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 medical consultants.

Financial Analysis of Current Mandates

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

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

Executive Summary

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

On a full-cost basis, the total cost for all the current mandates is about 15% of premium. As a percentage of Maryland's average wage, assuming the same average wage for all types of insurance contracts, the full cost ranges from 1.9% to 3.3% and averages about 2.3%.

On a marginal cost basis, for all the current mandates, the average cost is about 1.3% of premium across all insurance contracts. As a percentage of Maryland's average wage, the marginal cost ranges from 0.1% to 0.3% and averages 0.2%.

Compared to the costs specified in the Mandated Health Insurance Services Evaluation report prepared by Mercer in 2002, the cost of the mandates as a percentage of wages has increased slightly. This is because the cost of health care has been increasing faster than the average wage.

Financial, Social, and Medical Impact of Proposed Mandates

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

- Mandated health insurance coverage for mental health services provided to children and adolescents in a residential treatment center.

- Expansion of child wellness coverage mandate (Section 15-817) to include treatment, counseling, and prevention of obesity for children and youth.

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

Introduction

This report contains two sections. The first section evaluates the full cost of each existing mandated health insurance service as a percentage of the States 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 five prominent health plans in the Maryland market; all of them 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.

This year, we updated the estimate of the portion of policy holders that would purchase coverage for the benefits required by the mandates even if the mandates were repealed. This assumes that carriers would offer the benefits in the absence of the mandate. We developed the revised estimate by surveying self-funded employer sponsored health plans and the carriers that administer the plans on the plans' voluntary compliance with mandates. Under ERISA, self-funded plans are exempt from state mandates. Our survey revealed a higher voluntary compliance rate for most mandates when compared to prior surveys. One mandate where voluntary compliance has fallen is coverage of in vitro fertilization.

Mercer also conducted a telephone survey of Maryland collective bargaining agents. The sample included groups such as the AFL/CIO, Laborers International, AFSCME, Building and Construction Trades, and United Food and Commercial Workers. The survey assessed their level of interest in negotiating for coverage and their support for or opposition to the proposed mandates. While they consider some mandates socially desirable, monetary constraints may affect their willingness to negotiate for the coverage.

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

Also, legislative bills have accompanying Fiscal Notes with additional information on the cost impact.

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

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

Introduction

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 medical, actuarial, and research specialists. The medical staff coordinated 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.

The Mercer Survey of Employer-Sponsored Health Plans showed an average annual cost per contract of about $5,564 for Maryland employers in 2002. This is for health plans that cover medical and prescription drug benefits but excludes the cost of dental benefits. The survey covers employers in the medium and large group markets. (Mercer defines large employers as employers with 500 or more employees and small employers as those with 10 to 499 employees.) Based on MHCC reports on contract holder out-of-pocket expenses, we estimate an average out-of-pocket cost of $578 per employee. The total health care expenditure would then be $6,142 per employee. The focus of this survey is medium and large employers.

The MHCC annual monitoring report of small group plans including enhancements to the CSHBP shows an average annual premium of $4,869 per employee. Our estimate of the average out-of-pocket expenses is $506 per employee. The total health care expenditure would then be $5,375 annually per employee in the small group market.

We estimate that the average individual policy cost is about 40% higher than an employer-sponsored contract.

Financial Analysis of Current Mandates

Combining the estimates for the individual and group markets, our estimate of the 2002 average premium rate is $5,561 annually per contract holder. The estimated total annual health care expenditure is $6,139 per contract holder.

Our estimate of the cost of mandates is the total health care dollars spent before contract-holder out-of-pocket expenses. We assume the same portion of out-of-pocket expenses apply to the mandates as applies to other benefits. Therefore, we express the cost of the mandate as a percent of the total health care expenditures and project this ratio as the portion of premium spent on the mandate.

Exhibit 1 shows the estimated 2002 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 2002 was $39,360, according to statistics from the Maryland Department of Labor, Licensing and Regulation (DLLR). This is 2.7% higher than the 2001 Maryland average annual wage of $38,329.

On a full-cost basis, the total cost for all the current mandates is about 15% of premium. As a percentage of Maryland's average wage, assuming the same average wage for all types of insurance contracts, the full cost ranges from 1.9% to 3.3% and averages about 2.3%.

On a marginal cost basis, for all the current mandates, the cost averages about 1.3% 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.

On a full cost basis, compared to data in our 2002 report to the MHCC, the cost of the mandates as a percentage of wages increased slightly, from 2.2% to 2.3%. The full cost as a percentage of premium has remained at about 15%. The full cost of most mandates, as a percentage of wages, has increased because the cost of health care has increased faster than wages while the cost as a percentage of premium has remained constant because no new mandates were added.

