PROPOSED
MANDATED HEALTH INSURANCE BENEFIT
FOR
MENTAL ILLNESS

A Report to the
Joint Standing Committee on
Banking and Insurance
of the
117th Maine Legislature

Prepared by the
Bureau of Insurance
May 1995

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EXECUTIVE SUMMARY

The Joint Standing Committee on Banking and Insurance of the 117th Maine Legislature on March 27, 1995, directed the Bureau of Insurance to review LD 595 "An Act Regarding Insurance Coverage for Mental Illness." The review was to be conducted using the criteria outlined in 24-A M.R.S.A. § 2752 regarding the social and financial impact of the proposed mandate, and the medical efficacy of the procedure covered under the proposal.

This report also discusses the cost of providing coverage for the listed mental illnesses according to the requirements of the 1993 Public Law 441 effective on issue or renewal dates on or after January 1, 1994. Data is limited for several reasons: policies that renewed during 1994 would not reflect an entire year of claims under the new mandate; many companies have not provided their data for 1994 yet; and the accuracy of the data provided is questionable.

Due to the limited time available to collect more recent reports, studies and data, a more extensive report was not possible. Much of this report was based on the study completed in June 1992 by the Mandated Benefits Advisory Commission. Because the previous mandated benefit report only studied the effect on group policies there is limited information for individual policies and Health Maintenance Organization (HMO) plans.

Currently policies covering 20 or more employees (or members in the case of an association or trustee group) are required to provide a minimum level of mental health benefits. The small group and individual standardized plans also have a required level of mental

health benefits. 1993 Public Law 441 effective January 1, 1994 modified the required levels of coverage for mental illness in group insurance contracts for certain listed conditions. These conditions are covered at higher levels required by this law because they are biologically-based, diseases of the brain considered to be like any other diseased organ of the body.

LD 595 would expand benefits for those listed conditions to provide the same level of coverage as for medical treatment for physical illnesses. It would also apply the entire mental illness mandate to individual contracts, small group policies and Health Maintenance Organization (HMO) plans. As written the bill repeals the exceptions in the existing mandate for small groups and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement coverage.

While the effect on group plans with more than 20 employees would depend of the benefits offered for physical illnesses, there would in general be increased coverage of the listed conditions. Lifetime maximums could increase from the current level of $100,000 to the limit contained in the benefit plan if any (often $1 million). In addition, inpatient and outpatient could no longer be restricted to calendar year dollar maximums or number of days.

The effect on HMO and individual plans would be greater to the extent that there is very limited coverage for mental illnesses currently. Because there is no requirement that an individual have insurance coverage, if the policies become too expensive, especially for those not using the benefits, they may simply drop the coverage leaving fewer and often sicker individuals to spread the risk.

For group plans that cover mental illnesses at current mandated levels, Blue Cross Blue Shield estimates that this proposed mandate would increase the monthly cost per individual contract by around $5 and family coverage by $12-14. Monthly premiums for small group policies are estimated to increase from $6.96 - $10.18 per individual and $19.09 - $25.44 per family. The Healthchoice individual product monthly premiums are estimated to increase on average across all available deductible options by $3.57 per individual and $7.85 per family. The amount of premium increase depends on the structure of benefits in the policy including deductibles, coinsurance and managed care measures.

BACKGROUND

The Joint Standing Committee on Banking and Insurance of the 117th Maine Legislature on March 27, 1995, directed the Bureau of Insurance to review LD 595 "An Act Regarding Insurance Coverage for Mental Illness." The review was to be conducted using the criteria outlined in 24-A M.R.S.A. § 2752 regarding the social and financial impact of the proposed mandate, and the medical efficacy of the procedure covered under the proposal.

Current Mandate

Policies covering 20 or more employees (or members in the case of an association or trustee group) are required to provide a minimum level of mental health benefits. The small group and individual standardized plans also have a required level of mental health benefits. 1993 Public Law 441 effective January 1, 1994 modified the required levels of coverage for mental illness in group insurance contracts for certain listed conditions.

LD 595

LD 595 would extend the level of benefits for those listed conditions to provide coverage equal to that provided for medical treatment for physical illnesses. It would also apply this entire mental illness mandate to individual contracts, small group policies and Health Maintenance Organization (HMO) plans.

As written the bill repeals the exceptions in the existing mandate for small groups and CHAMPUS supplement coverage. CHAMPUS provides

coverage at civilian hospitals and doctors for military families and the supplements provide the additional coverage not paid for by CHAMPUS. While CHAMPUS does provide mental health benefits, to comply with this mandate the supplements would be required to cover in addition to the supplemental coverage benefits for mental illness not provided under CHAMPUS. There has been some difficulty convincing carriers providing this type of product to market in Maine because of mandates.

EVALUATION OF LD 595 BASED ON REQUIRED CRITERIA

SOCIAL IMPACT

A. The social impact of mandating the benefit which shall include:

1. The extent to which the treatment or service is utilized by a significant portion of the population;

The National Institute of Mental Health reports that approximately 15 percent of Americans over age 18 meet the diagnostic criteria for at least one mental disorder. The same studies estimate that over a lifetime one out of every three adults can expect to have a diagnosable mental disorder. According to a California psychiatric study, biological disorders that give rise to mental health benefits affected about 1% of the population. Important to note is that many people affected by mental illness are not in the insurance system and not affected by mandated benefits.

The proportion of claims for mental health treatment has remained relatively level, under 4% of the total health care claims in reports submitted to the Bureau of Insurance.

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

Maine residents utilize inpatient psychiatric services in a variety of settings including general hospitals, psychiatric hospitals, residential facilities, a veterans administration facility and various out-of-state facilities. Outpatient services are provided

by various providers including psychiatrists, licensed clinical social workers, psychologists and psychiatric nurses. Other professionals are licensed in Maine to treat mental illness but are currently not mandated to be reimbursed. These include marriage and family counselors, clinical professional counselors and pastoral counselors.

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

Policies covering 20 or more employees (or members in the case of an association or trustee group) are required to provide a minimum level of mental health benefits. 1993 Public Law 441 effective January 1, 1994 modified the required levels of coverage for mental illness in group insurance contracts for certain listed conditions. The small group and individual standardized plans offered by insurance companies and HMOs also have a required level of mental health benefits.

Individual, CHAMPUS supplement, small group and HMO health plans may provide some mental health coverage but in general are not at the same levels as mandated for large group policies. HMO Maine has stated that none of the products (except the statutory standardized plans) "currently marketed to any group size include either the existing mandated benefits for mental health services or the newly enacted benefits for organically-based mental illnesses."

4. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

Because of the current discrimination against those with mental illnesses appropriate diagnosis and treatment may carry a far greater personal cost for patients with these conditions than for those with other medical conditions. While the medical symptoms may be covered the underlying mental illness may go untreated because of the lack of coverage.

5. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

When benefit maximums are reached, the insured may be forced to take out loans, second mortgages, and use up savings to pay for treatment, or be placed into state services, where taxpayers pick up the tab. In addition to the financial difficulty of paying for treatment there are also lost wages from time away from work.

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

No information available.

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

The social stigma associated with diagnosis and treatment of a mental illness prevents many from voicing their need for coverage.

