L.D. 595

DATE: 6/16/95 (Filing No. H- 521)

MAJORITY
BANKING AND INSURANCE

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STATE OF MAINE
HOUSE OF REPRESENTATIVES
117TH LEGISLATURE
FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 432, L.D. 595, Bill, "An Act Regarding Insurance Coverage for Mental Illness"

Amend the bill by striking out everything after the title and before the statement of fact and inserting in its place the following:

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

Sec. 1. 24 MRSA §2325-A, sub-§5-C, as amended by PL 1995, c. 19, §1, is repealed and the following enacted in its place:

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

A. 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 mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

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(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

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

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.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 2. 24 MRSA §2325-A, sub-§5-D is enacted to read:

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 services 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:

(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.

B. Every nonprofit hospital and medical services 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 on or after July 1, 1996 that provides benefits meeting the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(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 or medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, 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.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug

dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 3. 24 MRSA §2325-A, sub-§8, as enacted by PL 1983, c. 515, §4, is amended to read:

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 ~~beginning with 1984~~ to the superintendent not later than April 30th of the following year. The report ~~shall~~ must be in a form prescribed by the superintendent and ~~shall~~ 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.

Sec. 4. 24 MRSA §2325-A, sub-§9, as amended by PL 1993, c. 586, §2, is repealed.

Sec. 5. 24-A MRSA §2749-C is enacted to read:

§2749-C. Mandated offer of coverage for certain mental illnesses

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

A. All individual policies 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:

(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.

B. All individual policies and contracts executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must make available coverage providing benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(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 reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual policy.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

2. Contracts; providers. Subject to approval by the superintendent pursuant to section 2305, 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.

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.

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.

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.

Sec. 6. 24-A MRSA §2843, sub-§5-C, as amended by PL 1995, c. 19, §1, is repealed and the following enacted in its place:

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

A. 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 mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(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.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

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

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.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 7. 24-A MRSA §2843, sub-§5-D is enacted to read:

5-D. Mandated offer of coverage for certain mental illnesses. Except as otherwise provided in subsection 5-C, coverage for medical treatment for mental illnesses listed in paragraph A by all group contracts is subject to this subsection.

A. All 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:

(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.

B. All group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must make available coverage providing benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(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 reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 8. 24-A MRSA §2843, sub-§7, as enacted by PL 1983, c. 515, §6, is amended to read:

7. Reports to the Superintendent of Insurance. Every insurer subject to this section shall report its experience for each calendar year ~~beginning with 1984~~ to the superintendent not later than April 30th of the following year. The report ~~shall~~ must be in a form prescribed by the superintendent and ~~shall~~ 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 insurers in an annual report.

Sec. 9. 24-A MRSA §2843, sub-§8, as amended by PL 1993, c. 586, §4, is repealed and the following enacted in its place:

8. Application. This section does not apply to accidental injury, specified disease, hospital indemnity, Medicare

supplement, long-term care or other limited benefit health insurance policies.

Sec. 10. 24-A MRSA §4234-A is enacted to read:

§4234-A. Mental health services coverage

1. Findings. The Legislature finds that:

A. Mental illness affects nearly 170,000 people of this State each year, resulting in anguish, grief, desperation, fear, isolation and a sense of hopelessness of significant levels among victims and families;

B. Consequences of mental illness include the expenditure of millions of dollars of public funds for treatment and losses of millions of dollars by businesses in the State in accidents, absenteeism, nonproductivity and turnover. Excessive stress and anxiety and other forms of mental illness clearly contribute to general health problems and costs;

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

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.

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 that are of significant consequence to the health of people of the State and that can be treated in a cost-effective manner;

B. Ensure that victims of mental and other illnesses have access to and choice of appropriate treatment at the earliest point of illness in the least restrictive settings;

C. Ensure that costs of treatment of mental illness are supported through an equitable combination of public and private responsibilities; and

D. Ensure that the Legislature reasonably exercises its legal responsibility for insurance policy in this State by prescribing types of illnesses and treatment for which benefits must be provided.

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 necessary 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 a day.

B. "Inpatient services" includes a range of physiological, psychological and other intervention concepts, techniques and processes used in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Human Services or in an accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting.

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.

D. "Person suffering from a mental or nervous condition" means a person whose psychobiological processes are impaired severely enough to manifest problems in the area 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 area of intellect, emotion or physical well-being.

E. "Provider" means an individual included in Title 24, section 2303, subsection 2, a licensed physician, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Mental Health and Mental Retardation. All agency or institutional providers named in this paragraph shall ensure that services are supervised by a psychiatrist or licensed psychologist.

4. Requirement. Every health maintenance organization that issues individual or group health care contracts providing coverage for hospital care 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.

5. Services. Each individual or group contract must provide, at a minimum, the following benefits for a person suffering from a mental or nervous condition:

A. Inpatient services;

B. Day treatment services; and

C. Outpatient services.

6. Coverage for treatment of certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A is subject to this subsection.

A. 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 mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(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.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(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 reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

This subsection does not apply to policies, contracts or 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.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

7. Mandated offer of coverage for certain mental illnesses. Except as provided in subsection 6, coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group contracts is subject to this subsection.

A. All individual and group contracts shall 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:

(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.

B. All individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must make available coverage providing benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(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 reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, 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.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

8. Contracts; providers. Subject to approval by the superintendent pursuant to section 4204, a health maintenance organization incorporated under this chapter shall allow providers to contract, subject to the health maintenance organization's credentialling policy, for the provision of mental health services within the scope of the provider's licensure.

9. 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.

10. Reports to the superintendent. Every health maintenance organization 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 and group health care contracts, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all health maintenance organizations in an annual report.

11. Application. Except as otherwise provided, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on and after July 1, 1996. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.'

Further amend the bill by inserting at the end before the statement of fact the following:

FISCAL NOTE

The requirement that health insurance policies provide the same level of coverage for certain mental illnesses as for physical illness will increase the costs of the state employee health insurance program during the current biennium by a total of $682,160 in fiscal year 1996-97. The General Fund share of these costs is $341,080; the Highway Fund share is $102,324; and the share for all other funds is $238,756. The ability of all state departments and agencies to absorb these additional personal services expenditures can not be determined at this time.

The Bureau of Insurance will incur some minor additional costs to process any new rate filings that may occur as a result of changes in the statutory requirements for insurance coverage for mental illness. These costs can be absorbed within the bureau's existing budgeted resources.'

STATEMENT OF FACT

This amendment replaces the original bill and does the following.

1. It removes the emergency preamble and emergency clause.

2. It requires parity for the treatment of biologically-based mental illnesses for all group policies and contracts covering employees of employers with more than twenty employees issued by nonprofit hospital and medical service organizations, commercial insurers and health maintenance organizations.

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3. It requires that nonprofit and commercial insurers and health maintenance organizations offer coverage for biologically-based mental illnesses to the same extent that coverage is provided for physical illnesses in individual and small group policies.

4. It removes childhood schizophrenia and psychotic depression from the list of biologically-based mental illnesses because these illnesses are now included in other diagnoses and specifies that treatment for alcoholism and other drug dependencies can not be provided through the diagnosis of a biologically-based mental illness.

5. It provides for an effective date of July 1, 1996.

6. It adds a fiscal note to the bill.