# 02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

**031 BUREAU OF INSURANCE**

**Chapter 330: MINIMUM STANDARDS FOR MENTAL ILLNESS BENEFITS - REVISED**

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**Section 1. Authority**

 This Rule is promulgated by the Superintendent pursuant to 24 M.R.S.A. § 2325-A, 24‑A M.R.S.A. § 2843, 24-A M.R.S.A. § 4234-A, and 24-A M.R.S.A. § 212.

**Section 2. Purpose**

 The purpose of this Rule is to clarify the requirements of 24 M.R.S.A. § 2325-A, 24‑A M.R.S.A. § 2843, and 24-A M.R.S.A. § 4234-A by establishing standards to assure equitable health care for the treatment of mental illness or nervous conditions.

**Section 3. Scope**

 This Rule applies to all policies subject to 24 M.R.S.A. § 2325-A, 24-A M.R.S.A. § 2843 and 24-A M.R.S.A. § 4234-A. Pursuant to those sections, this rule does not apply to employee group insurance policies issued to employers with 20 or fewer employees insured under the group policy. This rule does apply to other types of groups, such as association groups, and to all group HMO contracts, regardless of size. Nothing in this Rule requires benefit levels or maximum lifetime or annual benefits for treatment of mental illness that exceed the highest benefit levels payable for other covered illnesses and diseases.

**Section 4. Definitions**

 For purposes of this Rule, the following terms shall have the following meanings:

 A. "Usual Charge" means the most consistent charge by a provider for a given service.

 B. "Customary Charge" means a charge within the range of usual charges for a given service billed by most providers with similar training and experience taking into consideration the geographic area in which the services are provided and significant regional variations in the cost of services.

 C. "Reasonable Charge" means a charge that is not more than the usual and customary charge.

 D. "Allowable Charge" means the amount which would be payable for services of a preferred provider under a preferred provider arrangement prior to the application of any deductible or coinsurance.

 E. "Inpatient Services" means those services defined by 24 § 2325-A, 24-A M.R.S.A. § 2843, subsection 3, paragraph B, or 24-A M.R.S.A. § 4234-A, subsection 5, paragraph A, whether billed by the facility or by a physician or other professional.

 F. “Large Employer” means an employer who employed an average of at least 51 employees, including part-time employees, on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

 G. "Home Health Care Services” means those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if:

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

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

 3. The services are prescribed in writing by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness.

**Section 5. Minimum Benefits**

 Treatment for the mental illnesses listed in 24-A M.R.S.A. § 2843(5-C) must be covered at the same level of benefits as for treatment of physical illnesses (“parity”). Most mental illnesses fall into this category. The standards set forth in this section apply to other “unlisted” mental illnesses and to all mental illnesses under policies and certificates that are subject to this rule but exempt from the parity requirement. Policies subject to this rule but exempt from the parity requirement are group policies other than employee groups, such as association groups, to the extent they cover employees of employers with 20 or fewer employees. With respect to these unlisted conditions and exempt policies and certificates, and except as provided by Section 6, any policy subject to this Rule will be deemed to be in compliance with the requirements of 24-A M.R.S.A. § 2843 if it provides, at a minimum, the following benefits for a covered person suffering from a mental illness or nervous condition:

 A. Inpatient and Day Treatment Care.

 1. Annual Minimum. The policy must provide inpatient benefits for mental illness of at least 30 days per calendar year. However in no case need the total number of inpatient days allowed by the policy for all illnesses be exceeded. For purposes of this paragraph, two days of day treatment will be considered equivalent to one day of inpatient care.

 2. Coinsurance. The minimum level of benefits provided for mental illness must be at least the lesser of 80% of the charges or the highest level of benefits provided for other covered illnesses.

 B. Outpatient Care.

 1. Annual Maximum. The policy must provide an annual benefit of at least $1,500 for outpatient care for mental illness. In the large group market, the policy must contain no annual maximum except as permitted by Section 11.

 2. Coinsurance. The minimum level of benefits provided for mental illness must be at least 50% of the usual, customary and reasonable charge. An amount based on a relative value scale or other reasonable methodology may be substituted for the usual, customary and reasonable charge. In the case of either a preferred provider or a nonpreferred provider under a preferred provider arrangement approved pursuant to 24-A M.R.S.A. § 2675, the allowable charge may be substituted for the usual, customary, and reasonable charge.

 C. Home Health Care Services.

 1. Annual Maximum. The policy must provide an annual benefit of at least $1,500 for home health care services for mental illness. In the large group market, the policy must contain no annual maximum except as permitted by Section 11.

 2. Coinsurance. The minimum level of benefits provided for mental illness must be at least 50% of the usual, customary and reasonable charge. An amount based on a relative value scale or other reasonable methodology may be substituted for the usual, customary and reasonable charge. In the case of either a preferred provider or a nonpreferred provider under a preferred provider arrangement approved pursuant to 24-A M.R.S.A. § 2675, the allowable charge may be substituted for the usual, customary, and reasonable charge.

