

**Required Under Section 15-1501 of the Insurance Article**

*Annual Mandated Health Insurance Services Evaluation*



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Chair

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Insurance Article, § 15-1501, Annotated Code of Maryland, requires that the Commission annually assess the medical, social and financial impacts of a proposed mandated health insurance service that fails passage during the preceding legislative session or that is submitted to the MHCC by a Legislator by July 1<sup>st</sup> of each year. The report is due to the General Assembly annually by December 31<sup>st</sup>. In 2007, one proposed mandate required such analysis: coverage of habilitative services, regardless of age.

Mercer, the Commission's consulting actuary, has prepared the following evaluation of the proposed mandate on coverage of habilitative services.

As presented, HB 1192/SB 944 (2007) would have required a health insurer, nonprofit health service plan, Medicaid managed care organization, or HMO (further referred to as a "carrier") to provide coverage for habilitative services for persons of all ages who suffered "congenital or genetic birth defects" including but not limited to autism spectrum disorder (ASD) or cerebral palsy (CP). Guidance from the Maryland Department of Legislative Services (DLS) indicated that the intent of this proposed mandate was *to limit services to individuals who suffered developmental disabilities resulting from these conditions*. As defined in the proposed legislation, habilitative services are occupational, physical and speech therapy (OT, PT and ST) treatments that enhance the functioning ability of a person with the prescribed conditions. Mercer used this interpretation and definition for its analysis. If, for any reason, either the parameters for the services to be provided or the population to whom these services would be extended is significantly different from that assumed, these estimates would not be appropriate.

The state of Maryland currently mandates coverage of these services for children who are developmentally disabled by birth defects, ASD or CP through the age of 18 years. This proposed mandate would extend coverage to affected persons between 19 and 64 years of age.

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

## **MEDICAL IMPACT**

- ***To what extent is the service generally recognized by the medical community as being effective and efficacious in the treatment of patients?***

Both the American Occupational Therapy Association (AOTA) and the American Speech-Language Hearing Association (ASHA) have position statements and practice guidelines endorsing their therapies for the target population.

AOTA's 2005 "Statement: The Scope of Occupational Therapy Services for Individuals with Autism Spectrum Disorders Across the Lifespan" addresses the value of the association's therapies for both children and adults with ASD:

“Occupational therapy intervention helps individuals with autism develop or improve appropriate social, play, learning, community mobility, and vocational skills. The occupational therapy practitioner aids the individual in achieving and maintaining normal daily tasks such as getting dressed, engaging in social interactions, completing school activities, and working or playing.”<sup>1</sup>

A 2005 feature article from AOTA’s publication *OTPractice Online* advocates the role of OT for adults with developmental disabilities. It discusses specific ways OT can enhance employment, residential living and quality-of-life issues for adults with developmental disabilities.<sup>2</sup>

ASHA’s 2005 “Principles for Speech-Language Pathologists in Diagnosis, Assessment, and Treatment of Autism Spectrum Disorders Across the Life Span” states:

“The broad-based challenges in social communication experienced by individuals with ASD and their families may make them eligible to receive the services of a qualified speech-language pathologist regardless of intellectual status, age, or presumed prerequisites.”<sup>3</sup>

Similarly, ASHA’s 2005 “Principles for Speech-Language Pathologists Serving Persons with Mental Retardation/Developmental Disabilities” recommends ST to meet the special communication needs of adults with developmental disabilities. It notes the importance of developing and nurturing the socialization skills of this adult population for improved quality of life.<sup>4</sup>

Although the American Physical Therapy Association (APTA) does not offer any position statements or policy guidelines regarding the treatment of developmentally disabled adults, these individuals are included in its Physical Fitness for Special Populations (PFSP) program. This recently developed program targets individuals with acute and chronic impairments, functional limitations, and disabilities related to movement, function, and health. PFSP encourages physical therapists to work closely with these individuals to improve their physical fitness and their access to traditional and non-traditional programs and venues promoting their fitness, as described below.

