§2749-C. Mental health services coverage

1. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A-1 by all individual policies is subject to this section.

A. [PL 2019, c. 5, Pt. D, §1 (RP).]

A-1. All individual 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 as defined in section 2843, subsection 3, paragraph A-1, 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 use 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. [PL 2019, c. 5, Pt. D, §1 (NEW).]

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

(1) The 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 reimbursing insurer, 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 policy. An insurer may not deny treatment for mental health services that use evidence-based practices and are determined to be medically necessary health care for an individual 21 years of age or younger. For the purposes of this subparagraph, "evidence-based practices" means clinically sound and scientifically based policies, practices and programs that reflect expert consensus on the prevention, treatment and recovery science, including, but not limited to, policies, practices and programs published and disseminated by the Substance Abuse and Mental Health Services Administration and the Title IV-E Prevention Services Clearinghouse within the United States Department of Health and Human Services, the What Works Clearinghouse within the United States Department of

Education, Institute of Education Sciences and the California Evidence-Based Clearinghouse for Child Welfare within the California Department of Social Services, Office of Child Abuse Prevention. [PL 2021, c. 595, §2 (AMD).]

[PL 2021, c. 595, §2 (AMD).]

2. Contracts; providers. An insurer incorporated under this chapter shall offer contracts to providers authorizing the provision of mental health services within the scope of the provider's licensure.

[PL 2003, c. 20, Pt. VV, §9 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

3. Limits; coinsurance; deductibles. A policy or contract that 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.

[PL 1995, c. 407, §5 (NEW).]

4. Reports to the superintendent. Every insurer subject to this section shall report its experience for each calendar year to the superintendent no 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 individual health care policies, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

[PL 1995, c. 407, §5 (NEW).]

5. Application. Except as otherwise provided, the requirements of this section apply to all policies and contracts executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996. For purposes of this section, all policies are deemed renewed no later than the next yearly anniversary of the contract date. Nothing in this section applies to accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

[PL 1995, c. 407, §5 (NEW).]

SECTION HISTORY

PL 1995, c. 407, §5 (NEW). PL 1995, c. 637, §3 (AMD). PL 2003, c. 20, §§VV8,9 (AMD). PL 2003, c. 20, §VV25 (AFF). PL 2019, c. 5, Pt. D, §1 (AMD). PL 2021, c. 595, §§1, 2 (AMD).