

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2007

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HOUSE BILL 973  
Committee Substitute Favorable 5/8/07  
Committee Substitute #2 Favorable 5/22/07

Short Title: Mental Health Equitable Coverage.

(Public)

Sponsors:

Referred to:

March 22, 2007

1 A BILL TO BE ENTITLED  
2 AN ACT TO REQUIRE EQUITY IN HEALTH INSURANCE COVERAGE FOR  
3 MENTAL ILLNESS.

4 The General Assembly of North Carolina enacts:

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

6 "§ 58-51-55. No discrimination against ~~the~~ mentally ill and chemically  
7 ~~dependent.~~ dependent individuals.

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

9 (1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21);~~  
10 ~~and~~ G.S. 122C-3(21), with a mental disorder defined in the Diagnostic  
11 and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent  
12 edition published by the American Psychiatric Association, except  
13 those mental disorders coded in the DSM-IV or subsequent editions as  
14 substance-related disorders (291.0 through 292.9 and 303.0 through  
15 305.9) and those coded as 'V' codes.

16 (2) 'Chemical dependency' has the same meaning as defined in  
17 G.S. 58-51-50  
18 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders  
19 DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of  
20 those manuals.

21 (b) Coverage of Physical Illness. – No insurance company licensed in this State  
22 under this Chapter shall, solely because an individual to be insured has or had a mental  
23 illness or chemical dependency:

24 (1) Refuse to issue or deliver to that individual any policy that affords  
25 benefits or coverages for any medical treatment or service for physical  
26 illness or injury;  
27 (2) Have a higher premium rate or charge for physical illness or injury  
28 coverages or benefits for that individual; or

1           (3) Reduce physical illness or injury coverages or benefits for that  
2           individual.

3           ~~(b1) Coverage of Mental Illness.—A policy that covers both physical illness or~~  
4 ~~injury and mental illness may not impose a lesser lifetime or annual dollar limitation on~~  
5 ~~the mental health benefits than on the physical illness or injury benefits, subject to the~~  
6 ~~following:~~

7           ~~(1) A lifetime limit or annual limit may be made applicable to all benefits~~  
8 ~~under the policy, without distinguishing the mental health benefits.~~

9           ~~(2) If the policy contains lifetime limits only on selected physical illness~~  
10 ~~and injury benefits, and these benefits do not represent substantially all~~  
11 ~~of the physical illness and injury benefits under the policy, the insurer~~  
12 ~~may impose a lifetime limit on the mental health benefits that is based~~  
13 ~~on a weighted average of the respective lifetime limits on the selected~~  
14 ~~physical illness and injury benefits. The weighted average shall be~~  
15 ~~calculated in accordance with rules adopted by the Commissioner.~~

16           ~~(3) If the policy contains annual limits only on selected physical illness~~  
17 ~~and injury benefits, and these benefits do not represent substantially all~~  
18 ~~of the physical illness and injury benefits under the policy, the insurer~~  
19 ~~may impose an annual limit on the mental health benefits that is based~~  
20 ~~on a weighted average of the respective annual limits on the selected~~  
21 ~~physical illness and injury benefits. The weighted average shall be~~  
22 ~~calculated in accordance with rules adopted by the Commissioner.~~

23           ~~(4) Except as otherwise provided in this section, the policy may~~  
24 ~~distinguish between mental illness benefits and physical injury or~~  
25 ~~illness benefits with respect to other terms of the policy, including~~  
26 ~~coinsurance, limits on provider visits or days of coverage, and~~  
27 ~~requirements relating to medical necessity.~~

28           ~~(5) If the insurer offers two or more benefit package options under a~~  
29 ~~policy, each package must comply with this subsection.~~

30           ~~(6) This subsection does not apply to a policy if the insurer can~~  
31 ~~demonstrate to the Commissioner that compliance will increase the~~  
32 ~~cost of the policy by one percent (1%) or more.~~

33           ~~(7) This subsection expires October 1, 2001, but the expiration does not~~  
34 ~~affect services rendered before that date.~~

35           ~~(c) Mental Illness or Chemical Dependency Coverage Not Required. – Nothing~~  
36 ~~in this section requires an insurer to offer coverage for mental illness or chemical~~  
37 ~~dependency, except as provided in G.S. 58-51-50.~~