“Physical therapy positively influences an individual's overall health, wellness, and fitness by providing services that positively impact physical fitness.

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<sup>1</sup> American Occupational Therapy Association, “Statement: The Scope of Occupational Therapy Services for Individuals with Autism Spectrum Disorders Across the Lifespan,” *American Journal of Occupational Therapy*, (2005): 59, 680-683.

<sup>2</sup> Laura Vogtle and Bethany Brooks, “Common Issues for Adults with DD,” *OTPractice Online*, <http://www.aota.org/Pubs/OTP/Features/2005/f-090505.aspx>.

<sup>3</sup> American Speech-Language Hearing Association, “Principles for Speech-Language Pathologists in Diagnosis, Assessment, and Treatment of Autism Spectrum Disorders Across the Life Span,” (2006) <http://www.asha.org/docs/html/TR2006-00143.html#sec1.5>.

<sup>4</sup> American Speech-Language Hearing Association, “Principles for Speech-Language Pathologists Serving Persons with Mental Retardation/Developmental Disabilities,” (2005) <http://www.asha.org/docs/html/TR2005-00144.html#sec1.2>.

Improving an individual's level of physical fitness can prevent, remediate, improve, maintain, slow the decline of, or lower the risk of impairments, functional limitations, and disabilities. Physical therapy services that impact physical fitness include: interventions that affect cardiovascular/pulmonary endurance; muscle strength, power, endurance and flexibility; relaxation; and body composition.”<sup>5</sup>

In May 2006, APTA delivered public comments to the federal Medicaid Commission reiterating the role of physical therapists to “prevent, diagnose, and treat movement dysfunction and enhance the physical health and functional abilities of individuals in all age populations ... [and] with disabilities.”<sup>6</sup>

▪ ***To what extent is the service generally recognized by the medical community as demonstrated by a review of scientific and peer review literature?***

In the last 10 to 15 years, the benefits of OT, PT and ST for child populations that are affected by developmentally disabling birth defects, ASD and CP have been investigated quite thoroughly; however, the benefits for like adult populations have been researched significantly less. Mercer was unable to find any recent, large-scale studies supporting or disproving the effectiveness of these therapies to improve functional ability in developmentally disabled adults. However, there are some smaller-scale studies, case studies and anecdotal evidence that support therapeutic benefits and suggest the need for expanded research with adult populations.

A 1993 study published in the *American Journal of Mental Retardation* examined the effect of independent living training on 1,498 developmentally disabled adults living in their own homes. The study found that, by the end of the seven-year study period, individuals who had received greater amounts of independent living services and had improved or maintained their independent living skills were more likely to still live independently. However, there was no significant relation between the receipt of such services and the probability of improving or maintaining one's skills.<sup>7</sup>

A 2004 study by the American Association on Mental Retardation examined the effect of introducing a physical activity project into a day habilitation setting for a group of 12 older adults with intellectual disability and a variety of physical and behavioral conditions. Their findings indicated that, after 12 weeks, 92% of the participants had experienced improvement in at least one domain of physical function. Many participants

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<sup>5</sup> American Physical Therapy Association, “Physical Fitness for Special Populations,” (2007) [http://www.apta.org/AM/Template.cfm?Section=Physical\\_Fitness\\_for\\_Special\\_Populations1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=267&ContentID=30270](http://www.apta.org/AM/Template.cfm?Section=Physical_Fitness_for_Special_Populations1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=267&ContentID=30270).

