TESTIMONY OF STACY BERGENDAHL

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BUREAU OF INSURANCE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

L.D. 582

An Act to Require Health Insurance Carriers to Provide Coverage for Blood Testing for Perfluoroalkyl and Polyfluoroalkyl Substances

Presented by Senator Brenner

Before the Joint Standing Committee on Health Coverage, Insurance & Financial Services

March 4, 2025 at 1:00 p.m.

Senator Bailey, Representative Mathieson, and members of the Health Coverage, Insurance and Financial Services Committee, I am Stacy Bergendahl, Senior Staff Attorney of the Maine Bureau of Insurance. The Bureau of Insurance supports safe and effective medical treatment. Health care providers can better speak to the potential efficacy and whether there are benefits of PFAS blood testing, my testimony this afternoon is focused on who is affected by state-mandated benefits and the potential cost of the cumulative effect of adding mandates to coverage.

State-mandated benefits apply to people covered under a fully insured commercial health plan purchased by Maine individuals and Maine businesses on behalf of their employees. The Bureau estimates that 290,000 Mainers are enrolled in fully insured health plans.

Conversely, approximately 60% of the commercial health insurance market – or roughly 405,000 people – are in self-funded plans offered by their employers and are not required to cover any state-mandated benefits. Further, Mainers that receive coverage through federal or state programs, such as Medicare and Medicaid, as well as those covered through the VA and other plan sponsors are unaffected by state-mandated benefits.

These mandated benefits increase costs for individuals and businesses who are responsible in whole or in part for paying the health insurance premiums.

Pursuant to the federal Affordable Care Act, states are required to pay the costs of mandated benefits that are included in Qualified Health Plans sold to individuals through the health insurance exchange – CoverME.gov in Maine – unless the mandated benefit is part of the Essential Health Benefit Benchmark plan. This means the cost of the mandated benefit is not part of the premium paid by individuals, but rather the state must pay for the benefit on behalf of these individuals. This defrayal cost is a single factor when considering the cost of a mandated benefit, but it is not the only factor nor is it the most costly factor.

This bill would require carriers offering fully insured health plans in the State to provide coverage for PFAS blood tests. State law requires the Bureau to complete a review and evaluation of a mandated benefit proposal, known as a mandate study, before the bill may be enacted. The mandate study completed by the Bureau for an identical bill last session satisfies this statutory requirement. That report is attached as an appendix to my written testimony. In the report, the Bureau's contracted actuarial firm estimated the cost to be as much as $0.24 per member per month. Some carriers indicated that they may not increase premiums for this benefit mandate since they already include coverage for

medically necessary blood testing for PFAS. Other carriers indicated that though they do cover the test, increasing utilization of these tests may affect premiums.

While an individual mandate such as this one does not add significant costs, it cannot be considered alone. The cumulative costs of all state-mandated benefits can significantly increase the cost of health insurance. This cost increase impacts the affordability of health insurance for Maine citizens who have insurance plans regulated by the Bureau. Furthermore, there could be follow on effects in the market as a whole when premiums increase, even by small increments. When health insurance costs get too high, more employers may shift to self-funded plans, which are not subject to state-mandated benefits, increase employee cost sharing by raising deductibles, or drop health insurance as a benefit altogether. Self-funded plans are also not subject to consumer protections provided to people enrolled in fully insured plans, and the Bureau has no direct authority to oversee most self-funded plans.

In addition, as the cost of fully insured health plans increases, consumers may be tempted to move from the regulated market to sham policies that lure people with low premiums but fail to provide health benefits when policyholders seek care.

In balancing the potential benefits of this bill in terms of medical treatment versus cost, I urge the committee to consider the wider impact of state-mandated benefits on the health insurance market.

The bill includes a statement that the Legislature finds that the coverage required by this bill would not require cost defrayal because the required tests "are not an expansion of the State's essential health benefits," which already include coverage for outpatient laboratory services. This finding is problematic, because

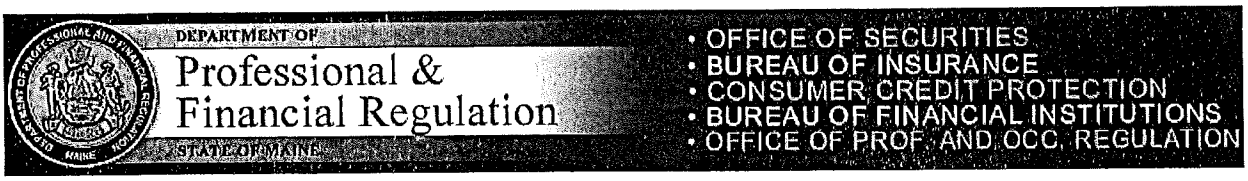
while the final determination is made by the State, it cannot be inconsistent with CMS guidance and must conform to the framework set forth in 45 C.F.R. Section 155.170. We have no evidence that such a framework has been used to make this determination. If the determination was made in error, the state would be vulnerable to lawsuits by the carriers for the amount of defrayal not paid.

