April 6, 2000

LEGISLATIVE RESEARCH COMMISSION

Mental Health and Chemical Dependency Parity

REPORT TO THE
2000 SESSION OF THE
1999 GENERAL ASSEMBLY
OF NORTH CAROLINA

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STATE OF NORTH CAROLINA
LEGISLATIVE RESEARCH COMMISSION
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May 4, 2000

TO THE MEMBERS OF THE 1999 GENERAL ASSEMBLY (REGULAR SESSION 2000):

The Legislative Research Commission herewith submits to you for your consideration its 2000 report on Mental Health and Chemical Dependency Parity report was prepared by the Legislative Research Commission's Committee on Mental Health and Chemical Dependency Parity pursuant to G.S. 120-30.17(1).

Respectfully submitted,

James B. Black
Speaker of the House

Marc Basnight
President Pro Tempore

Cochairs
Legislative Research Commission

1999 - 2000

LEGISLATIVE RESEARCH COMMISSION

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PREFACE

The Legislative Research Commission, established by Article 6B of Chapter 120 of the General Statutes, is the general purpose study group in the Legislative Branch of State Government. The Commission is cochaired by the Speaker of the House and the President Pro Tempore of the Senate and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" (G.S. 120-30.17(1)).

The Legislative Research Commission, prompted by actions during the 1998 Session and 1999 Sessions, has undertaken studies of numerous subjects. These studies were grouped into broad categories and each member of the Commission was given responsibility for one category of study. The Cochairs of the Legislative Research Commission, under the authority of G.S. 120-30.10(b) and (c), appointed committees consisting of members of the General Assembly and the public to conduct the studies. Cochairs, one from each house of the General Assembly, were designated for each committee.

The study of Mental Health and Chemical Dependency Parity was authorized by Section 2.1 (2)(b) of Chapter 395 of the 1999 Session Laws (Regular Session, 1999). Part II of Chapter 395 allows for studies authorized by that Part for the Legislative Research Commission to consider House Bill 713 or Senate Bill 836 in determining the nature, scope and aspects of the study. Section 1 of House Bill 713 reads in part: "The study may review other states' mental parity and chemical dependency parity laws, the cost-effectiveness of parity requirements, the use of case management and medical necessity

standards, the health benefits and potential cost savings of treatment, and related issues." The relevant portions of Chapter 395 and House Bill 713 are included in Appendix A.

The Legislative Research Commission authorized this study under authority of G.S. 120-30.17(1) and grouped this study in its Insurance and Managed Care Issues area under the direction of Representative Verla Insko. The Committee was chaired by Ms. Susan Green and Representative Martha Alexander. The full membership of the Committee is listed in Appendix B of this report. A Committee notebook containing the Committee minutes and all information presented to the Committee is filed in the Legislative Library.

COMMITTEE PROCEEDINGS

The Legislative Research Commission's Mental Health and Chemical Dependency Parity Study Committee met three times. The Committee agreed to address the issue of mental health and chemical dependency parity and report any recommendations the Committee makes to the General Assembly to either the 1999 Session/2000 Short Session or to the 2001 General Assembly.

At its first meeting, the Committee heard presentations by Lee Dixon and Tracy Delaney with the Health Policy Tracking Service of the National Conference of State Legislatures in Washington, DC; John Tote, Executive Director of the Mental Health Association of North Carolina and current chairperson of the North Carolina Coalition on Mental Health Care; and Tony Mulvihill, Executive Director of the Alcohol and Drug Council of North Carolina.

Lee Dixon and Tracy Delaney presented an overview of parity laws and legislation in other states and a summary of the policy issues in the parity debate. Mr. Dixon informed the Committee that Texas and North Carolina were the first two states to pass parity laws for mental health in 1991 for state employees. Five states, Maryland, Vermont, Minnesota, Connecticut, and Virginia have parity laws that cover both mental health and substance abuse. Thirteen states have parity laws for mental health or biologically based mental disorders. Twenty-eight percent of the adult US population has a diagnosed mental health or chemical dependency disorder, but only 8% receive treatment during any one-year period. Studies indicate the indirect cost to the US economy is $79 billion.

John Tote, an advocate of parity, addressed the Committee on the issues of cost and prevalence. He informed the Committee that one in five persons is affected by a mental illness – from serious long term to substance abuse problems. Over one-half of US citizens are now covered by mental health parity. According to Mr. Tote, the study of the State Employees Health Plan shows how cost-effective parity has been. He acknowledged that the mental health community understands the concerns about cost to the employers and insurance industry. An independent actuarial study performed by Coopers and Lybrand demonstrated that the expected NC employer contributions for insurance would rise by no more than 1.2%, which is in line with other findings. Blue Cross/Blue Shield's study showed only a few cents more increase. States have found that parity is extremely cost effective. The Mental Health Association found that nationwide only six groups have asked to be exempt from the Federal Legislation because of the 1% cost factor.

Tony Mulvihill addressed the Committee from the addictive perspective. Mr. Mulvihill said that the Council does not provide direct services, but they get 4,000+ calls a year seeking treatment or assistance. He presented 1998 study results which show that 784,000+ people are in need of services, 392,000 are in need of comprehensive services, 53,000 high school students are in need of services, and 50%-80% of the people in custody of the Department of Correction have some involvement with alcohol or drug abuse. Mr. Mulvihill stated that most of their calls come from slightly older people who have

finally sought help and find the mental health system hopelessly inadequate in addition services, and the victims have no money to pay for services. $5 billion is the approximate cost of addiction in NC in 1997.

At its second meeting, the Committee heard presentations by Jack Walker, Executive Administrator of the State of North Carolina Comprehensive Major Medical Plan and a panel representing various interests which included Ronald Bachman, Price Waterhouse Coopers; Paul Mahoney, Executive Director, NC Association of Health Plans; Perri Morgan, State Director, National Federation of Independent Businesses; Robert Paschal, Attorney, Young, Moore and Henderson, representing the Health Insurance Association of America; Robert Vanderberry, Retired Director of the Physicians' Health Program of the NC Medical Society; and Michael Zarzar, Psychiatrist in private practice.

Jack Walker provided the members of the Committee with an overview (covering fiscal year 1999) of the State Health Plan's mental health and chemical dependency parity. Dr. Walker stated that mental health and substance abuse claims amounted to 3.1% of state claims, costing approximately $22 million out of a total expenditure of $710 million. Two thirds of expenditures were for outpatient services.

Mental health parity coverage was enacted in 1992. In 1991, before mental health parity, the cost was $5.93 per member per month. In 1992, for about one quarter of the year, the cost was $6.49 per member per month, and in 1993, the first full year of coverage, the cost as 5.21 per member per month for mental health parity with active case management. The current cost is $4.49 working with case management services of ValueOptions. Chemical dependency coverage was enacted in 1997. In fiscal year 1997, prior to parity, the state spent $.18 for alcohol treatment and $.15 for drug treatment. For fiscal year 1998 with partial parity, the cost was $.22 for alcohol treatment and $.20 for drug treatment. For 1999 with full parity, the cost was $.23 for alcohol treatment and $.18 for drug treatment.