38           ~~(d) Applicability. – Subsection (b1) of this~~This ~~section applies only to group~~  
39 ~~health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25,~~  
40 ~~covering more than 50 employees. The remainder of this section applies only to group~~  
41 ~~health insurance contracts covering 20 or more employees. G.S. 58-68-25. For purposes~~  
42 ~~of this section, "group health insurance contracts" include MEWAs, as defined in~~  
43 ~~G.S. 58-49-30(a)."~~

1           **SECTION 2.** Article 3 of Chapter 58 of the General Statutes is amended by  
2 adding the following new section to read:

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

4       (a) Mental Health Equity Requirement. – An insurer shall provide in each group  
5 health benefit plan benefits for the necessary care and treatment of mental illness that  
6 are no less favorable than benefits for physical illness generally. Benefits for treatment  
7 of mental illness shall be subject to the same limits as benefits for physical illness  
8 generally. For purposes of this subsection, 'limits' includes durational limits,  
9 deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual  
10 and lifetime dollar limits, and any other dollar limits or fees for covered services.

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

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

25       (d) Definitions. – As used in this section:

26       (1) 'Health benefit plan' has the same meaning as in G.S. 58-3-167 and  
27 includes the Teachers' and State Employees' Comprehensive Major  
28 Medical Plan (Plan) and the Plan's optional PPO program.

29       (2) 'Insurer' has the same meaning as in G.S. 58-3-167.

30       (3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a  
31 mental disorder defined in the Diagnostic and Statistical Manual of  
32 Mental Disorders, DSM-IV, or subsequent editions published by the  
33 American Psychiatric Association, except those mental disorders  
34 coded in the DSM-IV or subsequent editions as substance-related  
35 disorders (291.0 through 292.9 and 303.0 through 305.9) and those  
36 coded as 'V' codes."

37       **SECTION 3.** G.S. 58-65-90 reads as rewritten:

38 **"§ 58-65-90. No discrimination against ~~the~~ mentally ill and chemically**  
39 **dependent-dependent individuals.**

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

41       (1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21);  
42 and G.S. 122C-3(21), with a mental disorder defined in the Diagnostic  
43 and Statistical Manual of Mental Disorders, DSM-IV, or subsequent  
44 editions published by the American Psychiatric Association, except

1                    those mental disorders coded in the DSM-IV or subsequent editions as  
2                    substance-related disorders (291.0 through 292.9 and 303.0 through  
3                    305.9) and those coded as 'V' codes.

- 4                    (2) 'Chemical dependency' has the same meaning as defined in  
5                    G.S. 58-65-75

6 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders  
7 DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of  
8 those manuals.

9                    (b) Coverage of Physical Illness. – No service corporation governed by this  
10 Chapter shall, solely because an individual to be insured has or had a mental illness or  
11 chemical dependency:

- 12                    (1) Refuse to issue or deliver to that individual any individual or group  
13                    subscriber contract in this State that affords benefits or coverage for  
14                    medical treatment or service for physical illness or injury;  
15                    (2) Have a higher premium rate or charge for physical illness or injury  
16                    coverages or benefits for that individual; or  
17                    (3) Reduce physical illness or injury coverages or benefits for that  
18                    individual.

19                    ~~(b1) Coverage of Mental Illness.—A subscriber contract that covers both physical~~  
20 ~~illness or injury and mental illness may not impose a lesser lifetime or annual dollar~~  
21 ~~limitation on the mental health benefits than on the physical illness or injury benefits,~~  
22 ~~subject to the following:~~

