MARYLAND HEALTH CARE COMMISSION

Required Under Section 15-1501 of the Insurance Article

Annual Mandated Health Insurance Services Evaluation

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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 41 "required health insurance benefits for services" (Sections 15-801 through 15-841) 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 15.4% of net premium. Net premium is defined as amount of premium allocated to fund claims. It is also referred to as "pure premium." The use of net premium represents a change in methodology from previous reports, which expressed the costs of mandates as a percent of gross premium. Gross premium is defined as net premium plus expenses plus profit. Gross premium is the premium actually charged by an insurer. Since the cost of mandates reflects only claims or net premium, a more precise measurement of their impact is to compare their net premiums to the aggregate net premium for all benefits. As a percentage of Maryland's average wage, assuming the same average wage for all types of insurance contracts, the full cost averages about 1.9%.

On a marginal cost basis, for all the current mandates, the average cost is about 1.9% of net premium across all insurance contracts. As a percentage of Maryland's average wage, the marginal cost averages 0.2%.

In 2004, Mercer was asked to perform a comprehensive update of the cost of each mandate which provided a re-calibration of these costs. For 2005, the Commission had Mercer adjust the cost estimates for mandates by utilization and unit cost trends.

Medical, Financial, and Social Impact of Proposed Mandates

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

- spinal manipulation services to treat children
- In vitro fertilization
- Coverage of outpatient treatment for behavioral disorders

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 medical, financial, and social impact of proposed mandates is the prerogative of the legislature. Decision makers should be cognizant of the fact that the presence of insurance induces demand, partly by reducing the out-of-pocket cost for the service. Economic theory tells us that if the price of a service decreases, then the demand for the service increases. This is also true for medical services. The presence of insurance reduces the out-of-pocket costs (or price to the consumer) for a particular service. Thus, for a particular benefit or service that is not currently covered (and therefore, requiring that the consumer pay 100% of the cost), mandating insurance coverage will reduce the amount the consumer will have to pay and increase the demand for the

service. This, by itself, may not be an adverse characteristic if it can be demonstrated that the induced demand results in better outcomes and/or is cost efficient.

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 and email 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 maintaining jobs and existing benefits.

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 two legislative bills with accompanying Fiscal Notes containing additional information on the cost impact: Senate Bill 918, In Vitro Fertilization Coverage, and Senate Bill 713, Coverage of Outpatient Treatment for Behavioral Disorders. There was one legislative request for evaluation: spinal manipulation services to treat children ages 12 and under. Mercer is providing an analysis for these three proposals.

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. As part of MHCC's agreement with Mercer, a significant portion of the research for the medical and social impact components of the proposed analysis for spinal manipulations for children 12 and under was performed by a minority business enterprise. Mercer provided support for this enterprise, completed the financial impact analysis, and performed the peer review.

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.

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 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.

There is one new mandate included in the analysis: smoking cessation treatment.

The Mercer Survey of Employer-Sponsored Health Plans showed an average gross annual cost per contract of about $6,879 for Maryland employers in 2004. 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 2004 average gross annual premium of $5,653 per employee. Excluding enhancements, the cost is $4,335 per employee. For small groups, our report compares the cost of mandates to the CSHBP premium rate excluding enhancements.

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.

Financial Analysis of Current Mandates

Combining the estimates for the individual and group markets, our estimate of the 2004 average gross premium rate is $6,285 annually per contract holder.

Exhibit 1 shows the estimated 2004 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 2004 was $42,584, according to statistics from the Maryland Department of Labor, Licensing and Regulation (DLLR). This is 4.6% higher than the 2003 Maryland average annual wage of $40,714.

On a full-cost basis, the total cost for all the current mandates is about 15.4% of net 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 1.1% to 2.2% and averages about 1.9%.

On a marginal cost basis, for all the current mandates, the cost averages about 1.9% 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
- Maternity care
- Choice of pharmacy

On a full cost basis, compared to data in our 2004 report to the MHCC, the cost of the mandates as a percentage of wages increased from 1.8% to 1.9%. The full cost as a percentage of premium increased from about 12.6% to 15.4%. Historically, the impact that mandates have on total premiums has been calculated by first estimating the claims costs each mandate will generate, both on a gross and marginal basis. These claims costs are then compared to the annual premium per contract to generate a percentage. The annual premium per contract reflects the costs of both claims and administration. Probably a more precise measurement is to compare the claims costs generated by the mandates to the expected annual claims cost per contract. The annual claims cost per contract is generated by estimating the amount of premium allocated for claims versus administration, profit, etc. This procedural change results in mandates being a

higher percentage of total premiums than in previous results. However, it is more indicative of the true costs.

On a marginal cost basis, compared to data in our 2004 report to the MHCC, the cost of the mandates as a percentage of premium increased from 1.5% to 1.9%; as a percentage of the average wage it held at 0.2%.

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) of the Insurance Article.

The report on the proposed mandates 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.

Health Insurance – Spinal Manipulation Services for Children Ages 12 and Under

This proposed mandate would require a health insurer, nonprofit health service plan, Medicaid managed care organization, or HMO (carrier) to provide coverage for spinal manipulation services for children 12 years of age and younger. Coverage would be required for up to 7 visits, including an initial consultation/exam.

Although the language of the mandate does not limit the spinal manipulation services to those provided by Doctors of Chiropractic (DCs) specifically, DCs account for more than 90% of spinal manipulations administered in a year -- much higher than for pediatricians, osteopaths, physical therapists and orthopedists. Therefore, this report investigates the spinal manipulation services provided by DCs to children 12 years and under.

To the extent possible, studies and guidelines consulted regarding the utilization, costs and efficacy of these treatments are limited to those regarding pediatric (child and/or adolescent) populations. This report resists applying findings from chiropractic studies on adults to children with like conditions or symptoms.

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

Medical

In this section we answer the following questions related to spinal manipulation services to treat children 12 years and under:

- Are spinal manipulation services for children 12 years and under recognized by the medical community as being effective and efficacious in the treatment of patients?
- Are spinal manipulation services for children 12 years and under recognized by the medical community, as demonstrated by a review of scientific and peer review literature?

Proposed Mandates

- Are spinal manipulation services for children 12 years and under available and utilized by treating physicians and/or other credentialed health care providers?

Spinal manipulation for children suffers from a fractured view of its own efficacy within the chiropractic profession, and views among conventional medical practitioners (pediatricians and family physicians) range from curious to skeptical to strongly opposed. Within the profession, DCs are divided by how closely they adhere to the tenet of subluxation in chiropractic.

A little over a hundred years ago, chiropractic was founded on the understanding that all illness (symptoms and conditions) sprung from spinal column or other joint misalignment, also known as subluxation. By manipulating the column and adjacent tissues to restore proper alignment and range of motion, DCs could treat the source of the symptoms and thereby achieve optimal health. The strictest adherents, or the "straights," claim that chiropractic does not treat any condition; instead, it is a broad wellness approach that resolves symptoms and prevents illness through spinal adjustment. By treating subluxation, DCs claim they can also treat non neuromusculoskeletal conditions like allergies, asthma, digestive disorders, otitis media (non-suppurative ear infection) and other disorders as new research is developed. Over time and controversy regarding the validity of subluxation as a condition or treatment philosophy, some DCs, (the "mixers"), took a more liberal approach, limiting their scope of practice more to the treatment of neuromusculoskeletal conditions and incorporating additional diagnostic tools and therapeutic techniques such as radiographic imaging and nutritional advice or supplements. Public demand and legislation in the last 30 years forced conventional medical doctors to recognize DCs; prior to that, MDs largely regarded chiropractic as an unscientific cult and systematically deterred patients from their services. To determine the extent to which the medical community now recognizes spinal manipulation services for children under age 13 as effective and efficacious, it is useful to examine the various clinical guidelines regarding the treatments and their practitioners.

Within chiropractic in the U.S., there are three main professional associations with policies on spinal manipulation services for children: American Chiropractic Association (ACA); International Chiropractors Association (ICA – with its specialty department, The Council on Chiropractic Pediatrics; members of the International Chiropractic Pediatric Association are a general sub-set of ICA); and National Association for Chiropractic Medicine (NACM). The ACA has the highest U.S. membership, with around 25% of DCs (the generally accepted number of U.S. DCs is about 50,000). The ICA only has around 5% to 10% of U.S. DCs as its members, but it has a higher prevalence of DCs who are self- and peer-identified as pediatric DCs (those with pediatric diploma and/or who see more children patients than a typical DC). NACM represents fewer than 2% of. the DCs in the United States.

