A Report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services of the 131st Maine Legislature

Review and Evaluation of Amendment to LD 1832, An Act to Require Reimbursement of Fees for Treatment Rendered by Public and Private Ambulance Services

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I. Executive Summary

The Joint Standing Committee on Health Coverage, Insurance and Financial Services (Committee) of the 131st Maine Legislature directed the Bureau of Insurance (Bureau) to review the committee amendment to LD 1832, An Act to Require Reimbursement of Fees for Treatment Rendered by Public and Private Ambulance Services. More specifically, the Bureau was directed to study the impact of mandating coverage for "community paramedicine" provided by Ambulance Service Providers throughout the State. The review was conducted as required by Title 24-A, Section 2752. This document and review are a collaborative effort of NovaRest, Inc. and the Bureau.

The amended bill adds to 24-A MRSA §4303-F, subsection 1-B stating that a carrier shall reimburse ambulance services provider for covered services delivered through community paramedicine in accordance with Title 32, section 84, subsection 4. The reimbursement paid by a carrier must meet the requirements of subsection 1. A carrier may require an ambulance service provider to obtain prior authorization before providing services delivered through community paramedicine. The requirement would be effective January 1, 2025.

The reimbursement requirements discussed in 24-A MRSA §4303-F subsection 1 indicate carriers must reimburse the ambulance service provider in the carrier's network at the ambulance service provider's rate or 200% of the Medicare rate (or 180% of the Medicare rate for out-of-network), whichever is less. In both cases, if the ambulance service provider is located in a rural or super rural area designated by HHS, CMS and eligible for additional Medicare reimbursement for services that were provided to a Medicare enrollee, the carrier shall increase the reimbursement to that ambulance service provider in the same amount as the additional Medicare reimbursement. Reimbursement is typically left to negotiations between providers and the insurance carrier. Some of the carriers indicated amended LD 1832 should be amended to allow carriers to contract with community paramedicine programs at a reasonable rate.

We conducted a survey of medical insurance carriers in Maine to determine the level of coverage already available and other critical information. Two of seven carriers indicated they currently reimburse ambulance service providers for community paramedicine services, although they would still need to increase costs to meet the reimbursement level discussed.

We estimate the total cost of coverage to each market for community paramedicine services to be between $40,000 and $500,000 annually. This amounts to between $0.05 to $0.25 on a PMPM basis and less than 0.05% on a percent of premium basis. Please note we did not analyze the cost impact of requiring ambulance service providers to be reimbursed for non-transport services, which was included in LD 1602 and signed into law by the governor. Those requirements will become effective January 1, 2024.[1] We had to make several assumptions to develop our cost estimate, which will be described in the following sections. Please note we expect that this premium impact will vary among carriers and products depending on each plan's cost sharing,

[1] "S.P. 634 - L.D. 1602: An Act to Implement the Recommendations of the Stakeholder Group Convened by the Emergency Medical Services' Board on Financial Health of Ambulance Services." State of Maine. https://legislature.maine.gov/legis/bills/getPDF.asp?paper=SP0634&item=6&snum=131

population, whether it is currently covered, and current reimbursement levels. Our estimate did not vary significantly between the individual, small group, or large group markets.

Beginning in 2014, states are required to defray the costs of all mandates that are included in Qualified Health Plans. The Affordable Care Act (ACA) directs states to make payments either to the individual enrollee or to the insurer.[2] Generally, mandates adopted by a state after December 31, 2011, have been excluded from the essential benefit package by federal regulators and thus are subject to the requirement for the state to defray the cost. However, the ACA does not consider provider mandates as an additional mandate that requires the cost to be defrayed. Based on our analysis and carrier responses, we believe that requiring reimbursement for ambulance service providers providing medically necessary services that are currently covered by other providers would not require defrayal because it would be considered a provider mandate. Bureau staff met with CMS staff in November 2023 to discuss the bill and CMS agreed with our assessment of the mandate as a provider mandate. This is not a legal interpretation, nor should it be considered legal advice.

II. Background

Community paramedicine is generally defined as "the practice by an emergency medical services provider primarily in an out-of-hospital setting of providing episodic patient evaluation, advice and treatment directed at preventing or improving a particular medical condition, within the scope of practice of the emergency medical services provider as specifically requested or directed by a physician."[3] These services are not in response to an emergency call, but is scheduled in advance by the consumer and provider.

In December 2022, the Maine Blue Ribbon Commission regarding Emergency Medical Services (EMS) in the State as part of Chapter 749 Public Law published a report. This report includes a comprehensive study of EMS in Maine. Community paramedicine was discussed as a potential model for reducing "the use of EMS for non-emergency 911 calls, the overcrowding of emergency departments and healthcare costs." [4] Twelve community paramedicine pilot projects were authorized in 2012[5] which was subsequently expanded to seventeen.[6]

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[2] See 45 CFR § 155.170, implementing ACA § 1311(d)(3)(B).

[3] "H.P. 981 - L.D. 1427 An Act To Make Community Paramedicine Services Permanent." State of Maine. https://www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine%20128%20-%20HP%20981%20item%203.pdf

[4] "Blue Ribbon Commission to Study Emergency Medical Services in the State." *Maine.Gov*, Maine EMS, www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report.pdf. Accessed 9 Oct. 2023.

[5] "Community Paramedicine: Presentation to the Blue Ribbon Commission to Study EMS October 6, 2022" https://legislature.maine.gov/doc/9058

[6] Vida Foubister, Martha Hostetter, Sarah Klein. "Can Community Paramedicine Improve Health Outcomes in Rural America?" March 24, 2023. https://www.commonwealthfund.org/publications/2023/mar/can-community-paramedicine-improve-health-outcomes-rural-america. Accessed 16 Oct. 2023.

Our understanding is the services that would be covered under community paramedicine are already typically covered by other providers and LD 1832 requires reimbursement for ambulance service providers for providing these services. This was echoed by the Blue Ribbon Commission report as well as public testimony. Specifically, there may be overlap between community paramedicine and home health care. We note that home health care is included in the Maine EHB Benchmark plan[7] and is therefore required to be covered by the individual and small group ACA markets. A list of services provided was published in the Maine EMS Community Paramedicine Pilot Program Evaluation as of 2015.[8]

Both public testimony and the Blue Ribbon Commission report mentioned that EMS services are currently underfunded. Currently, ambulance service providers would only be required to be reimbursed for providing emergency services with transport. LD 1602, which was signed into law by the governor, required reimbursement for emergency services, even if a person refuses transport to the hospital, but specifically did not require reimbursement for community paramedicine. Amended LD 1832 further specifies reimbursement levels for community paramedicine provided by ambulance service providers to be consistent with reimbursement for emergency services.