- 23                    ~~(1) A lifetime limit or annual limit may be made applicable to all benefits~~  
24 ~~under the subscriber contract, without distinguishing the mental health~~  
25 ~~benefits.~~  
26                    ~~(2) If the subscriber contract contains lifetime limits only on selected~~  
27 ~~physical illness or injury benefits, and these benefits do not represent~~  
28 ~~substantially all of the physical illness and injury benefits under the~~  
29 ~~subscriber contract, the service corporation may impose a lifetime~~  
30 ~~limit on the mental health benefits that is based on a weighted average~~  
31 ~~of the respective lifetime limits on the selected physical illness and~~  
32 ~~injury benefits. The weighted average shall be calculated in~~  
33 ~~accordance with rules adopted by the Commissioner.~~  
34                    ~~(3) If the subscriber contract contains annual limits only on selected~~  
35 ~~physical illness and injury benefits, and these benefits do not represent~~  
36 ~~substantially all of the physical illness and injury benefits under the~~  
37 ~~subscriber contract, the service corporation may impose an annual~~  
38 ~~limit on the mental health benefits that is based on a weighted average~~  
39 ~~of the respective annual limits on the selected physical illness and~~  
40 ~~injury benefits. The weighted average shall be calculated in~~  
41 ~~accordance with rules adopted by the Commissioner.~~  
42                    ~~(4) Except as otherwise provided in this section, the subscriber contract~~  
43 ~~may distinguish between mental illness benefits and physical injury or~~  
44 ~~illness benefits with respect to other terms of the subscriber contract,~~

1 including coinsurance, limits on provider visits or days of coverage,  
2 and requirements relating to medical necessity.

3 (5) ~~If the service corporation offers two or more benefit package options~~  
4 ~~under a subscriber contract, each package must comply with this~~  
5 ~~subsection.~~

6 (6) ~~This subsection does not apply to a subscriber contract if the service~~  
7 ~~corporation can demonstrate to the Commissioner that compliance will~~  
8 ~~increase the cost of the subscriber contract by one percent (1%) or~~  
9 ~~more.~~

10 (7) ~~This subsection expires October 1, 2001, but the expiration does not~~  
11 ~~affect services rendered before that date.~~

12 (c) ~~Mental Illness or Chemical Dependency Coverage Not Required.~~ – Nothing  
13 in this section requires a service corporation to offer coverage for ~~mental illness or~~  
14 ~~chemical dependency, except as provided in G.S. 58-65-75.~~

15 (d) ~~Applicability.~~— ~~Subsection (b1) of this section applies only to subscriber~~  
16 ~~contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than~~  
17 ~~50 employees. The remainder of this section applies only to group contracts covering 20~~  
18 ~~or more employees."~~

19 **SECTION 4.** G.S. 58-67-75 reads as rewritten:

20 "**§ 58-67-75. No discrimination against ~~the~~ mentally ill and chemically**  
21 **dependent dependent individuals.**

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

23 (1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21);~~  
24 ~~and~~ G.S. 122C-3(21), with a mental disorder defined in the Diagnostic  
25 and Statistical Manual of Mental Disorders, DSM-IV, or subsequent  
26 editions published by the American Psychiatric Association, except  
27 those mental disorders coded in the DSM-IV or subsequent editions as  
28 substance-related disorders (291.0 through 292.9 and 303.0 through  
29 305.9) and those coded as 'V' codes.

30 (2) 'Chemical dependency' has the same meaning as defined in  
31 G.S. 58-67-70

32 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders  
33 DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of  
34 those manuals.

35 (b) Coverage of Physical Illness. – No health maintenance organization governed  
36 by this Chapter shall, solely because an individual has or had a mental illness or  
37 chemical dependency:

38 (1) Refuse to enroll that individual in any health care plan covering  
39 physical illness or injury;

40 (2) Have a higher premium rate or charge for physical illness or injury  
41 coverages or benefits for that individual; or

42 (3) Reduce physical illness or injury coverages or benefits for that  
43 individual.

1       ~~(b1) Coverage of Mental Illness.—A health care plan that covers both physical~~  
2 ~~illness or injury and mental illness may not impose a lesser lifetime or annual dollar~~  
3 ~~limitation on the mental health benefits than on the physical illness or injury benefits,~~  
4 ~~subject to the following:~~