Proposed Mandates

Both the ACA and the ICA have policies stating that children may benefit from spinal adjustments. The ACA states that:

> "The Doctor of Chiropractic gives particular attention to spinal biomechanics (including the subluxation complex), musculoskeletal, neurological, vascular, nutritional, and environmental relationships in the restoration and maintenance of health. Infant and childcare is included in the scope of care provided by the chiropractic profession, as taught in and through accredited colleges of chiropractic…The chiropractic profession recognizes that poor posture, and physical injury, including birth trauma, may be common primary causes of illness in children, which can have a direct and significant impact on not only spinal biomechanics, but on other bodily functions."

The ICA states that:

> "Since vertebral subluxation may affect individuals at any age, chiropractic care may be indicated at any time after birth. As with any age group, however, care must be taken to select adjustment methods most appropriate to the patient's stage of development and overall spinal integrity. Parental education by the subluxation-centered chiropractor concerning the importance of evaluating children for the presence of vertebral subluxation is encouraged."

Although both groups support spinal adjustments for children, according to a 2000 survey, ACA members are more likely to be "mixer" DCs who use spinal manipulation in conjunction with a broader range of diagnostic tools and therapies, such as lab tests, nutritional supplements, herbal remedies, and lifestyle advice. ACA members are more likely to make more limited claims about their scope of practice and often restrict their practices to adults or specific conditions, such as lower back pain. The ACA sponsored the development of *The Mercy Guidelines* in the early 1990s, which focused largely on the safety and efficacy of spinal adjustments for the treatment of low-back pain in adults. An independent review in 2001 validated *The Mercy Guidelines* with a proviso that new scientific data should be considered. ACA's policy on spinal manipulation for children is adjunctive to these guidelines. ICA members are more likely to be "straight" DCs – relying primarily on chiropractic adjustments to promote health and embrace a wider range of health benefits from chiropractic. They rejected *The Mercy Guidelines* and developed their own in 1998 (updated in 2003), *The Council on Chiropractic Practice Clinical Practice Guidelines*. These guidelines relied more heavily on expert opinion and case studies for evidence. As noted, pediatric DCs are more likely to be ICA members.

The NACM states that:

> "…individuals under twelve (12) years of age should be seen only in conjunction with a licensed medical/osteopathic pediatrician… [and] Spinal

manipulative procedures are not generally accepted for the treatment of children under six (6) years of age."

NACM differs from ACA and ICA not only in the chiropractic treatment of children, but in the treatment of adults as well. NACM emphatically renounces subluxation as the root of disease or even as a scientifically valid term or condition. Their members believe that spinal manipulation is only useful for affecting joint dysfunctional disorders that result from normal or excessive "wear" on the joints. As such, they restrict their practices to the treatment of neuromusculoskeletal conditions and do not believe that DCs are sufficiently trained to serve as PCPs for either adults or children. The basis for NACM's position on children and spinal manipulation comes from the 1993 *Report to the Committees on Armed Services and Appropriations -- CHAMPUS Chiropractic Demonstration*. In this demonstration, only children 16 years and older were eligible for participation "based on review of chiropractic literature that efficacy of chiropractic treatment of young children had not been established and to present more risk than benefit."

Among pediatricians and family physicians, chiropractic is mentioned specifically in the practice guidelines for ear infections (Acute Otitis Media and Otitis Media with Effusion – AOM and OME) and asthma and allergies. The American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP) acknowledge increasing interest in CAM treatments along with many case reports, subjective reviews, and pilot studies assessing the effectiveness of chiropractic. However, they make no recommendations for CAM for treatment of AOM or OME based on limited or controversial data. With asthma and some allergy (sinusitis) treatment, they find that "chiropractic manipulation… [has] not been shown to be superior to placebo in controlled studies, although the data are limited." For the treatment of Attention-Deficit-Hyperactive-Disorder (ADHD), the AAP and AAFP clinical practice guidelines note the need for well-designed rigorous studies of currently promoted but less well-established therapies, such as occupational therapy, biofeedback, herbs, vitamins, and food supplements; however, chiropractic is not mentioned.

There is a distinct lack of large-scale, well-designed, randomized, and controlled studies regarding the efficacy of spinal manipulation services for children 12 years and under. Studies that have been published in mainstream scientific and peer review literature have had negative findings for the efficacy of spinal manipulation services in pediatric populations. DC researchers and proponents acknowledge this fact as well. However, they also contend that efficacy of the treatments may have less to do with this result than with overcoming barriers attached to chiropractic as an alternative medicine.

Spinal manipulation for the treatment of low back pain in adults was legitimized as a "mainstream" treatment by a government-sponsored report, "Clinical Practice Guideline for Low Back Pain" in 1994. Neck pain, headaches, sports injuries, and repetitive strains, as well as pains from arthritis followed as neuromusculoskeletal conditions of adults that could be treated by spinal manipulations. Spinal manipulation as a treatment

for non-neuromusculoskeletal conditions – which comprise many of the pediatric conditions in question such as ear infection, allergies, colic, and ADHD – remain outside what the larger medical community recognizes. DCs claim a pronounced anti-chiropractic and anti-CAM bias among review boards for both study grant funding and mainstream medical publication.

According to The Foundation for Chiropractic Education and Research (FCER), until DCs are able to secure more funding and wider publication, they place more value on well-documented case studies and expert opinion. DCs do not claim these studies to be conclusive or evidence for treatment; however, their suggestive and sometimes compelling results indicate a need for larger studies. There are two peer-reviewed journals that focus specifically on pediatric chiropractics: Chiropractic Pediatrics and the Journal of Clinical Chiropractic Pediatrics. However, MDs are not included on the editorial boards. Likewise, the editorial board for The New England Journal of Medicine (NEJM) does not include any DCs.

Some of the more common conditions among children under age 13 that DCs believe may be treated with spinal manipulation services include asthma and allergies, ear infections, persistent crying (colic), back pain and sports injuries, and neurological disorders such as ADHD, epilepsy, and autism. The following publications examine some of the scientific and peer review literature available regarding these conditions.

In 1998, NEJM published "A Comparison of Active and Simulated Chiropractic Manipulation as Adjunctive Treatment for Childhood Asthma." This randomized, controlled trial of chiropractic spinal manipulation for children with mild to moderate asthma found that "the addition of chiropractic spinal manipulation to usual medical care provided no benefit." The FCER countered that NEJM's published study's blinding technique for the control group was flawed and that the continued medication may have obscured the effects of the manipulation treatments. In 2001, the Journal of Manipulative Physiology Therapy published another randomized clinical pilot study on chronic pediatric asthma and added spinal manipulation to their optimal medical care. It found no important changes in lung function or hyper-responsiveness, but the children rated their quality of life substantially higher and their severity of asthma much lower. It concluded that the improvements were not likely a result of the manipulations alone but other aspects of the clinical encounter (such as more frequent, quality time with the DCs over standard treatment with MDs). DCs counter that the reason may have been the physical contact (hands of the DC on the patient) that led to the improvements, and these studies ignore that possibility and the additional anecdotal support for it. Similarly, a 1997 study in Journal of Vertebral Subluxation Research found that for children receiving spinal manipulation treatment, "chiropractic care, for correction of vertebral subluxation, is a safe nonpharmacologic health care approach which may also be associated with significant decreases in asthma related impairment as well as a decreased incidence of asthmatic "attacks." The findings suggest that chiropractic care should be further investigated relative to providing the most efficacious care management regimen for pediatric asthmatics.