Bureau staff met with CMS staff in November of 2023 to discuss last session's bill, and CMS indicated that because the bill requires a specific type of testing which is not required by federal law, the mandate would likely require the state to defray the cost. A subsequent GAO report released late last year[1], found that CMS has not been stringent enough in ensuring that federal funds are not used to pay for state mandated benefits the states are required to pay for (defray), which may mean that CMS may begin stricter enforcement of defrayal requirements.

If the committee decides to move forward with this bill, the Bureau recommends changing the effective date to January 1, 2027 to allow time for carriers to price for the mandate and to implement the changes required.

I would be happy to answer questions the committee members may have either now or during the work session.

[1] https://www.gao.gov/assets/880/874810.pdf GAO-25-107220, November 2024



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

Review and Evaluation of LD 132, An Act to Require Health Insurance to Provide Coverage for Blood Testing for Perfluoroalkyl and Polyfluoroalkyl Substances

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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 LD 132, An Act to Require Health Insurance Carriers to Provide Coverage for Blood Testing for Perfluoroalkyl and Polyfluoroalkyl Substances (PFAS). 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 bill requires all health insurance policies, contracts, and certificates executed, delivered, issued for delivery, continued or renewed in Maine on or after January 1, 2024 to provide coverage for blood testing for perfluoroalkyl and polyfluoroalkyl substances to an enrollee. There is no language included in the bill that prohibits medical management.

We had to make several assumptions to develop our cost estimate, which will be described in the following sections. To develop our cost estimate, we conducted a survey of the largest carriers in Maine to determine the level of coverage already available and other critical information. We also note that the difference in cost between the markets is slight, so our cost estimate applies to the individual, small group, and large group markets. We estimate the total cost of coverage for blood testing for PFAS to be between $300,000 and $800,000. This amounts to between $0.10 to $0.24 on a PMPM basis and less than 0.04% on a percent of premium basis. The estimate did not vary significantly between the individual, small group, or large group markets.

We note, however, that most carriers will not increase premiums for the benefit mandate as they indicated they already include coverage for blood testing for PFAS. Only one carrier indicated that this blood test is not currently covered, and therefore we believe the average cost to the market of adding coverage is not material and less than 0.001% as a percent of premium. Our assumptions are explained in the following sections.

States are required to pay for ("defray") the costs of all health insurance benefit mandates that are included in individual Qualified Health Plans (QHPs), unless the mandate was in effect prior to December 31, 2011 and part of the state's defined essential benefit package (EHB). The state must pay to defray the cost of the mandate's premium impact on those individual exchange/QHP plans. Defrayal only represents the impact of a mandate on Maine's individual exchange plans and does not consider the mandate's impact on the small or large group market.

The Affordable Care Act (ACA) describes a broad set of benefits that must be included in a state's EHB package.[1] Federal regulators consider state mandated health benefits that were in effect *prior to December 31, 2011* part of a state's EHB. Generally, mandates adopted by a state *after December 31, 2011* are subject to defrayal. The ACA permits certain narrow exceptions to

[1] The 10 categories of benefits in an EHB package are: 1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance use disorder services, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) lab services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services, including oral and vision care.

the defrayal requirements for mandates that are: an expansion of an existing mandate, required by federal law, a cost-sharing requirement, or a provider mandate.

Maine determined its current EHB benchmark plan based on guidance from the Federal Department of Health and Human Services (HHS)[2]. Maine chose the small group Anthem PPO Off Exchange Blue Choice, $2,500 Deductible as its benchmark plan.

Maine's current EHB benchmark plan does not include a PFAS testing mandate as set forth in LD 132. Bureau staff met with Centers for Medicare & Medicaid Services (CMS) staff in November 2023 and they indicated that because LD 132 requires a specific type of testing and is not required by federal law, the mandate, if enacted, would likely require the state to defray the cost. The defrayal amount if required based on 63,000 QHP members in Maine, would be approximately $80,000 to $180,000 for 2025.

CMS recently proposed that any mandated benefits included in a state's benchmark plan as of 2025 would not require defrayal.[3] States also have the opportunity to redesign their EHBs to include new benefits under CMS guidelines for 2027. However, it is important to note that the redesign process is complicated and any new EHB benchmark plan must meet typicality, generosity and other requirements. It could mean that a redesigned benchmark plan would need to eliminate some existing EHB benefits to achieve the generosity test.

This is not a legal interpretation, nor should it be considered legal advice.

We interviewed Dr. Abby Fleisch, MD, MPH who has done extensive research regarding PFAS for the Maine Health Institute for Research. We also reviewed numerous public comments for the bill.