Demand for the mandate from mental health care providers is quite strong especially from the social workers and therapists that often provide the lower cost outpatient care.

8. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts;

No information available.

9. The likelihood of achieving the objectives of meeting the consumer need as evidenced by the experience of other states;

A summary of mandated coverage in other states is included in Appendix C. Most states only mandate mental health benefits for group policies.

New Hampshire recently passed legislation to require coverage by group contracts and HMO plans of "biologically based" mental illnesses under the same terms and conditions as for physical illness. These provisions were effective for contracts issued or renewed on or after January 1, 1995.

Virginia requires coverage for mental illness the same as other illnesses except inpatient treatment may be limited to 30 days per policy year. The mandate applies to group and individual policies for inpatient benefits but only for group policies for the outpatient benefit. They will be working on a mandated benefit report later this year on parity issues for mental illness.

Rhode Island effective January 1, 1995 requires every health care insurer to provide coverage for the medical treatment of serious mental illness under the same terms and conditions as other illnesses and diseases.

California has a mandated offering for group policies to cover specifically mentioned biologically based severe mental disorders the same as other disorders of the brain. Levels for other mental illnesses are negotiated between the group policyholder and insurer.

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;

Several options available to address the mental illness treatment needs were discussed in the MBAC's 1992 report. Among these were encouragement of the use of employee assistance programs (EAP) and various ways to alter the benefit limits. Absent insurance coverage of mental illnesses, use of public mental health systems, both inpatient and community-based services, will continue and may increase.

12. Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance;

This mandate proposes to cover certain listed conditions at the same levels as physical illnesses because they are organically-based diseases of the brain. The rationale is that it would be inconsistent to treat one organ of the body differently than another. Extending coverage to individual policies causes a conflict between the need to provide mental health care to society and the effect of increasing premiums to the point that individuals prefer to go uninsured.

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

Traditionally, mental illnesses were viewed as "different" from physical disorders. Causes were mysterious, cures rare and a social stigma was attached to victims. Often only the physical problems were treated neglecting the less tangible underlying problems. Recently there has been more public spending in this area, lessening stigma and an increase in practical treatment alternatives. Many insurance companies have not changed their coverage or procedures to deal with these changes. Fearing expensive costs for psychiatric care and regarding mental illness as a subjective disease, health insurers place special limitations on benefits, particularly on outpatient treatment.

Mental illness still carries a strong stigma, and some people are reluctant to admit publicly (or even privately) that they need or could potentially need in the future, treatment for mental illness. This prevents people from aggressively seeking coverage of mental illness reimbursement from insurers or employers benefit plans.

The Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guidelines for Depression states that the social stigma contributes to:

- Resistance of patients to seek treatment
- Reluctance of practitioners to look for and formally diagnose depressions.
- Poor adherence by patients during long-term treatment of more chronic forms of depression.
- Low reimbursement rates by third-party payors for these conditions.
- Inappropriate emphasis on depression and other psychiatric disorders on applications for driver's license, employment, security clearance and other "routine" purposes.

14. The impact of this benefit upon the availability of other benefits currently being offered; and

No input received.

15. The impact of the benefit as it relates to employers shifting to self-insurance plans.

In the Employee Benefit Plan Review's 1994 Group Accident and Health Survey, they stated that the prevalence of self funding, as shown in the volume of Administrative Services Only (ASO) contracts and minimum premium business, has remained relatively constant over the last seven years. The drop in self-funded plans over the past few years has been directly offset by a similar rise in managed care plans.

FINANCIAL IMPACT

B. The financial impact of mandating the benefit which shall include:

1. The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next five years;

Because mental health services are already covered by group plans and to a lesser extent individual plans, a significant increase is not expected.

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

Because individual policies are not currently required to cover mental illnesses there may be an increase in utilization if the mandate were enacted. It is not known to what extent inappropriate use would increase.

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

An anticipated benefit from improved insurance coverage of mental illness is decreased utilization of medical services for other illnesses and avoidance of more costly levels of care. Postponing

treatment can lead to the need for expensive and aggressive treatments.

It would seem that the current system may encourage utilization of more costly treatment. The outpatient cap may be exhausted rather quickly. Once exhausted, the insured pays the full cost of any additional visits. There may be some incentive to switch to the more expensive and intensive inpatient treatment if it is reimbursable at 100% by the policy.

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

Most health insurance plans have utilization review or managed care networks in place to control excessive or inappropriate care. The 1992 report by the Mandated Benefits Advisory Commission on Mental Health stated that from data provided by medical doctors at Milliman & Robertson, it appears that a properly run managed care mental health care program, operating within the limits of Maine's mandated benefits law, could provide mental health coverage at a fraction of the current cost of an unmanaged program.

The proposed mandate allows the insurer to request from the provider data substantiating that initial or continued treatment is medically necessary and appropriate. The same criteria used for physical illnesses is to be used for mental illnesses. This provision is similar to one used by California.

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

In general, the number of providers of a service increases with the availability of reimbursement for that service.

6. The extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

One way to estimate the financial impact of mandating mental health benefits is to compare the cost of the benefits provided by insurers in Maine for mental health benefits to the total cost of all medical benefits. Appendix B presents figures submitted by insurers to the Bureau of Insurance each year from 1984 through 1994. They show the mental health claims as a percentage of the total claims. The percent of claims for mental health treatment has remained relatively level, under 4% of the total health care claims in reports submitted to the Bureau of Insurance. Data is presented separately for Blue Cross Blue Shield & BAMICO and for all other companies.

1993 Public Law 441 raised the required levels of coverage for listed organically-based mental illnesses in certain group insurance contracts. Because this mandate applied to policies issued or renewed on or after January 1, 1994, the claims data does not reflect a full year of increased coverage for these conditions. In general, the claims data provided to the Bureau is reported as claims paid, not incurred, so to the extent that there is some lag time in 1994 claims being reported and paid they may not be reflected in the 1994 figures.

There has been difficulty in obtaining relevant data from Blue Cross to determine the increase in claims paid due to the increased level of benefits under Public Law 441. Data reported either did not include the total organically-based illness claims or was reported on a claims incurred basis, thus not allowing a direct comparison to previous years' reports. Data for 1994 in Appendix B reflects claims incurred for all mental illnesses except that BAMICO data is incomplete for organically-based illnesses. Given the inconsistencies with the data reported, the ratio of mental illness claims to total group claims showed an increase from 2.42% in 1993 to 3.96% in 1994.

Absent accurate data from Blue Cross, it would seem that data from other carriers doing business in Maine would be helpful. The ratio of mental illness claims to total group claims from 1993 to 1994 for all these companies combined decreased from 4.1% to 3.6%. However this may reflect differences in the mix of companies reporting. For individual companies, the change in ratio varied from increases of 2.7% to decreases of 15.3% for the 20 companies reporting in both years. These companies together do not represent as large a portion of the market as does Blue Cross, so the numbers are not as credible as those from Blue Cross would have been.

For group plans that cover mental illnesses at current mandated levels, Blue Cross Blue Shield estimates that this proposed mandate would increase the monthly cost per individual contract by around $5 and family coverage by $12-14 depending on the type of coverage offered for physical illnesses. Monthly premiums for small group policies are estimated to increase for the full service plans by $10.18 per individual and $25.44 per family, and the CompCare plan with a $200 deductible $6.96 per individual and $19.09 per family.