An MD is currently directing a study under a grant from the Consortial Center for Chiropractic Research and the National Institutes of Health (NIH) National Center for Complementary and Alternative Medicine (NCCAM) to examine whether chiropractic treatment will reduce the likelihood of the persistence of effusion in children with OME when compared to usual care. Results are not yet available. A 1996 study published in the Journal of Manipulative Physiology Therapy studied 46 children ages 5 and under who were treated with spinal manipulation therapy for recurring ear infections and found that 93% of all episodes improved; (75% in 10 days or fewer and 43% with only one or two treatments). A 1997 study published in the Journal of Clinical Chiropractic Pediatrics examined 332 children from 27 days old to 5 years old. It found "a strong correlation between the chiropractic adjustment and the resolution of otitis media for the children in this study." Both of these studies lacked controls and clearly indicated a need for further study. A 2003 randomized control trial (RCT) published in Archives of Pediatric and Adolescent Medicine found that patients between 6 months old and 6 years old who had previous AOM and who received spinal manipulation services were less likely to have recurrences, less likely to need surgery, and were more normal typanogram types. It must be noted that these were osteopathic administrations, not chiropractic, and that it still has only a suggestive rather than definitive conclusion.

Two RCTs in 1999 indicated that spinal manipulation significantly helped reduce crying time and other symptoms of colic in up to 6 manipulation services administered over a 2-week period. In one study, the parents of 4-6 week old newborns receiving the manipulations reported a 70% reduction in crying time, versus the control group receiving a popular pharmaceutical intervention (dimethicone) who only reported a 20% reduction. The other RCT suggested that complete resolution of symptoms could be found in 93% of subjects. Another RCT published in 2001 in Archives of Disease in Childhood found no significant difference in reduced crying time between babies who received spinal manipulations (70% improved) and babies who were held for 10 minutes (60% improved). FCER counters that a number of issues could have affected the outcome of the 2001 study. For instance, infants' mothers being blinded, the severity of symptoms required, frequency over time and placement of treatments, as well as additional patient screening conditions may have obscured the results. A review of studies published in 2002 in Archives of Disease in Childhood asserted that, in the study published in the journal the previous year, the superior study (with parental bias removed) showed that manipulation has no benefit over placebo. However, the review did state that the other studies show that parents who take their children to chiropractors for colic will report fewer crying hours. This suggests that it could be helpful for parental bonding with the child.

According to the CDC, approximately 715,000 sports, recreation, and exercise (SRE) related injuries occur in school settings. Children younger than age 15 account for 40% of all SRE related visits to the emergency room. In a 1999 survey by an urban pediatric emergency department, direct trauma and muscle strain account for half the visits and, overwhelmingly, the pain is acute (59%) rather than chronic (11%). Although this is a

fairly common neuromusculoskeletal condition, there are very little data on spinal manipulation treatments for children to treat back pain or sports injuries. One prospective cohort study (both uncontrolled and not randomized) published in 2003 in Journal of Manipulative and Physiological Therapeutics examined 54 children between 4 and 18 years of age (19 children were under age 12, with an average age of 13.1 years) who sought chiropractic treatment for low back pain (47% attributed onset to a traumatic event, most often sports injury). The study found "important" improvement in 87% of the cases after 6 weeks on a subjective scale. The study also found that, overall, patients responded favorably to chiropractic, but based on the size and observational design of the study, it was unable to establish a cause and effect and, therefore, recommends further research.

FCER reports that the use of chiropractic in children for neurological conditions such as ADHD, epilepsy, and autism has had promising effects in limited observational and individual case studies published in Journal of Manipulative and Physiological Therapeutics, Journal of Clinical Chiropractic Pediatrics, and Chiropractic Pediatrics. Again, they stress the anecdotal nature of these findings and indicate the need for expanded research on its efficacy. The ACA Council on Neurology and the ICA Pediatrics Council are both involved in compiling data on spinal manipulation for ADHD; however, those data are not yet available.

According to James Vallone, Executive Director of the Maryland Board of Chiropractic Examiners, there are 758 DCs currently practicing in Maryland. Based on his day-to-day dealings with the chiropractors and, recently, their response to an insurer denying coverage for children, he estimates that up to 80% of the chiropractors see at least some children under age 13 in their practices. A random sampling of Maryland DCs found that children under age 13 account for 5% or fewer of the patients treated annually. DCs overwhelmingly provide spinal manipulations in their typical patient encounters; therefore, it is reasonable to assume that most of the children seen by DCs also receive spinal manipulations. This assumption is supported by findings in a 2000 study of DCs treating children in the Boston metropolitan area that spinal manipulations were the main therapeutic technique used in 89% of the visits. There is no indication of the number of DCs selected to serve as PCPs for Maryland children.

The extent to which MDs refer patients to DCs for treatment, especially for treatment of children, is more difficult to measure. Anecdotally, many DCs claim that they develop relationships with MDs, medical practice groups, or hospitals that readily refer patients. NBCE surveys indicate that DCs commonly co-manage many conditions with physicians. A 2000 study in the Archives of Family Medicine found that DCs were more willing to share patient information with MDs than MDs were willing to share this information with DCs. Groups exist, such as the American Academy of Spine Physicians, where DCs and MDs work together to provide patient care.

Proposed Mandates

In 2001, the AAP undertook a survey to assess the knowledge, attitudes, and behaviors of AAP members regarding CAM therapies in their practice. 87% of those surveyed replied, (indicating that a total of 745 pediatricians provide direct patient care). 59% of pediatricians reported an inquiry about chiropractic during the 3 months prior to the survey. Chiropractic was not recommended for recurrent upper respiratory infection, and may or may not account for some percentage of the recommendations made for "other CAM" in the treatment of allergies and ADHD (10% and 5%, respectively).

About one-fifth of pediatricians say they are knowledgeable about chiropractic. More than one-half of pediatricians think they should consider CAM as part of the possible range of treatments. However, almost one-half of pediatricians also think suggesting CAM could make them susceptible to malpractice claims. Many pediatricians are concerned that chiropractic care may delay or prevent appropriate medical diagnoses and treatment. They also have concerns about the safety of spinal manipulations in children (studies indicate the risk is very low for most manipulations which are gentler than those that adult patients receive). Another issue is chiropractic's failure to promote childhood immunizations. According to a 1994 survey, one-third of American DCs believe there is no scientific proof that immunization prevents disease and that vaccinations cause more disease than they prevent.

Financial

The American Chiropractic Association (ACA) reports that about 11% of Americans visit DCs annually. Of those patients, 16% are children and adolescents. A 1999 benefits design study supports that number by suggesting that children and adolescents should account for 162 of 1,000 visits. A 2000 study in Archives of Pediatric and Adolescent Medicine places the number of pediatric and adolescent visits closer to 11%. A 2003 survey by the National Board of Chiropractic Examiners (NBCE) found that 8.2% of patients were 5 years old or younger and 10% were between 6 and 17 years old. Using the above national data and 2004 Maryland census data, Mercer expects 9% of Maryland children (0-12) to use this benefit 1 – 2 times annually.

Mercer assumes that the benefit would be defined to include:

- An initial consultation/examination at an average cost of $85 (not all chiropractors require a more costly initial exam)

- Up to six subsequent spinal manipulation service visits at an average cost of $50 per visit. (According to a 2003 report by the Foundation for Chiropractic Education and Research (FCER), many of the more common infant and child conditions can be

treated in fewer than six visits; a NBCE survey found most chiropractors will stop treatment after seven sessions with no measurable improvement).

Mercer assumes that the total cost per initial course of treatment will be $235 (initial examination at $85 and three subsequent visits at $50). For patients that have more than one course of treatment, Mercer assumes that the initial examination fee will no longer be required and the cost will be three visits at $50 for a total of $150. Mercer assumes that for those who use this benefit, there will be 1.5 courses of treatment per year for a total cost of $310 ($235 for the initial course and $75 for the subsequent course ($150 x 0.5 since, on average, only one-half of the members will use the second course of treatment).

Children of age 12 and under represent about 20% of the total population. Mercer estimates that approximately 9.3% of the children under age 12 will take advantage of the proposed benefit. This generates an incidence rate of 1.86% (20% x 9.3% = 1.86%). The annual cost per member is $5.80 (1.86% x 310; there could be differences due to rounding). We are assuming 2.1 members per contract. This generates a total annual cost of $12.18. 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	0.2%	0.2%
Estimated cost as a percentage of average wage	0.03%	0.03%
Estimated annual per employee cost of mandated benefits for group policies	$12.18	$10.96

Mercer assumes that approximately 10% of the cost of the proposed benefit is currently covered. This represents mainly diagnostic procedures.

There was no fiscal analysis completed for this mandate. Thus, there is no estimate of the impact on the State Employee and Retiree Health and Welfare Benefit Plan (i.e., the State plan).

