6		$7	$0	0.1%	0.0%	0.02%	0.00%
Diagnostic & surgical procedures for bones of face, head, & neck	15-821	M		1.0	1.0	0.5	0.6	1.0	$2	$0	0.0%	0.0%	0.00%	0.00%
Coverage for diabetes equipment, supplies, & self management training	15-822	M	1.0	1.0	1.0	0.5	0.6	1.0	$44	$0	0.7%	0.0%	0.11%	0.00%
Coverage for osteoporosis treatment	15-823	M	1.0	1.0	1.0	0.5	0.6	1.0	$6	$0	0.1%	0.0%	0.01%	0.00%
Coverage for maintenance drugs	15-824	M	1.0	1.0	1.0	0.5	0.6	1.0	$4	$0	0.1%	0.0%	0.01%	0.00%
Coverage for detection of prostate cancer	15-825	M	1.0	1.0	1.0	0.5	0.6	1.0	$17	$0	0.3%	0.0%	0.04%	0.00%
Coverage for contraceptives	15-826	M	1.0	1.0	1.0	0.5	0.6	1.0	$41	$6	0.6%	0.1%	0.10%	0.01%
Coverage of clinical trials under specific conditions	15-827	M	1.0	1.0	1.0	0.5	0.6	1.0	$12	$1	0.2%	0.0%	0.03%	0.00%
Coverage for general anesthesia for dental care under specified conditions	15-828	M	1.0	1.0	1.0	0.5	0.6	1.0	$1	$0	0.0%	0.0%	0.00%	0.00%

Exhibit 1 – Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Chlamydia screening based on age and risk factors	15-829	M	1.0	1.0	1.0	0.5	0.6	1.0	$1	$0	0.0%	0.0%	0.00%	0.00%
Referrals to specialists	15-830	M	1.0	1.0	1.0	0.5	0.6	1.0	$2	$0	0.0%	0.0%	0.00%	0.00%
Coverage for prescription drugs and devices	15-831	M	1.0	1.0	1.0	0.5	0.6	1.0	$2	$1	0.0%	0.0%	0.00%	0.00%
Coverage for length of stay for mastectomies	15-832	M	1.0	1.0	1.0	0.5	0.6	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Extension of benefits	15-833	M	1.0	1.0	1.0	0.5	0.6	1.0	$8	$0	0.1%	0.0%	0.02%	0.00%
Coverage for prosthesis following mastectomy	15-834	M	1.0	1.0	1.0	0.5	0.6	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage of habilitative services for children	15-835	M	1.0	1.0	1.0	0.5	0.6	1.0	$4	$1	0.1%	0.0%	0.01%	0.00%
Coverage for wigs for hair loss resulting from chemotherapy	15-836	M	1.0	1.0	1.0	0.5	-	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage for Colorectal cancer screening	15-837	M	1.0	1.0	1.0	0.5	0.6	1.0	$16	$2	0.2%	0.0%	0.04%	0.00%
Coverage for hearing aids for a minor child	15-838	M	1.0	1.0	1.0	0.5	-	1.0	$8	$2	0.1%	0.0%	0.02%	0.00%
Coverage for treatment of morbid obesity	15-839	M	1.0	1.0	1.0	0.5	-	1.0	$42	$11	0.6%	0.2%	0.10%	0.03%

Exhibit 1 – Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Coverage of residential crisis services	15-840	M	1.0	1.0	1.0	0.5	0.6	1.0	$2	$0	0.0%	0.0%	0.00%	0.00%

Exhibit 1 – Financial Analysis of Current Mandates

Summary by Type of Policy

									Estimated Annual Cost of Mandated Benefits Per Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Policy		Estimated Cost as a Percent of Average Wage	
Type of Policy									Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Med. & Large Group Insurance									$834	$103	12.9%	1.6%	2.0%	0.3%
Individual Insurance									$417	$52	12.3%	1.5%	1.0%	0.1%
CSHBP									$431	$26	10.7%	0.6%	1.1%	0.1%
State Employees Benefit Plan									$916	$113	12.9%	1.6%	2.2%	0.3%
Composite									$749	$89	12.6%	1.5%	1.8%	0.2%