<sup>6</sup> American Physical Therapy Association, “Public Comments before the Medicaid Commission,” (May 2006). [http://www.apta.org/AM/Template.cfm?Section=Medicaid\\_Resource\\_Center&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=30994](http://www.apta.org/AM/Template.cfm?Section=Medicaid_Resource_Center&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=30994)

<sup>7</sup> B Lozano, “Independent Living: Relation among Training, Skills, and Success,” *American Journal of Mental Retardation*, 1993 Sep: 98(2): 249-62.

sustained functional gains one year after habilitation staff assumed responsibility for sessions.<sup>8</sup>

Although there are many studies and articles about the positive outcomes of the various therapies, the studies and articles do not access the cost of these therapies nor the cost benefit that results.

▪ ***To what extent is the service generally available and utilized by treating physicians?***

Data that track the use of these services by treating physicians for the target population were not available. The limited number of published studies and the limited amount of scientific literature indicate that some physicians are using these treatments for developmentally disabled adults, but it is not widespread.

Efforts to use data from the Maryland Medicaid program as a proxy proved problematic because claims data focus on the primary diagnosis being treated, not any underlying conditions that may have been present at birth. Therefore, a search of the claims data by diagnosis would yield a very modest return, especially for services rendered to adults. There is no clear identifier or reasonable proxy for sorting the Medicaid claims data.

## **SOCIAL IMPACT**

▪ ***To what extent is the service generally utilized by a significant portion of the population?***

While there are multiple sources for national and state disability statistics, developmental disabilities as a subset seem to be less extensively tracked. The best source for estimating developmentally disabled populations by age appears to be the 1994 to 1995 Disability Supplement to the National Health Interview Survey (NHIS-D), which gathered specific information about civilian and non-institutionalized individuals with mental retardation and/or developmental disabilities (MR/DD). It is estimated that those with MR/DD account for 0.9% of the adult population between the ages of 17 and 64.<sup>9</sup> Of the *total* population (including children under the age of 17), it is estimated that those who have MR/DD and are between the ages of 17 and 64 account for 0.6% of the population.<sup>10</sup>

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<sup>8</sup> Carol Podgorski et al., “Physical Activity Intervention for Older Adults with Intellectual Disability: Report on a Pilot Project,” *Mental Retardation*: Vol. 42, No. 4, 272–283, [http://aaid.allenpress.com/aamronline/?request=get-abstract&doi=10.1352%2F0047-6765\(2004\)42%3C272:PAIFOA%3E2.0.CO%3B2](http://aaid.allenpress.com/aamronline/?request=get-abstract&doi=10.1352%2F0047-6765(2004)42%3C272:PAIFOA%3E2.0.CO%3B2).

<sup>9</sup> Sheryl Larson, Ph.D. et al., “Demographic Characteristics of Persons with MR/DD Living in Their Own Homes or With Family Members: NHIS-D Analysis,” *MR/DD Data Brief*, Research and Training Center on Community Living and Institute on Community Integration (UAP), College of Education and Human Development, University of Minnesota (June 2001), <http://rtc.umn.edu/docs/dddb3-2.pdf>.

<sup>10</sup> See footnote 17.

Although it tracks developmental disability in children, the Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP), initiated by the Centers for Disease Control and Prevention (CDC) in 1984, is widely referenced as the best and most current source for prevalence rates. Its most recent prevalence rates from 1994 (for mental retardation and CP) and 1996 (for ASD) are shown in the following table:<sup>11</sup>

<b>Developmental Disability</b>	<b>Prevalence Rate per 1,000 Children</b>
Mental Retardation	9.7
Cerebral Palsy	2.8
Autism	3.4
Total	15.9 (or 1.6%)

The National Institutes of Health suggests using a prevalence rate of 0.50% for autism which means that, at any one time, 0.50% of the population could be diagnosed with autism.<sup>12</sup> The Association for Science in Autism Treatment states that ASD may occur in as many as one in 160 people, or at a rate of 0.625%.<sup>13</sup>

Estimates for the prevalence rate of cerebral palsy vary from a low of 0.15% to a high of 0.3%.<sup>14</sup>

The CDC estimates the prevalence of mental retardation at 1.2%.