Financial Analysis of Current Mandates

In the past, we relied on a Commission survey of a sample of Maryland employers and Mercer experience to estimate what portion of the mandated benefits would be covered in the absence of the Maryland mandates. This year, we updated the estimate through a more comprehensive survey on the coverage practices of self-funded employer sponsored health plans. Our estimate assumes that carriers would offer the benefits in the absence of the mandate. We developed the revised estimate by surveying self-funded employer sponsored health plans and the carriers that administer the plans on the plans' voluntary compliance with mandates. This included Aetna, CareFirst, Cigna, MAMSI/OCI, and United HealthCare. To check the reasonableness of the administrators' responses, we compared their answers to the benefit plans of eight Maryland based employers with self-funded plans. These eight employers cover over 100,000 employees or almost 300,000 people when including dependents. Our comparison confirmed the reasonableness of the administrators' answers. Our survey revealed a higher voluntary compliance rate for most mandates when compared to prior surveys.

On a full cost basis, compared to data in our 2002 report to the MHCC, the cost of the mandates as a percentage of wages decreased from 0.6% to 0.2%. The marginal cost as a percentage of premium decreased from 4.2% to 1.3%. The marginal cost decreased because our survey showed a higher rate of voluntary compliance.

One benefit where the voluntary compliance fell is coverage of in vitro fertilization (IVF). Previously we assumed that 20% of the costs are covered without a mandate. This has fallen to 15% of the cost. IVF represents about 0.8% of premium on a full cost basis and 0.7% of premium on a marginal cost basis.

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).

Residential Treatment Center (RTC) Insurance Coverage for Children

We were asked to review a request to require insurance coverage for inpatient treatment of acute or chronic mental illness at a hospital or residential treatment center (RTC) for children under the age of 18 years.

The definition of an RTC under Maryland Health-General, §19-301(p) is "a psychiatric institution that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbances who require a self-contained therapeutic, educational, and recreational program in a residential setting." An accredited RTC is an RTC accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Under Maryland's mental health parity mandate, the child should be covered for hospital inpatient care until the child is potentially eligible under Medicaid. This proposal would expand mental health coverage for children to include admissions to residential treatment centers.

Currently, if the length of stay exceeds 30 days, a child is considered a "family of one" and is eligible for coverage under Medicaid. However, it takes time for Medicaid to determine eligibility. Upon determining the child's eligibility, Medicaid pays for coverage dating back to the first day of the month in which a child became eligible. On average, for a RTC admission, this would leave a coverage gap of 15 days without Medicaid coverage.

To increase access to care, this proposal would require insurers, nonprofit health service plans, and HMOs to cover RTCs. This would eliminate the need for parents to "abandon" their child to Medicaid to get coverage and should remove the delay in payments to RTCs.

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

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

Financial

Based on a Mercer survey of managed behavioral health care vendors, for a commercial population (employer-sponsored plans) we estimate there are about two residential treatment center admissions annually for every 10,000 members. In a study of 20 residential treatment programs in Connecticut, the average length of stay was 298 days. In Maryland, the State Mental Hygiene Administration is attempting to reduce the stays in State-operated RTCs to nine months.

Proposed Mandates

We assume that all RTC admissions will have a length of stay that meets or exceeds the Medicaid eligibility requirement. We estimate that each year, assuming that RTCs are available, two in every 10,000 children require an RTC admission. We also estimate that under a carrier's managed care program, the length of stay will be contained to 275 days per admission on average. This would result in 55 days per 1,000 children.

Cost per day for residential treatment centers varies by facility and level or model of care. Many facilities contract only with Medicaid and are not prepared to accept patients covered by commercial contracts.

The Maryland Department of Health and Mental Hygiene (DHMH) has contracts with 14 accredited RTCs in Maryland and four accredited RTCs that are out-of-state. For fiscal year 2003, the Medicaid reimbursement rates range by facility from $183 to $367 per day. The average Medicaid rate for the Maryland RTCs is $340 per day. DHMH does not expect that many of these facilities would be able to accept patients outside of Medicaid.

We surveyed JCAHO accredited RTCs across the country and for those facilities that accept patients outside of Medicaid, the rate for a commercial population ranges from $350 to $450 per day. Information provided by the Maryland Disability Law Center states that Maryland RTCs cost $500 per day on average while costs for other out-of-state RTC facilities ranged from $135 to $250 per day. For our projections, we assumed that a child may be placed out-of-state and the average cost per day will be $400 for a comprehensive program, including psychiatric consultations.

Assuming 55 days per 1,000 children and $400 per day, the cost per child is $22 annually. Using an average of 0.6 children per contract, the cost per contract is $13.20 annually, or 0.2% of premium. Carriers we surveyed generally say that RTCs are covered for non-custodial care if it is the most appropriate place of treatment; however, one prominent carrier admitted that its network does not currently include any RTCs. We estimate that 25% of the cost of care is already covered by plans; therefore the marginal cost equals 75% of the full cost.