Exhibit 2 – Financial Analysis of Proposed Mandates

			Relative Cost Factor				Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
		Mandate or Required Offering	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Proposed Mandates												
Wraparound Mental Health Services for Children		M	1.0	0.5	0.6	1.0	$0.74	$0.67	0.0%	0.0%	0.00%	0.00%
Treatment for Smoking Cessation		M	1.0	0.5	0.6	1.0	$24.00	$6.00	0.4%	0.1%	0.06%	0.01%
Privatization of Helicopter Ambulance Services		M	1.0	0.5	0.6	1.0	$4.50	$4.50	0.1%	0.1%	0.01%	0.01%

Exhibit 2 – Financial Analysis of Proposed Mandates

Summary by Type of Policy

Estimated Cost By							Estimated Annual Cost of Mandated Benefits Per Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Policy		Estimated Cost as a Percent of Average Wage	
Type of Policy							Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Proposed Mandates:												
Med & Large Group Insurance							$29	$11	0.5%	0.2%	0.07%	0.03%
Individual Insurance							$15	$ 6	0.4%	0.2%	0.04%	0.01%
CSHBP							$18	$ 7	0.4%	0.2%	0.04%	0.02%
State Employees Benefit Plan							$32	$12	0.5%	0.2%	0.08%	0.03%
Composite							$29	$11	0.5%	0.2%	0.07%	0.03%

Exhibit 3 – Subtitle 15-1501. Mandated Health Insurance Services

§ 15-1501.

(a) (1) In this subtitle the following words have the meanings indicated.

(2) "Commission" means the Maryland Health Care Commission.

(3) (i) "Mandated health insurance service" means a legislative proposal or statute that would require a particular health care service to be provided or offered in a health benefit plan, by a carrier or other organization authorized to provide health benefit plans in the State.

(ii) "Mandated health insurance service", as applicable to all carriers, does not include services enumerated to describe a health maintenance organization under § 19-701(g)(2) of the Health - General Article.

(b) This subtitle does not affect the ability of the General Assembly to enact legislation on mandated health insurance services.

(c) (1) The Commission shall assess the social, medical, and financial impacts of a proposed mandated health insurance service.

(2) In assessing a proposed mandated health insurance service and to the extent that information is available, the Commission shall consider:

(i) social impacts, including:

1. the extent to which the service is generally utilized by a significant portion of the population;

2. the extent to which the insurance coverage is already generally available;

3. if coverage is not generally available, the extent to which the lack of coverage results in individuals avoiding necessary health care treatments;

4. if coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship;

5. the level of public demand for the service;

6. the level of public demand for insurance coverage of the service;

7. the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts; and

8. the extent to which the mandated health insurance service is covered by self-funded employer groups of employers in the State who employ at least 500 employees;

(ii) medical impacts, including:

1. the extent to which the service is generally recognized by the medical community as being effective and efficacious in the treatment of patients;

2. the extent to which the service is generally recognized by the medical community as demonstrated by a review of scientific and peer review literature; and

3. the extent to which the service is generally available and utilized by treating physicians; and

(iii) financial impacts, including:

1. the extent to which the coverage will increase or decrease the cost of the service;

2. the extent to which the coverage will increase the appropriate use of the service;

3. the extent to which the mandated service will be a substitute for a more expensive service;

4. the extent to which the coverage will increase or decrease the administrative expenses of insurers and the premium and administrative expenses of policy holders;

5. the impact of this coverage on the total cost of health care; and

6. the impact of all mandated health insurance services on employers' ability to purchase health benefits policies meeting their employees' needs.

(d) (1) In addition to the information required under subsection (c) of this section, the Commission shall annually determine the full cost of all existing mandated health insurance services in the State:

(i) as a percentage of Maryland's average annual wage; and

(ii) as a percentage of health insurance premiums.

(2) In making its determination, the Commission shall consider the full cost of the existing mandated health insurance services:

(i) under a typical group and individual health benefit plan in this State;

(ii) under the State employee health benefit plan for medical coverage; and

(iii) under the Comprehensive Standard Health Benefit Plan as defined in § 15-1201(p) of this title.

