

24 §2325-A. MENTAL HEALTH SERVICES COVERAGE

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1. Findings. The Legislature finds that:

A. Mental illness affects nearly 170,000 Maine people each year, resulting in anguish, grief, desperation, fear, isolation and a sense of hopelessness of significant levels among victims and families; [1983, c. 515, §4 (NEW).]

B. Consequences of mental illness include the expenditure of millions of dollars of public funds for treatment and losses of millions of dollars by Maine businesses in accidents, absenteeism, nonproductivity and turnover. Excessive stress and anxiety and other forms of mental illness clearly contribute to general health problems and costs; [1983, c. 515, §4 (NEW).]

C. Typical health coverage in this State discriminates against mental illness, the victims and affected families with nonexistent or limited benefits compared to provisions for other illnesses; and [1983, c. 515, §4 (NEW).]

D. Experience in this State and several other states demonstrates that the risk of mental illness can be insured at reasonable cost and with adequate controls on quality and utilization of treatment. [1983, c. 515, §4 (NEW).]

[1983, c. 515, §4 (NEW) .]

2. Policy and purpose. The Legislature declares that it is the policy of this State to:

A. Promote equitable and nondiscriminatory health coverage benefits for all forms of illness, including mental and emotional disorders, which are of significant consequence to the health of Maine people and which can be treated in a cost-effective manner; [1983, c. 515, §4 (NEW).]

B. Assure that victims of mental and other illnesses have access to and choice of appropriate treatment at the earliest point of illness in least restrictive settings; [1983, c. 515, §4 (NEW).]

C. Assure that costs of treatment of mental illness are supported through an equitable combination of public and private responsibilities; and [1983, c. 515, §4 (NEW).]

D. Assure that the Legislature reasonably exercises its legal responsibility for insurance policy in this State by prescribing types of illnesses and treatment for which benefits shall be provided. [1983, c. 515, §4 (NEW).]

[1983, c. 515, §4 (NEW) .]

3. Definitions. For purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Day treatment services" includes psychoeducational, physiological, psychological and psychosocial concepts, techniques and processes to maintain or develop functional skills of clients, provided to individuals and groups for periods of more than 2 hours but less than 24 hours per day. [1983, c. 515, §4 (NEW).]

A-1. "Diagnostic and statistical manual" means the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association. [2003, c. 20, Pt. VV, §1 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

A-2. "Home health care services" means those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if:

(1) Hospitalization or confinement in a residential treatment facility would otherwise have been required if home health care services were not provided;

(2) Hospitalization or confinement in a residential treatment facility is not required as an antecedent to the provision of home health care services; and

(3) The services are prescribed in writing by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [2003, c. 20, Pt. VV, §1 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

B. "Inpatient services" includes a range of physiological, psychological and other intervention concepts, techniques and processes in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Health and Human Services or accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting. [1983, c. 515, §4 (NEW); 2003, c. 689, Pt. B, §6 (REV).]

B-1. "Medically necessary health care" has the same meaning as in Title 24-A, section 4301-A, subsection 10-A. [2003, c. 20, Pt. VV, §2 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

C. "Outpatient services" includes screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventive concepts, techniques and processes provided to individuals and groups. [1983, c. 515, §4 (NEW).]

D. "Person suffering from a mental illness" means a person whose psychobiological processes are impaired severely enough to manifest problems in the areas of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion or physical well-being. [2003, c. 20, Pt. VV, §3 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

E. "Provider" means those individuals included in Title 24-A, section 2744, subsection 1, and a licensed physician, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Health and Human Services. All agency or institutional providers named in this paragraph shall ensure that services are supervised by a psychiatrist or licensed psychologist. [1999, c. 256, Pt. O, §1 (AMD); 2001, c. 354, §3 (AMD); 2003, c. 689, Pt. B, §6 (REV).]

[2003, c. 20, Pt. VV, §§1-3 (AMD); 2003, c. 20, Pt. VV, §25 (AFF); 2003, c. 689, Pt. B, §6 (REV) .]

4. Requirement. Every nonprofit hospital and medical service organization that issues group health care contracts providing coverage to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for conditions arising from mental illness.

[2003, c. 20, Pt. VV, §4 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

5. Services. Each group contract must provide for medically necessary health care for a person suffering from mental illness. Medically necessary health care includes, but is not limited to, the following services for a person suffering from a mental illness:

A. Inpatient care; [1983, c. 515, §4 (NEW).]

B. Day treatment services; [2003, c. 20, Pt. VV, §4 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

C. Outpatient services; and [2003, c. 20, Pt. VV, §4 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

D. Home health care services; and [2003, c. 20, Pt. VV, §4 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

[2003, c. 20, Pt. VV, §4 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

5-A. Exceptions. This section shall not apply to employee group insurance contracts issued to employers with 20 or fewer employees insured under the group contract or to group contracts designed primarily to supplement the Civilian Health and Medical Program of the Uniformed Services, as defined in the United States Code, Title 10, Section 1072, subsection 4.