Combining all of these sources, we generate a range of prevalence for mental retardation, cerebral palsy and autism ranging from 1.25% to 2.125%.

Considering these sources, Mercer estimates the prevalence of developmentally disabling birth defects, ASD and CP among people age 19 to 64 to be between 1% and 2%. Due to the low prevalence rates, it can be presumed that only a small portion of the population generally uses these services.

▪ ***To what extent is insurance coverage already generally available?***

The extent to which insurance coverage is available depends somewhat on the inclusion of the word “habilitative” in the legislation. For most private insurers, “habilitative” refers to the development of age-appropriate skills that were never present due to genetic

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<sup>11</sup> National Center on Birth Defects and Developmental Disabilities, “Metropolitan Atlanta Developmental Disabilities Surveillance Program: Prevalence Rates,” (October 2004),

<http://www.cdc.gov/ncbddd/dd/maddsp.htm#prev>.

<sup>12</sup> Jacobson, John W. Ph.D., “Is Autism on the Rise?” originally published in *Science in Autism Treatment*, Vol. 2, No. 1, Spring 2002, available on Association for Science in Autism.

[http://www.asatonline.org/about\\_autism/ontherise.html](http://www.asatonline.org/about_autism/ontherise.html), Accessed November 2007.

<sup>13</sup> *About Autism: Defining Autism Spectrum Disorder*. Association for Science in Autism Treatment.

[http://www.asatonline.org/about\\_autism/about\\_autism.html](http://www.asatonline.org/about_autism/about_autism.html), Accessed October 2007.

<sup>14</sup> Low estimate: “Cerebral Palsy,” by Christine Thorogood, MS, July 2005; High estimate: “Reaching for the States, a Foundation of Hope for Children with Cerebral Palsy.”

or birth defects. Medicaid defines “habilitative services” as those “designed to assist individuals in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.”<sup>15</sup>

Coverage for OT, PT and ST provided under habilitative services is thereby largely restricted to adults who are so disabled as to be eligible for institutionalized care (Medicaid) or to children. Insofar as the legislation addresses the provision of “occupational therapy, physical therapy, and speech therapy...to enhance the individual’s ability to function,” limited coverage may be more widely available as rehabilitative services.

Mercer interviewed a board member of the Maryland Health Insurance Plan (MHIP), the high- risk pool for individuals who cannot pass health underwriting in the non-group market.<sup>16</sup> MHIP currently follows the mandates that have been adopted by MHCC for the Comprehensive Standard Health Benefit Plan (CSHBP) for the small group market. The CSHBP currently provides habilitative services for children with developmental disabilities attributable to congenital or birth defects. The CSHBP and MHIP generally adopt commercial insurers’ interpretations of medically necessary services. Traditionally, these services for adults have not been viewed as insurable but have been defined as custodial-type care. MHIP probably would not extend habilitative coverage to adults.

Private insurance requires that services be medically necessary for the treatment of an illness or injury. Thus, insurance would cover rehabilitative services to the extent that such services result in continued and demonstrated improvement to recover skills that were lost due to an illness or injury. When these services no longer result in continued improvement, coverage is generally no longer available. In a previous study conducted by Mercer for the evaluation of habilitative services for children, it was found that about 60% of insurance companies provided these services in the absence of any mandate to some extent to enable the child to acquire as many age-appropriate skills as possible. Treatment plans would be required with periodic assessments to determine whether the therapies were working. If and when the therapies were no longer effective (and, therefore, no longer medically necessary) and/or continued treatment would no longer “enhance” the child’s ability to function, treatment would cease to be covered, as the services would then represent custodial care. Because of the requirement that services be medically necessary and not custodial in nature, private insurance coverage for habilitative services for people 19 to 64 with developmental disabilities from birth defects, ASD or CP is generally not available.