III. Social Impact

A. Social Impact of Mandating the Benefit

1. The extent to which the treatment or service is utilized by a significant portion of the population.

A report conducted by Maine EMS shows that most counties in Maine have 1 – 190 encounters between community paramedicine professionals and patients.[9] The Blue Ribbon Commission report indicated EMS received 288,273 calls in 2021, with 1.1% for community paramedicine, or about 3,200 calls. [10] We note this was prior to the 2022 expansion in the number of community paramedicine programs in Maine.

We do not know what the ultimate level of utilization will be, however, a report from a more established program in California indicated that 5% of EMS calls for community paramedicine.[11] 5% of 288,273 calls would amount to approximately 14,400 calls for community paramedicine.

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[7] "Maine EHB Benchmark Plan - Centers for Medicare & Medicaid Services." *CMS*, www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Maine-Benchmark-Summary.pdf. Accessed 9 Oct. 2023.

[8] Karen Pearson, MLIS, MA; George Shaler, MPH. "Maine EMS Community Paramedicine Pilot Program Evaluation." https://www.maine.gov/future/sites/maine.gov.ems/files/inline-files/cp_muskie_report.pdf

[9] "Maine Emergency Medical Services 2019 EMS Data Report." *Maine.Gov*, Maine EMS, www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/2019-Maine-EMS-Data-Report.pdf. Accessed 10 Oct. 2023.

[10] "Blue Ribbon Commission to Study Emergency Medical Services in the State." *Maine.Gov*, Maine EMS, www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report.pdf. Accessed 9 Oct. 2023.

[11] Deputy Chief Sandy Tong. Fire Commission Report January 2023. https://sf-fire.org/media/2708/download?inline. Accessed October 16, 2023.

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

There is no single model of community paramedicine – rather programs are based on community needs and services. Community paramedicine pilot projects were authorized by the 125th Maine Legislature and expanded during the 128th Maine Legislature.[12] There are currently 17 community paramedicine programs in Maine, with potential to expand the programs or apply for a new program.[13] As of January 2021, there are over 276 licensed services who deliver EMS services.

Amended LD 1832 specifies that reimbursement to ambulance service providers would be for covered services. Therefore, services are generally available to enrollees through other providers, however, we note that we believe the intent of the community paramedicine programs is to provide covered services to enrollees who are underserved and have difficulty accessing covered services through other providers due to limited number of providers, transportation difficulties, etc. These enrollees would instead rely on 9-1-1 for non-emergency services, which may be taxing on EMS services which is already underfunded and understaffed. [14]

It is also important to note that a community paramedicine program is not necessarily able to provide all available community paramedicine services, as can be seen in Table 2 of the pilot program evaluation report.[15] We do not have sufficient information to determine how many people would be able to receive each service through community paramedicine.

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

Two of 7 carriers in the market indicated coverage was currently available for community paramedicine through ambulance service providers. The services that are provided through community paramedicine are covered through other providers per the LD 1832 language; however, enrollees may have difficulty accessing these services through other providers.

See the carrier responses below for a description of the current level of coverage.

Aetna: Not currently covered. When a member calls an ambulance, but upon evaluation transport isn't needed, we consider the request for ambulance services necessary. This applies to all situations (it's not paramedic specific since paramedics don't usually provide transport.) This is under our current ambulance policy not as a paramedicine service.

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[12] "Blue Ribbon Commission to Study Emergency Medical Services in the State." Maine.Gov, Maine EMS, www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report.pdf. Accessed 9 Oct. 2023.

[13] Vida Foubister, Martha Hostetter, Sarah Klein. "Can Community Paramedicine Improve Health Outcomes in Rural America?" March 24, 2023. https://www.commonwealthfund.org/publications/2023/mar/can-community-paramedicine-improve-health-outcomes-rural-america. Accessed 16 Oct. 2023

[14] "Blue Ribbon Commission to Study Emergency Medical Services in the State." *Maine.Gov*, Maine EMS, www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report.pdf. Accessed 9 Oct. 2023.

[15] Karen Pearson, MLIS, MA; George Shaler, MPH. "Maine EMS Community Paramedicine Pilot Program Evaluation." https://www.maine.gov/future/sites/maine.gov.ems/files/inline-files/cp_muskie_report.pdf.

Anthem: The proposed amendment to L.D. 1832 is a provider mandate that requires reimbursement of covered services when rendered by community paramedicine providers. As such, the benefits are currently available through other providers.

Cigna: Cigna does have an ambulance reimbursement policy Ambulance Services (cigna.com) and when contracted, the following code is a reimbursable code when billed: A0998 Ambulance response and treatment, no transport.

Community Health Options: Currently, these services are not reimbursable (community paramedicine – distinctly different from the original version of this bill that was related to non-transport services which are no longer contemplated and of which we do cover).

Harvard Pilgrim: Currently HPHC reimburses for paramedicine services under code A0998 for ambulance response and treatment, no transport. The language of the bill as drafted is extremely unclear. What is the scope of community paramedic services? We have extreme concerns of the impact of potential services on the primary care model and member/primary care relationships.

Taro Health: We do not explicitly cover this benefit under our plans. Currently, we provide Benefits for Medically Necessary ambulance services. Benefits also include Medically Necessary treatment of a sickness or illness by medical professionals during an ambulance service, even if the member is not taken to a Facility.

UnitedHealthcare: We cover ambulatory services. However, until further details of the mandate are available, it is unclear if the mandate will require an expansion from our current benefits. Currently UHC policy does not allow us to include treat without transport on our payment appendices for INN providers, so that code will deny and pay nothing.

4. If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.

Enrollees are eligible to receive services through other providers. However, if access to other providers is difficult, people may not pursue necessary care, which could lead to more serious illness, or they may rely on 9-1-1 for nonemergency services. We note many sources cite a shortage of EMS workers[16] meaning 9-1-1 may not have capacity to provide nonemergency services if understaffed. Additionally, there may not be sufficient home health care workers to serve the increase in demand for home health care services.[17] A recent analysis found the number of home health care workers per participant in home and community-based services decreased by 11.6% from 2013 to 2019, with further decrease continuing into 2020. [18]

[16] "Maine EMS Workforce Shortage." *APEMS*, 8 Nov. 2021, www.apems.org/maine-ems-workforce-shortage.
[17] Natalie Krebs. "A shortage of health aides is forcing out those who wish to get care at home." May 5, 2022. https://www.npr.org/sections/health-shots/2022/05/05/1095050780/a-shortage-of-health-aides-is-forcing-out-those-who-wish-to-get-care-at-home.
[18] Amanda R Kreider and Rachel M. Werner. "The Home Care Workforce Has Not Kept Pace With Growth In Home And Community-Based Services." APRIL 19, 2023. Health Affairs 2023 42:5, 650-657. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01351?utm_medium=social&utm_source=twitter&utm_campaign=may+2023+issue&utm_content=aop&utm_term=kreider.