The full and marginal costs are summarized below:

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.2%	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	$13.20	$9.90

Proposed Mandates

Social

In this section, we address the following:

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

In Maryland, the population served by RTCs is typically divided into four categories:

- Population of children or adolescents at risk for over-staying in inpatient facilities ("Lisa L" population)
- Seriously emotionally disturbed delinquent youth adjudicated by the court and committed to the Maryland Department of Juvenile Justice
- Juvenile sex offenders committed by the courts to the Maryland Department of Juvenile Justice
- General RTC population that does not require a specialized program and committed by the court or medical necessity.

This proposal would address the last of the four categories for those committed by medical necessity.

As of October 2001, Maryland had 14 RTCs, which combined had 765 residential treatment center beds for children and adolescents. The January 1, 2002, Maryland Health Care Commission report, *An Analysis and Evaluation of Certificate of Need Regulation in Maryland*, states that at any given time, over 60 youth are awaiting RTC placement in respite care facilities for long-term psychiatric treatment. One of the pressures adding to the wait is that since 1997, two private psychiatric hospitals that provided inpatient psychiatric care for children and

adolescents have closed. In calendar year 2000, Johns Hopkins Hospital and Franklin Square Hospital Center treated 95% of the children receiving inpatient psychiatric care.

In the Commission's report, providers indicated that "RTCs are serving a patient population with more severe conduct disorders, lower IQs, more chronic sex offenders, co-morbid conditions, and more persistent mental illness."

The Commission reported that data collected from 2,152 Maryland Health Partners discharges indicates the following length of stay (LOS) distribution:

- 15.1% had an RTC LOS less than 90 days
- 14.5% had an RTC LOS between 91 and 180 days
- 35.6% had an RTC LOS between 181 and 365 days
- 22.0% had an RTC LOS between 1.0 and 1.5 years
- 12.8% had an RTC LOS greater than 1.5 years.

Maryland's mental health parity mandate, enacted in 1994, requires a carrier (health insurer, nonprofit health services plan, or HMO) to provide coverage for mental health services on the same terms as physical illness. Carriers must cover a minimum of 60 days of partial hospitalization for mental illness. Also, as to inpatient coverage of services provided in a licensed or certified facility including a hospital, the total number of days covered and the terms of coverage must be at least equal to those that apply to the benefits available under the policy for physical illness. Benefits may be provided through a carrier's managed care system.

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

One report on residential treatment use by children estimated that 35,000 children and adolescents used residential treatment centers in 1985 (Milazzo-Sayre, as cited in Krohn, 2000); however, use has been increasing. Another report stated that the use of residential treatment centers had risen from 6% of child and adolescent mental health service expenditures in 1986 to 28% of expenditures in 1991 (Burns, as cited in Krohn, 2000). In many cases, there is no local residential treatment center with capacity, and the only available center is out of state.

Proposed Mandates

Overall, the level of public demand for coverage of RTCs is low because of the low incidence rate among the general population. However, for those who need the service, the demand for either residential treatment center or in-home care is often urgent.

The responses from our survey of collective bargaining agents range from giving the proposal a high priority to giving it a low priority. The most common response was a high level of interest.

Based on responses from managed behavioral health care vendors, we estimate that few employers cover long-term RTC admissions.

The State of Maryland, Department of Budget and Management, Employee Benefits Division told Mercer that mental health coverage for state employees is administered by a managed behavioral health care vendor and that the benefit plan has excluded RTC treatment. The vendor does cover hospitalization, partial hospitalization (4 to 10 hours a day), intensive outpatient care, occasional overnight partial hospitalization, and outpatient services. The vendor says that it is not unusual for its clients to exclude coverage for RTCs. This vendor was not one of the managed behavioral health care vendors included in Mercer's survey.

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

Medical

In this section we answer the following questions related to RTC services:

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

The amount of studies focusing on children and adolescent care in RTCs is limited. We have included reports that also cover adults as an attempt to provide more information. The reader should be aware that the needs of children, adolescents, and adults may vary.

In the article *Randomized Trial of General Hospital and Residential Alternative Care for Patients With Severe and Persistent Mental Illness,* 185 adult patients who were enrolled in the Montgomery County Department of Mental Health's mental health program were randomly assigned to either Montgomery General Hospital in Olney, Maryland, or a residential alternative

care facility, McAuliffe House in Rockville, Maryland. In a survey conducted six months following discharge, psychosocial functioning, satisfaction, and acute care use were comparable for the two treatment settings. While the average length of stay for the alternative care facility was longer than for the hospital (18.7 days compared to 11.7 days), the cost per day for the alternative care facility was about half the cost per day for the hospital. Overall, the cost per admission for the alternative treatment facility was about half the cost per admission for the hospital.

RTCs are institutions that serve children who have difficulty maintaining socially appropriate behavior and functioning in academic, social, and family settings. One study, based on surveys of RTC staff, estimates that two-thirds of the children in RTC could have been placed in a less restrictive setting if one were available (Hoagwood & Cunningham, as cited in Krohn, 2000). Placement for care seems to be based more on availability than on the most appropriate level of care.

