A Report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services of the 130th Maine Legislature

Review and Evaluation of LD 665
An Act to Promote Better Dental Care for Cancer Survivors

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I. Executive Summary

The Joint Standing Committee on Health Coverage, Insurance and Financial Services (Committee) of the 130th Maine Legislature directed the Bureau of Insurance (Bureau) to review LD 665, An Act to Promote Better Dental Care for Cancer Survivors. The review was conducted as required by 24 A M.R.S.A § 2752 to answer prescribed questions about the bill including the estimated cost. This document and review are a collaborative effort of NovaRest, Inc. and the Bureau of Insurance, and are intended to respond to the Committee's request.

LD 665 states that a carrier offering a health plan shall provide coverage for medically necessary dental procedures that are the direct or indirect result of cancer treatments, including chemotherapy, biotherapy, or radiation therapy treatment. The coverage required under this section must include expenses for laboratory assessments, medications, and treatments associated with the medically necessary dental procedures.

During the committee's consideration of LD 665, two options for amending the bill were created. We were asked to evaluate the potential impact of both options. Both options offer alternative language. We understand the bill to apply to the individual, small group, and large group markets.

The entire language of Option 1 is provided in Appendix D and Option 2 is provided in Appendix E.

Similarities of the two options are below:

- Both options require coverage for medically necessary dental procedures for an enrollee who has been diagnosed with cancer.
- Both options require coverage for dental procedures that are medically necessary to reduce the risk of infection or to eliminate infection or to treat tooth loss or decay that are the direct or indirect result of cancer treatments, including chemotherapy, biotherapy, or radiation therapy treatment.
- Both options require coverage for laboratory, assessments, medications, and treatments.

Differences of the two options are below:

- Option 1 requires coverage for dental procedures that are medically necessary to reduce the risk of infection or to eliminate infection or to treat tooth loss or decay in an enrollee **prior to beginning cancer treatment**, including chemotherapy, biotherapy, or radiation therapy treatment. Option 2 requires coverage for dental procedures that are medically necessary to **begin cancer treatment.** Analysis of the differences is provided below.
- Option 1 does not require coverage for routine preventive dental care, cleaning, or sealants. Option 2 also does not require coverage for routine preventive dental care, cleaning, sealants or fluoride services.

The Affordable Care Act (ACA) describes a broad set of benefits that must be included in any Essential Health Benefits (EHB) package. In its December 2011 bulletin, the Department of Health and Human Services (HHS) provided guidance on the types of health benefit plans each state could consider when determining a benchmark EHB plan for its residents. Each state had the opportunity to update its benchmark plan effective for 2017. Maine has chosen the small group Anthem Health Plans of Maine (Anthem BCBS) PPO Off Exchange Blue Choice as its 2017-2022 benchmark plan. It is important to note that the ACA requires states to fund the cost of any mandates that are not included in the state specific EHB benchmark plan. The EHB benchmark plan currently does not cover dental services. Therefore, we believe this bill prescribes new benefits, and Maine would likely have to fund the cost of this mandate. Please note this is not a legal interpretation, nor should it be considered legal advice.

While some insurance carriers already have some form of dental coverage for cancer patients, we could not find any other states that have included dental care for cancer patients in their benchmark plan.

NovaRest anticipates this bill under Option 1 will result in increases in health insurance premiums between 0.05% to 0.11%, or $0.26 to $0.64 PMPM. Under Option 2, NovaRest anticipates an increase in health insurance premiums between 0.04% to 0.11%, or $0.23 to $0.59 PMPM. With an estimated 62,250 members in Maine enrolled in qualified health plans, we estimate the cost to the state of $194,000 to $477,000 for Option 1 and $172,000 to $440,000 for Option 2.

To develop this estimate, NovaRest relied upon publicly available information, the National Association of Insurance Commissioner's 2020 Maine Supplemental Health Care Exhibits, and a carrier survey facilitated by the Maine Bureau of Insurance. The following carriers responded to the survey.

- Aetna
- Anthem
- Harvard Pilgrim
- Cigna
- Community Health Options
- United Healthcare

Additionally, we relied on an interview of Dr. Rebecca Berry, DMD who also provided testimony on the bill.

The primary difference in the cost estimate is due to the interpretation of medically necessary and the difference between "prior to beginning cancer treatment" versus "to begin cancer treatment." Our interpretation of Option 1 is that any person diagnosed with cancer would be eligible for medically necessary dental care prior to cancer treatment, even if it is unlikely the

cancer treatment would impact oral health. Option 2 would restrict to medically necessary to begin cancer treatment, which in our interpretation would primarily limit eligibility to head or neck cancers for radiation therapy.