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

Paying out of pocket for services or transportation costs to receive covered services from other, or potentially more expensive providers (for example if a member must access services at a hospital as opposed to their primary care office) may be financially prohibitive. The Blue Ribbon Commission estimated a $492 reimbursement per call for delivering EMS, although we were unable to find a cost specific to providing community paramedicine benefits. The report notes that MaineCare pays at Medicare rates at the lowest geographic practice cost index (GPCI). The Medicare base rate for basic life support non-emergency transport in Maine is $266, although there may be adjustments for mileage and urban/rural settings.[19] Comparatively, home health care services in Maine vary in cost from $105 to $310 per service base fee depending on the provider type and services provided, with additional cost on some services depending on the time required.[20]

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

The Joint Standing Committee on Health Coverage, Insurance and Financial Services received 7 public hearing testimony items regarding LD 1832, with 3 letters in support of the legislation, 1 letter in opposition, and 3 letters neither for nor against.[21]

All testimony in support of LD 1832 were medical providers supporting required reimbursement for services.

There was one letter stating concern that LD 1832 would create a hospital-at-home scenario where community paramedicine could be inappropriately used instead of an inpatient hospital stay.

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

Two EMS providers and one medical service organization testified in support of individual and group coverage of the bill.

8. The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.

No information is available.

[19] "Ambulance Fee Schedule Public Use Files." CY2023, Contractor/Carrier 14112, Locality 99, HCPCS A0428, RVU 1. https://www.cms.gov/medicare/payment/fee-schedules/ambulance/ambulance-fee-schedule-public-use-files.

[20] "MaineHealth Care at Home Fees - Effective 4/12/2023." https://www.mainehealth.org/MaineHealth-Care-at-Home/About/Fees. Accessed October 16, 2023.

[21] 131st Maine Legislature, First Special Session. An Act to Require Reimbursement of Fees for Treatment Rendered by Public and Private Ambulance Services. https://legislature.maine.gov/bills/display_ps.asp?snum=131&paper=HP1164PID=1456#.

9. The likelihood of meeting a consumer's need as evidenced by experience in other states.

There have been many programs put in place across the U.S. regarding community paramedicine. Medicaid in Arizona, Georgia, Minnesota, Nevada, and Wyoming have begun reimbursement for community paramedicine services. In addition, fourteen (14) states provide some reimbursement for treatment without transport. There have also been pilot projects run by commercial carriers in seventeen (17) states to investigate payment models for community paramedicine programs.[22]

10. The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

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

11. The alternatives to meeting the identified need.

The following are the relevant portions of the responses from commercial insurance carriers to the Bureau's request for information. We are not opining on the validity of the following assumptions or conclusions, but rather are repeating them as provided. Only carriers who were able to provide a discussion of alternatives are included.

Anthem: Rather than require coverage of these services at a mandated reimbursement rate, carriers should be allowed to contract for community paramedicine at a reasonable reimbursement rate. If there is interest in mandating this coverage the reimbursement rate should be comparable to that paid to other providers rendering the same or similar services.

Cigna: Emergency Triage, Treat, and Transport (ET3) is a voluntary, five-year Centers for Medicare & Medicaid (CMS) payment model pilot that is intended to provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service (FFS) beneficiaries following a 911 call. CMS will continue to pay to transport a Medicare FFS beneficiary to a hospital emergency department or other covered destination. In addition, under the model, CMS will pay participants to 1) transport to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health center, or 2) initiate and facilitate treatment in place with a qualified health care partner, either at the scene of the 911 emergency response or via telehealth. (Source: Emergency Triage, Treat, and Transport (ET3) Model | CMS Innovation Center)

Community Health Options: The mandated reimbursement levels should be reconsidered and removed entirely (making this LD 1832 moot), thereby permitting the provider and payer to negotiate the fee schedule applicable to these mandated services.

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[22] "Strategies for Sustaining Community Paramedicine Programs." RHIhub Toolkit, www.ruralhealthinfo.org/toolkits/community-paramedicine/6/sustainability-strategies. Accessed 10 Oct. 2023.

Harvard Pilgrim: Dr. Jonnathan Busco, Emergency Medicine Specialist in Bangor, Maine has been working with a broad stakeholder group, including Dr. Jeff Sedlack, Medical Director for Harvard Pilgrim Health Care in Maine, as well as Rep. Anne Perry through a project called the Jackman Critical Access Extender Project. Public materials on the details of the project are not yet available but will be soon. The project broadly is working with the paramedic community and family doctors and others, to deeply dive into the issue of rural access to services. Legislation should not advance ahead of this project.

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

This benefit is consistent with the role of insurance. Amended LD 1832 would require ambulance service providers to be reimbursed for services already covered by other medical providers.

Amended LD 1832 would specify the reimbursement rates for ambulance service providers, unlike other medical providers performing the same services in a different setting. Reimbursement is typically left to negotiations between providers and the insurance carrier. Two of seven carriers indicated amended LD 1832 should be amended to allow carriers to contract with community paramedicine programs at a reasonable rate.

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

There is unlikely to be a social stigma attached to getting services through community paramedicine.

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

Community paramedicine services potentially prevent more serious illness by providing necessary medical care to people who are unable to reasonably access services from other providers.

There is concern community paramedicine would be used instead of necessary care by other providers. One carrier indicated "If primary care provider is open and available, service should be provided by primary care provider. Including delaying non emergent care until primary care provider is available. As stated above, we have extreme concerns about the impact of potential community paramedicine services on the value proven by the primary care model and member/primary care relationships. Paramedic needs to be qualified to provide reimbursable services and within their scope of practice." Another carrier indicated "It's possible that if mandated to be covered by insurers, some may take advantage of this benefit and call for ambulance treatment in place of going to an urgent care or doctor's office." Additionally, one public testimony stated, where used inappropriately instead of a necessary hospital stay, community paramedicine could also lead to serious illness.

15. The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.

As premiums increase, employers look for to have more control over the benefits they provide to employees to control the costs. While this mandate, considered individually, is expected to have a minimal impact on premiums, it does add to the cumulative impact of mandates on overall rates. The cumulative impact of mandates is likely a consideration for employers when considering moving out of the fully insured market or when shifting a higher cost-sharing responsibility to their covered employees.

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

Anthem indicated a cost estimate of $1.83 PMPM with $0 member cost share and $1.47 PMPM with plan member cost share to cover the services provided by community paramedicine for the State Employee Health Plan. We do not have information on how this estimate was determined or if it includes the impact of services that are already covered.