II. Background

Perfluoroalkyl and polyfluoroalkyl substances (PFAS) are a group of synthetic chemicals that were first discovered in the 1930s.[4] While there are thousands of types of PFAS, the most common are PFOA (perfluorooctanoic acid) and PFOS (perfluorooctanoic sulfonic acid). Since the 1950s, PFAS have been used in a variety of products and industries including firefighting foam, textiles, aerospace technology, and consumer products where they are the main ingredient in nonstick and waterproof coatings.[5] Other products containing these chemicals include cleaning products, water-resistant fabrics such as rain jackets, umbrellas, and tents, grease-resistant paper, and personal care products like shampoo, dental floss, nail polish, and eye

[2] https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/essential-health-benefits12162011a

[3] Notice of Benefit and Payment Parameters (NBPP) for 2025 https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-proposed-rule.

[4] Langenbach B, Wilson M. Per- and Polyfluoroalkyl Substances (PFAS): Significance and Considerations within the Regulatory Framework of the USA. Int J Environ Res Public Health. 2021 Oct 23;18(21):11142. doi: 10.3390/ijerph182111142. PMID: 34769660; PMCID: PMC8583519.

[5] Ross, Rachel. "What Are PFAS?" *Live Science*, 30 Apr. 2019, www.livescience.com/65364-pfas.html.

makeup.[6] The same chemical properties that make PFAS useful in the above-mentioned products make them difficult to remove from the environment.[7]

Although PFAS have been regularly used in these industries since the 1950s, these lasting effects were not widely studied until the early 2000s, when PFAS were detected in more than 98% of blood collected from the general U.S. population.[8] Many studies are underway examining the possible health impacts of PFAS exposure. Research currently suggests high levels of PFAS may lead to increased cholesterol levels, decreased vaccine response in children, changes in liver enzymes, increased risk of high blood pressure or pre-eclampsia in pregnant women, small decreases in infant birth weights, and increased risk of kidney or testicular cancer.[9]

Due to growing awareness of the harmful effects of PFAS, many manufacturers have phased out the production of these chemicals.[10] As of 2015, these chemicals are no longer manufactured in the U.S. per the EPA's stewardship program signed in 2006.[11] However, because of their inability to biodegrade, the effects of these chemicals in the environment remain indefinitely. In addition, PFOA and PFOS were replaced with other compounds belonging to the PFAS family.

In Maine, high PFAS levels in food and water have resulted from years of using sludge as compost.[12] The compost produced by wastewater treatment plants, using sludge contaminated with PFAS, was spread on farms throughout the state. Although the compost breaks down, PFAS do not because of their non-biodegradable nature. Because of the relatively recent awareness of the toxicity of PFAS chemicals among the wider public, Maine has begun efforts to identify and prevent further PFAS contamination. In 2016, Maine discovered high levels of PFAS in milk. In 2019, the Department of Environmental Protection (DEP) in Maine tested compost made from sludge and found that 89% had higher levels than the state's screening levels for PFOA and 74% for PFOS. Recently, the DEP has also begun testing waters and soils where sludge was spread.[13] As of early 2023, the DEP has identified 700 sites where PFAS residuals have been found and

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[6] "Chemicals: Perfluoroalkyl and Polyfluoroalkyl (PFAS) Substances." *Wisconsin Department of Health Services*, 14 Sept. 2023, www.dhs.wisconsin.gov/chemical/pfas.htm.

[7] Brennan, Nicole Marie et al. "Trends in the Regulation of Per- and Polyfluoroalkyl Substances (PFAS): A Scoping Review." *International journal of environmental research and public health* vol. 18,20 10900. 17 Oct. 2021, doi:10.3390/ijerph182010900

[8] "Pfas." Centers for Disease Control and Prevention, 8 Dec. 2020, www.atsdr.cdc.gov/2019atsdrannualreport/stories/pfas.html#:~:text=In%20the%20late%201960s%2C%20PFAS,population%2C%20suggesting%20widespread%20chemical%20exposure.

[9] "What are the health effects of PFAS?". Agency for Toxic Substances and Disease Registry. Centers for Disease Control and Prevention. November 1, 2022. https://www.atsdr.cdc.gov/pfas/health-effects/index.html

[10] "With the U.S. Pfas 'Phase-out' Clock Ticking, What Every Food Company Should Know." *JD Supra*, www.jdsupra.com/legalnews/with-the-u-s-pfas-phase-out-clock-3971871/#:~:text=Federal%20Updates%20in%20PFAS%20%E2%80%9CPhase,applications%20in%20the%20United%20States. Accessed 5 Oct. 2023.

[11] Ross, Rachel. "What Are PFAS?" *Live Science*, 30 Apr. 2019, www.livescience.com/65364-pfas.html.

[12] Schauffler, Marina. "A Spreading Problem: How Pfas Got into Soils and Food Systems." *The Maine Monitor*, 23 Oct. 2022, themainemonitor.org/a-spreading-problem-how-pfas-got-into-soils-and-food-systems/.

[l]Ibid.

nearly three dozen "Tier 1" towns, which are considered to be at a higher risk of contamination.[14]

Now, the proposed bill aims to provide insurance coverage for the testing of PFAS chemicals.

