GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2007

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.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-51-50~~ 58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association.

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

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

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

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

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

(b1) [Expired October 1, 2001.]

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

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

(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."

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

"**§ 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 limits, 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.

(h) Definitions. – As used in this section:

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

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

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions 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."

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

"**§ 58-65-90. 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 subsequent editions 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.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-65-75~~ 58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association.

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

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

(1) Refuse to issue or deliver to that individual any individual or group subscriber contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

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

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

(b1) [Expired October 1, 2001.]

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

(d) Applicability. – This ~~Subsection (b1) of this~~ section applies only to ~~subscriber~~ group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25. ~~58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~ For purposes of

this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).

(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."

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

"**§ 58-67-75. 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 subsequent editions 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.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-67-70~~ 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association.

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

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

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

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

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

(b1) [Expired October 1, 2001.]

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

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

(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."

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

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

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

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(7) Treatment of mental illness that is at least equal to the coverage required by G.S. 58-3-220. Nothing in this subdivision 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.

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

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

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.

In the General Assembly read three times and ratified this the 16th day of July, 2007.

s/ Marc Basnight
President Pro Tempore of the Senate

s/ Joe Hackney
Speaker of the House of Representatives

s/ Michael F. Easley
Governor

Approved 12:50 p.m. this 27th day of July, 2007