~~Indicates Matter Stricken~~

Indicates New Matter

COMMITTEE AMENDMENT ADOPTED

April 23, 2009

**S. 390**

Introduced by Senator Hayes

S. Printed 4/23/09--S. [SEC 4/24/09 12:33 PM]

Read the first time February 10, 2009.

**A** **BILL**

TO ENACT THE “MENTAL HEALTH PARITY AND ADDICTION ACT OF 2009”; AND TO AMEND SECTION 38‑71‑880, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO MEDICAL AND SURGICAL BENEFITS AND MENTAL BENEFITS COVERAGE, SO AS TO ADD PROVISIONS RELATING TO SUBSTANCE USE DISORDER COVERAGE, FINANCIAL REQUIREMENTS, AND TREATMENT LIMITATIONS AND TO PROVIDE FOR DEFINITIONS.

Amend Title To Conform

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. This act may be cited as the “Mental Health Parity and Addiction Equity Act of 2009”.

SECTION 2. Section 38‑71‑880 of the 1976 Code, as last amended by Act 332 of 2006, is further amended to read:

“Section 38‑71‑880. (A)(1) In the case of health insurance coverage offered in connection with a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits:

(a) if the coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits;

(b) if the coverage includes an aggregate lifetime limit, also referred to in this item as the ‘applicable lifetime limit’, on substantially all medical and surgical benefits, the coverage ~~shall~~ must either:

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of the limit between the medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(c) In the case of coverage that is not described in subitem (a) or (b) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the director ~~of Insurance shall~~ or his designee may promulgate regulations under which subitem (b) is applied to the coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to the categories.

(2) In the case of health insurance coverage offered in connection with a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits:

(a) if the coverage does not include an annual limit on substantially all medical and surgical benefits, the coverage may not impose any annual limit on mental health or substance use disorder benefits;

(b) if the coverage includes an annual limit on substantially all medical and surgical benefits, referred to as the ‘applicable annual limit’, the coverage ~~shall~~ must either:

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(c) In the case of coverage that is not described in subitem (a) or (b) and that includes no or different annual limits on different categories of medical and surgical benefits, the director ~~of Insurance shall~~ or his designee may promulgate regulations under which subitem (b) is applied to the coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to the categories.

(3) In the case of a group health plan, or health insurance coverage offered in connection with a plan, that provides both medical and surgical benefits and mental health or substance use disorder benefits, the plan or coverage must ensure that:

(a) the financial requirements applicable to the mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan or coverage and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(b) the treatment of limitations applicable to the mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan or coverage and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(4) In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out‑of‑network providers, the plan or coverage must provide coverage for mental health or substance use disorder benefits provided by out‑of‑network providers in a manner that is consistent with the requirements of this section.

(B) To the extent consistent with Section 38‑71‑737 and ~~any other~~ another applicable state law, nothing in this section ~~shall~~ may be construed:

(1) as requiring health insurance coverage offered in connection with a group health plan to provide any mental health or substance use disorder benefits; or

(2) in the case of ~~such coverage~~ a group health plan or health insurance coverage offered in connection with a plan that provides ~~such~~ mental health or substance use disorder benefits, as affecting the terms and conditions~~, including cost sharing, limits on number of visits or days of coverage, and requirements relating to medical necessity, relating to the amount, duration, or scope of mental health benefits under the coverage~~ of the plan or coverage relating to benefits under the plan or coverage, except as ~~specifically~~ provided in subsection (A) ~~in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits~~.

(C)(1)~~(a)~~ This section ~~shall~~ does not apply to ~~any~~ a group health insurance coverage offered in connection with a group health plan for any plan year of a small employer.

~~(b)~~(2) For purposes of ~~subitem (a)~~ this subsection, ‘small employer’ means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

~~(c)~~(3) For purposes of this ~~item~~ subsection:

~~(i)~~(a) All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 ~~shall be~~ are treated as one employer.

~~(ii)~~(b) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether ~~such~~ the employer is a small employer ~~shall be~~ is based on the average number of employees that it is reasonably expected ~~such~~ the employer will employ on business days in the current calendar year.