(e) Subject to the limitations of the State budget, the Commission may contract for actuarial services and other professional services to carry out the provisions of this section.

(f) (1) On or before December 31, 1998, and each December 31 thereafter, the Commission shall submit a report on its findings, including any recommendations, to the Governor and, subject to § 2-1246 of the State Government Article, the General Assembly.

Exhibit 3 – Subtitle 15-1501. Mandated Health Insurance Services

(2) The annual report prepared by the Commission shall include an evaluation of any mandated health insurance service enacted, legislatively proposed, or otherwise submitted to the Commission by a member of the General Assembly prior to July 1 of that year.

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
801	Benefits for Alzheimer's disease and care of elderly individuals		X	X		Health insurers must offer the option of including benefits for the expenses arising from the care of victims of Alzheimer's disease and the care of the elderly to all group purchasers.	Not specifically addressed as covered or excluded; could be covered by .03 A (28): "Any other service approved by a carrier's case management program"

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
802	Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse	19-703.1	X	X	X	All policies providing coverage for health care may not discriminate against any person with a mental illness, emotional disorder, or drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions that apply under the contract or policy for treatment of physical illness. **Inpatient:** Physical illness parity with a minimum of at least 60 days of partial hospitalization; **Outpatient:** 80% coverage for first 5 visits in any calendar year or benefit period; 65% coverage for 6-30 visits; 50% coverage for 31st visit and any visits after the 31st. **Scope:** medically necessary; One set of benefits covering mental illness, emotional disorders, drug abuse and alcohol abuse; may be delivered under a managed care system; cannot maintain separate out-of-pocket limits; medication management visit same as physical illness office visit	**.03 A (4):** "Inpatient mental illness and substance abuse services provided through a carrier's managed care system up to a maximum of 60 days per covered person per year in a hospital or related institution" **.03 A (5):** "Outpatient mental health and substance abuse services provided through a carrier's managed care system" **.03 A (7):** "Detoxification in a hospital or related institution" **.03 C:** "All mental health and substance abuse services described in § A (4) and (5) of this regulation shall be delivered through a carrier's managed care system" **.05 A:** "General Cost-Sharing Arrangement for Outpatient Mental Health and Substance Abuse Services." Except for out-of-network services of this regulation, "...the carrier shall pay for each service 70 percent of allowable charges"

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
803	Payments for blood products	X 19-706(r)	X	X	X	Health insurers may not exclude payments for blood products	Covered; .03 A (24): "All cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin"
804	Coverage for off-label use of drugs	X 19-706(i)	X	X	X	Requires coverage for approved off-label drugs	
805	Reimbursement for pharmaceutical products		X	X	X	Subject policies cannot establish varied reimbursement based on the type of prescribor and cannot vary copayments based on community pharmacy vs. mail order	
806	Choice of pharmacy for filling prescriptions		X			The non-profit health service plan shall allow the member to fill prescriptions at the pharmacy of choice	
807	Coverage for medical foods and modified food products	19-705.5	X	X	X	All insurers shall include under family member coverage, coverage for medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical foods or low protein modified food products are: (1) prescribed as medically necessary for therapeutic treatment of inherited metabolic diseases; and, (2) administered under the direction of a physician	Covered; .03 A (21): "Medical food for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders"

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
808	Benefits for home health care		X	X	X	Health insurance policies that provide coverage for inpatient hospital care on an expense-incurred basis must provide coverage for home health care. The minimum benefit is 40 visits in any calendar year	Covered; .03 A (11): "Home health care services…as an alternative to otherwise covered services in a hospital or related institution;…"
809	Benefits for hospice care		X	X	X	Health insurers must offer individuals and groups benefits for hospice care services	Covered; .03 A (12): "Hospice care services"
810	Benefits for in vitro fertilization (IVF)	X	X	X	X	Carriers that provide pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from IVF procedures. The benefits shall be provided to the same extent as benefits provided for other pregnancy-related procedures. The patient or the patient's spouse must have a history of infertility of at least 2 years or have become infertile from endometriosis, exposure to DES, blockage or removal of fallopian tubes, or abnormal male factors. Carriers may limit coverage of these benefits to 3 IVF attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.	Excluded; .06 B (11): "In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures"
811	Hospitalization benefits for childbirth	19-703 (g)	X	X	X	Every insurance policy that provides benefits for normal pregnancy must provide hospitalization benefits to the same extent as that for any covered illness	Covered; .03 A (25): "Pregnancy and maternity services, including abortion" §15-811 Adopted as mandate