Dr. Abby Fleisch, MD, MPH relayed that the recent National Academies of Sciences clinical guidelines recommend blood testing for PFAS in individuals likely to have a history of elevated exposure. This exposure could be from living in an area with an elevated level of PFAS, consuming fish and game from an area with elevated levels of PFAS, or from an occupational to PFAs. The guidelines also recommend blood testing for PFAS if a patient lives in an area where PFAS contamination may have occurred, including on farms where sewage sludge may have been used or near facilities that use PFAS.

However, there are some who do not agree with this view. Some of the carriers indicated that a PFAS blood test is not medically necessary since it will not give the patient information about any diseases caused by elevated PFAS levels. Per the CDC, blood tests for PFAS are best when used as part of a scientific or health study to help people in communities who were not tested estimate their likely PFAS blood level. For individual testing, the blood test will not provide any information about any health problems linked to elevated PFAS levels or predict or rule out the development of future health problems.[15]

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.

Six of the seven carriers surveyed indicate blood testing is already a covered service at least for a known exposure. Three of the seven carriers indicated an actual claims cost impact of less than $0.11 PMPM, which we believe means the service is not currently highly utilized.

It is important to note, however, that LD 132 does not restrict the population eligible for blood testing or the number of tests they receive. As discussed above, PFAS was discovered in approximately 98% of blood collected from the general U.S. population.[16] There is potential that a significant percentage of the population could utilize the service, and recent media coverage

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[14] "Pfas in Maine Agriculture." *MAINE FARMLAND TRUST*, 13 Mar. 2023, www.mainefarmlandtrust.org/farm-network/pfas-in-maine-agriculture/#:~:text=Currently%2C%20the%20DEP%20has%20identified,tested%20as%20of%20early%202023.

[15] "Blood Testing for Pfas." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 1 Nov. 2022, www.atsdr.cdc.gov/pfas/health-effects/blood-testing.html#:~:text=Individual%20testing&text=The%20blood%20test%20will%20not,related%20to%20a%20PFAS%20exposure.

[16] "Pfas." Centers for Disease Control and Prevention, 8 Dec. 2020, www.atsdr.cdc.gov/2019atsdrannualreport/stories/pfas.html#:~:text=In%20the%20late%201960s%2C%20PFAS,population%2C%20suggesting%20widespread%20chemical%20exposure.

and lawsuits could increase awareness and utilization of the service.

The National Academies of Sciences Engineering and Medicine recommends PFAS blood testing for patients who are likely to have a history of elevated exposure, such as those with occupational exposures or those who live in areas known to be contaminated.[17] Dr. Abby Fleisch also indicated that after the blood test, patients should work with their doctor to come up with a plan to reduce their exposure to these chemicals, and provide the option for retesting a year later to ensure that the levels of PFAS in their blood is decreasing.

Maine has published several resources regarding PFAS levels by area including levels measured in the water supply. We estimate approximately 5,000 covered members in the individual or group markets would pursue PFAS testing due to a known exposure to PFAS. We acknowledge LD 132 would allow coverage for members without a known exposure, however, we believe doctors would follow the consensus guidance regarding recommending a test. Additionally, LD 132 does not restrict cost sharing, so we believe the expense of the test would limit utilization as would the limited ability of the blood test to predict if someone will develop any health conditions.[18]

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

As of January 2022, there are no accredited labs in Maine that perform PFAS testing.[19] Sources indicate that blood tests for the general population are extremely hard to get.

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

Many carriers indicated that PFAS blood testing is currently covered. Although not specific to PFAS, the blood test would fall under lab services offered by the carrier through the specific International Classification of Diseases (ICD) codes mentioned below. Only one carrier, Aetna, indicated that they do not cover blood testing for PFAS. See the carrier responses below.

Aetna: We currently do not cover PFAS testing.

Anthem: Currently, claims for PFAS testing are paid. Although claims for PFAS testing are currently covered, it is likely that a mandated benefit without any limitations or parameters would result in increased utilization.

Cigna: There is no coverage policy specific to PFAS and it would depend on codes used to report these substances. Cigna will cover testing for exposure to environmental pollution and other hazardous substances if there is an indicated exposure. While not specific to PFAS, if a patient states that they've been exposed to a contaminant, any associated testing would fall under

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[17] National Academies of Sciences, Engineering, and Medicine. 2022. Guidance on PFAS Exposure, Testing, and Clinical Follow-Up. Washington, DC: The National Academies Press. https://doi.org/10.17226/26156.

[18] "Pfas Blood Testing: What You Need to Know - Pfas Exchange." *PFAS Research, Education, and Action for Community Health*, pfas-exchange.org/wp-content/uploads/PFAS-Blood-Testing-Document-May-2022.pdf. Accessed 28 Sept. 2023.

[19] "Division of Environmental and Community Health." *Maine Drinking Water Program Home Page*, www.maine.gov/dhhs/mecdc/environmental-health/dwp/. Accessed 28 Sept. 2023.

these codes: ICD-10 Z77.110 Contact with and (suspected) exposure to environmental pollution, ICD-10 Z77.29 Contact with and (suspected) exposure to other hazardous substance, and ICD-10 Z13.88 Encounter for screening for disorder due to exposure to contaminants.