Social

In this section, we address the following:

- The extent to which the service is generally utilized by a significant portion of the population;

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

Although chiropractic as a whole has maintained, for the most part, the significant popularity gains it made in the late 1990s, there is still a very small number of U.S. children aged 12 and under who receive spinal manipulations. A survey of studies indicates that only about 1-2% of children under age 13 visit chiropractors annually. The ACA says that 26 million Americans visited DCs about 192 million times in 2000 and 16% of the patients were 16 years old or younger. A 2000 study published in the Archives of Pediatric and Adolescent Medicine found that 11% of chiropractors' weekly patient visits were from children and adolescents. A 2003 survey by the NBCE found that 8.2% of patients were 5 years old or younger and 10% were between the ages of 6 and 17. A 2003 article in The Milbank Quarterly on chiropractic in the United States reported approximately 5% of infants and children have been treated with chiropractic therapy, and children and adolescents comprise 10 to 15% of chiropractic visits. Assuming that only about 10% of the total population sees DCs annually and about 20% of that population is children under age 13, a more accurate estimate of the total population of children under age 13 who are likely to see DCs is probably closer to about 2%.

One of the few studies that attempted to estimate children's complementary and alternative medicine (CAM) use on a nationally-representative basis supports this lower estimate. The 2003 study published in the Archives of Pediatric Adolescent Medicine used 1996 national medical expenditure survey data representing 6,262 children. Although the study looked at all types of CAM, it included chiropractic specifically and determined that "the proportion of childhood CAM use…attributable to use of chiropractic therapies is substantial." Still, this total number was only 1.8% with chiropractic and 1.2% without it (the separated out measure represented a statistically unreliable sample size). Accounting for growth in the pediatric sector of chiropractic usage between 1991 and 2003, that number goes up by not more than 8.5%. A second important finding of this study was that children who use CAM tend to be older. The mean age of CAM users was 10.3 years

old, and older adolescents used CAM almost 4 times more than children under 12 months. Children aged 15 to 17 were 2.6 times more likely to be CAM users, compared to all other age groups combined. When considering estimations that combine children and adolescents, it may be reasonable to assume that children over age 12 represent a more significant portion of the percentages. A second study, published in 2002 by the Journal of the American Board of Family Practitioners, examined visits to randomly selected acupuncturists, DCs, massage therapists, and naturopathic physicians in Arizona, Connecticut, Massachusetts, and Washington. Of 1,800 visits, children comprised 10% of visits to naturopathic physicians but only 1% to 4% of all visits to CAM and other providers.

According to the National Center for Complementary and Alternative Medicine (NCCAM), compared with CAM therapies as a whole (few of which are reimbursed), coverage of chiropractic services by insurance plans is extensive. As of 2002, more than 50 percent of health maintenance organizations (HMOs), more than 75 percent of private health care plans, and all state workers' compensation systems covered chiropractic treatment. DCs can bill Medicare, and over two-dozen states cover chiropractic treatment under Medicaid.

Of the six major Maryland insurers Mercer surveyed, only one insurer indicated it would not cover spinal manipulations for children 12 years and under. This insurer determined that there was insufficient/inadequate medical evidence supporting spinal manipulation in pediatric populations specifically; therefore, spinal manipulation services for children under age 13 are regarded as experimental and investigational. The other insurers made no distinction for coverage among any age group, citing only the restrictions that would apply to any member's chiropractic claim – most often medical necessity requirements, treatment durations, or experimental/investigational exclusions (usually chiropractic treatments for non neuromusculoskeletal conditions or preventive care).

Studies have shown that adult populations sometimes use chiropractic as a substitute for conventional medical care, as opposed to just an add-on service, but there have been no similar studies on pediatric populations. The 2003 NBCE survey indicates that, of the children seen by DCs, many parents have selected the DC as the primary care physician (PCP) for the child. The PCP designation does not imply these children are treated solely by chiropractors for all conditions. (The role of the DC as PCP and in providing care management is discussed further in the medical section below). A 2002 study in American Journal of Public Health found that a DC might also be more likely to serve as a PCP in rural or underserved locations. Anecdotal evidence and some case studies from pediatric DCs claim that parents sought their services because conventional medicine had not been effective for their child, or because they wanted a non-invasive or non-pharmaceutical treatment alternative.

Although there have been studies indicating that lack of coverage decreases chiropractic usage by adults, there have been no such studies of pediatric

populations. However, DCs often charge the same amounts for pediatric visits; therefore, some of those findings may reasonably translate. (Other DCs charge $5 to $10 less for follow-up visits with children). In cases where only a few treatments are required, it may not be cost-prohibitive. For example, some colic case studies indicate that fewer than three treatments will be needed. On the other hand, treatment of a chronic condition, like asthma, requires more visits and may become cost-prohibitive without coverage. (The efficacy of these treatments will be discussed in further detail below).

The level of demand for spinal manipulations for children 12 years and under is low, and the reasons seem to be twofold. First, with some important non-age-specific limiters, these services are already covered by most health plans. Second, the popular public perception remains that chiropractic treatments are for adults experiencing back, head, or neck pain. The NBCE reports that from 1991 (when the concept of pediatric chiropractic care gained increasing popularity through national campaigns, workshops, and expanded pediatric courses and seminars at the chiropractic colleges), to 2003, the pediatric population seeing DCs grew by 8.5%. The level of demand could increase if more studies confirm that chiropractic treatment is effective as or more effective than conventional treatments for children, especially in cases where pharmaceuticals or surgery could be avoided.

The interest of collective bargaining agents in negotiating spinal manipulations for children 12 years and under is negligible. Some bargaining agents were unsure as to whether their particular plans had any distinction of coverage based on age. The primary focus of interest of most bargaining agents is retaining jobs and existing health and pension benefits.

Major insurance carriers in Maryland indicated that self-funded employers in the State typically incorporate the same scope of services for chiropractic benefits as do fully insured plans. Thus, the main barrier to coverage is the interpretation of medical necessity that is also common to fully insured plans. Mercer's 2004 National Survey of Employer-Sponsored Health Plans shows that 86% of plans among employers with 500 or more employees provide coverage for some type of chiropractic services.

Proposed Mandates

Coverage of In Vitro Fertilization

This proposed mandate prohibits a health insurer, nonprofit health service plan, or HMO (carrier) from refusing to issue a policy that provides in vitro fertilization (IVF) benefits solely based on the fact that: (1) the applicant was tested for infertility; or (2) a test performed on the applicant resulted in a diagnosis of unexplained infertility or a similar diagnosis. In addition, the proposed mandate changes eligibility for IVF benefits under an enrollee's contract for a dependent spouse, thereby requiring a carrier to provide IVF benefits to an enrollee's spouse even if the spouse is not covered under the enrollee's contract.

Medical

In this section we answer the following questions related to coverage of IVF:

- 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?

With the implementation of Section 15-810 of the Insurance Article, Maryland recognized that IVF meets the medical efficacy requirements to become a mandated benefit. Therefore, a discussion of the merits of IVF already has been rigorously reviewed by the Maryland legislators and will not be replicated in this report. The proposed change in the law expands eligibility of benefits to an additional class, (i.e., an uninsured spouse). There are no new medical issues associated with this proposed expansion.

The proposed expansion of current law also eliminates an insurers' ability to deny issuing a policy solely on the basis of infertility testing or a diagnosis of infertility. As discussed later in the report, other than for individual health insurance, there are almost no instances where an insurer can permanently deny coverage to employees and/or dependents in group insurance. There are no medical issues associated with this provision.

Financial

A commonly accepted definition of infertility is twelve months or more of unprotected intercourse without pregnancy. Using this definition, the proposed benefit would be used by a small portion of the population.

Proposed Mandates

Mercer based its incidence rate on the number of IVF cycles performed nationwide. The Centers for Disease Control (CDC) is required to oversee advanced reproduction treatments (ARTs). In 2005, it released the results for cycles that began in 2002. Using the statistics for the number of cycles, in combination with census statistics regarding the number of females with insurance during approximately the same time, we are able to generate utilization rates for adult insured women. (Due to the high cost of IVF, we are assuming that only women with some type of insurance, even if this insurance does not specifically cover IVF, will take advantage of the treatment).