However, we note two additional observations with the language in Option #2:

1. Option #2 appears to explicitly exclude coverage of fluoride treatment, which appears to be a recommended treatment prior to and after radiation to the head or neck.[1]
2. It is unclear whether Option #2's definition of medically necessary to begin cancer treatment would include dental implants. Our analysis assumes dental implants would not be covered. However, for a person requiring radiation treatment to the jaw, it may be recommended that any dental implants be performed prior to treatment, as treatment on an irradiated jaw may not be possible.[2]

Other open questions about the bill language relate to the treatment timeline and how the proposed medical coverage would work with dental coverage.

Testimony mentioned direct and indirect results of cancer treatment. For example, Dr. Norma Desjardins' public testimony discusses a patient who had cancer treatment then required 3-4 dentist visits per year for 18 years culminating with 24 teeth being extracted and needing dentures. We assume this is a rare case and most cases would be processed in around a year, however, there is potential of long-term costs that are not estimated.

Dental carriers were not surveyed for this bill, but review of the coverage statements for Delta Dental, the largest dental carrier in Maine, appears to show that many of these treatments and services would be covered if an individual had dental insurance.

This report includes information from several sources to provide more than one perspective on the proposed mandate with the intention of providing an unbiased report. As a result, there may be some conflicting information within the contents. Although only sources considered credible were used, no opinions are offered regarding whether one source is more credible than another, leaving it to the reader to develop their own conclusions.

[1] U.S. Department of Health and Human Services. Dental Provider's Oncology Pocket Guide, https://www.nidcr.nih.gov/sites/default/files/2017-09/oncology-guide-dental-provider_0.pdf.
[2] Ibid.

II. Background

Condition

The most common dental side effects of cancer treatment are mouth sores, dry mouth, sensitive gums and gum disease, jaw pain, and infection.[3] Another source lists additional side effects consisting of thickened saliva, changes in taste, tooth decay, difficulty swallowing, difficulty chewing or opening the mouth, bone disease, inflammation, or pain in the lining of the mouth and tongue, and higher risk of tooth decay or gum disease.[4]

Patients of radiation therapy applied to the head or neck area may experience damaged oral tissue, salivary glands, and bone in addition to scarring and atrophy. Radiation therapy may cause short term or permanent tissue damage that would put a patient, with head or neck cancer, at risk for lifelong oral complications.

Dental care prior to radiation treatment is recommended by oncologists.[5] Those recommendations include an oral health examination, extraction of teeth in the radiation field which may be a problem in the future, oral surgical procedures, and any prosthetic surgery which may not be possible on irradiated bone after treatment.[6]

After radiation therapy, further care may be required. Checkups are recommended every 4 to 8 weeks for the first 6 months after cancer treatment, continuing fluoride use, and tooth extraction where absolutely necessary.[7] It is not recommended to perform elective oral surgery on irradiated bone.[8]

Chemotherapy drugs slow or stop the growth of cancer cells but may also affect healthy cells, including cells in the mouth. This treatment can prevent the growth of normal cells in the mouth which affects oral tissue. Chemo can also decrease the number of white blood cells which fight infection. That is why infections can occur more frequently.[9]

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[3] "Dental and Oral Complications of Cancer Treatment Facts." Dental and Oral Complications of Cancer Treatment Facts, Leukemia and Lymphoma Society, https://corp.dev.lls.org/sites/default/files/National/USA/Pdf/Publications/FS29_Dental_and_Oral_Fact_Sheet_FINAL_9.2016.pdf.
[4] "Dental and Oral Health." Cancer.Net, 18 Nov. 2021, https://www.cancer.net/coping-with-cancer/physical-emotional-and-social-effects-cancer/managing-physical-side-effects/dental-and-oral-health.
[5] Oncology Pocket Guide (n 1)
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] Dental and Oral Fact Sheet (n 3)

Dental care prior to chemotherapy is also recommended, although complications are dependent on the type of drug used, dosage, degree of dental disease and use of radiation.[10] The care is similar to pre-radiation, however, prosthetic surgery may not be necessary prior to chemotherapy treatment.

After chemotherapy, it is recommended patients are placed on a dental recall schedule. Chemotherapy covers significant risk of Mucositis,[11] when the lining of the digestive system becomes inflamed and often seen as sores in the mouth which is treated with medications, mouth rinses, and increased tooth brushing.[12]

Incidence

According to the National Institute of Dental and Craniofacial Research, more than one-third of cancer patients develop complications that affect the mouth and can range from mild to severe side effects. Oral complications occur in nearly 40% of patients who receive chemotherapy, approximately 80% who have a stem cell transplant, and in nearly all patients who receive radiation for head and neck malignancies.[13]

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.