Of four major private insurers surveyed in Maryland, only one specifically provides habilitative services for developmentally disabled persons beyond the mandated limiting

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<sup>15</sup> Centers for Medicare and Medicaid Services, (42 CFR §1915(c)), <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=413a73fc1cf054156badc5da8e8429b5&rgn=div5&view=text&node=42:4.0.1.1.9&idno=42>.

<sup>16</sup> Conversation with Dr. Rex Cowdry, board member of MHIP.

age, and that is in only about 5% of the insurer's plan offerings. Additional data regarding the enrollment and costs associated with such plans were not available. One insurer who does not differentiate between habilitative and rehabilitative services excludes OT and ST when the primary or only diagnosis for a member is mental retardation, perceptual handicaps, or developmental delay. However, this same insurer will sometimes provide therapy when the primary diagnosis is CP.

One carrier indicated that long-term rehabilitative therapy is not a covered benefit. If significant improvement is not achievable within a two-month period, benefits for rehabilitative services will be denied.

In some cases, adults with developmental disabilities resulting from birth defects, ASD or CP, can receive a limited number of therapy treatments under the private insurer's umbrella of rehabilitative services. The services would be rendered in accordance with the effect of enhancing functional ability, not in an effort to meet the habilitative criteria. If the member can be treated on an outpatient short-term basis with expected achievable improvement, the services are covered up to the treatment limits, irrespective of diagnosis. While the legislation does not limit the number of treatments an individual may receive, private plans do – usually by number of visits per condition per year. It is difficult to say what portion of the population targeted by this bill might receive like services under rehabilitation, but it should be assumed that it would be a subset of members and treatments covered.

Medicaid covers habilitative services for children developmentally disabled by birth defects, ASD or CP. According to the Kaiser Family Foundation, “a majority of children receiving Supplemental Security Income (SSI), one of the primary pathways to Medicaid coverage for disabled children, has a primary diagnosis of mental disorder, including mental retardation, developmental disability and mental illness.”<sup>17</sup>

Medicare and Medicaid provide habilitative services to persons 19 to 64 who meet the programs' eligibility requirements.<sup>18</sup> Eligibility requirements consider the applicant's disability and level of income. Some in the target population are eligible through both programs. Developmentally disabled adults ages 19 to 64 can only get Medicare through Social Security Disability Insurance (SSDI) if they have an employment history but are now disabled, or if they are the dependent child of a Social Security beneficiary. They also must be severely disabled under Social Security rules, meaning that they are not able to work and earn significant income.

Medicaid is the public alternative for the larger number of young adults with disabilities who cannot qualify for Medicare because they never worked and do not have retired parents. People who qualified for Medicaid assistance as children are re-evaluated when they become adults. The criteria are generally stricter, and not all people who qualified

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<sup>17</sup> Bob Williams and Jennifer Tolbert, “Aging Out of EPSDT: Issues for Young Adults with Disabilities,” Issue Paper January 2007, Kaiser Family Foundation, [www.kff.org](http://www.kff.org).

<sup>18</sup> E Fishman, “Aging Out of Coverage: Young Adults with Special Health Needs,” *Health Affairs* (2001): 20;(6): 254–266. <http://content.healthaffairs.org/cgi/content/full/20/6/254>.

for Medicaid as children continue to qualify as adults. According to the Kaiser Family Foundation, about 25% to 30% of these people lose Medicaid eligibility when they become adults.<sup>19</sup>

Medicaid provides habilitative services through the home and community-based service (HCBS) waivers. To participate in the waiver program, an individual must be so disabled as to be eligible for intermediate care facilities for persons with mental retardation (ICF/MR) services. Habilitative services may include OT, PT and ST as well as longer-term, custodial services such as case management, private nurse or personal care attendants, and home health services. Public or private providers may supply these services and supports. These services also may include “prevocational, education and supported employment services” that are not otherwise available through a local educational agency or through programs funded under section 110 of the Rehabilitation Act of 1973.