IV. Financial Impact

B. Financial Impact of Mandating Benefits

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

Amended LD 1832 specifies reimbursement consistent with LD 1602, which allows for ambulance service providers to increase their rates by no more than 5% annually if they are below 200% of the average Medicare rate. Therefore, passage of LD 1832 has the potential to increase the cost of the services up to 200% of the average Medicare rate over time.

Public testimony indicated ambulance service providers are not reimbursed adequately, and therefore we find it unlikely amended LD 1832 would lead to a decrease in cost.

2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.

The level of reimbursement specified in amended LD 1832 may lead to additional community paramedicine programs or expansions of current programs. As the community paramedicine program was recently expanded, we believe there is potential for an increase in the appropriate use of services, however, it is unclear how much additional use would be realized.

There is concern that community paramedicine would be used instead of necessary care by other providers. One carrier indicated "If primary care provider is open and available, service should be provided by primary care provider. Including delaying non emergent care until primary care provider is available. As stated above, we have extreme concerns about the impact of potential community paramedicine services on the value proven by the primary care model and

member/primary care relationships. Paramedic needs to be qualified to provide reimbursable services and within their scope of practice."

One public testimony indicated concern over potential inappropriate use of community paramedicine to create a hospital-at-home scenario. Title 32, section 84, subsection 4 requires that "community paramedicine services shall work with an identified primary care medical director, have an emergency medical services medical director and collect and submit data and written reports to the board."[23] Furthermore, specifying the services to be provided under community paramedicine as was done in the Maine EMS Community Paramedicine Pilot Program Evaluation as of 2015[24] may prevent this scenario.

Additionally, the Blue Ribbon Commission report indicated confusion around licensing requirements for home health versus community paramedicine licensing requirements which may need to be addressed to prevent inappropriate use. [25]

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

The Blue Ribbon Commission report indicated community paramedicine has been proven to reduce healthcare costs.[26]

Harvard Pilgrim indicated "Potentially, some limited benefits or cost savings may exist, however, the topic and language are too vague to provide an answer." Taro indicated "There appears to be research that demonstrates savings in health care costs when paramedicine is utilized effectively. By assessing and stabilizing at-risk patients, paramedics can avoid unnecessary emergency department visits, generating savings of approximately $1,900 per case." Other carriers did not identify savings.

We do not have reimbursement rates for other providers that provide covered services to determine whether the reimbursement specified under amended LD 1832 is more or less expensive. One carrier indicated if reimbursement was based on current negotiated rates instead of specified rates under amended LD 1832, the cost would be 30% lower.

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[23] Maine Legislature Maine Revised Statutes. Title 32 Professions and Occupations. Chapter 2-B: Maine Emergency Medical Services Act of 1982. https://legislature.maine.gov/statutes/32/title32sec84.html. Accessed October 16, 2023.

[24] Karen Pearson, MLIS, MA; George Shaler, MPH. "Maine EMS Community Paramedicine Pilot Program Evaluation." https://www.maine.gov/future/sites/maine.gov.ems/files/inline-files/cp_muskie_report.pdf . Accessed 9 Oct. 2023.

[25] "Blue Ribbon Commission to Study Emergency Medical Services in the State." *Maine.Gov*, Maine EMS, www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report.pdf. Accessed 9 Oct. 2023.

[26] "Blue Ribbon Commission to Study Emergency Medical Services in the State." *Maine.Gov*, Maine EMS, www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report.pdf. Accessed 9 Oct. 2023.

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

There is no language in the bill that prohibits medical management, in fact amended LD 1832 explicitly permits prior authorization. We believe carriers will be able to limit services to those that they determine to be medically necessary.

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

Community paramedicine is a relatively new program that has recently been expanded. The reimbursement rate specified in amended LD 1832 may increase the number of community paramedicine programs.

6. The extent to which the insurance coverage of the health care service or providers may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.

We have summarized the carrier response in the table below, while the carrier specific language is following the table.

Carrier	Estimated Premium Impact PMPM
Aetna	No material impact
Anthem	$1.37 to $1.70 PMPM (with $0 cost share) $1.03 to $1.28 PMPM (with member cost share)
Cigna	No material impact
Community Health Options	No estimate provided
Harvard	$0.50 to $1.00 PMPM
Taro Health	No material impact
UnitedHealthcare	No material impact

Aetna: Premium increase would be immaterial (same across all lines of business). No impact on administrative or indirect costs. We recommend more clarity on the type of services that carriers are expected to cover for paramedicine providers under this mandate given their scope of practice, as it appears to be expanded under the proposed mandated.

Anthem:

	2022 Actual Experience PMPM
Individual	$0.74
Small Group	$1.24
Large Group	$1.02
State of Maine Employee Plan	$1.03

The mandate would increase costs by potentially increasing utilization and by significantly increasing the rate at which these services are reimbursed.

	Premium Impact	
	$0 Member Cost Share	**w/ Plan Member Cost Share**
Individual	$1.37	$1.03
Small Group	$1.16	$0.87
Large Group	$1.70	$1.28
State of Maine Employee Plan	$1.83	$1.47

These estimates are based on the reimbursement rate required under the proposed amendment, which is significantly higher than the rate at which those services are reimbursed when rendered by other providers. If we were to reimburse for these services at the same rate as currently reimbursed, the costs would be approximately 30% lower.

Cigna: Running a data pull for CPT code A0998 for Maine using full year 2022 data, the impact to cover is immaterial. It's possible that if mandated to be covered by insurers, some may take advantage of this benefit and call for ambulance treatment in place of going to an urgent care or doctor's office. It's unclear if this would have an impact on pricing.

Community Health Options: There are a number of unknown variables needed to answer this question, including, but not limited to the development and publication of clinical policies that indicate appropriate engagement of community paramedicine services, any potential BOI rulemaking, service provider reporting of specific services to be rendered and the associated chargemasters for pricing, the benefit design implications of this mandate, the service providers' readiness (i.e. how many EMS providers are prepared and staffed to implement this offering), where the services are being offered, the relative availability of related services in the area. Depending on the necessity, approval, and utilization of these services, along with the proposed rate structure, this may result in higher premiums.

Harvard: Currently, code A0998 Ambulance response and treatment, no transport, costs less than $0.01 PMPM. However, given the lack of definition for community paramedicine, our best effort to approximate the cost of services mandated under the amended version of this bill, for which no specific codes are currently available, is assumed to be reimbursed on top of an ambulance response and treatment claim and is estimated to be $0.50-$1.00PMPM.

Taro Health: While we do pay for the treatment of a sickness or illness by medical professionals during an ambulance service, we do not have any claims experience yet for that benefit. We do not believe this level of benefit coverage would have impactful cost implications for us or our members.

UnitedHealthcare: Ambulance costs accumulated to $2.16 PMPM in 2020. This accounts for approximately 0.5% of our premium. Since ambulatory services are already covered, we do not expect any additional costs associated with this mandate.