The CDC published the rate of new cancers by state for 2018. They indicated 9,134 new cancer cases in Maine in 2018 for all sites.[14] We included cancers that we understand would likely result in radiation or chemotherapy to the head or neck area, which are as follows:[15]

[10] Oncology Pocket Guide (n 1)
[11] Ibid.
[12] "Mucositis." The Oral Cancer Foundation, https://oralcancerfoundation.org/complications/mucositis/.
[13] Dental and Oral Fact Sheet (n 3)
[14] "USCS Data Visualizations - CDC." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, https://gis.cdc.gov/Cancer/USCS/#/AtAGlance/.
[15] Ibid.

Type of Cancer	**New Cases, 2018**
Lung Bronchus	1438
Non-Hodgkin lymphoma	391
Oral Cavity and Pharynx	262
Thyroid	198
Esophagus	136
Brain	120
Larynx	67
Hodgkin Lymphoma	44
Kaposi sarcoma	0
Total	**2656**

We then implemented a total population growth factor of 1.1% to account for differences in Maine population from 2018 to 2023.[16] This produces 9,234 expected cancer cases in 2023, where 2,685 would be head or neck cancers.

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

The recommended services and treatments are routinely performed by dentists and oral surgeons and are widely available.

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

Services are not generally covered for health plans providing medical coverage. Please note the following responses are related to medical health plans. These services and treatments may currently be covered under dental plans, but we did not survey carriers providing dental plans.

Aetna stated, "Dental services provided for the routine care, treatment, or replacement of teeth or structures (e.g., root canals, fillings, crowns, bridges, dental prophylaxis, fluoride treatment, and extensive dental restoration) or structures directly supporting the teeth are generally excluded from coverage under Aetna's medical plans. A dental service that would otherwise be excluded from coverage under Aetna's medical plans may be a covered medical expense if the dental service is medically necessary and is incident to and an integral part of a service covered under the medical plan."

Anthem does not cover services to prepare for cancer treatment in the individual market. Certain services are covered for a cancer patient including evaluation, dental x-rays, extractions, and anesthesia in the small group and large group markets. Additionally, small and large group customers who have an Anthem medical plan and a qualifying Anthem dental plan receive coverage for a third dental cleaning, periodontal (gum) maintenance, scaling and root planing

[16] Office of the State Economist. "MAINE POPULATION OUTLOOK 2018 to 2028." Maine Department of Administrative and Financial Services, Apr. 2021. https://www.maine.gov/dafs/economist/sites/maine.gov.dafs.economist/files/inline-files/Maine%20Population%20Outlook%20to%202028.pdf

(deep cleaning below the gum line), full mouth debridement (plaque removal), fluoride and other services at 100%, with no out-of-pocket deductibles, copays or coinsurance.

Cigna stated, "If a patient needs dental treatment as a secondary result of cancer treatment, ie. chemo or radiation, this is not a covered benefit under medical. Some exceptions exist such as the need to remove teeth prior to radiation therapy. A diagnosis of "cancer" does not constitute an injury to sound teeth."

Community Health Options indicated they cover medically necessary medical care for Cancer Survivors, however, the list of benefits they provided do not appear to be consistent with the procedures recommended. They also indicated they do not provide benefits for dental services, including but not limited to dental surgery, dental implants, or orthognathic surgery. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly is not covered except as stated in the Covered Services section or as required by law. Fluoride trays are not covered by the plan.

Harvard Pilgrim HealthCare: Currently provides additional coverage for members with serious medical conditions including those that are undergoing head and neck radiation or have serious immunodeficiency due to medical conditions (including chemotherapy). Covered services include oral exams, x-rays as needed, cleaning, topical application of fluoride (including prescription stannous fluoride gel), and oral hygiene instruction. Also included are extractions of teeth, (including pre/post-operative care, x-rays, anesthesia and/or alveoplasty) and periodontal surgery.

United Healthcare did not specifically indicate what coverage they provide, although they provided a cost so we assume they do not currently provide 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.

If coverage by the medical plan is not generally available, treatment may be covered under a person's dental plan. For example, Delta Dental (Maine's largest stand-alone dental carrier) offers a low family plan that covers diagnostic, preventive, periodontics, oral surgery, denture repair, implant services, and crowns among other procedures.[17] Some expense is still incurred by an individual for copays or charges over the allowed amount in the policy. If a person does not have dental coverage, they would have to pay out of pocket for services for all the dental services.