There were slightly less than 86,000 cycles begun in 2002. There were approximately 37.7 million insured women ages 18 to 44. This generates an incidence rate of .0022 for each woman of child bearing age. Women of child bearing age represent approximately 26% of the Maryland under age 65 population. Of these, 36% have insurance through their spouses, and would already be covered for IVF benefits under existing Maryland law (for groups with 50 or more employees). The mandate applies to dependents that do not have coverage through a spouse (who is the enrollee in the health plan). Mercer estimates that about 25% of all adult females are married and do not have insurance through a spouse. This population is the primary focus group for this proposed mandate. Converting the previously cited incidence rate from a rate for all women of child bearing age to a rate for all members that represent only married females who do not have insurance through a spouse, results in an incidence rate of 0.00015, or 0.15 per thousand member years (0.0022 x 0.26 (representing the % of total population women of child bearing age) x 0.25 (% of all women who are married and who do not have insurance through their spouse). Inconsistencies could occur due to rounding.

Infertility treatments can be very costly. We are assuming that IVF includes IVF, GIFT and ZIFT, as explained below:

- IVF involves combining a man's sperm and a woman's egg in a laboratory dish where fertilization occurs. The embryo is then transferred to the uterus to develop. The average cost is about $10,000 per cycle, not including blood testing or hormones, which can add $3,000 to $5,000 per cycle. IVF was used in about 98% of ART cycles in 2000 and more than 99% in 2002.

- GIFT involves using a fiber-optic instrument to guide the transfer of the unfertilized eggs and sperm into the woman's fallopian tubes through a small incision in her abdomen. The cost is $8,000 to $13,000 per cycle, not including blood testing or hormones. In 2000 and 2002, GIFT accounted for less than 1% of all ART cycles.

- ZIFT involves fertilizing a woman's egg in the laboratory and then using a laparoscope to guide the transfer of the fertilized eggs (zygotes) into the fallopian tubes. In 2000, this represented about 1% of all ART cycles and less than 1% in

2002. The cost, not including blood testing or hormones, is between $10,000 and $13,000 per cycle.

Mercer assumes that the average cost per cycle in current dollars will be $13,000. On average, there will be 1.5 cycles per year for a total cost of $19,500.

The total cost per member per year is $2.86 ($19,500 x .00015; any difference is due to rounding). We are assuming there are 2.1 members per contract. The total cost per contract per year is $6.01. The full cost and marginal cost for this benefit are the same since the focus is to provide benefits for individuals who currently are not covered under the enrollee's health insurance plan.

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.1%	0.1%
Estimated cost as a percentage of average wage	0.01%	0.01%
Estimated annual per employee cost of mandated benefits for group policies	$6.01	$6.01

We have not included any costs attributed to the increase in complicated pregnancies, live births and multiple births that can be expected to result from increased access to IVF.

We have not explicitly included the price of the impact of eliminating an insurer's ability to deny coverage solely on the basis of diagnosis of infertility or on the basis that the applicant underwent tests for possible infertility. Based upon our analysis of the proposed mandate, less than 4% of the insured population would be impacted. This estimate, combined with the cost estimate given previously, results in an annual cost of less than $1.00 per contract per year.

Social

In this section, we address the following:

- 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?

Proposed Mandates

- 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?

As indicated previously, the number of women that will use IVF in any single year is very small.

There is a range of estimates regarding the incidence of infertility among women. In its 2000 report on ART, the Centers for Disease Control and Prevention (CDC) indicated that, in 1995, about 2% of women of reproductive age had had an infertility-related medical appointment within the previous year. The report further states that 13% of women of childbearing age had received infertility services at one time in their life. An article in the New England Journal of Medicine estimates that the number of infertile women of child bearing age is about 4 million. This study defined eligibility for infertility treatment to be limited to women 25 to 45 years of age. This, too, equates to an infertility incidence rate of about 13% of eligible women. Translating these statistics to Maryland's current population means that about 141,000 women of childbearing age will need infertility assistance in their lifetime and slightly less than 4,000 women will seek assistance in any one year. (Please note that not all infertility is associated with females; however, infertility treatments are almost 100% associated with females. Therefore, incidence rates are expressed in the number of women seeking treatment, which includes those situations involving male infertility as well).

The National Center for Health Statistics study found that infertility affects 10% of the female population 15 to 44 years of age. Using this definition, there are about 110,000 infertile Maryland women.

The number of cycles required before a woman conceives varies by age. The following chart shows the percentage of cycles resulting in pregnancies and live births by the age of the woman.

Age of Woman	% of Cycles Resulting in Pregnancies	% of Cycles Resulting in Live Birth
<35	42.5%	36.9%
35-37	36.4	30.6
38-40	27.5	20.5
41-42	17.3	10.7
43	11.5	6.3
>43	5.2	2.0

Success rates, defined as cycles that resulted in live births, are actually lower in states that have some type of mandated in vitro fertilization services, according to "Insurance Coverage and Outcomes of In Vitro Fertilization" published in the New England Journal of Medicine. The success rates for states that do not mandate coverage is slightly under 26%, versus 22% to 23% for states that have full or partial mandates. The reason for this apparent inconsistency is that, in states where there is some type of mandate, there are fewer embryos transferred in each cycle. Thus, there also are fewer multiple births.

As indicated previously, IVF treatments can be very costly. Mercer estimates the cost per cycle to be about $13,000. The lack of insurance has forced many infertility clinics to provide financial planning assistance, starting with the patient's first visit. Some clinics will offer an extended payment plan. Most clinics accept credit cards and some help to arrange funding from third parties. Some clinics are providing flexible payment programs for patients without insurance. One program, developed by Advanced Reproductive Care, Inc., based in San Francisco, has expanded to 90 clinics nationwide.

A program at some clinics is called the refund guarantee, or shared-risk program. Under this program, a woman pays for a specific number of cycles, say three. If she gets pregnant on the first cycle, she still pays for three cycles. However, if at the end of three cycles she is not pregnant, she receives a refund of the majority of the cost.

According to the CDC, there are eight clinics in Maryland and three clinics in the District of Columbia that provide IVF treatments. This demonstrates sufficient demand by the public to support eleven such providers. Whether or not the proposed bill would materially increase the demand is questionable, given the very small population to which the mandate would apply.

The section of the proposed law pertaining to the inability to deny coverage solely on the basis of diagnosis of infertility will impact very few. At the federal level, the Health Insurance Portability and Accountability Act (HIPAA) guarantees issuance of group coverage if an employee is continuously covered by insurance (or uncovered only due to waiting periods). Individuals who do not elect group insurance when initially offered can be subject to waiting periods under HIPAA, but the duration of the waiting periods are limited depending on the number of months without coverage. Thus, this portion of

the law primarily will affect those who purchase insurance directly, which is only about 4% of the total Maryland population.

Another potential source for individuals, for which insurance companies would have the ability to underwrite to deny or waive coverage for a specified period of time, is "late entrants." Late entrants are individuals who were offered group insurance, declined to participate and were not insured elsewhere; however, at some later point they wanted to gain access to the employer's plan. These individuals are different from those who access their employer's insurance at some time later than the initial enrollment due to a "qualified event." Federal law provides guaranteed access to an employer's plan without underwriting or waiting periods (assuming they have been previously satisfied) if the employee sustains a "qualified event." An example of one type of qualified event is if the employee had been covered under a spouse's contract and the spouse's insurance was terminated due to a layoff. The employee (and laid off spouse and any other dependents covered under the spouse's contract) would be eligible for immediate coverage under the employee's health plan (assuming that all the proper enrollment periods were met). There are qualified events that guarantee portability of coverage. The proposed mandate would not impact these individuals, which is the vast majority of late entrants.

The category of late entrants that would be impacted by the proposed mandate is comprised of individuals who were never covered under any other plan and still elected not to participate when initially offered insurance by the employer.

According to the Kaiser Family Foundation/Health Research and Educational Trust, Employer Health Benefits, 2004 Annual Survey, 82% of employees elect insurance when it is offered by their employers. Of the remaining 18%, it is reasonable to assume the reason for declining coverage is that they have access to insurance elsewhere. The same survey indicates that 80% of all firms offer insurance. Thus, it is reasonable to assume that, of the 18% that elected not to participate in an insurance plan through their own employers, at least 80% of these had access to insurance elsewhere (or through Medicaid or some other subsidized program). This leaves a total of 3.6% of working individuals.