The Healthchoice individual product monthly premiums would be estimated on average across all available deductible options to increase by $3.57 per individual and $7.85 per family.

Given that premiums for individual policies are already high and more than many consumers can afford, this may cause more individuals to drop coverage, especially the healthy and young. As more people drop their coverage the number of insureds over which to spread the risk would be reduced and cause further increases in premiums.

7. The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

Consequences of avoiding mental illness treatments include excessive losses both in the workplace and in the expenditure of public funds.

8. The impact of this coverage on the total cost of health care; and

The preface to a December 1979 issue of Medical Care, an Official Journal of the Medical Care Section, American Public Health Association, mentioned a hypothesis that the effect of treatment of alcoholism, drug abuse and mental illness (ADM) results in a subsequent reduction in treatment for other health disorders. "If such a reduction can be demonstrated, it would be reasonable to expect some lowering of costs in the general health care sector." The publication goes on to state that while numerous studies exist to confirm this hypothesis there were significant limitations in

the design, methodologies and settings of the studies. It suggested that future studies could improve upon those done previously. While no definite conclusion can be made about the impact on the total cost of health care in this report, the topic continues to be examined by other states and research groups.

9. The effects on the cost of health care to employers and employees, including the financial impact on small employers, medium-sized employers, and large employers.

Currently small employer plans are not required to cover mental health benefits. This bill would extend the same requirements of large employer plans to small employers. In general, small firms in highly competitive markets may be particularly adversely affected by legislated increases in costs. High premiums prevent employers from offering group coverage to their employees.

MEDICAL EFFICACY

C. The medical efficacy of mandating the benefit which shall include:

1. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

Numerous studies have shown benefits of treatment for mental illnesses for the health status of the population. The

recommendation to require coverage for the listed mental illnesses at the same levels as physical illnesses is based on the reasoning that they are diseases of the brain, another organ of the body. The AHCPR Clinical Practice Guidelines for Depression states that once identified, depression can almost always be treated successfully, either with medication, psychotherapy, or a combination of both. The cost of illness in pain, suffering, disability, and death is high if not treated.

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

Not applicable.

a. The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

Not applicable.

b. The methods of the appropriate professional organization that assure clinical proficiency.

Not applicable.

BALANCING THE EFFECTS

D. The effects of balancing the social, economic, and medical efficacy considerations which shall include:

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders; and

The AHCPR Clinical Practice Guidelines for Depression states that given the strong evidence that treatments are effective, third-party coverage for the diagnosis and treatment of depression should be equal to that available for other medical disorders. On the other hand because there is no requirement that an individual have insurance coverage, if the policies become too expensive, especially for those not using the benefits, they will simply drop the coverage leaving fewer and often sicker individuals to spread the risk.

Private insurance may decrease state expenditures by covering those patients now served in state facilities, or providing the means for these patients to seek care elsewhere. Public services are then made available only to those who cannot pay because of inadequate resources, not to those whose insurance plan has chosen not to cover the services. This mandate makes private options for financing mental health care more available for those persons who can pay. This is one way to assure that state mental health resources are utilized by persons who have no other options. This assumes that individuals have insurance coverage.

Mental health care can prevent many costly physical conditions and reduce costs in treating such ailments.

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

Traditionally, group policyholders do not view mandated offerings as desirable unless they are pressured by their certificate holders. Therefore, only those groups which contain members who have a high probability of utilizing the service are likely to request coverage. This would lead to higher premiums for the coverage because the risk would not be spread over as many covered individuals, and those with coverage are more likely to utilize the service. In addition, because of the strong social stigma attached to mental illness it is unlikely that certificate holders would pursue coverage with an employer.

For individual coverage, it would seem that severe antiselection would make the premiums excessively high: that is, only those who are likely to need the service would purchase coverage. Mental illness is a condition that an individual will typically deny having until treatment is desperately needed and it is too late to purchase coverage.

APPENDIX A

LD 595

Charge to the Bureau

State of Maine

One Hundred and Seventeenth Legislature

COMMITTEE ON BANKING AND INSURANCE

March 27, 1995

Mrs. Marti Hooper
Senior Insurance Analyst
Life & Health Division
Bureau of Insurance
State House Station 34
Augusta, Maine 04333

Dear Mrs. Hooper:

24-A MRSA § 2752 requires the Joint Standing Committee on Banking and Insurance 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. Pursuant to that statute, we request the Bureau prepare a review and evaluation of the following proposal:

LD 595 - An Act Regarding Insurance Coverage for Mental Illness.

A copy of the bill is enclosed. Please prepare the evaluation using the guidelines set out in 24-A MRSA § 2752 and submit the report to the committee before June 1, 1995 if possible. If you have any questions, please feel free to contact either one of us.

Sincerely,

I. Joel Abromson
Senate Chair

Marc J. Vigue
House Chair

BAN/cmm

117th MAINE LEGISLATURE

FIRST REGULAR SESSION-1995

Legislative Document No. 595

H.P. 432 House of Representatives, February 17, 1995

An Act Regarding Insurance Coverage for Mental Illness.

(EMERGENCY)

Reference to the Committee on Banking and Insurance suggested and ordered printed.

Joseph W. Mayo

JOSEPH W. MAYO, Clerk

Presented by Representative DORE of Auburn.
Cosponsored by Representatives: ADAMS of Portland, CAMERON of Rumford, CHASE of China, ETNIER of Harpswell, FITZPATRICK of Durham, GERRY of Auburn, GWADOSKY of Fairfield, JOSEPH of Waterville, KERR of Old Orchard Beach, MITCHELL of Vassalboro, MITCHELL of Portland, MORRISON of Bangor, SIMONEAU of Thomaston, WATSON of Farmingdale, Senators: ABROMSON of Cumberland, BERUBE of Androscoggin, McCORMICK of Kennebec, PARADIS of Aroostook, PINGREE of Knox, RAND of Cumberland.

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, mental illness affects many of the State's citizens each year, causing pain among its victims and their families; and

Whereas, the risk of mental illness can be insured at reasonable cost; and

Whereas, health insurance coverage for the treatment of mental illness can be comparable to coverage for the treatment of other physical illnesses; and

Whereas, the laws that provide for parity of benefits for the treatment of mental illness are repealed July 1, 1995; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

Sec. 1. 24 MRSA §2325-A, sub-§5-A, as amended by PL 1989, c. 490, §1, is repealed.

Sec. 2. 24 MRSA §2325-A, sub-§5-C, as amended by PL 1993, c. 586, §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:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Childhood schizophrenia;

(5) Psychotic depression, or involutional melancholia;

(6) Paranoia;

(7) Panic disorder;

(8) Obsessive-compulsive disorder; or

(9) Major depressive disorder.

B. All policies and certificates executed, delivered, issued for delivery, continued or renewed in this State on and after July 1, 1995 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 the nonprofit hospitals and medical service organizations, providers 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.

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. 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 illness 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 in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Human Services or 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 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.

E. "Provider" means any individual included in Title 24, section 2303, subsection 2 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 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 insurer that issues individual health care policies providing coverage for hospital care to residents of this State shall provide benefits required in this section to any subscriber or other person covered under those policies for conditions arising from mental illness.