The six panelists had ten minutes each to speak. Robert Paschal opened by citing the many different illnesses to be covered under mental health parity as being a deterrent to offering coverage of the scope that advocates would like. From the perspective of PPO's or HMO's there is no broad scope demand. It is a consumer demand issue. Mr. Paschal cited cost as being a second issue. He reviewed several bills passed in the 1999 Session of the General Assembly mandating coverage. He also mentioned the Managed Care Study Committee that was looking at 13 federal provisions that are not part of North Carolina's plan, and all of which will raise costs. He urged the General Assembly not to pursue parity issues in a vacuum. He suggests having some caps and limitations and looking at coverage globally, not each specific item.

Ronald Bachman, an actuary, provided to the Committee copies of a report, *Just the Facts*, which is a compilation of all major studies done in costing insurance coverage. He said there is no example in the country of any state that has passed mental health parity law in which the costs have gone up. The costs have been level or have actually gone down. In NC the cost saving since instituting mental health coverage for state employees has been approximately $6 million. NC, Ohio, Texas and Alaska have comparable coverage, and the figures all prove the same result.

Paul Mahoney, spoke about cost of coverage and subtle reduction of wages. He said that a bill that does not allow health plans to establish limits on the number of visits interferes with managed care, and they do believe managed care works to hold down costs. The area of disagreement is to what degree NC parity bills will change the way health plans are used and what kind of utilization review will be implemented. Several changes, including case management, limiting number of mental health visits, were instituted at the same time as parity in the State Health Plan mental health coverage plan. He also stated that parity was not the sole reason for lower costs experienced by the State Health Plan.

Perri Morgan made a presentation to the Committee emphasizing the cost of coverage for small employers. Her organization represents 15,000 small North Carolina businesses. She said they are not a big group; therefore, mental health insurance is very costly. The real issue for her constituents is not mental health coverage but state mandates that impact them unfairly. Some employers could be forced to drop health insurance coverage completely due to increases in premiums. Eighty-seven percent of the respondents to a survey oppose mental health parity.

Robert Vanderberry presented information related to substance abuse. He stated that 11.3% of the population have a problem with alcohol or drug addiction during their lifetime. Seventy-five percent of those persons are in the workforce and very few of those affected recognize their illness early and receive intervention treatment.

Michael Zarzar, the final speaker on the panel, presented information related to mental health issues. He stated that the lack of affordable coverage is a great deterrent to getting treatment. Another drawback is a limit on number of visits that often precludes treatment to a resolution or control of an illness. He cited a case in which a patient refused to return for treatment after reaching her limit because she could not afford any more visits and was too proud to work out a payment plan. His next contact with her was in the emergency room in serious condition. She did return for treatment under a payment plan. He said most people do not want to go to a psychiatrist. They are not flocking to the door, and he sees little danger in over-use of mental health insurance. He stated that 95% of suicides have treatable psychiatric conditions.

At its third meeting, the Committee heard presentations from two consumers – Jane Via and Shelia Singleton. Jane Via said that she is very glad the General Assembly is finally dealing with mental health and chemical dependency parity. She told the Committee about the four-year struggle she and her family have had trying to get her insurance company to pay for treatment for her child who has an addiction problem and a recently diagnosed mental illness. Although her insurance covers physical illnesses adequately, coverage for the substance abuse problem is not adequate, and the insurance representatives with whom she has tried to work have been unresponsive or rude, and she has had to fight for each dollar. Her family has spent a great deal of money out of pocket, going into debt to pay for medically recommended treatment, particularly residential care. She urged the Committee to enact parity legislation so that families can get help and not be financially destroyed, so that those with chemical dependency have a chance to be cured and become productive citizens.

Shelia Singleton spoke to the Committee about her mental illness. She suffers from depression. She said that her pills cost her about $200 a month of her own money. Her insurance limits her visits,

imposes higher co-payments, and charges more up front. She said there is not sufficient care because people cannot afford it. It takes four to six weeks for the Wake Mental Health Department to get an appointment for a referral. It is hard to find a doctor taking new patients. Her insurance is through her ex-husband. She pays a lot of her own bills so that she will not be dropped.

Linda Attarian, Staff Counsel, presented the three findings related to the prevalence, cost, efficacy of treatment and the cost of parity and drafts of three legislative proposals. The Committee discussed the proposed findings voted to accept them for inclusion into its report to the Legislative Research Commission pending minor clarifying amendments. The three bill drafts were presented as three options. Option A mandated coverage of mental illness and chemical dependency for all plans and mandated full parity for all plans. All of the durational limits, coinsurance factors and everything in the policy have to be equal in benefits for physical illness, mental illness, and chemical dependency. Option B mandated coverage of mental illness and chemical dependency for all plans; mandated partial parity (does not apply to deductibles, co-payments or co-insurance factors) for plans with less than 20 employees, and mandated full parity for plans covering 20 or more employees. Option C mandated coverage of mental illness and chemical dependency for plans with 5 or more employees, mandated partial parity (does not apply to deductibles, co-payments or co-insurance factors) for plans with 5 or more employees. No coverage or parity requirements apply to plans with less than 5 employees.

Following extensive questioning and discussion, Mr. Wood made the motion that the Committee move forward with a modified version of Option B providing for partial parity for coverage of mental illness and chemical dependency for businesses with less than five employees which will be moved to full parity in two years, and full parity for businesses with five or more employees. A study on the impact on small business will be conducted and recommendations reported in two years.

Senator Martin suggested a friendly modification to require partial parity for businesses with less than 10 employees. The modification was acceptable to Mr. Wood and the motion passed.

The Committee held its fourth meeting on March 28, 2000. Representative Alexander told the Committee of a letter dated March 24, 2000, that Mr. Paul J. Mahoney, Executive Director of the North Carolina Association of Health Plans had circulated to the members by mail. The letter expressed Mr. Mahoney's concern that information he presented to the Committee was not included in the Committee's Draft findings and recommendations. Rep. Alexander responded to the letter by noting that a summary of his remarks from the panel discussion on March 9, 2000, are included in the Committee Proceedings Section of the Committee's Report to the Legislative Research Commission. Rep. Alexander presented the Committee with a copy of a letter from the Governor of Vermont, Howard Dean, M.D. This letter stated his strong support for mental health parity and that there was no indication that Vermont's parity law was driving insurance rates higher.

Representative Alexander then asked the Committee to look at a handout from Ms. Perri Morgan of the National Federation of Independent Business. This showed the results of a question posed to legislators on whether or not the legislature should mandate that group health insurance policies offer coverage for mental health and chemical dependency treatment. The results were 11% YES, 87% NO, and 2% UNDECIDED.