Community Health Options: Community Health Options provides coverage for blood testing for PFAS. The testing is covered in the same way that other diagnostic lab services are provided, and we do not subject this lab test to prior approval or other clinical review. We do not expect that passage of this bill would expand coverage currently provided.

Harvard Pilgrim: Harvard Pilgrim Health Care plans in Maine currently cover services for PFAS testing. We do not expect the bill to expand coverage beyond what is already covered.

Taro Health: These benefits are not specifically covered under our current plans. However, with prior authorization, we would cover these benefits under our laboratory services benefits. This bill would expand coverage by mandating that we cover these benefits without requiring utilization management prior to rendering the services.

United Healthcare: Testing for Perfluoroalkyl substances is already covered as a diagnostic service. It is unclear if Polyfluoroalkyl Substances are covered or if that would require expanded coverage.

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.

Doctors who wrote in support of LD 132 testified that many of their patients opt not to get a blood test because of the cost.

Dr. Abby Fleisch indicated that a baseline PFAS blood test is important to guide clinical monitoring, and that a follow-up PFAS blood test is important to determine if actions are working to reduce levels. Lack of coverage for blood testing would not prohibit a patient from taking steps to reduce their PFAS levels. However, without the blood test, they would not know if their PFAS levels were elevated or if actions to reduce their PFAS levels were effective.

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

According to advocates in support of LD 132, due to high deductible insurance plans, many consumers would have to pay the full cost of the $400 - $600 per blood test. The carriers we surveyed indicated a similar cost for a blood test.

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 23 public hearing testimony items regarding LD 132, with 19 letters in support of the legislation, 2 letters in opposition, and 3 letters neither for nor against that provided additional information regarding PFAS.

PFAS contamination has recently been discussed in the media and is the subject of current lawsuits. Additionally, legislation has been passed in Maine requiring the testing of wells and soil.[20]

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

Much of the testimony in support of LD 132 reflected the cost to families for testing and treatment. The advocate input also indicated that many families were not able to pursue testing and treatment due to cost, which would be decreased significantly with individual or group coverage of testing. However, we note LD 132 does not appear to prohibit insurance carriers from applying cost sharing.

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.

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

Only one (1) other state, New Hampshire, has passed legislation requiring coverage for PFAS blood testing.[21] Their mandate was considered a clarification of existing lab testing coverage.

Many states have passed legislation phasing out the use of PFAS chemicals in favor of safer alternatives. Numerous states have enacted phase-outs of PFAS in food packaging or adopted restrictions on PFAS in carpets, rugs, aftermarket treatments, and/or upholstered furniture, apparel, oil and gas products, children's products, and ski wax among many other products. There are currently 197 policies in 33 states regarding regulating PFAS.[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.

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[20] H.P. 1189, 2021 Leg., 130th Sess. (Me 2021).

[21] Rizzuto, Pat, and Dean Scott. "Pfas Blood Test Costs a Barrier for Many Who Fear High Exposure." *Bloomberg Law*, 10 Apr. 2023, news.bloomberglaw.com/environment-and-energy/pfas-blood-test-costs-a-barrier-for-many-who-fear-high-exposure.

[22] "Pfas." *Safer States*, www.saferstates.org/toxic-chemicals/pfas/. Accessed 28 Sept. 2023.

Anthem: As noted above, PFAS blood tests do not indicate the existence of a medical condition and, therefore, is not a diagnostic test, nor does it inform treatment of any condition. As a result, there is no medical benefit associated with the test and requiring coverage under a health insurance plan is not appropriate. Public health surveillance testing would be more appropriate than mandating health insurance coverage of PFAS testing.

Cigna: Suggest consideration of adding exposure language: "coverage for blood testing for KNOWN EXPOSURE TO PFAS..."

Community Health Options: We are not opposed to requiring coverage of this service provided carriers may apply cost sharing.

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.

While PFAS blood test does not indicate the existence of a medical condition, our understanding is that it provides evidence of an additional risk factor for several conditions, therefore the benefit meets a medical need and coverage required by LD 132 is consistent with the role of insurance to provide medically necessary lab tests. However, this mandate may step outside the role of insurance in that, as some carriers pointed out in their responses, testing for PFAS is not routine or diagnostic lab work, nor does the bill specify coverage for a known exposure to PFAS. It would require testing be available to everyone.

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 lab work done for PFAS.

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

Several carriers indicated that this benefit is already covered under ICD codes related to lab work or screening due to exposure to contaminants. However, we believe this bill would expand these benefits due to the fact that it does not specify any requirements or medical necessity for testing.

Dr. Abby Fleisch indicated that elevated PFAS levels can be considered a risk factor for several medical conditions, and testing those with a known exposure could be the first step toward reducing that risk.