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

A. Inpatient care;

B. Day treatment services; and

C. Outpatient services.

6. 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 policies must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Childhood schizophrenia;

(5) Psychotic depression, or involutional melancholia;

(6) Paranoia;

(7) Panic disorder;

(8) Obsessive-compulsive disorder; or

(9) Major depressive disorder.

B. All policies 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 policies 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 the reimbursing insurers, all providers 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.

7. 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.

8. Limits; coinsurance; deductibles. Any 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.

9. Reports to the Superintendent of Insurance. 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 be must 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 between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

10. Application; expiration. Except as otherwise provided, the requirements of this section apply to all policies executed, delivered, issued for delivery, continued or renewed in this State on and after July 1, 1995. For purposes of this section, all policies are deemed renewed no later than the next yearly anniversary of the contract date.

Sec. 6. 24-A MRSA §2843, sub-§5-A, as amended by PL 1989, c. 490, §4, is repealed.

Sec. 7. 24-A MRSA §2843, sub-§5-C, as amended by PL 1993, c. 586, §3, 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:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Childhood schizophrenia;

(5) Psychotic depression, or involutional melancholia;

(6) Paranoia;

(7) Panic disorder;

(8) Obsessive-compulsive disorder; or

(9) Major depressive disorder.

B. All policies and certificates executed, delivered, issued for delivery, continued or renewed in this State on and after July 1, 1995, 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 treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than coverage provided for medical treatment for physical illnesses.

(2) At the request of the reimbursing insurers, all providers 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.

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.

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 in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Human Services or 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 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.

E. "Provider" means any individual included in Title 24, section 2303, subsection 2 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 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 shall provide, at a minimum, the following benefits for a person suffering from a mental or nervous condition:

A. Inpatient care;

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 individual and group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Childhood schizophrenia;

(5) Psychotic depression, or involutional melancholia;

(6) Paranoia;

(7) Panic disorder;

(8) Obsessive-compulsive disorder; or

(9) Major depressive disorder.

B. All policies and certificates 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 treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than benefits provided for any other type of medical treatment for physical illnesses.

(2) At the request of reimbursing health maintenance organizations, all providers 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.

7. Contracts; providers. Subject to approval by the Superintendent of Insurance pursuant to section 4204, a health maintenance 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.

8. Limits; coinsurance; deductibles. Any 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.

9. Reports to the Superintendent of Insurance. 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 between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all health maintenance organizations in an annual report.

10. Application; expiration. Except as otherwise provided, the requirements of this section apply to all policies and any certificates executed, delivered, issued for delivery, continued or renewed in this State on and after July 1, 1995. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect when approved.

STATEMENT OF FACT

This is an emergency bill that amends mental illness benefits provisions of group health insurance laws. The bill requires that all group health insurance policies in the State

provide coverage for certain mental illnesses at the same level as coverage for medical treatment for physical illnesses.

The bill also requires insurers who offer individual insurance policies and health maintenance organizations to provide the same benefits for medical treatment for mental illness as for all group health insurance policies.

APPENDIX B

Claims Experience Summary

Mandated Benefits Chart

	MANDATED BENEFITS AS A PERCENTAGE OF TOTAL BENEFITS										
TYPE OF CLAIMS\YEAR	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994•
	ALL COMPANIES										
SUBSTANCE ABUSE	0.61%•	1.35%	1.82%	1.74%	1.78%	1.55%	1.37%	1.11%	0.81%	0.68%	0.42%
MENTAL ILLNESS	1.57%•	2.41%	3.08%	3.10%	3.59%	3.53%	3.29%	3.70%	3.09%	2.90%	3.87%
	BLUE CROSS/BLUE SHIELD AND BAMICO										
SUBSTANCE ABUSE	0.28%•	1.24%	1.62%	1.47%	1.77%	1.47%	1.21%	1.09%	0.78%	0.53%	0.29%
MENTAL ILLNESS	0.70%•	2.07%	2.76%	2.84%	3.41%	3.13%	2.88%	3.53%	2.92%	2.42%	3.96%
	ALL OTHER										
SUBSTANCE ABUSE	1.81%•	1.72%	1.82%	1.46%	1.81%	1.71%	1.77%	1.16%	0.90%	1.03%	0.78%
MENTAL ILLNESS	4.76%•	3.53%	3.92%	3.81%	4.04%	4.29%	4.34%	4.17%	3.66%	4.08%	3.64%
	PROPORTION OF SUBSTANCE ABUSE CLAIMS										
	REPRESENTED BY INPATIENT AND OUTPATIENT										
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
	ALL COMPANIES										
INPATIENT	92.14%	93.01%	91.52%	90.74%	87.91%	85.13%	80.92%	78.36%	71.15%	70.39%	68.65%
OUTPATIENT	7.86%	6.99%	8.48%	9.26%	12.09%	14.87%	19.08%	21.64%	28.85%	29.61%	31.35%
	BLUE CROSS/BLUE SHIELD AND BAMICO										
INPATIENT	98.07%	94.16%	92.35%	91.44%	88.55%	84.89%	80.57%	77.37%	69.65%	63.28%	64.00%
OUTPATIENT	1.93%	5.84%	7.65%	8.56%	11.45%	15.11%	19.43%	22.63%	30.35%	36.72%	36.00%
	ALL OTHER										
INPATIENT	88.79%	90.24%	89.40%	88.60%	86.32%	85.52%	81.54%	80.95%	75.59%	79.36%	73.31%
OUTPATIENT	11.21%	9.76%	10.60%	11.40%	13.68%	14.48%	18.46%	19.05%	24.41%	20.64%	26.69%
	PROPORTION OF MENTAL ILLNESS CLAIMS										
	REPRESENTED BY INPATIENT AND OUTPATIENT										
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
	ALL COMPANIES										
INPATIENT	50.76%	59.25%	52.34%	57.13%	52.79%	52.10%	54.71%	53.84%	50.36%	51.08%	53.51%
DAY TREATMENT	1.09%	0.36%	0.91%	0.68%	0.74%	2.85%	2.72%	8.55%	0.21%	2.69%	2.99%
OUTPATIENT	48.13%	40.39%	46.75%	42.18%	46.48%	45.05%	42.57%	37.61%	49.44%	46.23%	43.50%
	BLUE CROSS/BLUE SHIELD AND BAMICO										
INPATIENT	40.08%	54.51%	49.96%	55.02%	50.53%	51.74%	52.09%	52.09%	51.64%	49.16%	54.36%
DAY TREATMENT	0.00%	0.10%	0.12%	0.07%	0.03%	0.09%	0.03%	9.16%	0.02%	0%	0.01%
OUTPATIENT	59.92%	45.39%	49.92%	44.91%	49.44%	48.17%	47.89%	40.98%	48.34%	50.84%	45.62%
	ALL OTHER										
INPATIENT	56.49%	68.51%	56.69%	61.72%	57.63%	52.59%	59.28%	63.22%	46.66%	53.64%	50.93%
DAY TREATMENT	1.67%	0.88%	2.34%	2.00%	2.25%	6.64%	7.41%	7.13%	0.72%	6.54%	11.82%
OUTPATIENT	41.84%	30.61%	40.97%	36.28%	40.12%	40.77%	33.31%	29.65%	52.42%	39.62%	37.25%

• Mandate in effect for only part of the year

♦ Blue Cross data on incurred basis not paid basis as for previous years. BAMICO data not complete.