Linda Attarian, Staff to the Committee presented a handout to the Committee showing employment figures by sizes of a business. The 1998 data indicated that 14 percent of North Carolina employees, or 429,682, are employed in businesses employing less than 10 employees. Out of the total number of employers in North Carolina, almost 73 percent are small employers, employing less than 10 employees.

Ms. Attarian also presented a chart showing that there are twenty (20) states providing full parity and six (6) states exempting "small employers. Those states define small employers as follows: 50 or fewer: three states; 25 or fewer: two states; 20 or fewer: one state.

The Committee reviewed a draft of the Committee Report. There were two substantive changes made to the proposed legislation. First, the Committee agreed to a three year, rather than a two year delayed effective date requiring small group health plans to offer coverage for mental illness and chemical dependency at full parity to benefits for physical illness on or after January 1, 2004. The extended period of time will provide an opportunity for the Mental Health Study Committee to rely on cost experience and coverage data collected over a longer period of time. Second, the proposed legislation was amended to require the Mental Health Commission to consult with the NC Institute of Medicine and other interested entities as it conducts its study.

FINDINGS AND RECOMMENDATIONS

The Committee finds that mental illness and chemical dependency continue to pose an enormous burden on the overall health and productivity of people in North Carolina. Close to 100,000 adults in North Carolina suffer from severe and persistent mental illness, and over 343,000 adults in North Carolina are in need of comprehensive addiction treatment. The total costs to the State of North Carolina stemming from alcohol and drug abuse is over 71/2 billion dollars, including almost 5 1/2 billion dollars in lost productivity. Nationally, over $67 billion, or 11.4 percent of all personal healthcare expenditures were spent on mental disorders in 1990, the latest year that cost figures are available. In addition to health care costs associated with mental illness, the indirect costs, including costs of lost productivity, lost earnings, and societal costs, are estimated to total $148 billion annually for the nation.

The Committee believes that treatment for mental illness and chemical dependency is efficacious and cost-effective. This Report cites various studies to support this finding. (See Appendix C.) For example, the treatment success rate for schizophrenia has been shown to be 60 percent, 80 percent for bipolar disorders, and 65 percent for major depression. In addition, studies from several states have consistently shown that appropriate treatment of chemical dependency results in a significant reduction in medical claims, absenteeism, and disability; an increase in productivity; and a healthier and safer environment for all employees

The Committee believes that mandated parity for mental illness and chemical dependency benefits is affordable. Comprehensive studies of the cost of parity laws in other states show that such laws have had a small effect on premiums. In this State, the NC State Employees' Health Plan has experienced cost decreases subsequent to the implementation of full parity for mental illness and chemical dependency. The Committee believes that published studies showing actuarial predictions of high premium increases, from 3.2 percent to 11.4 percent, resulting from mental illness and chemical dependency parity mandates were based on assumptions that are not included Committee's recommendations. These studies assumed that the mandate was for "optional riders" which increase costs due to adverse selection, or that the health plan could not implement a case management program to control health care costs. The Committee concludes that actuarial models based on a composite of health plans reflecting insurance coverage nationwide are more relevant. These models estimate full parity for mental health and chemical dependency benefits may increase premiums by 3.6 percent, on average. The Committee further believes that plans that tightly managed care may experience premium increases of less than 1 percent.

The Committee recommends all group health plans, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended or by any waiver of or other exception to the Act provided under federal law, to provide coverage of mental illness and chemical dependency. The Committee recommends group health plans covering 10 or more employees to provide coverage for mental illness and chemical dependency at full parity to the benefits for physical illness under the plan. Full parity means that the plan's benefit restrictions on day and visit limits, deductibles, coinsurance factors, co-payments, maximum out-of-payment limits, annual and lifetime dollar limits, and any other

dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit must not be less favorable than those for physical illness generally.

In addition, the Committee recommends group health plans covering less than 10 employees to provide coverage for mental illness and chemical dependency at partial parity to the benefits for physical illness under the plan for a period not to exceed three years, and at full parity at the end of the three-year period. Partial parity means that the plan's benefit restrictions on day and visit limits, maximum out-of-payment limits, and annual and lifetime dollar limits must not be less favorable than those for physical illness generally. Deductibles, coinsurance factors, co-payments, and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit may be more restrictive for mental illness and chemical dependency benefits than those for physical illness.

The Committee recommends that coverage of chemical dependency extend to the treatment for the "pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal."

The Committee recommends that coverage for mental illness include persons who have been diagnosed with an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or contro; or, in the case of a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is need of treatment." The Committee recommends that the following be excluded from mental illness coverage:

- Mental disorders coded in the DSM-IV as substance abuse related disorders (291.0 through 292.9 and 303.0 through 305.9). This list of exclusions consists of numerous disorders that fall into the categories of alcohol-related disorders, amphetamine and amphetamine-like related disorders, caffeine-related disorders, cannabis-related disorders, cocaine-related disorders, hallucinogen-related disorders, inhalant-related disorders, nicotine-related disorders, opiod-related disorders, phencyclidine-related disorders, sedative-hypnotic, or anxiolytic-related disorders, polysubstance-related disorders, and other (unknown) substance-related disorders.
- Mental disorders coded as "V" codes. This includes relational problems, problems related to abuse or neglect (if the focus of attention is on a person other than the victim), and certain additional conditions such as academic problems, bereavement, and antisocial behavior.

The Committee further recommends that the issue of whether the coverage and parity mandates are too onerous on small group health plans should be studied after enough time has passed to collect reliable cost and outcome data. After the study, a determination should be made as to whether these small plans should move to full parity at the end of the three-year period.

APPENDIX A

AUTHORIZING LEGISLATION

House Bill 713

A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY TREATMENT.

The General Assembly of North Carolina enacts:

Section 1. The Legislative Research Commission may study the issue of requiring mental health benefits and chemical dependency benefits in health benefit plans in parity with physical illness benefits provided under those plans. The study may review other states' mental parity and chemical dependency parity laws, the cost-effectiveness of parity requirements, the use of case management and medical necessity standards, the health benefits and potential cost savings of treatment, and related issues.

Section 2. The Legislative Research Commission shall report any findings and recommendations to the General Assembly prior to the convening of the 2000 Regular Session of the 1999 General Assembly.

Section 3. This act is effective when it becomes law.

CHAPTER 395
1999 Session Laws (1999 Session)

AN ACT TO AUTHORIZE STUDIES BY THE LEGISLATIVE RESEARCH COMMISSION, TO CREATE VARIOUS STUDY COMMISSIONS, TO DIRECT STATE AGENCIES AND LEGISLATIVE OVERSIGHT COMMITTEES AND COMMISSIONS TO STUDY SPECIFIED ISSUES, AND TO AMEND OTHER LAWS.

The General Assembly of North Carolina enacts:

PART I.-----TITLE

Section 1. This act shall be known as "The Studies Act of 1999".