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 and 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 shifting to 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 $0.31 PMPM to cover the testing listed under this proposed mandate for the State Employee Health Plan.

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.

Currently there are no labs in Maine certified to run the test – all lab work has to be sent out of state. Theoretically, an increase in demand would increase prices. However, we are unable to quantify this increase.

None of the carriers were able to identify any potential lowering of costs.

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.

We believe that since PFAS blood testing is currently covered by most carriers with a known exposure, utilization would not increase significantly.

LD 132 does not restrict usage of the benefit to a known exposure, potentially increasing utilization for members without a known exposure. This is contrary to current recommendations, and therefore may be considered an inappropriate use of testing.

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

There is currently no alternative to a blood test to detect PFAS. In May 2023, Michigan State University published a study where they concluded that a self-collected finger prick blood sample would be sufficient for testing for PFAS, especially in individuals with elevated exposure.[23] However, there has been no mention as to when this would be available to the public or how much the test would cost.

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. 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

[23] "Study Reveals New Way to Test Pfas in People's Blood." *Nicholas School of the Environment*, nicholas.duke.edu/news/study-reveals-new-way-test-pfas-peoples-blood. Accessed 29 Sept. 2023.

next five years.

As mentioned above, currently there are no labs in Maine certified to test for PFAS. Potentially increased demand could increase the supply of labs. However, we have no reason to believe that there will be an increase in any other type of providers since a blood draw is a standard and common practice.

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, followed by the carrier specific language.

Carrier	Estimated Premium Impact PMPM
Aetna	$0.10 to $0.25 PMPM
Anthem	$0.27 to $0.36 PMPM (with $0 cost share)
Cigna	No estimate provided, believe currently covered.
Community Health Options	No estimate provided, believe currently covered.
HPHC	$0.01 to $0.02 PMPM
Taro	No estimate provided, believe currently covered.
United	No estimate provided, believe currently covered.

Aetna: We estimate a $0.10 to $0.25 PMPM impact for requiring coverage for these tests.

Anthem: "Assuming full coverage with $0 cost share:

Individual	$0.27
Small Group	$0.31
Large Group	$0.36

Cigna: It depends if the law would require something beyond the codes provided.

Community Health Options: We identified one applicable claim. The median in-network submitted and allowable amounts for CPT 82542 are $90 and $26.20. Although there may be additional interest in testing as more information about the impacts of PFAS on human health are publicized, we do not anticipate a significant change in utilization resulting from passage of this bill provided carriers are not required to offer coverage of testing at preventive benefit levels.

HPHC: The current claims cost for PFAS testing is $0.01 to $0.02 PMPM. There may be additional utilization of these services as a result of the mandate, which could increase costs by an additional $0.01- $0.02 PMPM.

Taro Health: This additional coverage of these tests could increase not only our members premium amounts but also our administrative expenses due to the high cost of the tests. We anticipate the average test costing $500, which, depending on member utilization, could have a

significant impact on our pricing.

UHC: In 2022, claim costs for blood testing for Perfluoroalkyl and Polyfluoroalkyl substances accumulated to $0.03 PMPM. Given the low utilization, we do not expect this mandate to have any cost impact.

NovaRest Estimate

To estimate the number of people who are affected by high levels of PFAS contamination, we relied on the tap water testing and studies done by Maine. The results table listed all Maine Public Water Systems that were required to sample for PFAS by 12/31/22.[24] Levels higher than 20 PFAS ppt (parts per trillion) are considered elevated levels, so we looked at all water districts meeting this threshold. This resulted in approximately 2,500 people with a known exposure.

We also considered the fact that much of Maine is rural and people would have their own private wells. Sources state that about half (50%) of residents get their water from a private source.[25] Because the results of PFAS testing for private wells is not publicly available, we assumed the same amount of exposure to elevated PFAS levels for those who get their water from a private source as those who get their water from the Maine Public Water System. Therefore, we doubled the expected number of people with a known exposure and assumed 5,000 members with a known exposure.

In performing the cost estimate, we were not able to find data on the prevalence of PFAS blood testing. We relied on utilization statistics for other screening tests to get an estimate. For prostate cancer, 54% of men reported an up-to-date PSA screen. 45% reported up-to-date testing for colorectal cancer.[26] Another source states that only 21.6% of people in 2020 were not up to date with colorectal cancer screening. Expanding to all routine cancer screenings, 65% of Americans 21 years of age and older say they are not up to date with one or more routine cancer screenings.[27] In our estimate we assumed the utilization for a PFAS blood test in the first year would be anywhere from 20% to 40% of the eligible population.