- 5           ~~(1) A lifetime limit or annual limit may be made applicable to all benefits~~  
6 ~~under the plan, without distinguishing the mental health benefits.~~  
7           ~~(2) If the plan contains lifetime limits only on selected physical illness and~~  
8 ~~injury benefits, and these benefits do not represent substantially all of~~  
9 ~~the physical illness and injury benefits under the plan, the HMO may~~  
10 ~~impose a lifetime limit on the mental health benefits that is based on a~~  
11 ~~weighted average of the respective lifetime limits on the selected~~  
12 ~~physical illness and injury benefits. The weighted average shall be~~  
13 ~~calculated in accordance with rules adopted by the Commissioner.~~  
14           ~~(3) If the plan contains annual limits only on selected physical illness and~~  
15 ~~injury benefits, and these benefits do not represent substantially all of~~  
16 ~~the physical illness and injury benefits under the plan, the HMO may~~  
17 ~~impose an annual limit on the mental health benefits that is based on a~~  
18 ~~weighted average of the respective annual limits on the selected~~  
19 ~~physical illness and injury benefits. The weighted average shall be~~  
20 ~~calculated in accordance with rules adopted by the Commissioner.~~  
21           ~~(4) Except as otherwise provided in this section, the plan may distinguish~~  
22 ~~between mental illness benefits and physical injury or illness benefits~~  
23 ~~with respect to other terms of the plan, including coinsurance, limits on~~  
24 ~~provider visits or days of coverage, and requirements relating to~~  
25 ~~medical necessity.~~  
26           ~~(5) If the HMO offers two or more benefit package options under a plan,~~  
27 ~~each package must comply with this subsection.~~  
28           ~~(6) This subsection does not apply to a health benefit plan if the HMO can~~  
29 ~~demonstrate to the Commissioner that compliance will increase the~~  
30 ~~cost of the plan by one percent (1%) or more.~~  
31           ~~(7) This subsection expires October 1, 2001, but the expiration does not~~  
32 ~~affect services rendered before that date.~~

33       ~~(c) Mental Illness or Chemical Dependency Coverage Not Required. – Nothing~~  
34 ~~in this section requires an HMO to offer coverage for mental illness or chemical~~  
35 ~~dependency, except as provided in G.S. 58-67-70.~~

36       ~~(d) Applicability.—Subsection (b1) of this section applies only to group~~  
37 ~~contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than~~  
38 ~~50 employees. The remainder of this section applies only to group contracts covering 20~~  
39 ~~or more employees."~~

40           **SECTION 5.** G.S. 58-50-155 reads as rewritten:

41       **"§ 58-50-155. Standard and basic health care plan coverages.**

42       (a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and  
43 approved under G.S. 58-50-125 shall provide coverage for all of the following:

- 1 (1) Mammograms and pap smears at least equal to the coverage required  
2 by G.S. 58-51-57.
- 3 (2) Prostate-specific antigen (PSA) tests or equivalent tests for the  
4 presence of prostate cancer at least equal to the coverage required by  
5 G.S. 58-51-58.
- 6 (3) Reconstructive breast surgery resulting from a mastectomy at least  
7 equal to the coverage required by G.S. 58-51-62.
- 8 (4) For a qualified individual, scientifically proven bone mass  
9 measurement for the diagnosis and evaluation of osteoporosis or low  
10 bone mass at least equal to the coverage required by G.S. 58-3-174.
- 11 (5) Prescribed contraceptive drugs or devices that prevent pregnancy and  
12 that are approved by the United States Food and Drug Administration  
13 for use as contraceptives, or outpatient contraceptive services at least  
14 equal to the coverage required by G.S. 58-3-178, if the plan covers  
15 prescription drugs or devices, or outpatient services, as applicable. The  
16 same exceptions and exclusions as are provided under G.S. 58-3-178  
17 apply to standard plans developed and approved under G.S. 58-50-125.
- 18 (6) Colorectal cancer examinations and laboratory tests at least equal to  
19 the coverage required by G.S. 58-3-179.
- 20 (7) Treatment of mental illness that is at least equal to the coverage  
21 required by G.S. 58-51-50 and G.S. 58-3-220, respectively. Nothing in  
22 this subdivision prevents an insurer from applying utilization review  
23 criteria to determine medical necessity as defined in G.S. 58-50-61 as  
24 long as it does so in accordance with all requirements for utilization  
25 review programs and medical necessity determinations specified in  
26 that section, including the offering of an insurer appeal process and,  
27 where applicable, health benefit plan external review as provided for in  
28 Part 4 of Article 50 of Chapter 58 of the General Statutes.

29 (a1), (a2) Repealed by Session Laws 1999-197, s. 2.

30 (b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans  
31 under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to  
32 cost-effective and life-saving health care services and to cost-effective health care  
33 providers."

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