[1989, c. 490, §1 (AMD) .]

5-B. Coverage for certain mental illness treatment.

[1991, c. 881, §8 (RP) .]

5-C. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A-1 is subject to this subsection.

A. [2003, c. 20, Pt. VV, §25 (AFF); 2003, c. 20, Pt. VV, §5 (RP).]

A-1. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:

- (1) Psychotic disorders, including schizophrenia;
- (2) Dissociative disorders;
- (3) Mood disorders;
- (4) Anxiety disorders;
- (5) Personality disorders;
- (6) Paraphilias;
- (7) Attention deficit and disruptive behavior disorders;
- (8) Pervasive developmental disorders;
- (9) Tic disorders;
- (10) Eating disorders, including bulimia and anorexia; and
- (11) Substance abuse-related disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [2003, c. 20, Pt. VV, §5 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State must provide benefits that meet the requirements of this paragraph.

- (1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital and medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

(3) If benefits and coverage for treatment of physical illness are provided on an expense-incurred basis, the benefits and coverage required under this subsection may be delivered separately under a managed care system.

(4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.

(5) A health benefit plan may not impose a limitation on coverage or benefits for mental illness unless that same limitation is also imposed on the coverage and benefits for physical illness covered under the policy or contract.

(6) Copayments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance required under the policy or contract for a benefit or coverage for a physical illness.

(7) For the purposes of this section, a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits. [2003, c. 20, Pt. VV, §5 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

This subsection does not apply to policies, contracts and certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

[2003, c. 20, Pt. VV, §5 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

5-D. Mandated offer of coverage for certain mental illnesses. Except as otherwise provided, coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group nonprofit hospital and medical service organization health care plan contracts is subject to this subsection.

A. All individual and group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness:

- (1) Schizophrenia;
- (2) Bipolar disorder;
- (3) Pervasive developmental disorder, or autism;
- (4) Paranoia;
- (5) Panic disorder;
- (6) Obsessive-compulsive disorder; or
- (7) Major depressive disorder. [2003, c. 20, Pt. VV, §6 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

B. Every nonprofit hospital and medical service organization and nonprofit health care plan must make available coverage in all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State that provides benefits meeting the requirements of this paragraph.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital and medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual or group contract. [2003, c. 20, Pt. VV, §6 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

[2003, c. 20, Pt. VV, §6 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

6. Contracts; providers. Subject to the approval by the Superintendent of Insurance pursuant to section 2305, a nonprofit hospital and a medical service organization incorporated under this chapter shall offer contracts to providers authorizing the provision of mental health services within the scope of the provider's licensure.

[2003, c. 20, Pt. VV, §7 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

7. Limits; coinsurance; deductibles. Any policy or contract which provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1983, c. 515, §4 (NEW) .]

8. Reports to the Superintendent of Insurance. Every nonprofit hospital or medical service organization subject to this section shall report its experience for each calendar year to the superintendent not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all nonprofit hospital or medical service organizations in an annual report.

[1995, c. 407, §3 (AMD) .]

9. Application; expiration.

[1995, c. 407, §4 (RP) .]

10. Application. Except as otherwise provided in this section, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §6 (NEW) .]

SECTION HISTORY

1983, c. 515, §4 (NEW). 1987, c. 480, §2 (AMD). 1989, c. 490, §1 (AMD). 1991, c. 881, §§1,2 (AMD). 1991, c. 881, §§7,8 (AFF). 1993, c. 441, §§1,2 (AMD). 1993, c. 586, §§1,2 (AMD). 1995, c. 19, §1 (AMD). 1995, c. 332, §G1 (AMD). 1995, c. 407, §§1-4 (AMD). 1995, c. 560, §K82 (AMD). 1995, c. 625, §B6 (AMD). 1995, c. 637, §§1,2 (AMD). 1995, c. 560, §K83 (AFF). 1995, c. 625, §B7 (AFF). 1999, c. 256, §O1 (AMD). 2001, c. 354, §3 (AMD). 2003, c. 20, §§VV1-7 (AMD). 2003, c. 517, §B6 (AMD). 2003, c. 20, §VV25 (AFF). 2003, c. 689, §B6 (REV).

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