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

It is likely services and treatment not covered by medical health plans would be covered by dental plans. If services were not covered by dental plans, people would have to pay out of pocket.

[17] https://nedelta.com/SiteMedia/SiteResources/downloads/Exchange/ME/oocme20222.pdf

Preparing for cancer treatment would include at least an office visit and would likely include a fluoride gel tray with fluoride wash, which can cost over $600 according to an analysis of commercial costs in Maine.[18] We note fluoride would still not be covered under the language proposed under proposed bill Option 2. If a more invasive treatment such as tooth extraction, root canal, or implants are required the costs could be thousands of dollars depending on the number of teeth needing treatment, which can present a significant burden for some patients, especially when considering the additional costs related to the cancer treatment.

Additionally, some complications of cancer can be very costly. Periodontal treatment costs between $1,000 and $4,400. A study published in 2019 estimated that the incremental cost to treat mucositis alone would be $5,000 to $30,000 for patients receiving radiation therapy and $70,000 or more for cancer patients who have received stem cell transplants.[19]

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

We do not know the level of public demand for this treatment or service.

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

The Joint Standing Committee on Health Coverage, Insurance and Financial Services received 7 public hearing testimonies in support for LD 665 from medical providers, including from Angela Westhoff, then Executive Director of the Maine Dental Association (MDA). According to Westhoff, the MDA represents 85% of the dentists in Maine with 774 practicing and retired dentists who are active members. She stated that MDA member dentists wholeheartedly support passage of LD 665. In addition, many other dentists who frequently treat cancer patients have written testimonies in support of this 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.

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

While some insurance carriers already have some form of dental coverage for cancer patients, we could not find any other states that have included dental care for cancer patients in their benchmark plan.

[18] Section 25 Dental Services. Microsoft Excel file. Web. [https://www.maine.gov/governor/mills/sites/maine.gov.dhhs/files/inline-files/Section-25-Dental-Services.xlsx]
[19] Linda S Elting, Yu-Chia Chang, Costs of Oral Complications of Cancer Therapies: Estimates and a Blueprint for Future Study, JNCI Monographs, Volume 2019, Issue 53, August 2019, lgz010, https://doi.org/10.1093/jncimonographs/lgz010

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.

No information available.

11. The alternatives to meeting the identified need.

We do not know of any alternatives, and the carriers did not indicate any alternatives in their survey responses.

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.

The benefit is a medical need and coverage is not inconsistent with the role of insurance to provide medically necessary services for a condition. These services are more typically covered by a dental insurance policy.

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

There is unlikely to be social stigma attached to receiving treatments as most cancer patients will be treated with common dental treatments and services.

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

Coverage for dental benefits may reduce the financial costs of the individual's overall health care because it could prevent other, more serious complications. Untreated tooth infections, for example, can spread to other parts of the body and even be life-threatening.[20] In addition, bad oral health can lead to major diseases like cardiovascular disease, dementia, diabetes, and cancer.[21]

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 due to mandated benefits, some employers choose to self-insure in order to have more control over the benefits that they provide to employees and control the cost of health insurance premiums. Since this mandate will have a minimal impact on premiums it is unlikely this will cause any shifting to self-insurance.

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

Anthem provided a cost estimate of $0.23 PMPM. Please note we do not have information about

[20] Frothingham, Scott. "Symptoms of Tooth Infection Spreading to Body." Healthline, Healthline Media, 28 May 2019, https://www.healthline.com/health/symptoms-of-tooth-infection-spreading-to-body#symptoms-of-tooth-infection-spreading-to-body.
[21] Absolute Dental. "10 Health Issues Caused by Bad Oral Health." Absolute Dental, 11 Oct. 2021, https://www.absolutedental.com/blog/10-health-issues-caused-by-bad-oral-health/.

how Anthem determined their cost estimate and therefore do not know why it is different from our estimate.

IV. Financial Impact

B. Financial Impact of Mandating the 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.

The services and treatments are routine services that are widely available, we do not expect a change in cost for these services.

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

Both options of the bill would provide coverage for medically necessary dental services for a patient with a diagnosis of cancer. While dental plans may currently cover these benefits, we would expect an increase in the use of recommended care for those who do not have dental services.

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

We are unaware of alternative treatments. Some of the treatment and services are preventive, so may serve as a lower cost than if the condition worsens and require more invasive procedures.

