

North Carolina Psychological Association

IMPLEMENTATION OF MENTAL HEALTH PARITY - HOUSE BILL 973 EFFECTIVE DATE OF PROVISIONS – JULY 1, 2008

prepared by
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In 2007, the North Carolina General Assembly passed House Bill 973 sponsored by Rep. Martha Alexander which adds provisions on mental health parity to the insurance statutes of the state. The provisions of the bill become effective July 1, 2008.

BILL PROVISIONS

HB 973 provides that nine (9) diagnoses are covered at full parity with physical illness – bipolar disorder, major depressive disorder, obsessive compulsive disorder, paranoid and other psychotic disorder, schizoaffective disorder, schizophrenia, PTSD, anorexia nervosa and bulimia. The means there can be no durational limits set in insurance/managed care plans for these nine diagnoses. Insurance/managed care plans can use utilization review criteria to manage a mental health benefit.

All other mental illness diagnoses (using the definition in the law) are covered at what we are calling financial parity - meaning deductibles, coinsurance factors, co-payments, maximum out-of-pocket as well as annual and lifetime limits must be the same as for physical illnesses. Mental illness diagnoses not included in the nine (9) listed above may have different durational limits, but the minimum benefit required must provide for:

Thirty (30) combined inpatient and outpatient days per year and
Thirty (30) office visits per year

This puts all of the other diagnoses at parity other than for durational limits. For example, plans will no longer be able to have a 50/50 co-pay for mental illness and a 80/20 co-pay for physical illness. All mental illness diagnoses will be at whatever the plan sets for physical illness in terms of financial limits.

The parity law covers ALL group plans in North Carolina (unlike the current federal law and federal proposals which only cover employers of 50 or more employees).

The parity law does not cover the State Health Plan PPO plans – a strategic decision because the PPO plans have a broader benefit and includes parity for substance abuse.

IMPLEMENTATION

The implementation provision states that this takes effect in a plan on the date of initiation or renewal of a plan after July 1, 2008.

Here is the language in the statute:

“This act becomes effective July 1, 2008, and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after that date. For purposes of this act, renewal of a health benefit policy, contract, or plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.”

FOLLOW-UP

Please notify NCPA immediately of any problems with implementation of the new parity law. NCPA will work with the legal and regulatory system in North Carolina to assure appropriate implementation.

Note: the actual provisions from part of the law follow. For the full text of the bill go to www.ncleg.net and put in H973 in the bill look-up on right side of home page. In the actual legislation, the same language is repeated several times as that amends different part of the NC General Statutes.

PORTIONS OF THE PARITY LAW

SESSION LAW 2007-268 HOUSE BILL 973

AN ACT TO REQUIRE MANDATORY HEALTH INSURANCE COVERAGE OF CERTAIN MENTAL ILLNESSES AND TO REQUIRE AT LEAST A MINIMUM BENEFIT PACKAGE FOR OTHER MENTAL ILLNESSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-55 reads as rewritten:

"§ 58-51-55. No discrimination against ~~the~~ mentally ill and ~~or~~ chemically dependent.dependent individuals.

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes.

"§ 58-3-220. Mental illness benefits coverage.

(a) Mental Health Equity Requirement. – Except as provided in subsection (b), an insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illnesses that are no less favorable than benefits for physical illness generally, including application of the same limits. For purposes of this subsection, mental illnesses are as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes. For purposes of this subsection, 'limits' includes deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Minimum Required Benefits. – Except as provided in subsection (c), a group health benefit plan may apply durational limits to mental illnesses that differ from durational limits that apply to physical illnesses. A group health benefit plan shall provide at least the following minimum number of office visits and combined inpatient and outpatient days for all mental illnesses and disorders not listed in subsection (c), as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes:

- (1) Thirty combined inpatient and outpatient days per year.
- (2) Thirty office visits per year.

(c) Durational limits for the following mental illnesses shall be subject to the same limits as benefits for physical illness generally:

- (1) Bipolar Disorder.
- (2) Major Depressive Disorder.
- (3) Obsessive Compulsive Disorder.
- (4) Paranoid and Other Psychotic Disorder.
- (5) Schizoaffective Disorder.
- (6) Schizophrenia.
- (7) Post-Traumatic Stress Disorder.
- (8) Anorexia Nervosa.
- (9) Bulimia.

(d) Nothing in this section prevents an insurer from offering a group health benefit plan that provides greater than the minimum required benefits, as set forth in subsection (b).

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care.

(f) Weighted Average. – If a group health benefit plan contains annual limits, lifetime limit s, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the group health benefit plan, then the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(g) Nothing in this section prevents an insurer from applying utilization review criteria to determine medical necessity as defined in G.S. 58-50-61 as long as it does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in that section, including the offering of an insurer appeal process and, where applicable, health benefit plan external review as provided for in Part 4 of Article 50 of Chapter 58 of the General Statutes.

SECTION 6. This act becomes effective July 1, 2008, and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after that date. For purposes of this act, renewal of a health benefit policy, contract, or plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