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
812	Inpatient hospitalization coverage for mothers and newborn children	X 19-706(i)	X	X	X	Requires carriers to provide inpatient hospitalization coverage for a mother and newborn child for a minimum of 48 hours after an uncomplicated vaginal delivery and 96 hours after an uncomplicated caesarean section; authorizes a home visit by an experienced registered nurse if the mother requests a shorter hospital stay and an additional home visit if prescribed by the provider; authorizes coverage for up to four additional days for a newborn when the mother continues to be hospitalized; and prohibits sanctions against a provider who advocates a longer stay	Covered; Required by §19-1305.4; effective 7/1/96; §15-812 adopted as mandate
813	Benefits for disability caused by pregnancy on childbirth			X		Insurers must offer to groups purchasing a temporary disability policy the option of extending these benefits to temporary disabilities caused by pregnancy or childbirth	Disability caused by pregnancy/childbirth: Not addressed.
814	Coverage for mammograms		X	X	X	All hospital and major medical insurance policies must include coverage for a baseline mammogram for women who are 35 to 39, a biannual mammogram for women who are 40 to 49, and an annual mammogram for women who are at least 50	Covered; .03 A (10): "Mammography services for persons ages 40 to 49 once every other calendar year, and for ages 50 and above once per calendar year"
815	Coverage for reconstructive breast surgery	X 19-706 (d)(2)	X	X	X	Requires carriers to provide coverage for reconstructive breast surgery resulting from a mastectomy to reestablish symmetry between the two breasts	Covered; .03 A (30): "Breast reconstructive surgery as specified in Insurance Article, § 15-815, Annotated Code of Maryland, and breast prosthesis"

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
816	Benefits for routine gynecological care	X 19-706 (l)	X	X	X	Requires carriers to permit a woman to have direct access to gynecological care from an in-network obstetrician/ gynecologist or other non-physician, including a certified nurse midwife, who is not her primary care physician; requires an obstetrician/ gynecologist to confer with a primary care physician	§15-816 adopted as mandate
817	Coverage for child wellness services		X	X	X	Insurers must include child wellness services in a family policy. Minimally, this must include coverage for immunizations, PKU test, screening tests (tuberculosis, anemia, lead toxicity, hearing & vision), universal hearing screening of newborns; a physical exam, developmental assessment & parental anticipatory guidance services at each visit; and lab tests. Insurers may impose copayments but no deductible	Covered; in accordance with the schedule in the U.S. Preventive Services Task Force Guidelines
818	Benefits for treatment of cleft lip and cleft palate	19-706 (bb)	X	X	X	Every hospital or major medical insurance policy must include benefits for inpatient or outpatient expenses arising from the management of cleft lip, palate, or both	Covered; .03 A (23): "...habilitative services for children 0 to 19 years old for the treatment of congenital or genetic birth defects"
819	Coverage for outpatient services and second opinions		X	X	X	Health insurers must provide reimbursement for a second opinion when denied hospital admission by a utilization review program and when required by a utilization review program and outpatient coverage for a service for which an admission is denied	No specific references.