 D. Deductible. The policy may contain a deductible for mental illness benefits in one of the following ways:

 1. If the policy contains a policy deductible applicable to all benefits, mental illness benefits may be subject to that deductible and no separate deductible for mental illness may be required.

 2. Alternatively, the policy may contain a separate deductible for mental illness benefits not to exceed $150 per calendar year, regardless of whether the policy contains a deductible for other illnesses.

 E. Maximum Lifetime Benefit. Except for coverage applicable to a large employer, the policy may contain a separate maximum lifetime benefit for mental illness if the maximum benefit is at least $50,000 except the policy total maximum benefit, if any, need not be exceeded. The maximum applies to benefits actually paid, net of any applicable discount. Coverage applicable to large employers may only contain a lifetime maximum to the extent permitted by Section 11.

**Section 6. Supplemental Major Medical Policy**

 Any supplemental major medical policy subject to this Rule will be deemed to be in compliance with the requirements of 24-A M.R.S.A. § 2843, if it provides, at a minimum, the benefits provided under Section 5 above less an amount equal to the covered charges used to determine the benefit provided by any base coverage provided the same group by an insurer or nonprofit hospital and/or medical service organization. Although a supplemental major medical policy must contain the minimum required benefits, it is the intent of the Rule that a person covered under both base coverage and a supplemental major medical policy not be entitled to "stack" the mental illness benefits of the two policies. The two policies combined need not provide, in the aggregate, more than the minimum required benefits.

**Section 7. Nonprofit Hospital or Medical Service Corporation**

 For purposes of this Rule group contracts issued jointly by a nonprofit hospital service corporation and a nonprofit medical service corporation will be considered as one contract.

 Treatment for the mental illnesses listed in 24 M.R.S.A. § 2325-A(5-C) must be covered at the same level of benefits as for treatment of physical illnesses (“parity”). Most mental illnesses fall into this category. The standards set forth in this section apply to other “unlisted” mental illnesses and to all mental illnesses under contracts and certificates that are subject to this rule but exempt from the parity requirement. Contracts subject to this rule but exempt from the parity requirement are group contracts other than employee groups, such as association groups, to the extent they cover employees of employers with 20 or fewer employees. With respect to these unlisted conditions and exempt contracts and certificates, any group contract subject to this Rule will be deemed to be in compliance with 24 M.R.S.A. § 2325-A, if it provides, at a minimum, the following benefits for a covered person suffering from mental illness or nervous condition:

 A. Inpatient and Day Treatment Care.

 1. Annual Maximum. The contract must provide inpatient benefits for mental illness of at least 30 days per calendar year. However in no case need the total number of inpatient days allowed by the contract for all illnesses be exceeded. For purposes of this paragraph, two days of day treatment will be considered equivalent to one day of inpatient care.

 2. Coinsurance. The minimum level of benefits provided for mental illness must be at least the lesser of 80% of the charges or the highest level of benefits provided for other covered illnesses.

 B. Outpatient Care.

 1. Annual Maximum. The contract must provide an annual benefit of at least $1,500 for outpatient care for mental illness. In the large group market, the policy must contain no annual maximum except as permitted by Section 11.

 2. Coinsurance. The minimum level of benefits provided for mental illness must be at least 50% of the usual, customary and reasonable charge. An amount based on a relative value scale or other reasonable methodology may be substituted for the usual, customary, and reasonable charge. In the case of either a preferred provider or a nonpreferred provider under a preferred provider arrangement approved pursuant to 24 § 2337 or 24‑A M.R.S.A. § 2675, the allowable charge may be substituted for the usual, customary, and reasonable charge.

 C. Home Health Care Services.

 1. Annual Maximum. The contract must provide an annual benefit of at least $1,500 for home health care services for mental illness. In the large group market, the policy must contain no annual maximum except as permitted by Section 11.

 2. Coinsurance. The minimum level of benefits provided for mental illness must be at least 50% of the usual, customary and reasonable charge. An amount based on a relative value scale or other reasonable methodology may be substituted for the usual, customary, and reasonable charge. In the case of either a preferred provider or a nonpreferred provider under a preferred provider arrangement approved pursuant to 24 § 2337 or 24‑A M.R.S.A. § 2675, the allowable charge may be substituted for the usual, customary, and reasonable charge.

 D. Deductible. The contract may contain a deductible for mental illness benefits in one of the following ways:

 1. If the contract contains a contract deductible applicable to all benefits, mental illness benefits may be subject to that deductible and no separate deductible for mental illness may be required.

 2. Alternatively, the contract may contain a separate deductible for mental illness benefits not to exceed $150 per calendar year, regardless of whether the policy contains a deductible for other illnesses.

 E. Maximum Lifetime Benefit. Except for coverage applicable to a large employer, the contract may contain a separate maximum lifetime benefit for mental illness if the maximum benefit is at least $50,000 except the contract total maximum benefit, if any, need not be exceeded. The maximum applies to benefits actually paid, net of any applicable discount. Coverage applicable to large employers may only contain a lifetime maximum to the extent permitted by Section 11.