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

There is no language in the bill that prohibits medical management. Carriers will be able to limit services to those that they determine to be medically necessary. If treatment is not effective, medical management could discontinue coverage of the treatment.

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

No information.

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.

Carrier Estimates:

Aetna:
"We anticipate the cost implications to be less 0.1%."

Anthem:
"The Per Member Per Month (PMPM) cost estimates for coverage under the proposed mandate are as follows:

Individual	$0.28
Small Group	$0.08
Large Group	$0.11

Cigna:
"If limited to medically necessary dental procedures, we would anticipate a small, but not significant, impact."

Community Health Options:
"Individuals may need dental evaluation and management of any dental conditions prior to engaging in head or neck cancers. This is dental benefit and is not currently a covered benefit.

Community Health Options provides coverage for medically necessary post-cancer treatment to include mandibular reconstruction subject to standard plan cost-sharing which could include deductibles, coinsurance, co-payments subject to a maximum out-of-pocket limitation.

Community Health Options specifically excludes coverage for dental implants for treatment of oral cancer. Inclusion of dental implants as a covered service as treatment under this bill would be an enhancement to existing benefits likely resulting in significant impact on premiums.

Without more information as to specific services contemplated in treatment (such as radiographs, extraction, prophylaxis and periodontal therapy, etc.), permissible limits or exclusions, we are unable to estimate an impact on the rates."

Harvard Pilgrim HealthCare:
"Because our coverage of the services is extensive the estimate of the mandate to require coverage for previously denied dental coverage of cancer patients is small. Due to the lack of fully credible experience at the segment level of treatments that may happen, estimates cannot be provided separately for individual, small group, and large group plans."

United HealthCare:
"We do not believe the cost of providing care to cancer patients would vary greatly from the costs of non-cancer patients. Approximately 5% of the United States are cancer survivors, so costs would be approximately 5% of the costs provided for LD 441, if coverage was only offered to cancer survivors."
The PMPM costs provided for LD 441 are as follows:

	EHB Indiv	EHB Small	EHB Large
Premium	$ 14.52	$ 10.59	$ 9.93

Therefore, the cost estimate for LD 665 would be:

	EHB Indiv	EHB Small	EHB Large
Premium	$ 0.73	$ 0.53	$ 0.50

NovaRest Estimate

NovaRest anticipates this bill under Option 1 will result in increases in health insurance premiums between 0.05% to 0.11%, or $0.26 to $0.64 PMPM. Under Option 2, NovaRest anticipates an increase in health insurance premiums between 0.04% to 0.11%, or $0.23 to $0.59 PMPM. Both options were modelled in a similar manner, however, the populations receiving treatment varied and the use of fluoride under Option 2 was removed from the cost. In addition, there may be administrative costs related to carriers contracting with dental providers or processing dental related codes if they do not already provide dental coverage, although we are unable to model the cost. Our assumptions are as follows:

- Cancers in Maine in 2018 were from the CDC visualization tool.[22]
- We assume cancer would increase at a similar rate as the population from 2018 to 2023, so a growth rate factor of 1.1%[23] was applied to the 2018 cancer numbers to get 2023 cancer amounts.
- Census.gov was used to determine the age distribution of the Maine population as of 2020, the most recent year.[24]
- The National Association of Insurance Commissioners (NAIC) Annual Statements for 2020 were used for membership, claims, risk adjustment, and premiums.
- We assume biotherapy and chemotherapy would result in similar costs.[25]
- We assume approximately 70% of all cancer cases will use some form of chemotherapy, radiation therapy, or biotherapy. Of these we assume 56% use chemotherapy and 44% use radiation therapy. [26]
- We assume biotherapy is not widely used and is used with chemotherapy and/or radiation therapy.[27]
- We assume 100% of cancer to the head or neck would use some form of chemotherapy, radiation therapy, or biotherapy.[28] Of these, we assume 90% would be radiation therapy and 10% would be chemotherapy.[29]
- The primary treatments and services provided before and after treatment appear to be the following:
    - Medications (assume currently covered)
    - OTC treatments (assume would not be required to be covered)
    - Comprehensive Exam including imaging and tests (not including cleanings)
    - Fluoride tray and treatment (not in bill language Option #2)
    - Fillings
    - Extractions, implants, alveoloplasty

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[22] USCS Data Visualizations – CDC (n 14)

[23] MAINE POPULATION OUTLOOK 2018 to 2028 (n 16)

[24] Bureau, US Census. "State Population by Characteristics: 2010-2020." Census.gov, 8 Oct. 2021, https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-state-detail.html.