The paper *Children and Adolescent Residential Treatment Centers: An Evaluation of Treatment Efficacy* states:

> RTCs as a whole have evolved into placements for children and adolescents with behavior problems. Generally, RTCs serve a combination of children with behavioral, emotional, or mental health symptoms, but the portion of children with mental health diagnoses (e.g., thought, mood, and anxiety disorders) has been declining. The typical RTC, though a great variety of models exists, is oriented toward the conduct-disoriented male. For example, more children are transferred to RTCs from detention centers than to any other placement.

The paper also states that while the evidence is limited, there are studies that have demonstrated positive RTC treatment outcomes with:

- Children 13 years of age and younger (Prentice-Dunn)
- Children who had shorter stays (Hoagwood and Cunningham)
- Children who did not exhibit psychosis, neurological dysfunction, or antisocial behavior (Blotcky)
- Children (juvenile offenders in RTCs) whose treatment plan included family therapy (93% recidivism without family therapy) (Borduin)
- Children who had adequate time in the program and adequate aftercare services (Blotcky).

Cognitive-behavioral therapy was successful in reducing externalizing behavior, such as aggression, though the behavior remained within the clinically abnormal range. Programs that showed the greatest gain focused on developing academic and vocational skills, as well as providing strong case management that coordinated services with family, school, and community.

Other studies show that there is little efficacy in RTCs. For example:

- One study showed that 63% of the children and adolescents at discharge had either minimal or no treatment gains. Also, the more restrictive the treatment setting, the less effective the treatment (Hoagwood and Cunningham, as cited in Krohn, 2000).

- RTCs have less of a tendency to individualize a treatment program to the individual's needs than community-based programs (Lyons, as cited in Krohn, 2000).

Alternatives to RTC care may be as effective or even more effective. Day treatment programs have been shown to be as effective as RTC care, with the advantages of costing less, requiring minimal disruption to school and social life, and avoiding the institutional stigma. Also, wrap-around community-based programs have been shown to reduce subsequent RTC admissions. In a Canadian study, a 15-hour weekly individualized treatment program was perceived by case managers, parents, and children as effective, while costing only 16% of the combined average cost of all out-of-home placements (Brown & Hill, as cited in Krohn, 2000).

Mental Health: A Report of the Surgeon General reported the following findings relating to care of children and adolescents:

- Research on partial hospitalization/day treatment as an alternative to inpatient treatment generally finds benefit from a structured daily environment that allows youth to return home at night to be with family and friends.

- Day treatment has been used as a transitional service after residential treatment when 24-hour care is no longer needed, but the youth is not ready to be reintegrated into the school system.

- Research on day treatment points to positive gains related to academic and behavioral improvement, reduction in or delay of hospitalization or RTC placement, and about a 75% return-to-school rate for patients, but most studies are uncontrolled.

- Family participation during and following day treatment is essential for optimal results.

- One of the concerns about RTC is the risks of treatment, including failure to learn behavior needed in the community, the possibility of trauma associated with the separation from the family, difficulty reentering the family or even abandonment by the family, victimization by RTC staff, and learning of antisocial or bizarre behavior from intensive exposure to other disturbed children.

- Home-based services provide very intensive services within the youth's home in order to prevent out-of-home placement.

Proposed Mandates

Research generally seems to show that RTCs are appropriate in some cases but that in most cases patients do not benefit from the treatment. RTCs have the drawbacks of being costly, separating the patient from family and friends (in many cases the only available RTC is out of state), and not being coordinated with community-based care. Its advantages are that it is less costly than inpatient care and it is successful in some cases.

In-home care, community-based care, and day treatment seem to offer benefits similar to RTCs, excluding the most severe cases. These alternatives are also less costly than RTCs and can incorporate the family into the care of the patient. They also tend to be more individualized than RTCs and may better meet the patient's needs.

Proposed Mandates

Expansion of child wellness coverage mandate (Section 15-817) to include treatment, counseling, and prevention of obesity for children and youth

We were asked to review a request to require coverage for treatment, counseling and the prevention of obesity for children and youth by expanding subsection 15-817. Under this subsection, insurers must include child wellness services in a family policy. Currently, at a minimum, 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.

The request did not define obesity, treatment, counseling, or prevention. For the purpose of this evaluation we have developed definitions; however, the legislature may develop different definitions when writing a bill.

We define child obesity based on the NCHS age and gender specific body mass index (BMI). We assume this mandate will apply to children with a BMI greater than or equal to the 95th percentile, or a BMI greater than or equal to the 85th percentile with complications of obesity.

This subsection is intended to cover tests and evaluations; therefore we assume that the definition of treatment will exclude surgical treatment. Treatment would be limited to testing and guidance.

We assume that counseling could include separate counseling of the parents and children.