	Group Health Insurance Claims in Maine 1993										
	Total Group			Alcoholism/Drug Dependency		Mental Health(Non-Alcohol or Drug Related)			Totals		
Company	Inpatient	Day Treatment	Outpatient	Inpatient	Outpatient	Inpatient	Day Treatment	Outpatient	Total Group	Alcohol/Drug	Mental Health
AETNA LIFE	$7,670,982	$4,307,183	$5,766,093	$121,842	$32,607	$285,023	$31,464	$271,167	$17,744,258	$154,449	$587,654
AMERICAN NATIONAL	$213,826	$50,587	$94,356	$0	$0	$0	$0	$0	$358,769	$0	$0
BAMICO	$18,700,689	$0	$25,349,540	$1,141	$10,396	$103,500	$0	$71,331	$44,050,229	$11,537	$174,831
BCBS	$107,286,471	$2,970,791	$142,460,354	$1,003,496	$572,599	$3,425,003	$178	$3,577,826	$252,717,616	$1,576,095	$7,003,007
BOSTON MUTUAL	$2,718	$0	$11,173	$0	$0	$0	$0	$500	$13,891	$0	$500
CELTIC	$35,433	$0	$30,246	$0	$0	$0	$0	$0	$65,679	$0	$0
CIGNA	$12,186,886	$0	$12,107,224	$203,619	$33,486	$740,389	$0	$533,060	$24,294,110	$237,105	$1,273,449
CONTINENTAL ASSURANCE	$7,807,015		$9,995,282	$90,113	$44,092	$262,424	$0	$223,765	$17,802,297	$134,205	$486,189
CUNA MUTUAL				$0	$1,228	$3,475		$4,699	$316,846	$1,228	$8,174
DURHAM LIFE	$66,656	$0	$24,847	$0	$0	$0	$0	$49	$142,103	$0	$49
FORTIS	$106,334	$0	$129,964	$0	$0	$0	$0	$6,382	$236,299	$0	$6,382
GREAT WEST LIFE	$239,880	$74,964	$158,190	$1,100	$256	$0	$0	$82,341	$473,034	$1,356	$82,341
GUARDIAN LIFE	$1,091,614	$0	$864,879	$1,148	$38,458	$44,511	$0	$18,625	$1,956,493	$39,606	$63,136
JOHN HANCOCK	$419,508	$0	$332,979	$9,806	$1,496	$3,957	$0	$7,296	$782,487	$11,302	$11,253
LIBERTY LIFE ASSURAN	$1,649,788		$948,909	$0	$0	$240		$3,592	$2,598,697	$0	$3,832
LIFE INVESTORS	$5,066	$0	$3,831						$8,897		
LINCOLN NATIONAL	$62,599		$144,109	$0	$801	$9,869		$832	$206,708	$801	$10,701
MASS MUTUAL	$1,040,447		$1,681,572	$12,091	$4,392	$118,835		$62,658	$2,722,019	$16,483	$181,493
METROPOLITAN LIFE	$27,915	$0	$3,267	$27,243	$0	$0	$0	$74	$31,182	$27,243	$74
MONUMENTAL LIFE	$18,431	$0	$104,001					$1,851	$122,432		$1,851
MUTUAL OF OMAHA	$1,214,614		$954,601	$0	$1,181	$0		$769	$2,169,215	$1,181	$769
NEW ENGLAND MUTUA	$254,035	$44,730	$168,544	$4,171	$0	$0	$0	$66,060	$467,309	$4,171	$66,060
NEW YORK LIFE	$4,318,257		$4,952,820	$117,944	$42,276	$244,581		$156,595	$9,271,077	$160,220	$401,176
NORTHWESTERN NATIONAL	$607,558		$632,357	$193,788	$13,030	$169,099		$76,480	$1,239,915	$206,818	$245,579
PAYPOWER-FIDELITY SECURITY	$339,009		$229,809	$140,965	$26,562	$198,044		$203,247	$13,491,958	$167,527	$401,291
PFL	$329,126		$190,540	$15,159	$92	$34,096		$10,986	$519,666	$15,251	$45,081
PHOENIX HOME LIFE	$15,722	$0	$74,799	$0	$239	$0	$0	$1,096	$90,521	$239	$1,096
PRINCIPAL MUTUAL	$97,348		$251,044	$0	$390	$266		$23,102	$348,392	$390	$23,368
PROTECTIVE	$970,908	$260,644	$608,380	$325	$1,512	$18,238	$267	$24,526	$1,839,932	$1,837	$43,031
PROVIDENT	$68,627	$36,579	$33,043	$882	$213	$3,354	$1,703	$161	$138,249	$1,095	$5,218
PRUDENTIAL	$1,228,180		$2,387,832	$4,745	$19,441	$6,884		$119,700	$3,616,012	$24,186	$126,584
STATE FARM	$93,774	$0	$192,997	$0	$235	$0	$0	$8,462	$286,771	$235	$8,462
STATE MUTUAL	$6,009,439		$3,918,087	$43,897	$14,681	$227,961	$0	$201,032	$9,927,526	$58,578	$428,993
TIME	$645,924	$0	$927,617	$17,586	$3,309	$8,129	$0	$8,773	$1,573,541	$20,895	$16,902
TRAVELERS	$9,357,128	$5,158,111	$4,829,349	$55,180	$3,537	$476,396	$324,859	$32,435	$19,344,589	$58,717	$833,691

	Group Health Insurance Claims in Maine 1993										
	Total Group			Alcoholism/Drug Dependency		Mental Health(Non-Alcohol or Drug Related)			Totals		
Company	Inpatient	Day Treatment	Outpatient	Inpatient	Outpatient	Inpatient	Day Treatment	Outpatient	Total Group	Alcohol/Drug	Mental Health
UNITED OF OMAHA	$29,515		$110,227	$0	$42	$0		$1,453	$139,742	$42	$1,453
US LIFE	$3,789,598		$1,982,983	$59,312	$8,934	$117,891		$97,818	$5,772,581	$68,246	$215,709
TOTALS	$180,330,038	$8,596,406	$216,689,753	$2,003,710	$842,879	$6,217,142	$327,007	$5,627,575	$419,136,784	$2,846,589	$12,171,725