[25] We were unable to find much information on cost of biotherapy, but the treatment appears similar to chemotherapy. Its possible that the complications of biotherapy may be reduced from chemotherapy in which case our estimate may be slightly overstated.

[26] According to this source 50% receive chemotherapy and 40% use radiation therapy, with some overlap. We were unable to find statistics on usage of biotherapy separate from chemotherapy and radiation therapy and assume it would be small.
Baskar R, Lee KA, Yeo R, Yeoh KW. Cancer and Radiation Therapy: Current Advances and Future Directions. Int J Med Sci 2012; 9(3):193-199. doi:10.7150/ijms.3635. Available from https://www.medsci.org/v09p0193.htm

[27] "Biological Therapy for Cancer." Mayo Clinic, Mayo Foundation for Medical Education and Research, 13 Nov. 2020, https://www.mayoclinic.org/tests-procedures/biological-therapy-for-cancer/about/pac-20385261.

[28] We were unable to find statistics specific to this area, but most types of head or neck cancer appear to be treated with radiation.

[29] Some sources such as https://oralcancerfoundation.org/dental/pre-treatment-dental-issues/ appear to show as much as 97% radiation.

  - Root canal and crowns
  - Drain Abscess
  - Dental Equipment – dentures, braces removal, retainer etc.
  - Periodontal
- To determine costs for procedures, we relied on a MaineCare cost guide which included median commercial costs.[30]
- Procedure costs were grouped into simple procedure, moderate procedure, and intensive procedure based on the procedure type and costs to simplify assumptions.
  - Our range of cost estimate is driven by the range of costs by procedure as different codes produce different costs. If a commercial median cost was unavailable, we relied on the MaineCare cost.
- Costs were determined for 4 groupings, before radiation, after radiation, before chemotherapy, and after chemotherapy. Biotherapy was considered with chemotherapy.
  - Before radiation included exams for all patients, and a higher percentage of simple, moderate and intensive treatment than after radiation, where moderate and intensive procedures may not be possible due to increased risk of osteonecrosis.[31]
  - After radiation includes 6 months of regular check-ups every six weeks for all patients[32] and also includes periodontal for approximately 5% of cases.[33]
  - Before chemotherapy includes similar probabilities as before radiation, although fluoride treatment does not appear to be recommended.[34]
  - After chemotherapy includes a higher probability of moderate and intensive procedures than after radiation, as they would be able to be performed and may occur as a result of general oral deterioration as a result of chemotherapy which carries a high risk of mucositis. [35]
- We interpret Option #1's language of medically necessary treatment more broadly than Option #2. We assume Option #1 would allow all people with cancer diagnosis to receive medically necessary dental care, even if cancer treatment is unlikely to worsen oral health. Option #2 would only consider dental care medically necessary if it would be affected by cancer treatment. Both options would cover direct and indirectly as a result of cancer treatment.
- We grouped the patients diagnosed with cancer into 4 groupings:
  - Radiation – not head or neck cancer
    - Eligible for care prior to cancer treatment for Option #1, although fluoride would not be necessary. Not eligible for care under Option #2. Care as a

[30] Section 25 Dental Services.xlsx (n 17)
[31] Oncology Pocket Guide (n 1)
[32] Ibid
[33] Decker, A M et al. "Periodontal Treatment in Cancer Patients: An Interdisciplinary Approach." Current oral health reports vol. 5,1 (2018): 7-12.
[34] Oncology Pocket Guide (n 1)
[35] Ibid.

direct or indirect result of cancer treatment unlikely under both options.

- Radiation – head or neck cancer
  - Eligible for care prior to cancer treatment and as a direct or indirect result of cancer treatment under both options. Fluoride not covered under Option #2.
- Chemotherapy or biotherapy– not head or neck cancer
  - Eligible for care prior to cancer treatment and as a direct or indirect result of cancer treatment under both options.
- Chemotherapy or biotherapy - head or neck cancer
  - Eligible for care prior to cancer treatment and as a direct or indirect result of cancer treatment under both options.

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.

No information.

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.

Preventive care would likely result in less expensive treatments down the road. Community Health Options acknowledged that benefit coverage for clearance by a dentist prior to the enrollee beginning cancer treatments is beneficial if they have not had routine dental care. UHC also stated, "Preventive dental does provide cost savings by reducing the utilization of crowns, restoration services and root canals and other more expensive dental services."