PART II.-----LEGISLATIVE RESEARCH COMMISSION

Section 2.1. The Legislative Research Commission may study the topics listed below. When applicable, the bill or resolution that originally proposed the issue or study and the name of the sponsor is listed. Unless otherwise specified, the listed bill or resolution refers to the measure introduced in the 1999 Regular Session of the 1999 General Assembly. The Commission may consider the original bill or resolution in determining the nature, scope, and aspects of the study. The following groupings are for reference only:

. . .

(2) Insurance and Managed Care Issues:

a. Managed care issues, including any willing provider, patients' rights, managed care entity liability, office of consumer advocacy for insurance, prompt payment of health claims, and related issues (S.B. 1089 - Harris, H.J.R. 1461 - Mosley).
b. Mental health and chemical dependency parity (H.B. 713 - Alexander; S.B. 836 - Martin of Pitt).
c. Health reform recommendations of the Health Care Planning Commission and its advisory committees (established by Section 1.2 of Chapter 529 of the 1993 Session Laws) that have not been implemented but are still needed and other health reform issues (Insko).
d. Pharmacy choice/competition (H.B. 1277 - Cole; S.B. 137 - Rand).

. . .

Section 21B.4. The Commission may make an interim report to the 1999 General Assembly, Regular Session 2000, upon its convening, and shall make its final report to the 2001 General Assembly upon its convening, and to the Governor. Upon submitting its final report, the Commission shall expire.

Section 21B.5. Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign appropriate professional staff from the Legislative Services Office of the General Assembly to assist with the study. The House of Representatives' and the Senate's Supervisors of Clerks shall assign clerical staff to the Commission, upon the direction of the Legislative Services Commission. The Commission may meet in the Legislative Building or the Legislative Office Building upon the approval of the Legislative Services Commission.

Section 21B.6. The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall each designate a cochair of the Commission. The Commission shall meet upon the call of the cochairs. A quorum of the Commission is 10 members. While in the discharge of its official duties, the Commission has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1. Members of the Commission shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate.

Section 21B.7. From funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds for the expenses of the Study Commission on Children With Special Needs.

APPENDIX B

MENTAL HEALTH AND CHEMICAL DEPENDENCY PARITY COMMITTEE (LRC)

1999-2001

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APPENDIX C

DATA AND FACTS CONCERNING PREVALENCE, COST, AND TREATMENT EFFICACY OF MENTAL ILLNESS AND CHEMICAL DEPENDENCY

Prevalence of Mental Illness and Chemical Dependency

Adults:

- It is estimated that there are 99,000 adults in North Carolina who suffer from severe and persistent mental illness. (*Report to the General Assembly by DMA/DD/SAS, June 1999*).
- A study conducted by the Research Triangle Institute estimated that there were 343,000 adults in North Carolina in need of comprehensive addiction treatment. This figure represents 6.6 percent of North Carolina's population over the age of 18. (*Substance Use and Need for Comprehensive Treatment and Services in North Carolina's Adult Household Population: 1995, Research Triangle Institute, 1997).*
- 19 percent of Americans have a mental disorder alone in any given year. 3 percent have both mental and addictive disorders. 6 percent have addictive disorders alone, and 28 – 30 percent have either a mental or addictive disorder. *(Regier et al.,1993; Kessler et al., 1994).*
- Between 2 – 3 percent of Americans are affected by severe mental disorders. *(Regier et al., 1993; Kessler et al., 1994).*
- An estimated 19.9 million Americans – 8.8 percent of the population—experience phobias. About 9.1 million – 5.1 percent – live with major depression. Some 3.9 million have obsessive-compulsive disorder; 2.0 million have schizophrenia; 2.4 million have panic disorder; and 2.0 million experience bipolar disorders. *(National Mental Health Association - NMHA, 1993; Mental Health, U.S., 1994).*
- One in four families will have a member with a mental illness. *(NMHA).*

Children:

- Prevalence estimates by the US Department of Health and Human Services indicate that in North Carolina, 170,000-204,000 children suffer from a severe emotional disturbance. In addition, it is estimated that 204,000-270,000 children have emotional problems without significant impairment of functioning. In these two categories, area programs served 76,000 children in North Carolina in FY 1997-98. (*Report to the General Assembly by DMA/DD/SAS, June 1999*).
- A study conducted by the Research Triangle Institute found that in 1997, 23.9 % of middle school and 42.2 % of high school students had used alcohol in the past month. The same data shows that 10.5% of high school students participated in "heavy" alcohol use, i.e. 5 more drinks in a row on 3 or more days in the past month. For middle school students, in their lifetime, 60% had used alcohol, 20.6% had used marihuana, 5.4% cocaine, 18.6% inhalants, 3.7% steroids, and 2.2% had injected drugs. For high school students, 75.5% had used alcohol in their lifetimes, 44.8% marihuana, 7.2% cocaine, 10.9% hallucinogens, 3.2% heroin, 14.9% uppers, 17.4% inhalants, 4.0% steroids, and 2.5% had injected drugs. (*Use of Alcohol and Illicit Drugs and Need for Prevention among North Carolina Middle and High School Students: 1997, Greene, Weimer, Ringwalt, Research Triangle Institute, October 1999).*

- During the 1997-98 fiscal year, over 112,000 persons received mental health and substance abuse services from the State's 41 area mental health programs. *(North Carolina Area Programs Admission Characteristics, Fiscal Year 1998, DMH/DD/SAS)*
- Mental Health problems affect one in every five young people at any given time. *(U.S. Department of Health and Human Services - DHHS).*
- Serious Emotional Disturbance (SED) affects 1 in every 10 young people at any given time (DHHS, U.S.).Less than one-third of the children under age 18 with an SED receive mental health services. Often, the services are inappropriate. *(Children's Defense Fund; CMHS; Mental Health, U.S., 1994).*
- 6.1 percent of youth, ages 12 –18, were illicit drug users in 1996. (*Substance Abuse and Mental Health Services Administration - SAMHSA).*

Older Adults

- Approximately 19.8 percent of older adults (55 years and older) suffer from a diagnosable mental disorder during a one-year period. *(Mental Health Report: A Report of the Surgeon General, 1999).*
- The rate of suicide, which is frequently a consequence of depression, is highest among older adults relative to all other age groups. (Hoyert et al., 1999).