Our Estimate

We used 1,385,340 for the population of Maine.[27] We then used 2022 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) to determine the covered lives by market for the individual, small group, and large group markets.

We used the Blue Ribbon Commission report to estimate approximately 290,000 EMS calls.[28] We used a range of 1%[29] to 5%[30] as the number of EMS calls related to community paramedicine. We assume the number of EMS calls related to community paramedicine are distributed uniformly across the markets.

We do not have access to actual carrier reimbursement rates. For current reimbursement, we used $215 per service based on MaineHealth care at home fees up to 2 hours as of 4/12/2023.[31] We assume community paramedicine services would not exceed 2 hours. We compared this cost to the 200%[32] of the base Medicare reimbursement for ambulance basic life services in Maine, or around $530 for a service.[33]

We assume a 75% cost sharing, which is based on average cost sharing in the individual and small group ACA market, although we recognize large group plans may be richer. Additionally, we assume an 80% loss ratio for the individual and small group markets, and an 85% loss ratio for the large group market based on federal MLR thresholds. Membership and premiums were determined using SHCE.

Using these assumptions, we estimate a $0.05 to $0.25 PMPM impact on premiums on a gross basis. We expect that this premium impact will vary among carriers and products depending on each plan's cost sharing, population, whether it is currently covered, and current reimbursement levels.

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[27] Quickfacts Maine. United States Census Bureau. https://www.census.gov/quickfacts/fact/table/ME#. Accessed October 16, 2023.
[28] "Blue Ribbon Commission to Study Emergency Medical Services in the State." *Maine.Gov*, Maine EMS, www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report.pdf. Accessed 9 Oct. 2023.
[29] "Blue Ribbon Commission to Study Emergency Medical Services in the State." *Maine.Gov*, Maine EMS, www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report.pdf. Accessed 9 Oct. 2023.
[30] Deputy Chief Sandy Tong. Fire Commission Report January 2023. https://sf-fire.org/media/2708/download?inline. Accessed October 16, 2023
[31] "MaineHealth Care at Home Fees - Effective 4/12/2023." https://www.mainehealth.org/MaineHealth-Care-at-Home/About/Fees. Accessed October 16, 2023.
[32] While out-of-network providers would only be reimbursed 180%, we used 200% for conservatism considering we did not estimate mileage reimbursement.
[33] "Ambulance Fee Schedule Public Use Files." Centers for Medicare & Medicaid Services. https://www.cms.gov/medicare/payment/fee-schedules/ambulance/ambulance-fee-schedule-public-use-files. Accessed October 16, 2023.

7. The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.

There should not be any additional cost effect beyond benefit and administrative costs.

8. The impact on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.

The Blue Ribbon Commission report indicated community paramedicine has been proven to reduce healthcare costs.[34] Additional review of cost-impact studies found 2 out of 3 showed cost-effectiveness of community paramedicine.[35]

Harvard Pilgrim indicated "Potentially, some limited benefits or cost savings may exist, however, the topic and language are too vague to provide an answer." Taro Health indicated "There appears to be research that demonstrates savings in health care costs when paramedicine is utilized effectively. By assessing and stabilizing at-risk patients, paramedics can avoid unnecessary emergency department visits, generating savings of approximately $1,900 per case." Other carriers did not identify savings.

While it appears there is some evidence of cost-effectiveness of community paramedicine, we are unable to determine if there would be savings at the reimbursement prescribed under amended LD 1832.

9. The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.

The carriers' responses indicate a cost impact of anywhere from $0 to $1.28 PMPM on employer group premiums.

10. The effect of the proposed mandates on cost-shifting between private and public payers of health care coverage and on the overall cost of the health care delivery system in this State.

We do not anticipate any significant cost-shifting for requiring reimbursement for ambulance service providers for services already covered by other medical providers.

[34] "Blue Ribbon Commission to Study Emergency Medical Services in the State." *Maine.Gov*, Maine EMS, www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report.pdf. Accessed 9 Oct. 2023.

[35] Elden OE, Uleberg O, Lysne M, Haugdahl HS. Community paramedicine: cost-benefit analysis and safety evaluation in paramedical emergency services in rural areas - a scoping review. BMJ Open. 2022 Jun 9;12(6):e057752. doi: 10.1136/bmjopen-2021-057752. PMID: 35680256; PMCID: PMC9185415.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit

1. The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.

The coverage of services done by community paramedicine providers could benefit the quality of patient care and health status, especially for those living in rural areas. Rural residents tend to be older and sicker and have to travel longer distances to reach care.[36] Community paramedicine can be used to close this gap in care. Community paramedicine could also be used to lower emergency room visits, reduce 9-1-1 emergencies, and improve patient quality of life by providing non-emergency treatments.[37]

2. If the legislation seeks to mandate coverage of an additional class of practitioners:

a. The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

Amended LD 1832 does not require an additional class of providers. Community paramedicine programs are already available in Maine and were recently expanded. Amended LD 1832 which specifies the reimbursement level and mandates coverage may result in additional community paramedicine programs in Maine similar to those already started.

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

Community paramedicine providers are currently overseen by the Community Paramedicine (CP) Advisory Committee.[38]

[36] "Can Community Paramedicine Improve Health Outcomes in Rural America?" *Can Community Paramedicine Improve Health Outcomes Rural America? | Commonwealth Fund*, 24 Mar. 2023, www.commonwealthfund.org/publications/2023/mar/can-community-paramedicine-improve-health-outcomes-rural-america.

[37] Amell, Kevin. "The Community Paramedicine Program and Its Pros and Cons." *Julota*, 8 Mar. 2022, www.julota.com/news/what-are-the-pros-and-cons-of-a-community-paramedicine-program/#:~:text=A%20well%2Doiled%20community%20paramedicine,these%20programs%20to%20duplicate%20services.

[38] "Community Paramedicine." *Community Paramedicine | Maine Emergency Medical Services*, www.maine.gov/ems/boards-committees/community-paramedicine. Accessed 12 Oct. 2023.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.

While services are already covered when rendered by other providers, reimbursing ambulance service providers for community paramedicine services would allow for additional access to necessary care for people who lack reasonable access to providers and either defer care, possibly leading to more serious illness, or rely on 9-1-1 for nonemergency services, which overburdens EMS staff that already are experiencing shortages.

Amended LD 1832 would specify reimbursement levels which would restrict carriers' ability to negotiate reimbursements, likely leading to higher premiums.

2. The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.

It is likely that only those who live in areas where access to EMS providers or hospitals is limited would purchase the coverage. This would result in alternative coverage that would cost more than the anticipated additional cost of services because administrative charges would be added to benefit costs. This cost would be reduced if the option were only available when the coverage was initially purchased, but it would then be less effective because many individuals would not anticipate needing the coverage and, therefore, would not purchase it. In addition, separate riders for ACA plans are prohibited.