~~(iii)~~(c) ~~Any~~ A reference in this ~~item~~ subsection to an employer ~~shall include~~ includes a reference to any predecessor of the employer.

(2) This section ~~shall~~ does not apply with respect to health insurance coverage offered in connection with a group health plan if the application of this section to ~~such~~ this coverage results in an increase in the actual total cost for ~~such~~ the coverage of at least ~~one~~ two percent in the case of the first plan year or at least one percent in the case of a subsequent plan year. Determinations as to increases in actual total costs under a plan or coverage for purposes of this subsection must be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. Determinations must be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, must be maintained by the group health plan and the health insurance issuer for a period of six years.

(3) When a group health insurance coverage offered in connection with a group health plan that qualifies for exemption pursuant to the provisions of item (2), the plan or coverage must continue to apply the requirements of applicable state law, including Sections 38-71-290 and 38-71-737, where required.

(D) In the case of health insurance coverage offered in connection with a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, ~~subsections (A) and (C)(2), shall be~~ the requirements of this section are applied separately with respect to each ~~such~~ option.

(E) For purposes of this section:

(1) ‘Aggregate lifetime limit’ means, with respect to benefits under health insurance coverage, a dollar limitation on the total amount that may be paid with respect to the benefits under the health insurance coverage with respect to an individual or other coverage unit.

(2) ‘Annual limit’ means, with respect to benefits under health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to the benefits in a twelve‑month period under the health insurance coverage with respect to an individual or other coverage unit.

(3) ‘Financial requirement’ includes deductibles, copayments, coinsurance, and out‑of‑pocket expense, but excludes an aggregate lifetime limit and annual limit subject to subsections (A)(3)(a) and (A)(3)(b).

(4) ‘Medical or surgical benefits’ means benefits with respect to medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

~~(4)~~(5) ‘Mental health benefits’ means benefits with respect to services for mental health ~~services~~ conditions, as defined under the terms of the plan~~, but does not include benefits with respect to treatment of substance abuse or chemical dependency~~ and in accordance with applicable federal and state law.

(6) ‘Predominant’ means a financial requirement or treatment limit that is the most common or frequent of the type of requirement or limit.

(7) ‘Substance use disorder benefits’ means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable federal and state law.

(8) ‘Treatment limitation’ includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

~~(F)~~ ~~This section does not apply to benefits for services furnished on or after December 31, 2006.~~”

SECTION 3. Section 38-71-290(A)(1) of the 1976 Code is amended to read:

“(1) ‘Health insurance plan’ means a health insurance policy or health benefit plan offered by ~~a health insurer or a health maintenance organization~~ an insurance issuer, including a qualified health benefit plan offered or administered by the State, or a subdivision or instrumentality of the State, that provides group health insurance coverage as defined by Section ~~38‑71‑670(6)~~ 38-71-840(12).”

SECTION 4. Section 38-71-290(F) of the 1976 Code is amended to read:

“(F) The provisions of this section do not:

(1) limit the provision of specialized medical services for individuals with mental health disorders;

(2) supersede the provisions of federal law, federal or state Medicaid policy, or the terms and conditions imposed on a Medicaid waiver granted to the State for the provision of services to individuals with mental health disorders; ~~or~~

(3) require a health insurance plan to provide rates, terms, or conditions for access to treatment for mental illness that are identical to rates, terms, or conditions for access to treatment for a physical condition~~.~~;

(4) apply to a health insurance plan that is individually underwritten; or

(5) apply to a health insurance plan provided to a small employer, as defined in Section 38-71-1330(18).”

SECTION 5. Section 38-71-290 of the 1976 Code is amended by adding an appropriately lettered subsection to read:

“(G) The provisions of this section apply where required regardless of the applicability of Section 38-71-880 regarding parity in the application of certain limits to mental health and substance use disorder benefits.”

SECTION 6. This act takes effect upon approval by the Governor and applies to group health plans for plan years beginning after October 2, 2009.

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