Group Health Insurance Claims in Maine 1994

	Total Group			Alcoholism/Drug Dependency		Mental Health(Non-Alcohol or Drug Related)			Totals		
Company	Inpatient	Day Treatment	Outpatient	Inpatient	Outpatient	Inpatient	Day Treatment	Outpatient	Total Group	Alcohol/ Drug	Mental Health
AETNA LIFE	$7,035,500	$4,285,148	$5,347,538	$113,077	$27,222	$334,052	$32,325	$228,859	$16,668,186	$140,299	$595,236
BAMICO	$15,537,459	$0	$21,262,766	$1,343	$10,776	$9,861	$0	$57,077	$36,800,225	$12,120	$66,937
BCBS	$118,822,019	$2,050,581	$160,555,468	$587,630	$320,485	$6,840,834	$839	$5,689,088	$281,428,068	$908,115	$12,529,922
CELTIC	$540	$0	$3,444	$0	$0	$0	$0	$0	$3,984	$0	$0
CONNECTICUT GENER	$9,178,457	$0	$11,306,491	$127,251	$22,844	$369,643	$0	$447,947	$20,484,948	$150,095	$817,590
CONTINENTAL ASSURANCE	$7,831,211		$9,948,476	$53,219	$23,128	$251,738		$207,293	$17,779,687	$76,347	$459,031
CUNA MUTUAL	$219,385		$213,837	$0	$2,010	$4,790		$9,117	$433,212	$2,010	$13,907
FORTIS	$35,921	$0	$79,010	$8,740	$0	$784	$0	$5,458	$114,932	$8,740	$6,242
GREAT WEST LIFE	$258,603	$82,538	$155,797	$19,820	$266	$18,341	$0	$3,896	$496,940	$20,086	$22,237
GUARDIAN LIFE	$1,650,178	$489	$1,507,825	$35,230	$49,276	$20,910	$489	$48,282	$3,158,493	$84,506	$69,681
JOHN HANCOCK	$470,908	$0	$370,393	$4,130	$200	$766	$0	$9,451	$841,301	$4,330	$10,217
LINCOLN NATIONAL	$2,254		$72,370	$0	$0	$0	$0	$0	$74,624	$0	$0
MASS MUTUAL	$548,809		$1,425,377	$7,874	$3,419	$66,415		$58,322	$1,974,186	$11,293	$124,737
NEW YORK LIFE	$7,437,901		$8,225,379	$68,470	$19,839	$432,764		$40,613	$15,663,279	$88,309	$473,377
NORTHWESTERN NATIONAL	$599,185	$1,347	$670,852	$5,584	$4,942	$38,011	$43	$18,782	$1,270,037	$10,526	$56,793
PAYPOWER-FIDELITY SECURITY				$72,612	$30,106	$133,975		$227,229	$10,987,608	$102,718	$360,904
PFL	$937,202		$822,659	$18,511	$5,821	$25,168		$40,834	$1,759,862	$24,332	$66,002
PRINCIPAL MUTUAL	$456,574		$634,221	$9,377	$4,928	$21,650		$51,090	$1,090,794	$14,305	$72,740
PROTECTIVE LIFE	$610,040	$219,756	$548,553	$19,711	$2,253	$21,912	$1,126	$31,125	$1,378,349	$21,964	$54,163
PROVIDENT	$59,433	$27,291	$27,010	$187	$80	$4,527	$1,535	$85	$113,734	$267	$6,147
PRUDENTIAL	$1,204,035	$0	$3,568,179	$6,407	$44,109		$0	$84,950	$4,772,214	$50,516	$85,412
STATE FARM											
STATE MUTUAL	$7,680,369		$5,529,353	$54,955	$20,250	$251,912		$248,741	$13,209,722	$75,205	$500,653
TIME	$354,055	$0	$843,518	$14,061	$2,087	$22,086	$0	$12,075	$1,197,573	$16,148	$34,161
TRAVELERS	$9,740,644	$5,180,725	$5,249,578	$146,215	$9,173	$483,651	$500,086	$41,037	$20,170,947	$155,388	$1,024,774
UNITED OF OMAHA											
UNUM	$5,388		$1,240						$6,628		
US LIFE	$6,669,070		$5,030,906	$120,312	$11,470	$87,320		$238,037	$11,729,982	$131,782	$325,357
TOTALS	$183,640,570	$7,562,727	$233,021,796	$1,261,328	$575,992	$9,019,738	$504,118	$7,332,492	$435,211,346	$1,837,320	$16,855,627

* Blue Cross Data is reported on incurred basis not claims paid as done in previous years. BAMICO data is not complete.

APPENDIX C

States With Mandates

MANDATED BENEFITS:

TREATMENT OF MENTAL ILLNESS

State	Citation	Summary
AR	§ 23-86-113 (group) (1983/1985)	Coverage with at least specified minimum benefits unless refused by insured.
CA	§§ 10125 (group) (1983/1990); 11512.5 (nonprofits) (1983/1990)	Mandated offering of coverage.
CO	§§ 10-16-104 (group) (1992/1993)	Mandated coverage with at least specified minimum benefits in every group contract. copayment may not differ from that established for other conditions.
CT	§ 38a-514 (group) (1971/1992)	Mandated coverage with at least specified minimum benefits in every group contract.
DC	§§ 35-2302, 35-2304 (1987/1992)	Mandated coverage with at least specified minimum benefits in every group contract.
FL	§ 627.668 (group) (1976/1992)	Every group or prepaid contract must offer coverage for mental illness to levels specified.
GA	§ 33-24-28.1 (1981/1989)	Mandated offering of coverage for treatment of mental disorders to the same extent as treatment for physical illnesses.
ID	HB 61 (1994)	Workers compensation benefits will be paid for psychological injuries incurred as a result of a physical workplace accident. Eff. 7-1-94
IL	215 ILCS 5/370c (group) (1979/1990)	Every group or prepaid contract must offer coverage for mental illness to levels specified.
KS	§ 40-2,105 (1977/1986)	Every policy must include coverage with at least specified minimum benefits.
KY	§ 304.17-318 (1986)	Mandated offering of coverage at least that offered for physical illness.
LA	§ 22:669 (group) (1981/1985)	Group plans must include option to purchase coverage same as for physical illness.
ME	24 § 2325-A (nonprofits) (1983/1989) 24-A § 2843 (group) (1983/1992)	Mandated coverage with at least specified minimum benefits in certain group contracts.
MD	Art. 48A § 477E (group) (1973/1991)	Every policy must include coverage with at least specified minimum benefit.
MA	c.175 § 47B (1973/1991)	Every policy must include coverage with at least specified minimum benefit.
MN	§ 62A.152 (group) (1975/1993)	Mandated coverage with at least specified minimum benefits in every group contract.
MS	§ 83-9-39 (1991)	Mandated offering of coverage.
MO	§ 376.381 (1980)	Mandated offering of coverage with at least specified minimum benefit.
MT	§ 33-22-701 to § 33-22-705 (group) (1979/1987)	Mandated coverage with at least specified minimum benefits in every group contract.