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

The estimated cost of current Maine mandates is detailed in Appendix A. For most of these mandates, our estimate is based on the net impact on premiums as estimated at the time the mandate was enacted. Four of the mandates – mental health, substance abuse, chiropractic, and screening mammograms – require carriers to report annually the number of claims paid for these benefits and the estimates are based on that data. The true cost for the Maine mandates is impacted by the fact that:

1. Some services would be provided and reimbursed in the absence of a mandate.
2. Certain services or providers will reduce claims in other areas.
3. Some mandates are required by Federal law.

Cumulative % of Premium Impact of Current Maine Mandates			
	Without Required Reimbursement	With Required Reimbursement (Low End)	With Required Reimbursement (High End)
Total cost for groups larger than 20:	10.41%	10.42%	10.46%
Total cost for groups of 20 or fewer:	10.46%	10.47%	10.51%
Total cost for individual contracts:	10.49%	10.50%	10.54%

Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate of the proposed bill. Any judgments as to the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis by be incorrect. Appropriate staff are available to explain and/or clarify any matter presented herein. It is assumed that any user of this report will seek such explanations as to any matter in question.

NovaRest has developed projections in conformity with what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that actual future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by carrier, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings and inherent potential for normal random fluctuations in experience.

Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of the bill's consideration. The reliance of parties other than the Maine Bureau of Insurance and the Joint Standing Committee on Health Coverage, Insurance and Financial Services on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of information provided by carriers included in the data call. We also made assumptions based on information gained from interviews with medical professionals. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision. While we have relied on information without independent investigation or verification, the medical professionals we spoke to are fully qualified and knowledgeable in their field.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice.

We have no conflicts of interest in performing this review and providing this report.

We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

VII. Appendices

Appendix A: Cumulative Impact of Mandates

Bureau of Insurance
Cumulative Impact of Mandates in Maine

Report for the Year 2023

This report provides data for medical insurance coverage of mandates as required by 24-A M.R.S.A. §2752 and compiled by the Bureau of Insurance. While some data was provided through annual mandate reports by insurers, other figures were estimated as a part of the proposed mandates study. The following provides a brief description of each state mandate and the estimated claim cost as a percentage of premium. Many of these mandates are now required by the federal Affordable Care Act (ACA). In addition, the ACA requires benefits covered by the benchmark plan which includes all state mandates to be covered by all individual and small group plans effective January 1, 2014. A summary chart is provided at the end of this report.

- ***Mental Health*** (Enacted 1983)

Mental health parity for group plans in Maine became effective in 1996 and was expanded in 2003. The percentage of mental health group claims paid has been tracked since 1984 and has historically been between 3% - 4% of total group health claims. Claims jumped sharply in 2020 by 1.3% to 5.2% for groups after steadily declining by a half point per year for the previous 3 years. For 2022, group claims were 4.11% of total medical claims.

Maine mental health parity was only a mandated offer for individual plans until it was included in the essential health benefits for ACA (Affordable Care Act) individual and small group plans beginning 2014. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) amended the PHS Act, ERISA, and the Code to provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits and extended parity to all individual plans. As expected, mental health claims have stabilized back to a lower level of 2.5% in 2017 after meeting pent-up demand of 9.4% in 2015. For 2022, individual claims are 3.07% of total medical claims.

- ***Substance Abuse*** (Enacted 1983)

Maine's mandate initially only applied to group coverage. Effective in 2003, substance abuse was added to the list of mental health conditions for which parity is required. Effective in 2014 the federal Affordable Care Act requires substance abuse treatment benefits for individual and small group plans as part of the essential health benefits. The percentage of claims paid for group plans has been tracked since 1984. Substance abuse claims paid have remained flat at 1% average for the past 3 years of the total group health claims. Individual substance abuse health claims have also remained flat at 1% for the past 3 years. As expected, substance abuse claims have leveled out as pent-up demand is met and carriers manage utilization. For 2022, group claims for substance abuse were reported as 1.10% and individual claims 0.77% of total medical claims.

- ***Chiropractic*** (Enacted 1986)

This mandate requires coverage for the services of chiropractors to the extent that the same services would be covered if performed by a physician. Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1986 and, in 2022, was 0.52% of total health claims. Individual claims at 0.32% (group at 0.58%) in 2022 have continued a trend of lower than group claims since 2017 when they were equivalent.

- ***Screening Mammography*** (Enacted 1990)

This mandate requires that benefits be provided for screening mammography at no cost to the insured. We estimate the current 2022 levels of 0.66% for group and 1.2% for individual going forward. Coverage is required by ACA for preventive services.

- ***Dentists*** (Enacted 1975)

This mandate requires coverage for dentists' services to the extent that the same services would be covered if performed by a physician. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998)

This mandate requires coverage for reconstruction of both breasts to produce a symmetrical appearance after a mastectomy. At the time this mandate was being considered in 1995, one carrier estimated the cost at $0.20 per month per individual. We do not have a more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995)

This mandate requires coverage for metabolic formula and prescribed modified low-protein food products. At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We do not have a more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996)

This mandate requires that benefits be provided for medically necessary diabetic supplies and equipment. Based on data collected in 2006, most carriers reported that there would be no cost increase or an insignificant cost increase because they already provide this coverage. Based on our report we estimate 0.2%.

- ***Minimum Maternity Stay*** (Enacted 1996)

This mandate requires that if a policy provides maternity benefits, the maternity (length of stay) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care." Based on carrier responses indicating that they did not limit maternity stays below those recommended, we estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996)

This mandate requires that benefits be provided for screening Pap smear tests. We estimate a negligible impact of 0.01%. Coverage is required by ACA for preventive services.

- ***Annual GYN Exam Without Referral*** (Enacted 1996)

This mandate only affects HMO plans and similar plans, and it requires the provision of benefits for annual gynecological exams without prior approval from a primary care physician. To the extent the Primary Care Physician (PCP) would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher; therefore, we include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997)

This mandate requires that benefits for breast cancer treatment be provided for a medically appropriate period of time as determined by the physician in consultation with the patient. Claims for breast cancer treatment in 2022 remain level with past years at 1.7% of total medical claims.

- ***Off-label Use Prescription Drugs*** (Enacted 1998)

This mandate requires coverage of off-label prescription drugs in the treatment of cancer, HIV, and AIDS. Our 1998 report stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. Because the HMOs claimed to already cover off-label drugs, in which case there would be no additional cost; and, providers testified that claims have been denied on this basis, we include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998)

This mandate requires prostate cancer screenings. Our report estimated additional claims cost would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or approximately 0.07% of total premiums. Coverage is required by ACA for preventive services.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999)

This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999)

This mandate requires health plans that cover prescription drugs to cover contraceptives. Our report estimated an increase of premium of 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999)

This mandate requires health plans that cover surgical first assistants to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000)

This mandate requires that coverage be provided for an eligible enrollee to participate in approved clinical trials. Our report estimated a cost of 0.19% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000)

This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001)

No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Because carriers generally covered hospice care prior to the mandate, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001)

This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001)

This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ***Prosthetics*** (Enacted 2003)

This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20, and a cost of 0.08% of premium for small employer groups and individuals.