The Financial Burden of Mental Illness and Chemical Dependency

Economic, Social and Indirect Costs

- The combined indirect and related costs of mental illnesses, including costs of lost productivity, lost earnings, and societal costs, are estimated to total $148 billion. (NIMH, 1999).
- The indirect costs of all mental illnesses imposed nearly a $79 billion loss on the U.S. economy in 1990 (the most recent year for which estimates are available). *(Rice and Miller, 1996).* $63 billion of the $79 billion loss reflects morbidity costs—the loss of productivity in usual activities because of illness, $12 billion in mortality costs—lost productivity due to premature death, and almost $4 billion in productivity losses for incarcerated individuals and for the time of individuals providing family care. (*Mental Health Report: A Report of the Surgeon General*, 1999).
- For schizophrenia alone, the total indirect cost was almost $15 billion in 1990. These estimates are conservative because they do not capture some measure of the pain, suffering, disruption, and reduced productivity that are not reflected in earnings. (*Mental Health Report: A Report of the Surgeon General*, 1999).
- In a study of the national costs of alcohol and drug abuse to society, the total costs were estimated to be $247.7 billion in 1992, and increased to $276.3 billion in 1995. (SAMHSA).
- For North Carolina, the total costs of alcohol and drug abuse amount to $7,557,000,000. It is estimated that drug and alcohol abuse costs North Carolina almost $5,426,000,000 just in lost productivity. (*The Economic Costs of Alcohol and Drug Abuse in the United States, 1995, The Lewin Group, NIDA, NIAAA).*
- Clinical depression alone costs the U.S. $43.7 billion annually, including workplace costs for absenteeism and lost productivity ($23.8 billion), direct costs for treatment and rehabilitation ($12.4 billion) and loss of expected lifetime earnings due to depression-induced suicides ($7.5 billion). *(Massachusetts Institute of Technology - MIT, 1993).*

- The cost of alcohol and illicit drug use in the workplace, including lost productivity, medical claims and accidents, amounts to $140 billion per year. *(National Drug Addiction Recovery Month Kit, 1998).*

Healthcare Costs

- Expenditures for professional healthcare for persons suffering from mental disorders accounted for $67 billion, or 11.4 percent of all personal healthcare expenditures in 1990. This included care in mental specialty institutions, hospitals and nursing homes, physician and other professional services, and prescription drugs. *(Rice and Miller, 1993).*
- In 1996, the United States spent more than $99 billion for the direct treatment of mental disorders, as well as substance abuse, Alzheimer's disease and other types of dementia. More than two-thirds of this amount ($69 billion or more than seven percent of total health spending) was for mental health services. Spending for direct treatment of substance abuse was almost $13 billion (more than one percent of total health spending). (*Mental Health Report: A Report of the Surgeon General*, 1999).
- In North Carolina, it is estimated that 884 million health care dollars are spent on alcohol and drug abuse.
- People with mental illnesses fill almost 21 percent of hospital beds. *(SAMHSA, 1995).*
- As many as half of all visits to primary care physicians are due to conditions caused or exacerbated by mental health or emotional problems. *(Collaborative Family Healthcare Coalition, 1998)*
- Anxiety disorders cost the U.S. $46.8 billion in 1990, nearly one-third of the nation's total mental health bill. *(NIMH).*

Efficacy and Cost-Effectiveness of Treatment of Mental Illness and Chemical Dependency

- The treatment success rate for schizophrenia is 60 percent, 80 percent for bipolar disorders, and 65 percent for major depression, whereas the treatment success rate for heart disease ranges only 41 to 52 percent. *(SAMHSA, 1995).*
- Studies from several states have consistently shown that drug treatment is a cost-effective approach to the problem. These state experiences demonstrate that treatment results in marked decreases in drug use and illegal behavior across the board.
    1. California. Its study, Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA) found that criminal activity declined by 66 percent, drug and alcohol use declined by 40 percent, and hospitalizations declined by 33 percent. Moreover, every dollar invested in drug treatment averaged a seven-dollar return.
    2. Ohio. The State of Ohio realized eleven dollars in savings on health care costs for every dollar spent on prevention and treatment.
    3. Minnesota. The State of Minnesota found that nearly 80 percent of the costs for treatment substance abusers were offset in the first year alone by reductions in medical and substance abuse hospitalization, detoxification, and arrests.
    4. Oregon. An Oregon study of societal outcomes and cost savings found that $5.60 is saved by taxpayers for every dollar spent on those who complete treatment.

- In a before-and-after drug abuse treatment study of 4,411 people in federally funded treatment, the prevalence of illicit drug abuse was cut by about one-half for each illicit substance (i.e. cocaine,

marijuana, crack, or heroin), and the number of those troubled by alcohol abuse dropped by more than two-thirds 5 to 16 months after treatment. Furthermore, the percentage of people selling drugs, shoplifting, or assaulting others dropped by almost 80 percent 5 to 16 months after treatment. In addition, the percentage of clients receiving welfare declined from 40 percent to 35 percent—an almost 11 percent overall decrease. *Gerstein DR, Datta RA, Ingels JS, Johnson RA, Rasinski KA, Schildhaus S, Talley K, and others. Final Report: National Treatment Improvement Evaluation Survey. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1997.*

- The following research studies have shown that substance abuse treatment results in a significant reduction in medical claims, absenteeism, and disability; an increase in productivity; and a healthier and safer environment for all employees:

  1. General Motors Corporation's EAP saves the company $37 million per year in lost productivity--$3,700 for each of the 10,000 employees enrolled in the program. *American Society for Industrial Security, O.P. Norton Information Resources Center, Substance Abuse: A Guide to Workplace Issues. American Society for Industrial Security, 1990*
  2. United Airlines estimates that it has a $16.95 return in the form of higher productivity for every dollar invested in employee assistance. *American Society for Industrial Security, O.P. Norton Information Resources Center, Substance Abuse: A Guide to Workplace Issues. American Society for Industrial Security, 1990*
  3. Northrop Corporation saw productivity increase 43 percent in the first 100 employees to enter an alcohol treatment program. After 3 years of sobriety, savings per rehabilitated employee approached $20,000. *Campbell D. and Graham M. Drugs and Alcohol in the Workplace: A Guide for Managers, New York: Facts on File Publications, 1988.*
  4. Oldsmobile's Lansing, Michigan, plant saw the following results one year after employees with alcoholism programs received treatment: Lost man-hours declined by 49 percent, health care benefit costs by 29 percent, absences by 56 percent, grievances by 78 percent, disciplinary problems by 63 percent, and accidents by 82 percent. *Campbell D. and Graham M. Drugs and Alcohol in the Workplace: A Guide for Managers, New York: Facts on File Publications, 1988.*

Cost of Mandated Parity:

- Full parity for mental health and substance abuse services in private health insurance plans that tightly manage care is estimated to increase family insurance premiums less than 1 percent. *SAMHSA, The Cost and Effects of Parity for Mental Health and Substance Abuse Insurance, 1998.*
- A study, published in the Journal of the American Medical Association, looked at the cost implications of the 1996 federal mental health parity legislation (Federal Mental Health Parity Act of 1996). Assumptions used in the congressional debate over parity legislation had suggested that unlimited mental health care benefits would greatly increase costs. RAND researcher Roland Sturm tested these assumptions by studying managed care plans that already implemented full parity. The study found that the assumptions used during the parity-legislation debate had substantially overstated the actual cost of mental health services under managed care. The study fount that unlimited mental health benefits under managed care cost virtually the same as capped benefits. The average increase

was about $1 per employee compared with costs under a $25,000 cap, which was a typical limit in other existing plans. *How Expensive Is Unlimited Mental Health Care Coverage Under Managed Care? Sturm, R. JAMA, Vol. 78, No. 18, 1997, pp. 1533-1537.*