Under Option 1, mental health costs may also be reduced, as preventative care would greatly reduce the decay and tooth loss during and after receiving cancer treatment. Tooth loss comes with a big social stigma, often associated with being low income or having poor hygiene. This can lead to low confidence and self-esteem, impacting social and work situations. In a study done by the American Dental Association, 86% of dentists stated that one of the major consequences of tooth loss in patients is social embarrassment.[36] However, these savings might not be seen with Option 2, as tooth loss may be more prevalent under this option. Since fluoride wash would not been covered, this would result in more tooth decay.

[36] "The Emotional Impact of Missing Teeth in Dallas: Dental Implants." Daily Smiles Dental Dallas Blog, 28 Aug. 2020, https://www.dailysmilesdental.com/blog/2020/08/28/the-psychological-effects-of-missing-teeth/.

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 may be some cost to revising contracts and provider agreements to add these services onto the medical contracts that would be passed along to employers. It is anticipated to be minimal.

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 services are already covered under MaineCare and are likely covered by dental plans in the state. Additionally, most of the services and treatments being proposed are relatively inexpensive and are for a small number of people in Maine. We do not expect cost-shifting.

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.

Providing dental benefits for cancer patients, especially before the start of cancer treatment reduces the risk of oral complications. Visiting a dentist 4 weeks prior to the start of cancer treatment would allow them to treat any infected or decayed teeth while also allowing sufficient time to heal.[37]

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

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

[37] "Dental and Oral Health." Cancer.Net, 18 Nov. 2021, https://www.cancer.net/coping-with-cancer/physical-emotional-and-social-effects-cancer/managing-physical-side-effects/dental-and-oral-health.

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.

Coverage for the treatment and services proposed while already covered in dental plans, would lead to better outcomes if covered by medical plans when an individual is diagnosed with cancer and needs immediate treatment.

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

Many of the proposed treatments and services are likely currently covered by dental plans, which are not mandated to be purchased. In other words, the coverage is already available from dental plans, so this approach would not resolve the problem.

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.

NovaRest anticipates this bill under Option 1 will result in increases in health insurance premiums between 0.05% to 0.11%. The cumulative cost of all mandates include the high end of the estimated range are as follows.

Total cost for groups larger than 20:	**12.70%**
Total cost for groups of 20 or fewer:	**12.75%**
Total cost for individual contracts:	**11.01%**

Under Option 2, NovaRest anticipates an increase in health insurance premiums between 0.03% to 0.08%.

Total cost for groups larger than 20:	**12.67%**
Total cost for groups of 20 or fewer:	**12.72%**
Total cost for individual contracts:	**10.98%**

VII. Actuarial Memoranda

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 is 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.

VIII. Appendices

Appendix A: Cumulative Impact of Mandates

Bureau of Insurance
Cumulative Impact of Mandates in Maine
Report for the Year 2020

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 July 1, 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.

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. From 2018 to 2020 claims have increased slightly to an average of 3.5%, but still within a stabilized range.

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

Maine's mandate only applied to group coverage. Effective October 1, 2003, substance abuse was added to the list of mental health conditions for which parity is required. Effective on January 1, 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 1.2% average for the past 3 years of the total group health claims. Individual substance abuse health claims have also remained flat at 1.0% for the past 3 years. As expected, substance abuse claims have leveled out as pent-up demand is met, and carriers manage utilization.

- ***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 2020, was 0.80% of total health claims. Prior to 2014, the level has typically been lower for individual than for group. Individual claims at 0.4% in 2020 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. We estimate the current 2020 levels of 0.9% for group and 1.0% 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. HMOs would typically cover these costs and, for non-HMO plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. 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. Group claims in 2020 were 2.0% compared to individual claims at 1.4% with the combined impact remaining level with past years at 1.7%.

- ***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 is 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.

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	1.24%
		Individual	1.13%
1975 1983 1995 2003	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups	5.15%
		Individual	3.58%
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	0.83%
		Individual	0.61%
1990 1997	Benefits must be made available for screening **mammography**.	Group	0.85%
		Individual	0.96%
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	0.10%
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	2.57%
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 serve as primary care providers.	All Managed Care Contracts	0.16%
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	0.04%
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
	Total cost for groups larger than 20:		**12.59%**
	Total cost for groups of 20 or fewer:		**12.64%**
	Total cost for individual contracts:		**10.90%**

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

STATE OF MAINE
ONE HUNDRED AND THIRTIETH LEGISLATURE
COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

June 30, 2021

Eric A. Cioppa
Superintendent
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Superintendent Cioppa:

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 665, An Act To Promote Better Dental Care for Cancer Survivors.**