The state of Alaska now requires a treatment plan with specific goals, assessments and outcomes for each mentally retarded or developmentally disabled individual served by its Medicaid waiver program.<sup>20</sup>

Although habilitative services are covered only by the waiver and are technically not allowable under the Medicaid Rehabilitative Services Option, Medicaid has been providing reimbursement for habilitation services under the Rehabilitative Services Option for many years.<sup>21</sup> In this way, members whose severity of disability does not qualify them for waivers have been able to receive therapy treatments that enhance their ability to function. They have relied on some “grayness” between the habilitative and rehabilitative services, as both aim to maximally reduce the disability and restore and maintain the best possible functional level of ability.

In August 2007, the Centers for Medicare and Medicaid Services (CMS) proposed a new regulatory rule for the Medicaid Rehabilitative Services Option that would end this practice. For people with MR/DD, the rule clarifies that the rehabilitation service category does not cover habilitation services. Organizations within the disability community oppose the sudden differentiation between habilitative and rehabilitative services. These organizations believe that if the proposed rule is adopted, it could significantly impact Medicaid reimbursement for community rehabilitation services and severely restrict access to important programs for individuals with developmental, cognitive and other disabilities.<sup>22</sup>

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<sup>19</sup> See footnote 22.

<sup>20</sup> Alaska Health and Social Services, Senior and Disabilities Services, “Development of the Habilitation Plan of Care” (2007), <http://www.hss.state.ak.us/dsds/carecoordinationtraining/segmentM.html>

<sup>21</sup> Thomas, Peter, “Update on Administrative Changes to Medicaid Rehabilitative Services,” ACCSES-DSPA Alliance, (October 2006), [www.accses-dspa.org/vendorimages/Alliance/2006\\_ACCSES\\_DSPA\\_PPSV\\_Memo\\_Adm\\_Changes\\_Medicaid\\_\(10.03.06\).DOC](http://www.accses-dspa.org/vendorimages/Alliance/2006_ACCSES_DSPA_PPSV_Memo_Adm_Changes_Medicaid_(10.03.06).DOC).

<sup>22</sup> Ibid.

OT, PT and ST can also sometimes be provided to developmentally disabled adults through nonprofit organizations within the community. Many of these offer day habilitation programs for developmentally disabled adults that may include these services. Arc of Montgomery County serves 1,250 individuals, including developmentally disabled adults. According to the Maryland Developmental Disabilities Administration, more than 100 different organizations across the state of Maryland provide various types of assistance to adults disabled by birth defects, ASD and CP.<sup>23</sup> However, not all of them provide OT, PT and ST, and not all do so at no charge. There also can be long waiting lists for enrollment and services provided by these organizations. Some employers have special work programs in place to train disabled adults for positions within their organizations, but this is still more of the exception than the normal case.

▪ ***To what extent does lack of coverage result in individuals' avoiding necessary health care treatments?***

While some data (case studies, small-scale trials, surveys, etc.) suggest that adults with developmental disabilities from birth defects, ASD and CP benefit from therapies that enhance their abilities for self-care, employment and quality of life, there is a lack of large-scale studies to support the conclusion that these services are necessary health care treatments.

▪ ***To what extent does lack of coverage result in unreasonable financial hardship?***

Statistics for incidence and costs of habilitative services for adults disabled by birth defects, ASD and CP are not readily available.

One study of the costs of autism reported that, while the typical American spends about \$317,000 over his or her lifetime in direct medical costs, incurring 60% of those costs after age 65, a person with autism will incur an additional \$307,000 in direct medical costs, incurring 60% of these costs after age 21. Direct medical costs average about \$1,500 per year. These are incremental costs above and beyond the costs a normal adult would expect to incur.<sup>24</sup> We will assume that a significant portion of these costs (50%) is attributable to therapies that would not be required for a person without this diagnosis, or \$750 per adult diagnosed with autism per year in 2003 dollars. If we assume a medical trend of 10% per year, this would equate to approximately \$1,100 per year in 2007 dollars. However, some unknown proportion of these additional medical costs will be borne by health insurance without the mandate, so the hardship associated with lack of coverage cannot be reliably estimated. This same study estimated the indirect costs of autism over a lifetime at approximately \$2.6 million; the proportion of these indirect costs that could be averted through the proposed coverage is unclear.