- ***LCPCs*** (Enacted 2003)

This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

- ***Licensed Pastoral Counselors and Marriage & Family Therapists*** (Enacted 2005)

This mandate requires coverage of licensed pastoral counselors and marriage & family therapists. Our report indicated no measurable cost impact for this coverage.

- ***Hearing Aids*** (Enacted 2007 and revised 2019)

The prior mandate required coverage for a hearing aid for each ear every 36 months for children age 18 and under. The mandate was phased-in between 2008 and 2010, and our report estimated a cost of 0.1% of premium. For 1/2020 the hearing aid mandate was expanded to require adult hearing aids. Based on rate filings and a proposed mandate study we estimate 0.2% addition impact to rates to provide hearing aids to adults.

- ***Infant Formulas*** (Enacted 2008)

This mandate requires coverage for amino acid-based elemental infant formulas for children two years of age and under, regardless of delivery method. This mandate is effective January 2009, and our report estimated a cost of 0.1% of premium.

- ***Colorectal Cancer Screening*** (Enacted 2008)

This mandate requires coverage for colorectal cancer screening. This mandate is effective January 2009. No carriers stated they denied coverage prior to this mandate; therefore, our report estimated no impact on premium. Coverage is required by ACA for preventive services.

- ***Independent Dental Hygienist*** (Enacted 2009)

This mandate requires individual dental insurance or health insurance that includes coverage for dental services to provide coverage for dental services performed by an independent practice dental hygienist. This mandate applies only to policies with dental coverage; therefore, there is no estimated impact on medical plan premiums.

- ***Autism Spectrum Disorders*** (Enacted 2010)

This mandate was effective January 2011 and required all contracts to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals five years of age or under. It was expanded to age 10 for January 2014 effective dates. A recent report estimated a cost of 0.3% of premium once the mandate is fully implemented if it included those under age 10. Based on that estimate and recently reported experience we are estimating this going forward.

- ***Children's Early Intervention Services*** (Enacted 2010)

This mandate requires all contracts to provide coverage for children's early intervention services from birth to 36 months for a child identified with a developmental disability or delay. This mandate was effective January 2011, and our report estimated a cost of 0.05% of premium.

- ***Chemotherapy Oral Medications*** (Enacted 2014)

Policies that provide chemotherapy treatment must provide coverage for prescribed orally administered anticancer medications equivalent to the coverage for IV or injected anticancer medication. No material increase in premium is expected.

- ***Bone Marrow Donor Testing*** (Enacted 2014)

Reimbursement for human leukocyte antigen testing to register as a bone marrow donor. Limited to $150 per lifetime. May not be applied to any deductible or other cost share. No material increase in premium is expected.

- ***Dental Hygienist*** (Enacted 2014)

Coverage for services provided by a dental hygiene therapist for policies with dental coverage. No material increase in premium is expected.

- ***Abuse-Deterrent Opioid Analgesic Drugs*** (Enacted 2015)

Coverage for abuse-deterrent opioid analgesic drugs on a basis not less favorable than that for opioid analgesic drugs that are not abuse-deterrent and are covered by the health plan. No material increase in premium is expected.

- ***Preventive Health Services*** (Enacted 2018)

Coverage for preventive health services including evidence-based items or services with a rating of A or B in the United States Preventive Services Task Force or equivalent, preventive care and screenings and immunizations supported by the federal DHHS. Currently covered and no material increase in premium is expected.

- ***Naturopathic Doctor*** (Enacted 2018)

Coverage for services provided by a naturopathic doctor when those services are covered when provided by any other health care provided and within the lawful scope of practice of the naturopathic doctor. No material increase in costs is expected and if the services are a substitute for medical doctor services, there may be a decrease in cost for some patients.

- ***Abortion Coverage*** (Enacted 2019)

This mandate requires that health insurance carriers who provide coverage for maternity services also provide coverage for abortion services except for employers granted a religious exclusion.

- ***Coverage for certified registered nurse anesthetists (CRNA)*** (Enacted 2021)

This mandate requires insurers, health maintenance organizations and nonprofit hospitals or medical service organizations to provide coverage for the services of certified registered nurse anesthetists provided to individuals.

- ***Coverage for certified midwives*** (Enacted 2021)

This mandate requires insurers, health maintenance organizations and nonprofit hospitals or medical service organizations to provide coverage under those contracts for services performed by a certified nurse midwife to a patient who is referred to the certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the certified nurse midwife.

- ***Coverage for HIV prevention drugs*** (Enacted Federal 2021)

This mandate requires health insurance carriers to provide coverage for an enrollee for HIV prevention drugs that have been determined to be medically necessary by a health care provider.

- ***Mental health parity for individuals 21 years of age or younger*** (Enacted 2022)

This mandate requires health insurance carriers to provide coverage for mental health services that use evidence-based practices and are determined to be medically necessary health care for individuals 21 years of age or younger. No material premium impact expected.

- ***Expanded coverage for contraceptives without cost-sharing*** (Enacted 2022)

This mandate requires health insurance carriers to provide coverage for all prescription contraceptives without cost-sharing.

- ***Expanded coverage for postpartum care*** (Enacted 2022)

Health insurance carriers must provide coverage to include recommendations in the "Optimizing Postpartum Care" opinion published May 2018 by the American College of Obstetricians and Gynecologists including pelvic floor surgery. Our report estimated a cost of 0.15% of premium.

- ***Fertility care*** (Enacted 2022)

This mandate effective 1/1/2024 requires health insurance carriers to provide coverage for fertility diagnostic care, fertility treatment if the enrollee is a fertility patient and for fertility preservation services. Our report along with limits in the proposed regulation estimated a cost of 0.56% of premium.

- ***Prosthetic needs of children for recreational purposes*** (Enacted 2022)

This mandate requires health insurance carriers to provide coverage for prosthetic devices of those under 18 years of age to meet the recreational needs of an enrollee in addition to their medical needs. No material premium impact expected. Our report estimated a cost of 0.01% of premium.

- ***Medically necessary dental procedures for cancer patients*** (Enacted 2022)

This mandate requires health insurance carriers to provide coverage for dental procedures that are medically necessary to reduce the risk of infection, eliminate infection, or to treat tooth loss or decay in an enrollee prior to beginning cancer treatment or that are the direct or indirect result of cancer treatment. Our report estimated a cost of 0.2% of premium.