During the committee's consideration of LD 665, the committee prepared a discussion draft outlining 2 options for amending the bill. We ask that you evaluate the potential impact of both options using the guidelines set out in Title 24-A § 2752. Copies of the discussion draft and the original bill are attached. 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 1, 2022 so the committee can take final action on LD 665 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. Heather B. Sanborn
Senate Chair

Rep. Denise A. Tepler
House Chair

Enclosure: LD 665

cc: Marti Hooper, Bureau of Insurance
Rep. Margaret Craven

Appendix C: Initial Proposed LD 665 Language

130th MAINE LEGISLATURE

FIRST REGULAR SESSION-2021

Legislative Document **No. 665**

H.P. 492 House of Representatives, March 3, 2021

An Act To Promote Better Dental Care for Cancer Survivors

Received by the Clerk of the House on March 1, 2021. Referred to the Committee on Health Coverage, Insurance and Financial Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

Robert B. Hunt

ROBERT B. HUNT
Clerk

Presented by Representative CRAVEN of Lewiston.
Cosponsored by Representatives: BROOKS of Lewiston, STOVER of Boothbay, TALBOT ROSS of Portland, WHITE of Waterville, Senator: LIBBY of Androscoggin.

Printed on recycled paper

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

Sec. 1. 24-A MRSA §5320-P is enacted to read:

§5320-P. Dental services for cancer survivors

A carrier offering a health plan in the State shall provide coverage for medically necessary dental procedures that are the direct or indirect result of cancer treatments, including chemotherapy, biotherapy or radiation therapy treatment. The coverage required under this section must include expenses for laboratory assessments, medications and treatments associated with the medically necessary dental procedures.

SUMMARY

This bill requires a health plan to include medically necessary dental procedures that are the direct or indirect result of cancer treatments.

Appendix D: Proposed LD 665 Language – Option #1

LD 665
Draft Proposed by HCIFS Committee
For purposes of Mandate Review by the Bureau of Insurance

PROPOSED DRAFT COMMITTEE AMENDMENT:
LD 665, An Act To Promote Better Dental Care for Cancer Survivors

OPTION #1 (suggested by proponents of bill)

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

Sec. 1. 24-A MRSA §5320-P is enacted to read:

§5320-P. Dental services for cancer patients

1. Required coverage. Except as provided in subsection 2, a carrier offering a health plan in this State shall provide coverage for medically necessary dental procedures for an enrollee who has been diagnosed with cancer in accordance with the following.

A. Coverage must be provided for dental procedures that are medically necessary to reduce the risk of infection or to eliminate infection or to treat tooth loss or decay in an enrollee prior to beginning cancer treatment, including chemotherapy, biotherapy or radiation therapy treatment and fluoride treatment.

B. Coverage must be provided for dental procedures that are medically necessary to reduce the risk of infection or to eliminate infection or to treat tooth loss or decay that are the direct or indirect result of cancer treatments, including chemotherapy, biotherapy or radiation therapy treatment.

C. Coverage required under this subsection must include coverage for laboratory assessments, medications and treatments.

2. Routine preventive dental care not required. A carrier is not required to provide coverage for routine preventive dental care, cleaning, ***or*** sealants ~~or fluoride services.~~

Appendix E: Proposed LD 665 Language – Option #2

LD 665
Draft Proposed by HCIFS Committee
For purposes of Mandate Review by the Bureau of Insurance

OPTION #2 (suggested by carrier representatives)

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

Sec. 1. 24-A MRSA §5320-P is enacted to read:

§5320-P. Dental services for cancer patients

1. Required coverage. Except as provided in subsection 2, a carrier offering a health plan in this State shall provide coverage for medically necessary dental procedures for an enrollee who has been diagnosed with cancer in accordance with the following.

A. Coverage must be provided for dental procedures that are medically necessary to ***begin cancer treatment, including chemotherapy, biotherapy or radiation therapy treatment and fluoride treatment. These procedures may*** reduce the risk of infection or to eliminate infection or to treat tooth loss or decay in an enrollee ~~prior to beginning cancer treatment, including chemotherapy, biotherapy or radiation therapy treatment and fluoride treatment.~~

B. Coverage must be provided for dental procedures that are medically necessary to reduce the risk of infection or to eliminate infection or to treat tooth loss or decay that are the direct or indirect result of cancer treatments, including chemotherapy, biotherapy or radiation therapy treatment.

C. Coverage required under this subsection must include coverage for laboratory assessments, medications and treatments.

2. Routine preventive dental care not required. A carrier is not required to provide coverage for routine preventive dental care, including cleaning, sealants or fluoride services.

[apply requirements to the 2023 plan year]