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<sup>23</sup> Maryland Department of Health and Mental Hygiene – Developmental Disabilities Administration, “Services Provided by DDA,” <http://www.ddamarilyland.org/services.html>

<sup>24</sup> Ganz, Michael L., PhD. The Lifetime Distribution of the Incremental Societal Costs of Autism.” Arch Pediatrics Adolescent Medicine, Vol. 161, Apr 2007. [www.archpediatrics.com](http://www.archpediatrics.com)

Testimony given by an activist in support of the failed mandate indicated that the annual therapy costs for him and his brother, who both have cerebral palsy, exceed \$17,000.<sup>25</sup> This equates to \$8,500 per individual per year. Based on the statistics inferred by his testimony, therapy sessions cost \$80 to \$90, and individuals would attend 100 sessions per year, or approximately two sessions per week.

▪ ***What is the level of public demand for the service?***

The level of public demand for the services is relatively small and generally limited to those affected by the developmental disability (and their families) and organizations that advocate on their behalf, such as the American Congress of Community Support & Employment Services (ACSES) and the national and affiliated state chapters of The Arc of the United States, United Cerebral Palsy (UCP), and Autism Society of America (ASA). At the same time, lengthy waiting lists for both community-based and federally funded programs indicate that demand for services still outpaces supply.

▪ ***How interested are collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts?***

Most collective bargaining agents that Mercer surveyed indicated that their existing benefits provide for habilitative services for children but do not extend coverage to adults. Most unions do not place the extension of habilitative services high on their priority list of collective bargaining issues. Most funds already extend coverage for disabled dependents beyond age 19, although habilitative services may not be covered. Unions understand that increased mandates and/or benefits translate into increased costs, making collective bargaining more difficult because there are generally only so many dollars available for higher wages and benefits combined. Most unions are focusing on retaining existing benefits and/or contributions to health care funds.

▪ ***To what extent is the service covered by self-funded employers in the state who employ at least 500 employees?***

Mercer's survey of insurance companies participating in the self-funded market in Maryland indicated that most self-funded employers in the state do not follow Maryland's mandates. While the insurance companies did not provide specific data, they indicated it would be unlikely for self-funded plans to modify their current definitions.

Mercer estimates that only a very small number of self-funded employers with at least 500 employees provide habilitative services to those age 19 to 64 with developmental disabilities resulting from birth defects, ASD, or CP. Only one of the major Maryland insurers even provides plans that cover habilitative services for adults, and these account for only 5% of their plan offerings.

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<sup>25</sup> Maryland Politics Watch. "District 18 Activist Aaron Kaufmann Testifies for Health Care." March 23, 2007. <http://maryland-politics.blogspot.com/2007/03/district-18-activist-aaron-kaufmann.html>

## FINANCIAL IMPACT

Mercer surveyed four major carriers in Maryland to obtain information on current practices regarding habilitative services. Mercer also asked these companies to provide financial estimates as to how rates would be affected by the extension of habilitative services to adults.

As indicated previously, there is concern regarding the existing language contained in the current bill. Here are some examples of the responses received.