Financial

Because there are few programs currently that specifically address child obesity and wide-spread attention to this issue is relatively recent, we projected the costs based on the types of program we would expect to be developed. This is based on research presented later in this section.

Estimates of the percentage of children who are obese currently range from 5% to 33%. The most common estimate is 15%, so in our projections, we assume that 15% of children would be eligible for this benefit. We estimate that annually, only 5% to 10% of these eligible children will use the benefit; therefore we estimate that about 1% of children will use the benefit.

The initial screening should already be covered as part of the child wellness exam. We estimate that the cost of the counseling, treatment, and prevention approved by the insurer will cost between $50 and $150. We are using $100 in our estimate.

Assuming that 1% of the children use this benefit and the average cost per child using this benefit is $100 annually, the cost per child will be $1 annually. We estimate there are 0.6 covered children per contract; therefore the annual cost will be $0.60 per contract. Because this

is a new and developing program, we estimate that the marginal cost will be the same as the full cost.

The full and marginal costs are summarized below:

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.0%	0.0%
Estimated cost as a percentage of average wage	0.00%	0.00%
Estimated annual per-employee cost of mandated benefits for group policies	$0.60	$0.60

Social

In this section, we address the following:

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

Estimates of the percentage of children who are obese currently range from 5% to 33%. The most common estimate is 15%. Child obesity is also correlated to obesity in either the mother or father. Overweight toddlers whose parents are of normal weight have a 10% chance of being an obese adult while those with at least one parent who is overweight has a 40% chance of being an obese adult.

Proposed Mandates

Currently there is a low demand from parents for treatment of their obese child. One reason is that most parents do not recognize when their child is overweight. Results of a study presented at the May 19, 2000 combined annual meeting of the Pediatric Academic Societies and the American Academy of Pediatrics showed that for parents of overweight children:

- 3% considered the child to be overweight
- 8% considered the child to be underweight
- The balance considered the child to be normal.

In another study of 260 inner-city youth, aged 3 to 10 years, 38% of the children where defined obese but only half of the parents recognized it, even though more than a third of the parents of overweight children had actually been told previously by the child's physician that their child was obese.

Many parents believe that their child will grow out of the obesity.

The Virginia Department of Health developed an intervention to educate parents of overweight children enrolled in their WIC Program. Only 7% of the targeted members entered the program. 48% of those who started the program completed the program; therefore about 3.4% of the targeted members completed the program. The program consisted of an initial assessment, two group sessions for the parent, two group sessions for the child, and an individual final assessment.

There are several published packages that include educational and motivational material and newsletters. These packages cost about $19. Therefore, without coverage, affordable programs are available. However, until parents are convinced of the need to enroll themselves and their child in such a program, the demand will be low.

Currently, such programs are not covered by large, employer-sponsored health plans.

Medical

In this section we answer the following questions related to child obesity:

- Are child obesity services recognized by the medical community as being effective and efficacious in the treatment of patients?

- Are child obesity services recognized by the medical community as demonstrated by a review of scientific and peer review literature?

- Are child obesity services available and utilized by treating physicians?

Proposed Mandates

Currently there is not a consensus as to whether obesity should be classified as a disease. In a Washington Post article, *Is Obesity a Disease?*, it explains the debate:

> "Proponents argue that new scientific understanding has clearly established that obesity is a discrete medical condition that independently affects health. Officially classifying obesity as a disease would have a profound impact by helping to destigmatize the condition, much as the classification of alcoholism as a disease made it easier for many alcoholics to get treatment, experts say. But equally important, the move would immediately remove key economic and regulatory hurdles to prevention and treatment, they say.
>
> "Opponents contend that obesity is more akin to high cholesterol or cigarette smoking -- a risk factor that predisposes someone to illness but is not an ailment in itself, such as lung cancer or heart disease. Labeling it a bona fide disease would divert scarce resources, distract public health efforts from the most effective countermeasures and unnecessarily medicalize the condition, they say."

The article goes on to show the mixed opinions, even in the medical community:

- "For ages, obesity has been regarded as a personal moral failing -- a behavioral issue that's easily fixed by people who have sufficient willpower to do so," said Morgan Downey, executive director of the American Obesity Association, a Washington-based advocacy group that has been lobbying for obesity to be reclassified. "The modern scientific understanding of obesity is that it is a complex disease in its own right."

- "There's no question that obesity is a disease," said Arthur Frank, medical director of George Washington University's Weight Management Program. "Obesity is a disease where there's a disregulation of eating -- just like diabetes is a disease where the system of controlling blood sugar is not functioning properly."

- "You can be overweight and healthy if you are active," said Tim Church, medical director of the Cooper Institute in Dallas, a nonprofit research center focused on exercise. "In fact, an overweight individual who exercises is healthier than a normal-weight individual who is sedentary. You could say that if obesity is a disease, then not enough exercise is a disease or not eating right is a disease."