The Health Insurance Portability and Accountability Act (HIPAA) guarantees that health plans cannot exclude participation or limit benefit payment based on a preexisting condition for any period greater than 12 months (18 months for late enrollees). This time period is reduced for any creditable coverage that the individual may have through previous coverage under another plan. Even in these situations, the proposed mandate is not applicable for the slightly less than 4% of working adults that waived insurance (and were uninsured as a result) since the insurer cannot deny coverage; at most the insurer could exclude benefits for a specified period of time due to preexisting conditions.

According to the Mercer 2004 Survey of Employer-Sponsored Health Plans, only 4% of large employers deny coverage to employees' spouses who have other available

coverage. An additional 3% of large employers require a surcharge in premium. Therefore, 96% of spouses of enrollees of large employers can obtain IVF coverage by simply enrolling as a dependent, even if they have coverage through their employer.

Section 15-810 of the Insurance Article requires large employers to cover the outpatient costs of IVF. Coverage is limited to 3 IVF cycles per live birth achieved, with a maximum lifetime benefit of $100,000. Such benefits are not required for the Comprehensive Standard Health Benefit Plan for small employers. However, existing law requires that the individual receiving treatment must be insured under the plan. The proposed mandate waives this requirement. Thus, uncovered spouses (presumably females since they would automatically have coverage if the employee was a female) would now be eligible for treatment (and conceivably begin a new lifetime benefit if she had expended such coverage under a policy in her own name).

Dr. Tarun Jain, et al., discovered that states that do not require insurance coverage for infertility procedures have the highest number of embryos transferred per cycle resulting in the highest rates of pregnancies and live births from IVF, but also the highest number of live births of multiple infants, especially three or more. As the lifetime maximum under the existing mandate is approached, there may be more incentive to transfer a greater number of embryos. This proposed legislation would partially mitigate this need if both spouses have health insurance coverage under their own name. (Of course, the need also could be mitigated by both spouses purchasing family coverage).

Multiple births represent a short term and long term risk to the mother in the form of premature labor, premature delivery, pregnancy-induced hypertension, gestational diabetes, and uterine hemorrhage. Children born prematurely are at higher risk for respiratory distress syndrome, intracranial hemorrhage, cerebral palsy, blindness, physical and mental developmental disabilities, as well as death. Multiple births require a personal as well as a financial cost for the parents.

In 2000, the estimated cost per family of delivering multiple-gestation pregnancies resulting from ART procedures ranged from $58,865 for twins to $281,698 for quadruplets. The cost per delivery resulting from IVF pregnancies was about $39,000 for pregnancies with one or two fetuses and $340,000 per pregnancy with triplets and quadruplets. Obstetrical and neonatal costs of quadruplets have exceeded $1,000,000. It is in the best interest of all impacted parties to minimize the number of multiple births. As previously stated, our survey of collective bargaining agents indicated that their primary focus is to retain jobs and existing health and pension benefits. There is little interest in expanding benefits.

The Mercer Survey shows that only about one-fifth of employers with 500 or more employees covers IVF. Advanced reproductive therapies are covered by 12%, (up 10% from 2003). The larger the employer, the more likely it is to cover each type of service. Among those with 20,000 or more employees, 24% cover advanced reproductive

therapies. However, providing benefits for uninsured spouses (regardless of the benefit, other than organ retrieval costs associated with organ transplants) is almost never done.

The Fiscal Summary indicated minimal impact to the State plan attributable to this proposed change.

Proposed Mandates

Coverage of Outpatient Treatment for Behavioral Disorders

This proposed mandate would require that outpatient treatment for mental illnesses, emotional disorders, and drug abuse include intensive mental health case management, home health psychiatric treatment, and crisis treatment. According to the Fiscal and Policy Note issued by the Department of Legislative Services, the modification does not apply to HMO contracts.

Medical

In this section, we address the following:

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

Intensive case management can be viewed as a subset of disease management. The following definition was provided at the Society of Actuaries Spring 2005 Meeting and attributed to The Disease Management Association of America:

> "a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management:
>
> - supports the physician or practitioner/patient relationship and plan of care,
> - emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and
> - evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.
>
> Disease Management Components includes:
>
> 1. Population identification process
> 2. Evidence-based practice guidelines
> 3. Collaborative practice models to include physician and support-service providers
> 4. Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance)
> 5. Process and outcomes measurement, evaluation and management
> 6. Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

Proposed Mandates

Full service Disease Management Programs must include all 6 components."

Recently, there has been a rapid interest in the emergence of disease management organizations, products, and cost/benefits. The disease management "movement" is still evolving, with numerous models and approaches that encompass the six disease management components.

Assertive community treatment (ACT) may also be viewed as intensive case management. According to a 2001 study by G.R. Bond, et al. entitled, "Assertive Community Treatment for People with Severe Mental Illness: Critical Ingredients and Impact on Patients," ACT services are costly but are successful in reducing psychiatric hospital use, increasing housing stability, and moderately improving symptoms and subjective quality of life. This article also indicated that the more closely case management programs follow ACT principles, the better the outcome. The focus of this study, however, was on individuals with severe mental illnesses, which is under-represented in the privately insured population.

A study conducted in the United Kingdom found that there was no statistically significant difference between the outcomes for severely mentally ill patients that had treatments that incorporated intensive case management and those that were subject to traditional treatments. In this study, 708 patients with psychosis and a history of repeated hospital admissions were randomly allocated to standard or intensive case management. Clinical and resource use data were assessed over two years. The conclusion of this study was that intensive case management had no clear beneficial effect on costs, clinical outcomes, or cost-effectiveness. Once again, this study focused on the severely mentally ill.

The Veterans Health Administration (VHA) conducted several studies involving veterans with severe mental illness. The VHA estimated that approximately 20% of severely mentally ill patients are in need of intensive community based case management services. The approach involved a multidisciplinary team focusing on ambulatory care in coordination with the community and its services. Three different VHA studies showed that the intervention is cost effective, particularly where the service is offered to chronically ill, hospitalized patients and where the model is rigorously adhered to with respect to assertiveness of the intervention and maintaining low caseloads. A fiscal year 1998 survey revealed that just over 8,000 veterans received some form of mental health team case management from the VHA, and, of those treated, only 2,000 met the assertive community treatment criteria for intensive case management. Thus, there is a tendency to approve inappropriate cases for the more intensive services resulting in additional and presumably unnecessary costs to the VHA.

Currently, there is significant variation in how the effectiveness and cost/benefit analysis of disease management programs should be measured. This area is still a relatively new concept in the health benefit/insurance field.

Proposed Mandates

In 2004, the Congressional Budget Office found insufficient evidence to conclude that disease management programs can generally reduce overall health spending, although they did note that such programs may have value even if they do not reduce costs.

The Robert Wood Johnson Foundation has supported development of the Chronic Care Model (CCM). The goal of the model is to improve the care of patients with chronic illnesses. So, while CCM may not be disease management according to the six components previously identified, it has the same goals, is based upon clinical experience and medical evidence, and has other characteristics of a typical disease management program. In the February 2004 article, "An Evaluation of Collaborative Interventions to Improve Chronic Illness Care: Framework and Study Design," S.Cretin, et al., noted that, "despite its evidence-based origins and intuitive appearance, the CCM has not been evaluated in controlled studies….CCM is attractive and plausible, but its effectiveness has not been adequately tested."

Another study, chronicled in CHCS's "Disease Management for Chronic Behavioral Health and Substance Use Disorders," references that "ongoing survey of the peer-reviewed literature suggests, at best, weak empirical evidence for long-term (Medicare) savings resulting from existing disease management programs."

In their paper, "Return on Investment in Disease Management: A Review," Ron Z. Goetzel, Ph.D., et al., demonstrated positive returns on disease management programs for some conditions; however, none of the studies examined found a medical cost offset for appropriate treatment of depression. Quite uniformly across all the various studies reviewed, good treatment for depression costs more money than was saved ($500 more a year). These studies did not take into consideration changes in productivity, such as absence, disability, on-the-job productivity, and performing daily life activities.

Three success evaluations concluded that the Florida Medicaid disease management initiatives that began in 2001, which did not include mental health or substance abuse disorders, had not met the State's cost savings or health outcomes expectations and have been allowed to expire.