APPENDIX D

RECOMMENDED LEGISLATION

SECTION BY SECTION ANALYSIS OF PROPOSED LEGISLATION

CURRENT LAW

Chemical Dependency: Under current law, insurers, service corporations (Blue Cross), and HMOs must offer coverage for chemical dependency to all group and blanket policyholders that is no less favorable than the coverage provided under the policy for physical benefits generally. If the group policyholder accepts the coverage, the benefits must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as benefits for physical illness generally. If the policy provides more than $8,000 in total annual benefits for all illnesses under the policy, it must also provide chemical dependency coverage of at least $8,000 *per year* and at least $16,000 over the *lifetime* of the policy.

Mental illness: Insurers, service corporations and HMOs are not required to provide or offer mental health benefits in their plans. However, if the plan does provide mental health benefits, it must ensure that any lifetime and annual limits on that coverage is no less favorable than the benefits provided for physical benefits generally under the plan. Any plan that can show a 1% increase in costs as a result of this requirement can opt out of the requirement, and any plan that has 50 or fewer employees is exempt. This law expires October 1, 2001.

Self-funded plans. Self-funded, employer-based health plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA). This federal law regulates, with some exceptions, all employer-based pension and welfare benefits, including employer-based health plans. ERISA regulation preempts all state laws that "relate to" an employee benefit plan. Self-funded plans are not required to comply with state-mandated benefits. While the exact number of people who receive health care through self-funded employer-based health plans is unknown, it is estimated that 40 percent of insured people are enrolled in self-funded plans, plans that are free from state regulation. Plans governed by ERISA are subject to the federal Mental Health Parity Act of 1996. The Act prohibits these plans from imposing annual or lifetime dollar limits on reimbursement ceilings for mental health benefits that are more restrictive than those applied to care for physical illness. Thus, both insured and self-funded group plans in North Carolina are covered by the limited mental parity requirement.

BILL ANALYSIS

Coverage and Parity Requirements:

Effective January 1, 2001: The proposed bill requires all group health benefit plans to provide chemical dependency and mental illness benefits. Plans covering 10 or more employees.are required provide these

benefits in full parity with benefits for physical illness generally under the policy. The plan cannot provide for lower annual and lifetime dollar limits, different deductibles, co-payments, or coinsurance factors, lower maximum out-of-pocket limits, or more restrictive day and visit limits for mental illness and chemical dependency benefits than the plan provides for physical illness benefits generally under the policy

Group health benefit plans that cover less than 10 employees.are required to provide mental illness and chemical dependency benefits in *partial* parity with the benefits provided for physical illness generally under the policy. The plan may not provide for lower annual and lifetime dollar limits, lower maximum out-of-pocket limits, or more restrictive day and visit limits. The plan may provide for different deductibles, co-payments, or coinsurance factors prior to reaching any maximum limits for mental illness and chemical dependency benefits than the plan provides for physical benefits generally under the policy.

Effective January 1, 2004: After a period of three years, effective on January 1, 2004, small employer group plans covering less than 10 employees will be required to provide chemical dependency and mental illness benefit in full parity with benefits for physical illness generally under the policy. Thus, after January 1, 2004, all group health benefit plans will be required to cover benefits for mental illness and chemical dependency that are no less restrictive than those the plan provides for physical illness generally.

Cost Control Provisions:

The bill authorizes insurers, service corporations (Blue Cross), and HMOs to use case management programs in conjunction with their coverage of chemical dependency and mental illness benefits. Case management programs, which would be required to comply with rules adopted by the Commissioner of Insurance, are used to evaluate and determine medically necessary and medically appropriate care for each patient. In addition, nothing in the bill prohibits health plans from using common managed care procedures, such as pre-admission screening and prior authorization, to determine whether treatment for mental illness or chemical dependency is medically necessary in a particular case. Finally, plans will meet the parity requirements in the bill if at least one of the patient's choices of treatment options within the patient's policy meets the parity requirement.

Utilization Review for Chemical Dependency Treatment:

The bill requires the use of ASAM (American Society of Addiction Medicine Patient Placement) criteria or other criteria adopted by the insurer or its utilization review organization in the utilization review of placement decisions relating to the treatment of chemical dependency.

Definitions of Mental Illness and Chemical Dependency:

*Chemical Dependency:*Chemical dependency, for purposes of the chemical dependency parity requirement, is defined as the *"pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal."*

Another section of the current law, which prohibits insurers from discriminating against mentally ill or chemically dependent individuals in the issuance of policies providing physical benefits, defines

"chemically dependent" in the same manner, but the bill adds a requirement that the dependency be accompanied by a mental disorder recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or subsequent editions). See Sections 3, 8, and 11.

Mental Illness: Mental illness, for purposes of both the parity requirement and the anti-discrimination requirement, is defined under the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, with the additional requirement that it be accompanied by a recognized mental disorder also. The MH/DD/SA Act defines "mental illness" as follows: *"(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is need of treatment."(GS 122C-3(21)).*

The bill specifically excludes from the mental illness coverage requirement the following disorders:

- Mental disorders coded in the DSM-IV as substance abuse related disorders (291.0 through 292.9 and 303.0 through 305.9). This list of exclusions consists of numerous disorders that fall into the categories of alcohol-related disorders, amphetamine and amphetamine-like related disorders, caffeine-related disorders, cannabis-related disorders, cocaine-related disorders, hallucinogen-related disorders, inhalant-related disorders, nicotine-related disorders, opiod-related disorders, phencyclidine-related disorders, sedative-hypnotic, or anxiolytic-related disorders, polysubstance-related disorders, and other (unknown) substance-related disorders.
- Mental disorders coded as "V" codes. This includes relational problems, problems related to abuse or neglect (if the focus of attention is on a person other than the victim), and certain additional conditions such as academic problems, bereavement, and antisocial behavior.

Study:

The bill requires the Mental Health Study Commission to study the issue of mandating mental illness and chemical dependency benefits at full parity for small employer group plans with less than 10 employees. The Commission must consult with the NC Institute of Medicine and other interested entities in conducting the study and report its recommendations to the General Assembly upon the convening of the 2003 Regular Session.