Last year, the Internal Revenue Service ruled that, for tax purposes, obesity is a disease. This allows Americans to claim a deduction for some health expenses related to obesity. The Medicaid and Medicare programs are conducting a review to determine if it should consider obesity a disease.

While many overweight children see the weight problem as a social and cosmetic problem, few understand the health problems. The health conditions related to obesity in children are:

Proposed Mandates

- High cholesterol
- High blood pressure
- Early heart disease
- Diabetes
- Bone problems
- Skin conditions such as heat rash, fungal infections and acne
- Mental illness including defiance and depression.

Medications are not currently a treatment alternative for children. According to the University of Michigan Health System:

> "None of the new medicines to treat obesity are approved for children or adolescents to use. They may affect your child's growth and development, and the risk of dangerous complications is far greater than any benefit they might have. By far the best approach is helping your whole family—including your child—change behavior."

In the report, *Obesity Evaluation and Treatment: Expert Committee Recommendations,* Sarah E. Barlow, MD, MPH and William H. Dietz, MD, PhD present recommendations for physicians, nurse practitioners, and nutritionists to guide the evaluation and treatment of overweight children and adolescents. The recommendations where developed by a committee of pediatric obesity experts convened by the Maternal and Child Health Bureau, Health Resources and Services Administration, and the Department of Health and Human Services.

The committee recommended that children with a BMI greater than or equal to the 95th percentile, or with a BMI greater than or equal to the 85th percentile with complications of obesity, undergo evaluation and possible treatment. While they present recommendations, they acknowledge that few studies have been performed; therefore their approaches to evaluation and therapy are rarely evidence based. They also acknowledge that if a parent or adolescent is not ready for change, then a program may be futile or even harmful because an unsuccessful weight management program may diminish the child's self-esteem and impair future efforts.

The goals in the committee's recommendations are to improve behavior with regard to healthy eating and activity, improve or resolve secondary complications of obesity, and prolong weight management to reduce weight or maintain weight while gradually decreasing the BMI as the child grows in height.

The general approach to therapy presented by the committee states:

- Intervention should begin early
- The family must be ready for change
- Clinicians should educate families about medical complications of obesity
- Clinicians should involve the family and all caregivers in the treatment program

Proposed Mandates

- Treatment programs should institute permanent changes
- The treatment program should teach the family to monitor eating and activity
- The treatment program should help the family make small gradual changes
- Clinicians should encourage and empathize rather than criticize
- Many aspects of a weight management program can be accomplished by a variety of experienced professionals.

In November 2002, The Maryland Department of Health and Mental Hygiene (DHMH) released the report *Preventing Childhood Overweight in Maryland, Recommendations and Report of a Work Group Session.* The report presents the following research findings:

- The definition of overweight in children as having a BMI at or above the 95th percentile. At risk for overweight in children is having a BMI between the 85th and 95th percentile.
- 15% of U.S. children and adolescents are overweight.
- Annual national hospital costs associated with childhood overweight increased from $35 million in 1979 to $127 million in 1999 as the percentage of children who are overweight has nearly doubled.
- 80% of adolescents do not consume the recommended daily servings of fruits and vegetables.
- Soft drinks are the leading source of added sugar in adolescent's diets, equating to eleven teaspoons of added sugar daily.
- Children spend a large amount of time in sedentary activities. Approximately 10% of adolescents do not engage in any regular physical activity.
- 18% of the children ages one to four years who were enrolled in the Maryland WIC Program in 2001 were overweight.

The DHMH work group report identifies that overweight and obesity result primarily from excess calorie consumption combined with inadequate physical activity and prevention must address both factors. The work group used two models to develop recommendations, The Social-Ecological model using five levels of influence on an individual's health and behavior and The Precede-Proceed model focusing on desirable outcomes. The recommendations address families and individuals, schools, media and education, health care providers, neighborhood and community factors, (future) research and data collection. All these areas of society play a role in the recommendation.

As for health care providers, the work group report in 2002 recommended the development of access to reasonably priced prevention and treatment services with knowledgeable health care providers. Details from the recommendation for health care providers are:

- Reimbursement and Policy
    - Make overweight prevention and treatment a billable code
    - Mandate insurer coverage of overweight prevention and treatment
    - Ensure that all children and families have health insurance

Proposed Mandates

- Health Care Provider Education
    - Provide educational materials on childhood overweight issues to health professionals
    - Ensure that health care providers have the training, counseling skills, and cultural competence to help patients make behavior changes
    - Require health professional credentialing agencies to mandate continuing education in nutrition and overweight prevention

- Patient Education
    - Provide education to patients in provider's offices
    - Offer patients practical and do-able tips about healthy eating and physical activity
    - Write "prescriptions" for patients to engage in exercise and activity
    - Create a nutrition education curriculum to be implemented by churches, schools, and the health care community.