Dr. Abby Fleisch recommended that people get retested a year later to ensure that the medical plan provided by their doctor is working to lower their PFAS blood levels. To estimate the utilization of patients who will return for another blood test, we also relied on utilization statistics for other exams. In a study done on ambulatory patients, 6.8% of abnormal laboratory results alerts were not followed up within 30 days and 62% of abnormal glucose tests not

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[24] *Pfas Compounds in Parts per Trillion (PPT) - Maine*, www.maine.gov/dhhs/mecdc/environmental-health/dwp/cet/documents/pfasResults.pdf. Accessed 3 Oct. 2023.
[25] "Well Water - University of Maine Cooperative Extension." *Cooperative Extension*, 9 May 2022, extension.umaine.edu/well-water/.
[26] Brenda E. Sirovich, MD. "Screening Men for Prostate and Colorectal Cancer in the United States." *JAMA*, JAMA Network, 19 Mar. 2003, jamanetwork.com/journals/jama/fullarticle/196199.
[27] "65% of Americans 21 Years of Age and Older Report Not Being up to Date on at Least One Routine Cancer Screening." *Prevent Cancer Foundation*, www.preventcancer.org/2023/02/65-of-americans-21-years-of-age-and-older-report-not-being-up-to-date-on-at-least-one-routine-cancer-screening/. Accessed 2 Oct. 2023.

followed up.[28] In the study done for prostate and colorectal cancer, we see that there was a drop of about 20% of men who kept up with screening a year later.[29] In our analysis, we assume 10% less utilization for the second blood test recommended a year later.

For the cost of the blood test, we assumed $500 per test since most sources cited $400 – $600 per blood test.[30] [31] We also factored in 75% cost sharing. Since the bill does not include any language about the limitations of medical management, we assume this test will be subject to prior authorization and cost sharing similar to other laboratory tests.

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 the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) for 2022.

Using these assumptions, we estimate a $0.10 to $0.24 PMPM impact on premiums on a gross basis for PFAS blood testing. However, as most carriers indicated that PFAS blood testing is already covered we estimate a $0.00 PMPM impact to total premiums due to the mandate.

The EHB-Benchmark Plan currently does cover laboratory tests but does not specify coverage for blood testing for PFAS. Bureau staff met with Centers for Medicare & Medicaid Services (CMS) in November 2023 and they indicated LD 132 mandating PFAS testing because it requires a specific test and is not currently required federally would likely require defrayal payments. However, CMS recently proposed in their Notice of Benefit and Payment Parameters (NBPP) for 2025 plans that new mandates would not lose EHB status and would therefore not require defrayal if the required benefit was included in an EHB redesign for 2027. The defrayal amount if required based on 63,000 QHP members in Maine, the estimated total defrayal cost would be approximately $80,000 to $180,000.

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.

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[28] Callen, Joanne L et al. "Failure to follow-up test results for ambulatory patients: a systematic review." *Journal of general internal medicine* vol. 27,10 (2012): 1334-48. doi:10.1007/s11606-011-1949-5

[29] Brenda E. Sirovich, MD. "Screening Men for Prostate and Colorectal Cancer in the United States." *JAMA*, JAMA Network, 19 Mar. 2003, jamanetwork.com/journals/jama/fullarticle/196199.

[30] *Pfas Blood Testing: What You Need to Know - Pfas Exchange*, pfas-exchange.org/wp-content/uploads/PFAS-Blood-Testing-Document-May-2022.pdf. Accessed 3 Oct. 2023.

[31] Dan Lampariello, CBS13 I-Team. "Pfas in Your Blood: New Guidance Offers Better Insight but Cost, Education Remain Hurdles." *WGME*, wgme.com/news/i-team/this-is-brand-new-pfas-blood-tests-offer-new-insight-but-cost-education-remain-hurdles. Accessed 3 Oct. 2023.

Dr. Abby Fleisch stated that the National Academies of Sciences found strong evidence that high levels of PFAS in the blood are associated with high cholesterol, kidney cancer, decreased vaccine antibody response, and lower birthweight.

A report done by the National Academies of Sciences, Engineering, and Medicine provides guidance on PFAS testing and clinical follow-up.[32] The report states that there is strong evidence that high PFAS blood levels are correlated with reductions in birthweight, dyslipidemia in adults and children, and kidney cancer in adults. There is some evidence to suggest that high PFAS levels are associated with decreased vaccine antibody response in adults and children, breast cancer, pregnancy induced hypertension, elevated liver enzymes in adults and children, testicular cancer in adults, thyroid dysfunction in adults, and ulcerative colitis in adults. If a patient knows they have had high PFAS levels in their blood, they may be encouraged to test early for these diseases to potentially diagnose them early enough to avoid more intensive treatments.

Carrier responses and public testimony were mixed about potential savings. Some carriers like Taro noted that there are benefits of early detection of PFAS for their members. They state that covering these blood tests would give PFAS impacted members and their doctors the necessary information to help patients set up monitoring, and if necessary, treatment plans. Other carriers, like Anthem, argue that there are no potential savings or benefits because these tests will not provide information on whether PFAS are causing a current health problem or predict if a health problem will arise in the future.

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.