Section by Section Description:

The mental parity requirement is contained primarily in Sections 4 and 5 of the bill, which applies to insurers, service corporations, and HMOs. The chemical dependency parity requirement is provided for in Sections 1, 2, 6, 7, 9, and 10. The same language is set out several times in the bill because the State has separate laws for insurers, service corporations, and HMOs. Sections 1 and 2 apply to insurers, Sections 6 and 7 apply to service corporations, and Sections 9 and 10 apply to HMOs. In addition, the bill provides for staggered parity requirements after a period of three years for group health plans of less than 10 employees. Thus, each of the parity provisions are set out twice, one effective January 1, 2001 and second, its companion, effective three years later on January 1, 2004. Sections 3, 8, and 11 amends the definition of chemical dependency in current law prohibiting insurers from discriminating against mentally ill or chemically dependent individuals in the issuance of policies providing physical benefits.

Section 12 makes both the mental illness and chemical dependency coverage and parity requirements applicable to the standard health plan offered in the small employer group market. Section 13 requires the Mental Health Study Commission to study the issue of mandating mental illness and chemical dependency at full parity with benefits for physical illness on small employers and to report its recommendations to the 2003 General Assembly. Section 14 sets forth the effective dates of the sections of the bill, and provides that they are applicable to health benefit plans that are delivered, issued, or renewed on or after the specified dates. For the purposes of the 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

RMZ05

Short Title: Mental Health/Chem. Dep. Parity. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY TREATMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-51-50 reads as rewritten:

"**§ 58-51-50. Coverage for chemical dependency treatment.**

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

(1) '~~chemical~~ Chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(2) 'Health benefit plan' has the same meaning as in G.S. 58-3-220.

(3) 'Insurer' has the same meaning as in G.S. 58-3-220.

(b) Chemical Dependency Parity Requirement for Health Insurance Contracts Covering Ten or More Employees. -- ~~Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1985, shall offer to its insureds~~ Every health insurer shall provide in each group health benefit plan covering 10 or more employees benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally.

~~Except as provided in subsection (c) of this section, benefits~~ Benefits for treatment of chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(c) Chemical Dependency Parity Requirement for Health Insurance Contracts Covering Less Than Ten Employees. -- Every health insurer shall provide, in each group health benefit plan covering less than 10 employees, benefits for the necessary care and treatment of chemical dependency. Benefits for treatment of chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors, and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(d) Case Management. -- An insurer may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(e) Medical Necessity. -- Nothing in this section prohibits a group health benefit plan from managing the provision of benefits

through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the 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 utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

~~(c) Every group policy or group contract of insurance that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars ($8,000) is subject to the following conditions:~~

~~(1) The policy or contract shall provide, for each 12-month period, a minimum benefit of eight thousand dollars ($8,000) for the necessary care and treatment of chemical dependency.~~

~~(2) The policy or contract shall provide a minimum benefit of sixteen thousand dollars ($16,000) for the necessary care and treatment of chemical dependency for the life of the policy or contract.~~

~~(d)~~(g) Provisions for benefits for necessary care and treatment of chemical dependency in group policies or group contracts of insurance shall provide benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of ~~General Statutes Chapter 131E:~~ Chapter 131E of the General Statutes:

a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~ licensed facilities;

b. Medical units;

c. Psychiatric units; and

(2) The following facilities or programs licensed ~~after July 1, 1984,~~ under Article 2 of Chapter 122C of the General Statutes: ~~Statutes Chapter 122C:~~
a. Chemical dependency units in psychiatric hospitals;
b. Chemical dependency hospitals;
c. Residential chemical dependency treatment facilities;
d. Social setting detoxification facilities or programs;
e. Medical detoxification or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed ~~after July 1, 1984,~~ under Article 2 of ~~General Statutes Chapter 122C.~~ Chapter 122C of the General Statutes.

~~Provided, however, that nothing in this subsection shall~~ This subsection does not prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(e) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group policy holder or group contract holder who rejects the coverage in writing.~~"

Section 2. Effective January 1, 2004, G.S. 58-51-50, as amended by Section 1 of this act, reads as rewritten:

"**§ 58-51-50. Coverage for chemical dependency treatment.**

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

(1) 'Chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(2) 'Health benefit plan' has the same meaning as in G.S. 58-3-220.

(3) 'Insurer' has the same meaning as in G.S. 58-3-220.

(b) Chemical Dependency Parity ~~Requirement for Health Insurance Contracts Covering 10 or More Employees.~~ Requirement. -- Every health insurer shall provide in each group health benefit plan

~~covering 10 or more employees~~ benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. Benefits for treatment of chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

~~(c) Chemical Dependency Parity Requirement for Health Insurance Contracts Covering Less Than 10 Employees. -- Every health insurer shall provide in each group health benefit plan covering less than 10 employees benefits for the necessary care and treatment of chemical dependency. Benefits for treatment of chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.~~

(d) Case Management. -- An insurer may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(e) Medical Necessity. -- Nothing in this section prohibits a group health benefit plan from managing the provision of benefits

through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the 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 utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

(g) Provisions for benefits for necessary care and treatment of chemical dependency in group policies or group contracts of insurance shall provide benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of Chapter 131E of the General Statutes:
   a. Chemical dependency units in licensed facilities;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed under Article 2 of Chapter 122C of the General Statutes:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities

licensed under Article 2 of Chapter 122C of the General Statutes.

This subsection does not prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency."

Section 3. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against ~~the~~ mentally ill and 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~~ 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 edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) 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 of this manual.

~~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) Coverage of Mental Illness. -- A policy that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health~~

~~benefits than on the physical illness or injury benefits, subject to the following:~~

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

~~(2) If the policy contains lifetime 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 policy, the insurer may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

~~(3) If the policy contains annual 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 policy, the insurer may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

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

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

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

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

~~(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 section applies only to group health insurance contracts, other than excepted benefits as defined in G.S. 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).~~"

Section 4. 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 Illness Parity Requirement for Health Benefit Plans Covering Ten or More Employees. -- A health insurer shall provide, in each group health benefit plan covering 10 or more employees, benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, 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 prior to reaching any out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(b) Mental Illness Parity Requirement for Health Benefit Plans Covering Less Than Ten Employees. -- Every health insurer shall provide, in each group health benefit plan covering less than 10 employees, benefits for the necessary care and treatment of mental illness. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors, and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a

policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(c) Case Management. -- An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules may only ensure that case management programs are not designed to avoid the requirements of this section for parity between the benefits for mental illness and those for physical illness generally.

(d) Medical Necessity. -- Nothing in this section prohibits a group health benefit plan from managing the provision of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental illness only to those that are deemed medically necessary.

(e) Definitions. -- As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' includes a blanket health policy or blanket accident and health policy. 'Health benefit plan' does not mean any of the following kinds of insurance:

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. Insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability policy or equivalent self-insurance.
l. Hospital income or indemnity.
m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) 'Insurer' means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(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 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 292.9 and 303.0 through 305.9) and those coded as 'V' codes."