- ***Donor breast milk for infants (***Enacted 2023)

This mandate requires health insurance carriers to provide coverage for donor breast milk for infants when medically necessary. No material increase in premium is expected.

- ***First dollar coverage for diagnostic breast exams*** (Enacted 2023)

Health insurance carriers are prohibited from imposing cost-sharing on diagnostic breast examinations, including mammography, MRI, or ultrasound. No material premium impact expected.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts	0.10%
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups	1.10%
		Individual	0.77%
1975 1983 1995 2003	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups	4.11%
		Individual	3.07%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services.	Group	0.58%
		Individual	0.32%
1990 1997	Benefits must be made available for screening **mammography**.	Group	0.66%
		Individual	1.20%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%
1996	If policies provide maternity benefits, the **maternity (length of stay**) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care."	All Contracts	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.20%
1996	Benefits must be provided for **screening Pap tests**.	All	0.01%
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	0
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	1.71%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%
1998	Coverage required for **prostate cancer screening**.	All Contracts	0.07%
1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts	0
1999	Prescription drug must include **contraceptives**.	All Contracts	0.80%

1999	Coverage for **registered nurse first assistants**.	All Contracts	0
2000	Access to **clinical trials**.	All Contracts	0.19%
2000	Access to **prescription drugs**.	All Managed Care Contracts	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0
2001	Access to **eye care**.	Plans with participating eye care professionals	0
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg	Groups >20	0.03%
		All other	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0
2007	Coverage of hearing aids for children	All Contracts	0.1%
2008	Coverage for amino acid-based elemental **infant formulas**	All Contracts	0.1%
2008	Coverage for **colorectal cancer screening**	All Contracts	0
2009	Coverage for **independent dental hygienist**	All Contracts	0
2010	Coverage for **autism spectrum**	All Contracts	0.3%
2010	Coverage for **children's early intervention services**	All Contracts	0.05%
2014	Coverage for **chemotherapy oral medications**	All Contracts	0
2014	Coverage for **human leukocyte antigen testing**	All Contracts	0
2014	Coverage for **dental hygienist**	All Contracts	0
2015	Coverage for **abuse-deterrent opioid analgesic medications**	All Contracts	0
2018	Coverage for **naturopath**	All Contracts	0
2018	Coverage for **preventive services**	All Contracts	0
2019	Coverage for **adult hearing aids**	All Contracts	0.20%
2019	Coverage for **abortion services**	Individual	0.14%
		Group	0.19%
2021	Coverage for **certified registered nurse anesthetists**	All Contracts	0
2021	Coverage for **certified midwives**	All Contracts	0
2021	Coverage for **HIV prevention drugs**	All Contracts	0
2022	Mental health parity for those 21 and younger	All Contracts	0
2022	Expanded coverage for contraceptives without cost-sharing	All Contracts	0
2022	Expanded coverage for postpartum care	All Contracts	0.15%
2022	Coverage for fertility care	All Contracts	0.56%
2022	Prosthetics for the recreational needs of children	All Contracts	0.01%
2022	Medically necessary dental procedures for cancer patients	All Contracts	0.02%
2023	Coverage for donor breast milk for infants	All Contracts	0
2023	First dollar coverage for diagnostic breast exams	All Contracts	0
	Total cost for groups larger than 20:		**10.41%**
	Total cost for groups of 20 or fewer:		**10.46%**
	Total cost for individual contracts:		**10.49%**

Appendix B: Letter from the Joint Standing Committee on Health Coverage, Insurance and Financial Services with Proposed Legislation

SENATE

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CAMERON D. RENY, DISTRICT 13
ERIC D. BRAKEY, DISTRICT 20

COLLEEN MCCARTHY REID, PRINCIPAL LEGISLATIVE ANALYST
EDNA GAYFORD, COMMITTEE CLERK

HOUSE

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SCOTT W. CYRWAY, ALBION
GREGORY LEWIS SWALLOW, HOULTON

STATE OF MAINE
ONE HUNDRED AND THIRTY-FIRST LEGISLATURE
COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

June 7, 2023

Timothy A. Schott
Acting Superintendent
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Acting Superintendent Schott,

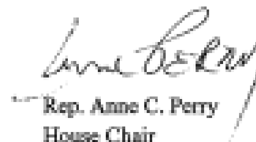
Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on Health Coverage, Insurance and Financial Services to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing on the proposed legislation. Pursuant to that statute, we request that the Bureau of Insurance prepare a review and evaluation of **LD 1832, An Act to Require Reimbursement of Fees for Treatment Rendered by Public and Private Ambulance Services, as amended.**

A copy of the committee's proposed amendment to LD 1832 is enclosed. Please prepare the evaluation based on the amendment and using the guidelines set out in Title 24-A § 2752. In addition, we ask that the Bureau provide an analysis of the extent to which the bill expands coverage beyond the State's essential benefits package and, if so, the estimated costs to the State to defray the costs of including the coverage in qualified health plans.

Please submit the report to the committee no later than January 15, 2024 so the committee can take final action on LD 1832 before the end of the Second Regular Session. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,

Sen. Donna A. Bailey
Senate Chair



Rep. Anne C. Perry
House Chair

100 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0100 TELEPHONE 207-287-1314

Appendix C: Amended LD 1832

LD 1832
Proposed HCIFS Committee Amendment
Proposed by Rep. Arford

PROPOSED DRAFT COMMITTEE AMENDMENT:
LD 1832, An Act to Require Reimbursement of Fees for Treatment Rendered by Public and Private Ambulance Services

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

Sec. 1. 24-A MRSA §4303-F, sub-1-B is enacted to read:

1-B. Reimbursement for community paramedicine services. A carrier shall reimburse an ambulance services provider for covered services delivered through community paramedicine in accordance with Title 32, section 84, subsection 4. The reimbursement paid by a carrier must meet the requirements of subsection 1. A carrier may require an ambulance service provider to obtain prior authorization before providing services delivered through community paramedicine.

Sec. 2. Application. This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2025. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

SUMMARY

This amendment replaces the bill and requires carriers offering health plans in this State to provide reimbursement to an ambulance services provider for covered services delivered through community paramedicine. The requirements of the bill apply to health plans issued or renewed on or after January 1, 2025.

DRAFT

Appendix D: Acronyms and Initialisms

ACA	Affordable Care Act
CHO	Community Health Options
EMS	Emergency and Medical Services
HPHC	Harvard Pilgrim
MHPAEA	The Mental Health Parity and Addiction Equity Act of 2008
NAIC	National Association Insurance Commissioners
PCP	Primary Care Physician
PMPM	Per member per month
SHCE	Supplemental Health Care Exhibit
UHC	United Health Care