These recommendations were made prior to the State's current budget situation and continued double digit increases in commercial health insurance premiums.

The Virginia Department of Health developed an intervention to educate parents of overweight children enrolled in their WIC Program. It was a three-month intervention program that consisted of an initial assessment, two group sessions for the parent, two group sessions for the child, and an individual final assessment. Results of the intervention were:

- There was a decrease in the percentage of children who were in the "at risk of overweight" and "overweight" categories after the intervention (37% to 33%). There was no change in parents' BMI or BMI category after the intervention.

- There was no statistically significant change in the amount of physical activity or inactivity of the parent or child.

- The number of snacks per week for children increased during the intervention; however, they were proportionately lower in fat (54% were high fat snacks in the pre-test assessment compared to 48% in the post-test assessment).

- More participants of the intervention met their weekly goal for dairy consumption after the intervention (percentage meeting goal: 9% (pre-test) to 42% (post-test) in parents, and from 17% (pre-test) to 46% (post-test) in children). The percentage of children drinking whole milk decreased from 44% to 35% and the percentage drinking skim milk increased from 56% to 65% after the intervention.

- There was a reduction in the amount of frying (from 34% to 24%) and an increase in the amount of broiling, grilling and stir frying (64% to 78%) after the intervention.

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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	1.4	0.9	1.0	$300	$30	4.9%	0.5%	0.76%	0.08%
Payment for blood products	15-803	M	0.9	1.0	1.0	1.4	0.9	1.0	$28	$0	0.5%	0.0%	0.07%	0.00%
Coverage for off-label use of drugs	15-804	M	0.9	1.0	1.0	1.4	-	1.0	$16	$2	0.3%	0.0%	0.04%	0.01%
Reimbursement for pharmaceutical products	15-805	M		1.0	1.0	1.4	-	1.0	$8	$4	0.1%	0.1%	0.02%	0.01%
Choice of pharmacy	15-806	M		1.0			-		$81	$12	1.3%	0.2%	0.21%	0.03%
Medical foods & modified food products	15-807	M		1.0	1.0	1.4	0.9	1.0	$3	$0	0.0%	0.0%	0.01%	0.00%
Home health care	15-808	M		1.0	1.0	1.4	0.9	1.0	$27	$0	0.4%	0.0%	0.07%	0.00%
Hospice care	15-809	RO		1.0	1.0	1.4	0.9	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
In vitro fertilization	15-810	M	0.9						$29	$25	0.5%	0.4%	0.07%	0.06%

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
				1.0	1.0	1.4	-	1.0						
Hospitalization benefits. for childbirth	15-811	M		1.0	1.0	1.4	0.9	1.0	$126	$0	2.1%	0.0%	0.32%	0.00%
IP hosp. coverage for mothers of newborn children (minimum length of stay)	15-812	M	0.9	1.0	1.0	1.4	0.9	1.0	$60	$0	1.0%	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	1.4	0.9	1.0	$30	$1	0.5%	0.0%	0.08%	0.00%
Coverage for reconstructive breast surgery	15-815	M	0.9	1.0	1.0	1.4	0.9	1.0	$9	$0	0.1%	0.0%	0.02%	0.00%
Benefits for routine gynecological care	15-816	M	0.9	1.0	1.0	1.4	0.9	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage for child wellness	15-817	M		1.0	1.0	1.4	0.9	1.0	$45	$0	0.7%	0.0%	0.11%	0.00%
Benefits for treatment of cleft lip and cleft palate	15-818	M		1.0	1.0	1.4	0.9	1.0	$15	$0	0.2%	0.0%	0.04%	0.00%
Coverage for OP services and second	15-819	M		1.0	1.0	1.4	-	1.0	$1	$0	0.0%	0.0%	0.00%	0.00%

Exhibit 1 – Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
opinions														
Benefits for prosthetic devices and orthopedic braces	15-820	M		1.0			0.9		$7	$0	0.1%	0.0%	0.02%	0.00%
Diagnostic & surgical procedures for bones of face, head, & neck	15-821	M		1.0	1.0	1.4	0.9	1.0	$18	$0	0.3%	0.0%	0.05%	0.00%
Coverage for diabetes equipment, supplies, & self management training	15-822	M	0.9	1.0	1.0	1.4	0.9	1.0	$36	$0	0.6%	0.0%	0.09%	0.00%
Coverage for osteoporosis treatment	15-823	M	0.9	1.0	1.0	1.4	0.9	1.0	$28	$1	0.5%	0.0%	0.07%	0.00%
Coverage for maintenance drugs	15-824	M	0.9	1.0	1.0	1.4	0.9	1.0	$5	$0	0.1%	0.0%	0.01%	0.00%
Coverage for detection of prostate cancer	15-825	M	0.9	1.0	1.0	1.4	0.9	1.0	$43	$0	0.7%	0.0%	0.11%	0.00%
Coverage for contraceptives	15-826	M	0.9	1.0	1.0	1.4	0.9	1.0	$12	$2	0.2%	0.0%	0.03%	0.01%
Coverage of clinical trials under specific conditions	15-827	M	0.9	1.0	1.0	1.4	0.9	1.0	$12	$1	0.2%	0.0%	0.03%	0.00%
Coverage for general anesthesia for dental	15-828	M	0.9	1.0	1.0	1.4	0.9	1.0	$1	$0	0.0%	0.0%	0.00%	0.00%