### *Carrier A*

“It is very difficult to anticipate premium increases, but, in addition to costs of care, we anticipate programming and operational changes costing in the 10’s of millions of dollars to include:

- Single benefit carve-outs within a product are difficult to administer and require costly system modifications – there could be a need to segregate these claims and process them manually.
- The systems changes and administrative burden in terms of service training, enrollment and account implementation, medical management tracking, audits, etc. would run in the multi-millions to accommodate this type of policy (covering one specific medical condition for the life of the patient).
- New/unique identification cards would need to be created and generated to clearly identify that the individual has coverage limited to habilitative services only.
- Contract language and eligibility schedules would need to be created, filed and approved by the MIA.
- Enrollment issues – termination dates are automatically loaded when enrollment is processed.
- What happens when the parents are Medicare beneficiaries and they have individual Medicare Supplemental policies?
- What if the child is married, has other health coverage, resides in another state, etc.?
- How would we deal with retroactivity and re-adding individuals to parent’s policies?
- There are potential IRS tax implications to members and employer groups.”

### *Carrier B*

This company’s actuaries indicated that there was no way to estimate the increase in premium based on the language in the proposed mandate. With no defined scope of services, and with the wide variety of possible conditions and treatments, they felt they could not begin to quantify that information.

### *Carrier C*

Company C's response was: "Long term rehabilitative therapy is not a covered benefit. If significant improvement is not achievable within a 2-month period, benefits for rehabilitative services will be denied.... This has the potential to be a significant benefit modification. Removing age limits would require a rate increase of between \$4.00 and \$8.00 pmpm." Our calculations indicate that this equates to 2% to 3% of premium.

### *Carrier D*

This is the only carrier that did not express concerns regarding the claims cost and/or administrative complexities regarding the language in the proposed mandate. This carrier estimated that premiums would increase by 0.7%.

In its Fiscal and Policy Note, the Maryland Department of Legislative Services (DLS) estimated that extending habilitative services to individuals with congenital or genetic birth defects regardless of age would increase the state plan expenditures by 2%. This translates into an increase of about \$11 million in Fiscal Year 2008 (FY2008) to almost \$16 million in FY 2012.<sup>26</sup>

Because of the very limited amount of data available on the use and cost of habilitative services for adults who suffer from developmental disabilities associated with congenital or genetic birth defects, Mercer is providing a range of estimates for the cost of this proposed mandate, outlined as Approach A and Approach B below.

All of these estimates assume that this mandate will impact 1% to 2% of the membership of the insured population.

Since these benefits are not generally covered under existing policies, Mercer assumes that the full cost and the marginal cost of providing these services would be the same.

Most policies have some type of cost-sharing provisions. Therefore, Mercer assumes that insuring entities would be responsible for 90% of total costs.

Approach A assumes that, based on previously-referenced testimony, the average cost for therapy is between \$80 and \$90 per session. It is typical for policies to have limits on the number of therapy sessions that are eligible for payments within a year. These limits typically range from 30 to 100 sessions.

Approach B starts with the Medicaid experience in the three states that provide habilitative services for adults with developmental disabilities, adjusts for the differences in costs among these states and Maryland, adjusts for differences in reimbursement levels for Medicaid and commercial payers, and applies the range in prevalence.

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<sup>26</sup> Maryland Department of Legislative Services, Health Insurance – Habilitative Services – Covered Persons, HB 1192, 2007. [http://www.mlis.state.md.us/2007RS/fnotes/bil\\_0002/hb1192.pdf](http://www.mlis.state.md.us/2007RS/fnotes/bil_0002/hb1192.pdf).

Please note that the estimates in the following table only reflect the impact on claims costs. These estimates do *not* reflect any administrative costs associated with implementing this change. Based on the comments from the carriers, administrative costs could be very significant.

	<b>Approach A</b>		<b>Approach B</b>	
	<b>Low</b>	<b>High</b>	<b>Low</b>	<b>High</b>
Estimated cost of mandated benefits as a percentage of average cost per Maryland small employer policy	0.8%	5.1%	0.9%	1.9%
Estimated cost as a percentage of average wage	0.1%	0.4%	0.1%	0.2%
Estimated annual per-employee cost of mandated benefits for Maryland's small employer group policies	\$39	\$261	\$50	\$100