There is a concern that mandatory coverage of PFAS blood testing will lead to an increase in utilization. However, as discussed above, the bill does not prohibit medical management and carriers will be able to limit services to those that they determine to be medically necessary. There also might be an increase in administrative expenses because an increase in PFAS blood testing means that carriers will be paying for more tests out of state that would require contracting with those labs. As stated earlier in the report, there are currently no labs in Maine certified to test for PFAS.

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.

These additional services are not currently covered by MaineCare or other public payers. Therefore, we do not anticipate any cost-shifting.

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[32] "Read 'Guidance on PFAS Exposure, Testing, and Clinical Follow-up' at Nap.Edu." *Front Matter | Guidance on PFAS Exposure, Testing, and Clinical Follow-Up | The National Academies Press*, nap.nationalacademies.org/read/26156/chapter/1. Accessed 3 Oct. 2023.

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.

A report done by the National Academies of Sciences, Engineering, and Medicine provides guidance on PFAS testing and clinical follow-up.[33] The report states that there is strong evidence that high PFAS blood levels are correlated with a number of serious conditions in children and adults.

Also, as mentioned Dr. Abby Fleisch indicated high levels of PFAS in members blood would be considered a risk factor linked to several conditions, and knowing their levels, members could take steps to reduce this risk factor.

However, this blood test does not give insight into any current or future conditions that are caused by high levels of PFAS. As Anthem states in their response:

"The tests cannot determine whether a health condition or concern is related to PFAS exposure, nor can it inform treatment. The U.S. CDC's Agency for Toxic Substances and Disease Registry states the following: If you are concerned and choose to have your blood tested, test results will tell you how much of each PFAS is in your blood, but it is unclear what the results mean in terms of possible health effects. The blood test will not provide information to pinpoint a health problem, nor will it provide information for treatment. The blood test results will not predict or rule out the development of future health problems related to PFAS exposure. Similarly, the Maine CDC states: A blood test will not provide information on whether any PFAS are causing a current health problem, nor will a blood test predict a health problem. There are no health-based screening levels to which your doctor can compare the levels measured in your blood. There are also no treatments that will directly result from having a blood test for PFAS."

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

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

The bill does not mandate coverage of an additional class of practitioners.

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[33] "Read 'Guidance on PFAS Exposure, Testing, and Clinical Follow-up' at Nap.Edu." *Front Matter | Guidance on PFAS Exposure, Testing, and Clinical Follow-Up | The National Academies Press*, nap.nationalacademies.org/read/26156/chapter/1. Accessed 3 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.

All carriers except one indicated that PFAS blood testing was already covered in some form, so mandating the benefit would only be beneficial for a small portion of policyholders who currently do not have that coverage.

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 would benefit from the services would purchase the coverage. This would result in alternative coverage that would cost more than the additional cost of services because of the administrative charges that 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 Blood Testing for PFAS	**With Blood Testing for PFAS**
Total cost for groups larger than 20:	**10.41%**	**10.41%**
Total cost for groups of 20 or fewer:	**10.46%**	**10.46%**
Total cost for individual contracts:	**10.49%**	**10.49%**

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

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 132, An Act to Require Health Insurance Carriers to Provide Coverage for Blood Testing for Perfluoroalkyl and Polyfluoroalkyl Substances.**

A copy of the bill is enclosed. Please prepare the evaluation 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 132 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: LD 132

131st MAINE LEGISLATURE

FIRST REGULAR SESSION-2023

Legislative Document	**No. 132**
S.P. 71	In Senate, January 10, 2023

An Act to Require Health Insurance Carriers to Provide Coverage for Blood Testing for Perfluoroalkyl and Polyfluoroalkyl Substances

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator BRENNER of Cumberland.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §4320-V is enacted to read:

§4320-V. Coverage for blood testing for perfluoroalkyl and polyfluoroalkyl substances

1. Definition. As used in this section, unless the context otherwise indicates, "perfluoroalkyl and polyfluoroalkyl substances" means any member of the class of fluorinated organic chemicals containing at least one fully fluorinated carbon atom.

2. Required coverage. A carrier offering a health plan in this State shall provide coverage for blood testing for perfluoroalkyl and polyfluoroalkyl substances to an enrollee.

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, 2024. 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 bill requires carriers offering health plans in this State to provide coverage for blood testing for perfluoroalkyl and polyfluoroalkyl substances. The requirements of the bill apply to health plans issued or renewed on or after January 1, 2024.

Appendix D: Acronyms and Initialisms

ACA	Affordable Care Act
CHO	Community Health Options
DEP	Department of Environmental Protection
EPA	Environmental Protection Agency
HPHC	Harvard Pilgrim
MHPAEA	The Mental Health Parity and Addiction Equity Act of 2008
NAIC	National Association Insurance Commissioners
PCP	Primary Care Physician
PFAS	Perfluoroalkyl and Polyfluoroalkyl Substances
PFOA	Perfluorooctanoic Acid
PFOS	Perfluorooctanoic Sulfonic Acid
PMPM	Per member per month
SHCE	Supplemental Health Care Exhibit
UHC	United Healthcare