MANDATED BENEFITS:

TREATMENT OF MENTAL ILLNESS

State	Citation	Summary
NH	§§ 415:18-a (group) (1975/1992); 419:5-a, 420:5-a (service corps.) (1975/1992)	Mandated coverage with at least specified minimum benefits in every group contract.
	§ 417-E:1	Cover "biologically based" mental illness under the same terms and conditions as for other types of health care for physical illness. Includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.
NY	§ 3221(l)(5)(A) (group) (1991/1992)	Every group or prepaid contract must offer coverage for mental illness to levels specified.
ND	§ 26.1-36-09 (group) (1985/1993)	Mandated coverage with at least specified minimum benefits in every group contract.
OR	§ 743.556 (group) (1987/1991)	Group policy shall provide coverage the same as for other illness.
SC	§ 38-71-737	Group policy must have been offered rider for psychiatric benefits with minimum of $2000 coverage per member per benefit year. Includes mental and nervous conditions and other psychiatric disorders described in referenced material.
TN	§ 56-7-1003 (1974/1992)	Coverage with specified minimum benefits in all group policies unless refused by insured.
TX	art. 3.51-14 (group) (1991)	Must offer benefits at least as favorable as coverage for other services and benefits.
VT	Tit. 8 § 4089 (group) (1975/1989)	Mandated offering of coverage in group policies at least equal to minimums specified.
VA	§ 38.2-3412.1 (1993)	Mandated coverage same as other illness except may be limited to 30 days per policy year.
WA	§ 48.21.240 (group) (1983/1987)	Mandated offering of coverage in group policies at least equal to minimums specified.
WV	§ 33-16-3a (group) (1977)	Mandated offering of coverage with at least specified minimum benefits.
WI	§ 632.89 (group) (1975/1993)	Mandated coverage with at least specified minimum benefits in every group contract.

State	Citation	Summary
AR	§ 23-86-113 (group) (1983/1985)	Mandated coverage (unless refused by insured) meeting the following minimum requirements: • Copayment requirement shall not exceed 20%. • Insurer may not impose limits on benefits with regard to deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization which differ from benefits for any other condition or illness, provided such insurer or hospital and medical service corporation may impose an annual maximum benefit payable which shall not be less than $7,500 per calendar year.
CA	§§ 10125 (group) (1983/1990); 11512.5 (nonprofits) (1983/1990)	Mandated offering of coverage meeting the following minimum requirements: • Group policies must include coverage for the treatment of the specifically mentioned biologically based severe mental disorders on the same terms and conditions as treatment of other disorders of the brain. Insurer may reserve the right to confirm diagnoses and review appropriateness of treatment plans. • Coverage for treatment of other mental and nervous disorders are covered under the terms and conditions agreed upon between the group policyholder and insurer and shall be offered to the group policyholder.
CO	§ 10-16-104 (5) (group) (1992/1993)	Mandated coverage in every group contract meeting the following minimum requirements: • Inpatient benefits shall be payable for at least 45 days in any 12 month period. • Partial hospitalization benefits shall be payable for at least 90 days in any 12 month period. • Each two days of partial hospitalization shall reduce by one day the 45 days of inpatient coverage; each day of inpatient shall reduce by two days the 90 days of partial hospitalization. • Each day of confinement as an inpatient or two days of partial hospitalization shall reduce by one day the total days available for all other illnesses during one 12 month period. • Each day of inpatient care or two days of partial hospitalization shall reduce by one day coverage available for alcohol treatment. • Outpatient benefits shall be payable for treatment at least once every 90 days in any 12 month period. • Copayment and deductibles may not differ from that established for other conditions; copayment requirement may not exceed 50%. • Aggregate benefits may be limited to $1,000 in any 12 month benefit period.

CT	§ 38a-514 (group) (1971/1992)	Mandated coverage meeting the following minimum requirements: • Inpatient benefits shall be payable for at least 60 days in any calendar year. • Partial hospitalization benefits shall be payable for at least 120 sessions in any calendar year. If cost per session does not exceed 50% of cost of inpatient session, the session shall equal two partial sessions. If cost exceeds 50%, each session shall equal one inpatient session. • Major medical shall have a rate of 50% for covered expenses (not inpatient) and benefits shall be available up to a maximum of $2,000 per calendar year; additional benefits available upon request up to a maximum of $2,000.
DC	§§ 35-2302 and 35-2304 (1987/1992)	Mandated coverage in every group contract meeting the following minimum requirements: • Inpatient/ residential care benefits shall be payable for a minimum of 45 days per year. • Outpatient benefits shall provide coverage with a minimum rate of 75% for the first 40 visits per year and a rate of 60% for any visit thereafter per year. • Lifetime payment shall have a limit of not less than $80,000 or one third of lifetime maximum for physical illness (whichever is greater) .
FL	§ 627.688 (group) (1976/1992)	Mandated offering of coverage in every group or prepaid contract meeting the following minimum requirements: • Benefits shall not be less favorable than physical illness; however, if treatment goes beyond specified limit, benefits need not be the same as physical. • Inpatient benefits shall be payable for not less than 30 days/ benefit year. • The total partial hospitalization benefits shall not exceed the cost of 30 days of inpatient hospitalization. • The total outpatient benefits paid may be limited to $1,000 for consultation.
GA	§ 33-24-28.1 (1981/1989)	Mandated offering of coverage meeting the following minimum requirements: • Benefits are to be to the same extent as treatment for physical illnesses. Individual policies: • Inpatient: Insurer is not required to cover more than a maximum of 30 days per policy year: • Outpatient: Insurer is not required to cover more than a maximum of 48 visits per policy year. Group: • Inpatient: Insurer is not required to cover more than a maximum of 60 days per policy year. • Outpatient: Insurer is not required to cover more than a maximum of 50 visits per policy year.

IL	215 ILCS 5/370c (group) (1979/1990)	Mandated offering of coverage in every group or prepaid contract meeting the following minimum requirements: • Coverage shall be the same as other conditions or disorders. • Insured may be required to pay up to 50% of expenses incurred. • The annual benefit limit may be limited to $10,000 or 25% of the lifetime policy limit, whichever is lesser.
KS	§ 40-2, 105 (1977/1986)	Mandated coverage meeting the following minimum requirements: • Inpatient benefits covering not less than 30 days per year. • Outpatient benefits covering not less than 100% of the first $100, 80% of the next $100, and 50% of the next $1,640 in any year; limited to not less than $7,500 in such person's lifetime.
KY	§ 304.17-318 (1986)	Mandated offering of coverage providing at least that offered for physical illness (minimum).
LA	§ 22:669 (group) (1981/1985)	Mandated offering of coverage in group plans that include option to purchase coverage same as for physical illness (minimum).
ME	24 § 2325-A (nonprofit) (1983/1989) 24-A § 2843 (group) (1983/1992)	Mandated coverage in group contract meeting the following minimum requirements: Groups with more than 12 employees shall provide: • Inpatient: minimum of 60 days; • Outpatient: minimum of $2,000 covered at least 50%; • Lifetime: Maximum benefit of at least $100,000. Illnesses/disorders covered are specifically listed. • Groups with more than 20 employees shall provide coverage for inpatient, day treatment and outpatient services, and may contain provisions for maximum benefit and coinsurance and reasonable limitations, deductibles and exclusions.
MD	Art. 48A § 477E (group) (1973/1991)	Mandated coverage in every policy meeting the following minimum requirements (unless coverage is waived by policyholder): • Benefits must be comparable to coverage of other conditions or illnesses. • Inpatient coverage provided for 30 days. • Partial/residential care coverage provided for 120 days at not less than 75% of the per diem rate. • Outpatient benefits providing 65% coverage for the first 20 outpatient visits and 50% coverage for visits thereafter based on amount paid for outpatient visits for other types of illnesses. • Benefits paid for inpatient and residential treatment may not exceed the benefits available for all inpatient care in the policy.