A study in 2000 found that a disease management program for alcohol abuse was cost effective if there were no other dependency or mental health co-morbidities.

The National Evaluation Data Services 2002 "Cost Effectiveness and Cost Benefit Analysis of Substance Abuse Treatment: A Literature Review," cites several studies supporting the cost/benefit analysis of substance abuse treatment in general. It cites several studies supporting the transition to ambulatory care from inpatient treatment for many patients. It also states that the economic value of intensity of care (e.g., staff to client ratio, hours of counseling per client) had little effect for substance abuse patients. It also cautioned that these conclusions were specific to particular populations and treatment approaches and should not be broadly generalized to all types of care.

Proposed Mandates

It must be emphasized that commercial disease management programs, in general, report positive results. According to the Mercer 2004 Survey Report, 41% of the largest employers providing disease management programs have attempted to measure their return on investment. 31% say their program reports a positive return. Only 10% report that the costs exceed the savings, which is most common in programs delivered to all members in a vendor's health plan rather than on an employer-specific basis. The information shown in this report focuses specifically on disease management for mental health and substance abuse programs, which have not, to date, shown to have many positive results.

Financial

There is some confusion regarding the intent of the proposed mandate. Federal law requires mental health parity for large groups (groups with more than 50 employees). Section 15-802 of the Insurance Article requires parity for mental health and substance abuse (MHSA). Minimum coverage levels are prescribed for outpatient services. The Fiscal and Policy Note issued by the Department of Legislative Services indicated the modification does not apply to HMO contracts.

Current law requires outpatient coverage that is medically necessary. A policy must provide 80% coverage for the first five outpatient visits in one calendar year; 65% coverage for 6 to 30 visits; and 50% coverage for more than 30 visits. It is Mercer's interpretation that the main focus of the proposed mandate is to provide payments for the intensive mental health (and presumably substance abuse) case management. It is Mercer's interpretation that outpatient crisis treatment is covered under existing law, if it is deemed treatable and medically necessary. Mercer's analysis classifies home health psychiatric treatment as part of a disease management program.

There is very little public information pertaining to outpatient mental health and substance abuse crisis treatment. Mercer's proprietary data base shows an incidence rate of between two and three crisis treatment services per thousand member years for mental health and/or substance abuse conditions. The gross charge per service ranges between $110 and $160. Cost sharing features would reduce this further. National statistics show that average cost sharing for private insurance for mental health and substance abuse services is about 33%. This reduces the gross charge to about $75 to $105 (rounded to the nearest $5). If we assume the average utilization is 2.5 visits per thousand member years, the total costs would be $0.20 to $0.26 per member per year, or $0.42 to $0.55 per contract per year. This is not significant. At least part of this would be covered under existing benefits. For this reason, we have not expressly considered crisis treatment in the financial section of this analysis.

Mercer's proprietary data base shows that the incidence rate for home health psychiatric care is too minimal to be accurately measured. Inclusion of this benefit will not have any

measurable impact on costs. Possibly, this is due to the fact that, currently, very few mental health and/or substance abuse professionals are willing to make home visits.

Statistics show that 5% to 7% of the population suffers from a serious mental health and or substance abuse disorder, which is the population that would benefit most from intensive case management. The private market represents about 20% of all mental health/substance abuse expenditures. The cost per year for intensive case management for depression only can vary dramatically, from as little as $50 to over $5,000, with the average being $500. If we assume a cost of $500 and an incidence rate of 0.012 (6% of the population has serious mental health and or substance abuse x 20% covered by private insurance = 0.012), we generate a cost per member per year of $6.00. If we assume 2.1 members per contract, then the total cost per contract is $12.60.

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.2%	0.1%
Estimated cost as a percentage of average wage	0.03%	0.01%
Estimated annual per employee cost of mandated benefits for group policies	$12.60	$4.16

Social

In this section, we address the following:

- The extent to which the service is generally utilized by a significant portion of the population;
- The extent to which the insurance coverage is already generally available;
- The extent to which lack of coverage results in individuals avoiding necessary health care treatments;
- The extent to which lack of coverage results in unreasonable financial hardship;
- The level of public demand for the services;
- The level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts; and

Proposed Mandates

- 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 U.S. Spending for Mental Health and Substance Abuse Treatment 1991-2001, an estimated 28% to 30% of the adult U.S. population suffers from a mental or substance use disorder during the course of a year. About 5% to 7% of adults have a serious mental illness. The same study estimates that 5% to 9% of children have a serious emotional disturbance. However, the services for a significant portion, (65% of mental health/substance abuse services), are funded by public programs; (either Medicare, Medicaid, or other federal grants, such as Veterans Affairs, Department of Defense, federal block, other state and local funds, including incarcerations). Only 20% of the MHSA expenditures in 2001 were funded by private insurance. About 12% of MHSA dollars in 2001 reflect out-of-pocket payments by individuals. 3% of MHSA expenditures in 2001 were funded by charities.

In 2001, MHSA expenditures represented 7.6% of all health care expenditures, and 4.3% of all private insured health care dollars.

An article in the June 2005 edition of the New England Journal of Medicine by Ronald C. Kessler, Ph.D. et al., found that the prevalence of mental disorders did not change during the decade between 1990-1992 and 2001-2003; however, the rate of treatment increased. Approximately 30.5% of people aged 15 to 54 had anxiety disorders, mood disorders, and substance abuse disorders that qualified as such, using the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Thus, there have been no material changes in the prevalence of serious disorders. The same study found that only one-fourth of the patients that had qualifiable diagnoses received treatment. Between 2001 and 2003, 20.1% of the population received treatment for emotional disorders. Roughly half of these had disorders that met diagnostic criteria for a mental disorder. One-fourth of the patients who had a mental disorder (the 30.5% of the population age 15 to 54 noted above) received treatment. This study concluded that, despite an increase in the rate of treatment, most patients with a mental disorder did not receive treatment.

The National Committee for Quality Assurance (NCQA) has expanded its HEDIS measures to include two new chemical dependency items. The Washington Circle, a not-for-profit policy group, estimates that about five million people who need treatment for substance abuse are not receiving it, despite the availability of treatment resources. One-fifth of patients with mental disorders had a substance abuse disorder within the last six months.

The Department of Health and Human Resources estimates that two-thirds of people with mental disorders do not obtain treatment.

Proposed Mandates

The treatment of MHSA is steadily moving from the inpatient environment to the outpatient setting. Lengths-of-stay have been declining dramatically over the last ten years. In 1991, 40% of all MHSA dollars were expended for inpatient stays. By 2001, 24% of all MHSA dollars were spent for inpatient stays. During this same time period, outpatient dollars increased from 36% to 50% of all MHSA expenditures. Residential expenditures remained fairly constant, at 19% in 1991 and 20% in 2001 (with insurance administration representing the balance). As outpatient treatment is emphasized more, it is important to ensure that it is being used efficiently and effectively.

Few Managed Care Organization (MCO) commercial products (21%) require mental health screenings by primary care physicians. 67% of commercial products rely on specific conditions to trigger screening. MCO executives attribute the low screening rates to the belief that it has been difficult to find a screening instrument that is brief, easy to score, and easy to interpret.

The vast majority of policies offer emergency room (96%) and telephone triage (82%) in case of a sudden mental health and/or substance abuse crisis. 58% of commercial MCO products have in-person crisis services available.

Intensive case management can be viewed as a subset of disease management. Disease management programs have been and continue to be of high interest as health care costs increase and there are more pressures to control these costs. CMS is sponsoring small disease management pilots and has approved several state Medicaid waivers to encourage more experimentation with disease management in that program. To date, most of the CMS emphasis has been on physical health.

According to the Center for Health Care Strategies, although the major accrediting organizations do have the capacity to accredit vendors of disease management programs, few mental health or substance abuse disease management programs exist, let alone have the "seal of accreditation" that many public entities and employers seek to protect themselves and their fiduciary responsibilities. The Joint Commission on Accreditation of Healthcare Organization (JCAHO) lists many organizations accredited to provide what it calls "Disease-Specific Care," but virtually none of these organizations include mental health and/or substance abuse as diseases for which they are certified. Of the NCQA's 29 organizations to which it has extended disease management accreditation, only two offer programs in mental health and for depression only. Thus, currently, there are not an adequate number of disease management entities that have attained accreditation in the fields of mental health and substance abuse. This makes it more difficult for purchasers to properly assess a vendor's expertise in this area.