Exhibit 1 – Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
care under specified conditions														
Chlamydia screening based on age and risk factors	15-829	M	0.9	1.0	1.0	1.4	0.9	1.0	$4	$0	0.1%	0.0%	0.01%	0.00%
Referrals to specialists	15-830	M	0.9	1.0	1.0	1.4	0.9	1.0	$2	$0	0.0%	0.0%	0.01%	0.00%
Coverage for prescription drugs and devices	15-831	M	0.9	1.0	1.0	1.4	0.9	1.0	$1	$0	0.0%	0.0%	0.00%	0.00%
Coverage for length of stay for mastectomies	15-832	M	0.9	1.0	1.0	1.4	0.9	1.0	$1	$0	0.0%	0.0%	0.00%	0.00%
Extension of benefits	15-833	M	0.9	1.0	1.0	1.4	0.9	1.0	$1	$0	0.0%	0.0%	0.00%	0.00%
Coverage for prosthesis following mastectomy	15-834	M	0.9	1.0	1.0	1.4	0.9	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage of habilitative services for children	15-835	M	0.9	1.0	1.0	1.4	0.9	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage for wigs for hair loss resulting from chemotherapy	15-836	M	0.9	1.0	1.0	1.4	-	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage for routine gynecological care by OB/GYN provider	15-816 expan-sion	M	0.9	1.0	1.0	1.4	0.7	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%

Exhibit 1 – Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Standing referral to obstetrician for pregnancy	15-816 expan-sion	M	0.9	1.0	1.0	1.4	0.7	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
IVF for male factor infertility reduce 5 year infertility history requirement	15-810 expan-sion	M	0.9	1.0	1.0	1.4	-	1.0	$20	$17	0.3%	0.3%	0.05%	0.04%
Coverage for Colorectal cancer screening	15-837	M	0.9	1.0	1.0	1.4	0.9	1.0	$7	$1	0.1%	0.0%	0.02%	0.00%
Coverage for hearing aids for a minor child	15-838	M	0.9	1.0	1.0	1.4	-	1.0	$9	$2	0.1%	0.0%	0.02%	0.01%
Coverage for treatment of morbid obesity	15-839	M	0.9	1.0	1.0	1.4	-	1.0	$33	$8	0.5%	0.1%	0.08%	0.02%
Habilitative services – modification and clarification	15-835	M	0.9	1.0	1.0	1.4	0.9	1.0	$3	$1	0.0%	0.0%	0.01%	0.00%
Coverage of residential crisis services	15-840	M	0.9	1.0	1.0	1.4	0.9	1.0	$2	$0	0.0%	0.0%	0.01%	0.00%

Summary by Type of Policy

Exhibit 1 – Financial Analysis of Current Mandates

									Estimated Annual Cost of Mandated Benefits Per Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Policy		Estimated Cost as a Percent of Average Wage	
Type of Policy									Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Med. & Large Group Insurance									$935	$95	15.2%	1.5%	2.4%	0.2%
Individual Insurance									$1,309	$133	15.2%	1.5%	3.3%	0.3%
CSHBP									$743	$33	13.8%	0.6%	1.9%	0.1%
State Employees Benefit Plan									$993	$101	16.2%	1.6%	2.5%	0.3%
Composite									$916	$83	14.9%	1.3%	2.3%	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												
Child Obesity Coverage Under Wellness Benefits		M	1.0	1.3		1.0	$0.60	$0.60	0.0%	0.0%	0.00%	0.00%
Mental Illness Coverage for Children -- RTCs		M	1.0	1.3		1.0	$13.20	$9.90	0.2%	0.2%	0.03%	0.03%

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							$14	$11	0.2%	0.2%	0.04%	0.03%
Individual Insurance							$18	$14	0.2%	0.2%	0.05%	0.03%
CSHBP							$0	$0	0.0%	0.0%	0.00%	0.00%
State Employees Benefit Plan							$15	$11	0.2%	0.2%	0.04%	0.03%
Composite							$11	$8	0.2%	0.1%	0.03%	0.02%

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

§ 15-1501.

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

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

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

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

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

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

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

(i) social impacts, including:

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

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

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

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

5. the level of public demand for the service;

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

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

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

(ii) medical impacts, including:

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

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

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

(iii) financial impacts, including:

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

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

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

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

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

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

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

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

(ii) as a percentage of health insurance premiums.

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

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

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

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

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

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

(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.