MA	c.175 § 47B (1973/1991)	Mandated coverage in every policy meeting the following minimum requirements: • Insurer must provide coverage for at least sixty days in any calendar year. • No lifetime maximum monetary limit unless the limit is at least equal to any lifetime maximum monetary limit of treatments of conditions not including mental or nervous conditions.
MN	§ 62A.152 (group) (1975/1993)	Mandated coverage in every group policy meeting the following minimum requirements: • Coverage for at least 90 % of first $600 of cost incurred over a 12 month period while insured person is not a bed patient in a hospital.
MS	§ 83-9-39 and § 83-9-41 (1991)	Mandated offering of coverage, except for policies only providing coverage for specific diseases and other limits, meeting the following minimum requirements: • Rejection of coverage must be in writing. • Inpatient benefits must cover a minimum of 30 days per year. • Partial hospitalization benefits shall be 60 days per year; rate of payment for inpatient services and partial hospitalization shall be the same as provided for other conditions. • Outpatient benefits cover 25 visits per year; a minimum of 50% of covered expenses which may be limited to a maximum payment of $50 per visit. • Lifetime payments for treatment may be limited, but no less than $50,000.
MO	§ 376.381 (1980/1993)	Mandated offering of coverage meeting the following minimum requirements: • Inpatient benefits for recognized mental illness shall be the same as for any other illness, benefits may be limited. • Outpatient benefits must cover at least 30 days; benefits for outpatients must cover no less than 50% of the reasonable and customary charges and up to the maximum benefit of $1,500 during each policy contract. • Benefits cover not less than 50% of reasonable and customary charges for 20 psychotherapy or professional counseling sessions during any policy contract coverage for at least one session during any 7 consecutive days.

MT	§ 33-22-701 to § 33-22-705 (group) (1979/1991)	Mandated coverage in every group meeting the following minimum requirements: • Coverage shall not be less favorable than for physical illness; however, benefits may be limited to not less than 30 calendar days per year. • Benefits consisting of durational limits, dollar limits/deductibles, and coinsurance factors may not be less than for physical illness. • Inpatient benefits may be limited to no less than 30 calendar days per year. If provided beyond 30 calendar days per year, the durational limits; dollar limits/deductibles, and coinsurance factors do not have to be the same as applied to physical illness. • Regarding outpatient coverage, the coinsurance may not exceed 50% or the coinsurance applicable to physical illness (whichever is greater); maximum benefit during the benefit period may be limited to not less than $1,000. • Maximum lifetime benefits shall be no less than those applicable to physical illness.
NH	§§ 415:18-a (group) (1975/1992); 419:5-a, 420:5-a (service corps.) (1975/1992)	Mandated coverage in every group contract meeting the following minimum requirements: • Coverage provided for biologically based mental illnesses. • Group policies must include coverage for mental health benefits that reimburses an equivalent amount as comparable medical-surgical benefits. • Benefits may be limited to $3,000 in any consecutive 12 month period and $10,000 per individual in a lifetime.
NY	§ 3221(1)(5)(A) (group) (1991/1992)	Mandated offering of coverage in every group or prepaid contract meeting the following minimum requirements: • Inpatient benefits may be limited to not less than 30 days in any calendar year. • Outpatient benefits may be limited to not less than $700 in any calendar year.
ND	§ 26.1-36-09 (group) (1985/1993)	Mandated coverage in every group contract meeting the following minimum requirements: • Inpatient benefits cover a minimum of 60 days in any calendar year. • Partial hospitalization benefits cover a minimum of 120 days in any calendar year; each day of inpatient care is equal to two days of partial hospitalization (provided that no more than 46 days of inpatient treatment benefits required may be traded for treatment by partial hospitalization). • Outpatient benefits cover a minimum of 30 hours in any calendar year.

OR	§ 743.556 (group) (1987/1991)	Group policy shall provide coverage the same as for other illnesses. • Regarding inpatient coverage, deductibles and coinsurance for treatment shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness; benefits shall cover no less than $4,000 for adults and $6,000 for children/adolescents. • Partial hospitalization benefits shall cover no less than $1,000 for adults and $2,500 for children/adolescents; for a combination of inpatient and partial treatment, benefits shall cover no less than $8,500 for adults and $10,500 for children/adolescents. • Regarding outpatient coverage, deductibles and coinsurance for treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness; benefits shall cover no less than $2,500.
TN	§ 56-7-2601 (1974/1992)	Mandated coverage in all group policies (unless refused by insured) meeting the following minimum requirements: • Benefits shall be provided at the usual and customary rates established by the community mental health center for the services rendered. • Benefits provided shall be subject to deductibles and coinsurance factors that are not less than for physical illness. • Insurers are not required to cover more than 30 outpatient visits per year.
TX	art. 3.51-14 (group) (1991)	Mandated coverage meeting the following minimum requirements: • Insurers must offer benefits at least as favorable as coverage for other services and benefits; policies issued to most state and local public employees must include coverage, durational limits, amount limits, deductibles, and coinsurance factors for treatment of serious mental illness that is at least favorable as that for other major illnesses. • Coverage may be limited to not more than three separate series of treatments for each covered individual. • Texas Department of Insurance and the Texas Commission on Alcohol and Drug Abuse is to formulate standards for use by insurers for the reasonable control of costs, and benefits that are subject to those standards.

VT	Tit. 8 § 4089 (group) (1975/1989)	Mandated offering of coverage meeting the following minimum requirements: • Inpatient benefits shall provide coverage for 45 days per policy/calendar year. • Partial hospitalization benefits shall provide coverage for 45 days per policy/calendar year. • Outpatient benefits shall be provided at a rate of 100% with respect to the first 5 visits and at a rate of 80% thereafter; benefits may be limited to $500 per policy/calendar year.
VA	§ 38.2-3412.1 (1993)	Mandated coverage meeting the following minimum requirements: • Insurers are to provide coverage that is as favorable as that of other illness. • Inpatient benefits providing coverage for an adult minimum of 20 days in a policy/contract year; a minimum of 25 days for children/adolescents; up to 10 days of the inpatient benefit may be converted to a partial hospitalization benefit at an exchange no less favorable than 1.5 days partial hospitalization for every one inpatient day of coverage. • Outpatient benefits providing a minimum of twenty visits each policy/contract year; no more restrictive than physical illness; however, the coinsurance factor applicable to outpatient visit beyond the first 5 visits covered in any policy shall be at least 50%.
WA	§ 48.21.240 (group) (1983/1987)	Mandated offering of coverage in group policies. Treatment shall be covered at the usual and customary rates.
WV	§ 33-16-3a (group) (1977/1993)	Mandated offering of coverage meeting the following minimum requirements: • Inpatient benefits payable for at least 45 days in any calendar year. • Inpatient benefits shall be no less comparable than that offered for physical illness. • Outpatient benefits covering 50% of eligible expenses of up to $500 over a 12 month period.
WI	§ 632.89 (group) (1975/1993)	Mandated coverage in every group contract meeting the following minimum requirements: • Total inpatient and outpatient coverage under the policy need not exceed $7000. • Inpatient benefits providing coverage for not less than the lesser of the expenses of the first 30 days; the first $7,000 minus a copayment of up to 10% for hospital care or first $6,300 for HMO care. • Outpatient benefits providing coverage for not less than the first $3,000 minus a copayment of up to 10% for hospital care or $2,700 for HMO care.