Assertive community treatment (ACT) may also be viewed as intensive case management. Conventional wisdom has held that intensive case management and ACT will have greater impacts on populations with severe mental illness with or without substance abuse as a co-morbidity. ACT, generally ascribed as a model for people with severe mental illness, is an intensive mental health program model in which a

multidisciplinary team of professionals serves patients who do not readily use clinic-based services, but are at high risk for psychiatric hospitalizations. Most ACT contact occurs in the community setting and takes a holistic approach to services, including helping with medications, housing, and finances. ACT has generally been used with the Medicaid population.

There is recognition that mental illness and substance abuse are diseases that may be helped by various forms and levels of disease management. Martin Sipkoff's article, "Insurers Give Substance Abuse New Identity: It's a Disease," states that 80% of workers who receive treatment for an alcohol or other drug problem through the EAP (employee assistance plan) reported that their work attendance improved. In the same article, the vice president of PacifiCare Behavioral Health talks about a paradigm shift in the way primary care physicians perceive substance abuse. Michael Brase, MD and vice president and medical director of WellPoint Behavioral Health, the subsidiary that manages mental illness and substance abuse for WellPoint's 23.8 million insured lives (prior to WellPoint's merger with Anthem) states that employers are interested in offering benefits that are highly tailored to their particular workforce demographics and are increasingly aware of the overall cost/benefit ratio in treating substance abuse.

One study shows that, in 2003, 71% of health plans "out-sourced" treatment to specialty contracts. These specialty contracts are generally managed behavioral health organizations (MBHOs).

In its report titled, "The Provision of Mental Health Services in Managed Care Organizations (MCO)," the Department of Health and Human Services has developed three categories of behavioral health arrangements employed by managed care organizations. (For purposes of this discussion, MCOs include HMOs, PPOs and POS plans):

- *Specialty contracting arrangements* in which MCOs carve out mental health services to a vendor that specializes in the delivery of and management of behavioral health services;

- *Comprehensive contracting arrangements* in which the insurers or self-funded employers contract with a single vendor or network for both behavioral health and general medical services; and

- *Internal arrangements* in which insurers or self-funded employers provide behavioral health services and medical services within the organization, either through salaried providers or through a network managed by the insurer.

This study shows that 75% of behavioral contracting arrangements are either specialty contracts or comprehensive contracts with the breakdown by HMO, POS and PPO as follows: 88% (HMO), 68% (POS) and 58% (PPO). 96% of all specialty contracts

include case management which is described as a "more intensive clinical review of care and tends to focus on high users of care." 54% of comprehensive contracts include case management. Overall, 87% of products report having a case management program. Case management can include coordination of services (85% of all products), assisting patients in accessing community resources (76%), flexing or extending benefits (62%), and meeting regularly with clients in person or by telephone (46%). Master's level clinicians are "typically" used more often than doctoral-level psychologists or registered nurses to provide case management services.

Collective bargaining agents' primary focus is to retain jobs and existing health and pension benefits. There is little interest in expanding benefits.

Aetna indicated that, effective January 1, 2006, they are adopting a holistic approach to disease management for behavioral health which includes intensive case management. This will be a standard benefit for its fully insured HMO products and most PPO products. The approach will use medical claims and pharmaceutical data to identify the people who need help, and work with their primary care physicians to reach these members. It will not be available to the traditional indemnity product. Self-insured clients will have the option of purchasing Aetna Behavioral Health.

Analysis completed by the Department of Legislative Services indicated that the State plan currently provides intensive mental health case management and home health psychiatric treatment. Since there was no definition for "crisis treatment," the Department of Legislative Services could not quantify the impact, although it indicated that most types of crisis treatment are already covered under the State plan. Any increase in cost for non-covered crisis services would be negligible.

Mercer's survey shows that over two-thirds of large employers provide case management for mental health and substance abuse benefits. There was no distinction between case management and intensive case management in the survey.

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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	$335	$34	6.0%	0.6%	0.79%	0.08%
Payment for blood products	15-803	M	1.0	1.0	1.0	0.5	0.6	1.0	$14	$0	0.3%	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	$17	$3	0.3%	0.1%	0.04%	0.01%
Reimbursement for pharmaceutical products	15-805	M		1.0	1.0	0.5	-	1.0	$12	$6	0.2%	0.1%	0.03%	0.01%
Choice of pharmacy	15-806	M		1.0			-		$129	$19	2.3%	0.3%	0.30%	0.04%
Medical foods & modified food products	15-807	M		1.0	1.0	0.5	0.6	1.0	$4	$0	0.1%	0.0%	0.01%	0.00%
Home health care	15-808	M		1.0	1.0	0.5	0.6	1.0	$20	$0	0.4%	0.0%	0.05%	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	$52	$44	0.9%	0.8%	0.12%	0.10%
Hospitalization benefits. for childbirth	15-811	M		1.0	1.0	0.5	0.6	1.0	$68	$0	1.2%	0.0%	0.16%	0.00%

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	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														
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	$63	$0	1.1%	0.0%	0.15%	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	$35	$1	0.6%	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	$4	$0	0.1%	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	$51	$1	0.9%	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%
Benefits for prosthetic devices and orthopedic braces	15-820	M		1.0			0.6		$8	$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	$48	$0	0.9%	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	$7	$0	0.1%	0.0%	0.02%	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%

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														
Coverage for detection of prostate cancer	15-825	M	1.0	1.0	1.0	0.5	0.6	1.0	$18	$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	$46	$7	0.8%	0.1%	0.11%	0.02%
Coverage of clinical trials under specific conditions	15-827	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 general anesthesia for dental care under specified conditions	15-828	M	1.0	1.0	1.0	0.5	0.6	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
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	$5	$2	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	$17	$2	0.3%	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	$9	$2	0.2%	0.0%	0.02%	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
Current Mandates														
Coverage for treatment of morbid obesity	15-839	M	1.0	1.0	1.0	0.5	-	1.0	$45	$11	0.8%	0.2%	0.11%	0.03%
Coverage of residential crisis services	15-840	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 Smoking Cessation Drugs	15-841	M	1.0	1.0	1.0	0.5	-	1.0	$24	$6	0.4%	0.1%	0.06%	0.01%

Exhibit 1 – Financial Analysis of Current Mandates

Summary by Type of Policy

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	
									Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Med. & Large Group Insurance									$916	$120	16.4%	2.1%	2.2%	0.3%
Individual Insurance									$458	$60	17.9%	2.3%	1.1%	0.1%
CSHBP									$458	$29	13.2%	0.8%	1.1%	0.1%
State Employees Benefit Plan									$925	$121	16.4%	2.1%	2.2%	0.3%
Composite									$820	$103	15.4%	1.9%	1.9%	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											
Spinal Manipulation Services for Children Ages 12 and Under	M	1.0	0.5	0.6	1.0	$12	$11	0.2%	0.2%	0.03%	0.03%
In Virtro Fertilization	M	1.0	0.5	0.6	1.0	$6	$6	0.1%	0.1%	0.01%	0.01%
Outpatient Treatment for Behavioral Disorders	M	1.0	0.5	0.6	1.0	$13	$4	0.2%	0.1%	0.03%	0.01%

Exhibit 2 – Financial Analysis of Proposed Mandates

Summary by Type of Policy

Estimated Cost 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	
							Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Proposed Mandates:												
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. 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.

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

(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.

(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.	As of July 1, 1998 copayment will be $30 (twice normal $15) Regs. modified .03 E (i) – (s); effective July 1, 2000 , 2-time single dispensing fee is: 2 x generic @ $15 or $30; 2 x pref. @ $20 or $40; 2 x non-pref. @ $30 or $60
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 treatment of morbid obesity through gastric bypass surgery or another surgical method that is: 1) recognized by the NIH as effective for the long-term reversal of morbid obesity; and 2) consistent with criteria 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.

Exhibit 4 – Subtitle 8. Required Health Insurance Benefits

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
841	Coverage for smoking cessation treatment	X	X	X	X	As of October 1, 2005, carriers that provide prescription drug coverage must provide coverage for 1) any prescribed drug approved by the US Food and Drug Administration as an aid for the cessation of the use of tobacco products; and 2) two 90-day courses of nicotine replacement therapy during each policy year.	.