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
820	Benefits for prosthetic devices and orthopedic braces.		X			Individual and group contracts written by a non-profit health service plan must provide benefits for prosthetic devices and orthopedic braces	Covered; .03 A (13): "Durable medical equipment, including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses"
821	Diagnostic and surgical procedures for bones of face, neck, and head		X	X	X	Health insurers that provide coverage for a diagnostic or surgical procedure involving a bone or joint of the skeletal structure may not exclude or deny coverage for the same diagnostic or surgical procedure involving a bone or joint of the face, neck, or head if the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.	Covered; .06 B (43): "TMJ treatment and treatment for CPS" are excluded, EXCEPT "for surgical services for TMJ and CPS, if medically necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury"
822	Coverage for diabetes equipment, supplies, and self-management training	X 19-706(x)	X	X	X	Carriers shall provide coverage for all medically appropriate and necessary diabetes equipment, diabetes supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy for insulin users, non-insulin users, or elevated blood glucose levels induced by pregnancy	Provides coverage for all medically necessary supplies and equipment; includes 6 nutritional visits. Does not include other educational services.
823	Coverage for osteoporosis prevention and treatment	X 19-706(p)	X	X	X	Carrier shall include coverage for qualified individuals for bone mass measurement when requested by a health care provider	Covered under terms of "medical necessity" as of July 1, 1998; §15-823 adopted as mandate

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
824	Coverage for maintenance drugs	X 19-706(q)	X	X	X	Carrier shall allow the insured to receive up to a 90-day supply of a prescribed maintenance drug in a single dispensing, except for new prescriptions or changes in prescriptions. If carrier increases copayment, they shall proportionally increase the dispensing fee.	Effective July 1, 2004, a copayment for 2 times a single dispensing fee shall apply as follows: 2 x generic @ $15 or $30; 2 x pref. @ $25 or $50; 2 x non-pref. @ $50 or $100
825	Coverage for detection of prostate cancer	X 19-706(u)	X	X	X	Coverage shall be provided for a medically recognized diagnostic examination including a digital rectal exam and prostate – specific antigen (PSA) test for: 1) men between 40 & 75; 2) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; 3) when used for staging in determining the need for a bone scan in patients with prostate cancer; or 4) when used for male patients who are at high risk for prostate cancer.	As of July 1, 1998 adopts American Cancer Society recommendations: 1) annual DRE for both prostate and colorectal cancer beginning at age 40; 2) annual PSA for African American men and all men age 40 or older with a family history of prostate cancer; and 3) an annual PSA screening for all other men age 50 and older.
826	Coverage for contraceptive drugs and devices	X 19-706(i)	X	X	X	Coverage shall be provided for 1) any contraceptive drug or device that is approved by the U.S. F.D.A. for use as a contraceptive and that is obtained under a prescription written by an authorized prescriber; 2) the insertion or removal, and any medically necessary exam associated with the use of such drug or device. An entity may not impose a different copay or coinsurance for a contraceptive drug or device that is imposed for any other Rx.	Covered, effective July 1, 1999; .03 A (22): "Family planning services, including: (a) Prescription contraceptive drugs or devices…"

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
827	Coverage for patient cost for clinical trials	X 19-706 (aa)	X	X	X	Coverage shall be provided for patient cost to a member in a clinical trial as a result of 1) treatment provided for a life-threatening condition; or 2) prevention , early detection, and treatment studies on cancer.	Covered; .03 A (27): "Controlled clinical trials"
828	Coverage for general anesthesia for dental care under specified conditions	X 19-706 (i)	X	X	X	Coverage shall be provided for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to an enrollee or insured under specified conditions.	Covered, effective July 1, 1999; .03 A (32): "General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to the following…"
829	Coverage for detection of chlamydia	X	X	X	X	Coverage shall be provided for an annual routine chlamydia screening test for women who are under the age of 20 if they are sexually active and at least 20 if they have multiple risk factors; and for men who have multiple risk factors	Covered, effective July 1, 2000; .03 A (33): An annual chlamydia screening test for women who are younger than 20 years old who are sexually active or at least 20 years old who have multiple risk factors and men who have multiple risk factors.
830	Referrals to specialists	X	X	X	X	Requires carriers that do not allow direct access to specialists to establish & implement a procedure by which a member may receive under certain circumstances a standing referral to a participating specialist & under certain circumstances to a non-participating specialist; provides pregnant members with a standing referral to an OB	§15-830 adopted as part of the "Patients' Bill of Rights Act," effective Nov. 1, 1999; standing referral for pregnancy adopted, effective October 1, 2000