**Section 8. Health Maintenance Organizations**

 Treatment for certain mental illnesses listed in 24-A M.R.S.A. § 4234-A(6) must be covered at the same level of benefits as for treatment of physical illnesses (“parity”). Most mental illnesses fall into this category. The standards set forth in this section apply to other “unlisted” mental illnesses and to all mental illnesses under contracts and certificates that are subject to this rule but exempt from the parity requirement. Contracts subject to this rule but exempt from the parity requirement are group contracts to the extent they cover employees of employers with 20 or fewer employees. With respect to these unlisted conditions and exempt contracts and certificates, any group contract subject to this Rule will be deemed to be in compliance with 24-A M.R.S.A. §4234-A, if it provides, at a minimum, benefit levels described in Section 5 or 7, or the following benefits for a covered person suffering from mental illness or nervous condition:

 A. Inpatient and Day Treatment Care. The contract must provide inpatient treatment up to a maximum of 30 days in a calendar year subject to the same copayment that applies for other illnesses. Two days of day treatment will be considered one day of inpatient treatment. Day treatment is subject to a copayment of no more than 50% of the copayment applicable to inpatient treatment and may be applied only once per course of treatment.

 B. Outpatient Care. The contract must provide outpatient services up to a maximum benefit of $1,500 in a calendar year and subject to a copayment of $10 per visit or the copayment applicable to other illnesses. In the large group market, the contract must contain no annual maximum except as permitted by Section 11.

 C. Home Health Care Services. The contract must provide home health care services up to a maximum benefit of $1,500 in a calendar year and subject to a copayment of $10 per visit or the copayment applicable to other illnesses. In the large group market, the contract must contain no annual maximum except as permitted by Section 11.

 D. Maximum Lifetime Benefit. Except for coverage applicable to a large employer, the contract may contain a separate maximum lifetime benefit for mental illness if the maximum benefit is at least $50,000 except the contract total maximum benefit, if any, need not be exceeded. The maximum applies to benefits actually paid, net of any applicable discount. Coverage applicable to large employers may only contain a lifetime maximum to the extent permitted by Section 11.

 E. Point-of Service-Plans. For a point-of-service plan, the standards in subsections A through D apply to the in-network benefit level.

**Section 9. Managed Care**

 When a preferred provider arrangement is used, benefits for services of a non-preferred provider may not reduce benefits below the minimums set forth in this rule. If a point-of-service option is provided as part of an HMO plan, benefit levels may be lower than the mandated levels only for the self-referred services. No penalties under a utilization review program may reduce benefits below the minimums set forth in this rule.

**Section 10. Coordination With Medicare**

 Any policy or contract subject to this Rule may limit or exclude benefits for mental illness treatment to the extent benefits would otherwise duplicate and be secondary to benefits provided by the United States Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, Public Law 89-97 as amended (Medicare). To the extent Medicare may provide benefits for mental illness less than the minimum required by this Rule, policies and contracts other than Medicare supplement policies subject to 24-A M.R.S.A., Chapter 67, must cover the difference between Medicare and minimum required benefits.

**Section 11. Federal Parity Requirements**

 This section applies to all policies identified in section 3 to the extent they cover large employers and are issued or renewed on or after January 1, 1998. This section applies only to conditions other than those listed in 24-A M.R.S.A. § 2843(5-C).

 A. Annual Maximums for Unlisted Conditions.

 1. If the policy contains no annual dollar maximum for other illnesses, it shall contain no annual dollar maximum for mental illness, but may include annual maximum numbers of visits if the maximum is not less than the following:

 a. For outpatient care, 40 visits; and

 b. For home health care services, 40 visits.

 2. If the policy contains an annual dollar maximum for other illnesses, it may:

 a. Apply that maximum to the policy as a whole, including mental illness, or

 b. Include a separate annual dollar maximum for mental illness that is no less than the annual maximum for other illnesses, or

 c. Include annual maximum numbers of visits if the maximum is not less than that permitted in Paragraph 1.

 3. Any maximum applies to benefits actually paid, net of any applicable discount.

 B. Maximum Lifetime Benefit for Unlisted Conditions.

 1. If the policy contains no lifetime maximum for other illnesses, it shall contain no lifetime maximum for mental illness.

 2. If the policy contains a lifetime maximum for other illnesses, it may:

 a. Apply that maximum to the policy as a whole, including mental illness, or

 b. Include a separate lifetime maximum for mental illness that is no less than the lifetime maximum for other illnesses.

 3. Any maximum applies to benefits actually paid, net of any applicable discount.

**Section 12. Effective Date**

 The provisions of this Rule are effective June 1, 1984. The 1993 amendments to this Rule apply to policies and certificates executed, delivered, issued for delivery, or renewed on or after July 15, 1993. The 1996 amendments to this Rule apply to policies and certificates executed, delivered, issued for delivery, or renewed on or after July 9, 1996. The 1997 amendments to this rule are effective December 1, 1997. The 2001 amendments to this rule are effective August 20, 2001. The 2004 amendments to this rule are effective March 1, 2004.

STATUTORY AUTHORITY: 24 M.R.S.A. §2325-A; 24-A M.R.S.A. §§ 212, 2843, 4234-A.

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