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GENERAL ASSEMBLY OF NORTH CAROLINA
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S **D**

SENATE BILL DRS35239-MR-64A

Short Title:	Health Benefit Plans/Mental Health Parity.	(Public)
Sponsors:	Senator Burgin (Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ACHIEVE MENTAL HEALTH PARITY UNDER HEALTH BENEFIT PLANS REGULATED BY THE NORTH CAROLINA DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-220 reads as rewritten:

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

(a) For the purposes of this section, the following definitions apply:

(1) Coverage limits. – Deductibles, coinsurance, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(2) Reserved for future codification purposes.

(3) Medical necessity. – As defined in G.S. 58-50-61.

(4) Mental illness. – Either of following:

a. As defined in G.S. 122C-3.

b. Any mental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except those mental disorders coded as autism spectrum disorder (299.00), as sexual dysfunctions not due to organic disease (302.70 through 302.79), and as "V" codes.

(a1) Mental Health Equity Requirement. – Except as provided in subsection ~~(b),~~ (b) of this section, 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 coverage limits. ~~For purposes of this subsection, mental illnesses are as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent edition as autism spectrum disorder (299.00), 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),~~ (c) of this section, 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-5, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent edition as autism spectrum disorder (299.00), 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:~~any mental illness not listed under subsection (c) of this section:

(1) Thirty combined inpatient and outpatient days per year.

(2) Thirty office visits per year.

…

(d) Additional Benefits Not Prohibited. – 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).~~this section.

…

(f) Weighted Average. – If a ~~group~~ health benefit plan contains ~~annual limits, lifetime limits, co-payments, deductibles, or coinsurance~~ coverage limits 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~~ Utilization Review. – An insurer shall not be prevented from applying utilization review criteria to determine medical necessity ~~as defined in G.S. 58-50-61~~ as long as ~~it~~ the insurer does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in ~~that section,~~ this subsection and in G.S. 58-50-61, 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. When determining the medical necessity for a treatment modality for a mental illness, the following shall apply:

(1) An insurer is required to make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy.

(2) Medical necessity determinations related to substance use disorders shall be in accordance with appropriate evidence-based criteria established by a leading medical necessity guideline source.

~~(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-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent editions as autism spectrum disorder (299.00), 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 2.(a) G.S. 58-50-61 reads as rewritten:

"**§ 58-50-61. Utilization review.**

(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

…

(7) "Health benefit plan" ~~means any of the following if offered by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:~~has the same meaning as in G.S. 58-3-167.

~~a. Accident.~~
~~b. Credit.~~
~~c. Disability income.~~
~~d. Long-term or nursing home care.~~
~~e. Medicare supplement.~~
~~f. Specified disease.~~
~~g. Dental or vision.~~
~~h. Coverage issued as a supplement to liability insurance.~~
~~i. Workers' compensation.~~
~~j. Medical payments under automobile or homeowners.~~
~~k. Hospital income or indemnity.~~
~~l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.~~

…

(d) Program Operations. – In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be ~~either (i) the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii) criteria adopted by the insurer or its URO.~~ made in accordance with appropriate evidence-based criteria established by a leading medical necessity guideline source. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO.

Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section.

…."

SECTION 2.(b) G.S. 58-51-55(a)(1) reads as rewritten:

"(1) "Mental illness" has the same meaning as defined in ~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent editions as autism spectrum disorder (299.00), 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.~~G.S. 58-3-220."

SECTION 2.(c) G.S. 58-65-90(a)(1) reads as rewritten:

"(1) "Mental illness" has the same meaning as defined in ~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as autism spectrum disorder (299.00), sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.~~G.S. 58-3-220."

SECTION 2.(d) G.S. 58-67-75(a)(1) reads as rewritten:

"(1) "Mental illness" has the same meaning as defined in ~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent editions as autism spectrum disorder (299.00), 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.~~G.S. 58-3-220."

SECTION 2.(e) The following General Statutes are repealed:

(1) Subsections (b) and (c) of G.S. 58-51-50.
(2) Subsections (b) and (c) of G.S. 58-65-75.
(3) Subsections (b) and (c) of G.S. 58-67-70.
(4) G.S. 58-51-55(c).
(5) G.S. 58-65-90(c).
(6) G.S. 58-67-75(c).

SECTION 3. This act is effective October 1, 2023, and applies to insurance contracts issued, renewed, or amended on or after that date.