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
831	Coverage of prescription drugs and devices	X	X	X	X	Each entity limiting its coverage of Rx drugs or devices to those in a formulary shall establish & implement a procedure for a member to receive a Rx drug or device that is not in the entity's formulary when there is no equivalent Rx drug or device in the entity's formulary, an equivalent Rx drug is ineffective or has caused an adverse reaction	§15-831 adopted as part of the "Patients' Bill of Rights Act," effective Nov. 1, 1999
832	Coverage for mastectomies	X	X	X	X	Requires carriers to cover at least 1 home health visit within 24 hrs. after discharge for a patient who had <48 hrs. of inpatient hospitalization after a mastectomy or surgical removal of a testicle, or who undergoes either procedure on an outpatient basis	§15-832 adopted as part of the "Patients' Bill of Rights Act," effective Nov. 1, 1999
833	Extension of benefits	X	X	X	X	Requires carriers to extend certain benefits under specific circumstances except when coverage is terminated because of specified conditions. Charging of premiums is prohibited when benefits are extended	Law impacted CSHBP; effective Oct. 1, 1999
834	Coverage for prostheses	X	X	X	X	Requires carriers to provide coverage for a prosthesis prescribed by a physician for a member who has undergone a mastectomy & has not had breast reconstruction	Covered; .03 A (30): "Breast reconstructive surgery as specified in Insurance Article, § 15-815, Annotated Code of Maryland, and breast prosthesis

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
835	Coverage for habilitative services for children under 19 years of age	X	X	X	X	Requires carriers to provide coverage of habilitative services for children under the age of 19 years with a congenital or genetic birth defect, including autism & cerebral palsy, and may do so through a managed care system; carriers must provide notice annually to its members about the required coverage; carriers are not required to reimburse for habilitative services delivered through early intervention or school services; carriers denying payment for services because it is not a congenital or genetic birth defect is considered an adverse decision.	Covered; .03 B; Coverage shall be provided through the carrier's managed care system
836	Hair prosthesis	X	X	X	X	Requires carriers to provide one hair prosthesis at a cost not to exceed $350 for a member whose hair loss results from chemotherapy or radiation treatment for cancer	Excluded; .06 B (40); "Wigs or cranial prosthesis"
837	Colorectal cancer screening coverage	X	X	X	X	As of July 1, 2001, carriers shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society (ACS)	As of July 1, 2001, adopts ACS recommendations: colorectal screening covered for men & women ages 50 and older as follows: a) a yearly FOBT w/DRE & flexible sigmoidoscopy every 5 yrs.; b) colonoscopy w/DRE every 10 yrs.; or c) double contrast barium enema w/DRE every 5 yrs.

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
838	Hearing aid coverage for a minor child	X	X	X	X	As of October 1, 2001, carriers shall provide coverage for hearing aids for a minor child covered under a policy if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. Carriers may limit the benefit to $1,400 per hearing aid for each hearing-impaired ear every 36 months	Covered; .03 A (34), effective July 1, 2002: "…hearing aids for persons ages 0 to 18 years of age, up to $1,400 per hearing aid for each hearing-impaired ear every 36 months"
839	Coverage for treatment of morbid obesity	X	X	X	X	As of October 1, 2001, carriers shall provide coverage for the surgical treatment of morbid obesity that is recognized by the NIH as effective for the long-term reversal of morbid obesity and consistent with guidelines approved by the NIH. Carriers shall provide coverage for this benefit to the same extent as for other medically necessary surgical procedures under the insured's policy.	Excluded; .06 B (14): "Medical or surgical treatment for obesity, unless otherwise specified in the covered services"
840	Coverage for medically necessary residential crisis services	X	X	X	X	As of October 1, 2002, carriers shall provide coverage for medically necessary residential crisis services defined as intensive mental health & support services 1) provided to a child or an adult with a mental illness at risk of a psychiatric crisis; 2) designed to prevent or provide an alternative to a psychiatric inpatient admission, or shorten the length of inpatient stay; 3) provided at the residence on a short-term basis; and 4) provided by DHMH-licensed entities.	Effective July 1, 2003, provisions of §15-840 will be incorporated into the regulations.