Section 5. Effective January 1, 2004, G.S. 58-3-220, as enacted by this act, reads as rewritten:

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

(a) Mental Illness Parity ~~Requirement for Health Benefit Plans Covering 10 or More Employees.~~ Requirement. -- A health insurer shall provide in each group health benefit plan ~~covering 10 or more employees~~ benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, 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 prior to reaching any out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to

be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

~~(b) Mental Illness Parity Requirement for Health Benefit Plans Covering Less Than 10 Employees. -- Every health insurer shall provide in each group health benefit plan covering less than 10 employees benefits for the necessary care and treatment of mental illness. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.~~

(c) Case Management. -- An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules may only ensure that case management programs are not designed to avoid the requirements of this section for parity between the benefits for mental illness and those for physical illness generally.

(d) Medical Necessity. -- Nothing in this section prohibits a group health benefit plan from managing the provision of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental illness only to those that are deemed medically necessary.

(e) Definitions. -- As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as

amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' includes a blanket health policy or blanket accident and health policy. 'Health benefit plan' does not mean any of the following kinds of insurance:

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. Insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability policy or equivalent self-insurance.
l. Hospital income or indemnity.
m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) 'Insurer' means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(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 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 292.9 and 303.0 through 305.9) and those coded as 'V' codes."

Section 6. G.S. 58-65-75 reads as rewritten:

"**§ 58-65-75. Coverage for chemical dependency treatment.**

(a) Definition. -- As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Chemical Dependency Parity Requirement for Group Insurance Certificate or Group Subscriber Contracts Covering Ten or More Employees. -- Every group insurance certificate or group subscriber contract covering 10 or more employees under any hospital or medical plan governed by this Article and Article 66 of this Chapter ~~that is issued, renewed, or amended on or after January 1, 1985, shall offer~~ shall provide to its insureds benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(c) Chemical Dependency Parity Requirement for Group Insurance Certificate or Group Subscriber Contracts Covering Less Than Ten Employees. -- Every group insurance certificate or group subscriber contract covering less than 10 employees under any hospital or medical plan governed by this Article and Article 66 of this Chapter shall provide to its insureds benefits for the necessary care and treatment of chemical dependency benefits for the necessary care and treatment of chemical dependency. Benefits for treatment of chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors, and any other dollar limits or

fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(d) Case Management. -- A group insurance certificate or group subscriber contract may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient; provided, that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(e) Medical Necessity. -- Nothing in this section prohibits a group hospital or medical plan governed by this Article from managing the provision of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the 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 utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

~~(c) Every group insurance certificate or group subscriber contract that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars ($8,000) is subject to the following conditions:~~

~~(1) The certificate or contract shall provide, for each 12-month period, a minimum benefit of eight thousand dollars ($8,000) for the necessary care and treatment of chemical dependency.~~

~~(2) The certificate or contract shall provide a minimum benefit of sixteen thousand dollars ($16,000) for the necessary care and treatment of chemical dependency for the life of the certificate or contract.~~

~~(d)~~(g) Provisions for benefits for necessary care and treatment of chemical dependency in group certificates or group contracts shall provide for benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of ~~General Statutes Chapter 131E:~~ Chapter 131E of the General Statutes:

a. Chemical dependency units in licensed facilities; ~~facilities licensed after October 1, 1984;~~

b. Medical units;

c. Psychiatric units; and

(2) The following facilities or programs licensed ~~after July 1, 1984,~~ under Article 2 of ~~General Statutes Chapter 122C:~~ Chapter 122C of the General Statutes:

a. Chemical dependency units in psychiatric hospitals;

b. Chemical dependency hospitals;

c. Residential chemical dependency treatment facilities;

d. Social setting detoxification facilities or programs;

e. Medical detoxification facilities or programs; and

(3) Duly licensed physicians and duly licensed psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed ~~after July 1, 1984,~~ under Article 2 of ~~General Statutes Chapter 122C.~~ Chapter 122C of the General Statutes. ~~After January 1, 1995, 'duly~~ 'Duly licensed psychologists' ~~shall be~~ are defined as licensed psychologists who hold permanent licensure and certification as health services provider psychologist issued by the North Carolina Psychology Board.

~~Provided, however, that nothing in this subsection shall~~ This section does not prohibit any certificate or contract from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(c) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group certificate holder or group subscriber contract holder who rejects the coverage in writing.~~"

Section 7. Effective January 1, 2004, G.S. 58-65-75, as amended by Section 6 of this act, reads as rewritten:

"**§ 58-65-75. Coverage for chemical dependency treatment.**

(a) Definition. -- As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Chemical Dependency Parity ~~Requirement for Group Insurance Certificate or Group Subscriber Contracts Covering 10 or More Employees.~~ Requirement. -- Every group insurance certificate or group subscriber contract ~~covering 10 or more employees~~ under any hospital or medical plan governed by this Article and Article 66 of this Chapter shall provide to its insureds benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. Benefits for chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

~~(c) Chemical Dependency Parity Requirement for Group Insurance Certificate or Group Subscriber Contracts Covering Less Than 10 Employees. -- Every group insurance certificate or group subscriber contract covering less than 10 employees under any hospital or medical plan governed by this Article and Article 66~~

~~of this Chapter shall provide to its insureds benefits for the necessary care and treatment of chemical dependency benefits for the necessary care and treatment of chemical dependency. Benefits for treatment of chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.~~

(d) Case Management. -- A group insurance certificate or group subscriber contract may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(e) Medical Necessity. -- Nothing in this section prohibits a hospital or medical plan governed by this Article from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the 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 utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

(g) Provisions for benefits for necessary care and treatment of chemical dependency in group certificates or group contracts shall provide for benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of Chapter 131E of the General Statutes:
   a. Chemical dependency units in licensed facilities;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed under Article 2 of Chapter 122C of the General Statutes:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification facilities or programs; and

(3) Duly licensed physicians and duly licensed psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed under Article 2 of Chapter 122C of the General Statutes. 'Duly licensed psychologists' are defined as licensed psychologists who hold permanent licensure and certification as health services provider psychologist issued by the North Carolina Psychology Board.

This subsection does not prohibit any certificate or contract from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency."

Section 8. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against ~~the~~ mentally ill and 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~~ 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 edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) 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 of this manual.

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

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

~~(2) If the subscriber contract contains lifetime limits only on selected physical illness or injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose a lifetime limit on the mental health benefits that is based on a~~

~~weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

~~(3) If the subscriber contract contains annual 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 subscriber contract, the service corporation may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

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

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

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

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

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

Section 9. G.S. 58-67-70 reads as rewritten:

"**§ 58-67-70. Coverage for chemical dependency treatment.**

(a) Definition. -- As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) ~~On and after January 1, 1985, every~~ Chemical Dependency Parity Requirement For Health Care Plans Covering Ten or More Employees. -- Every health maintenance organization that writes a health care plan on a group basis covering 10 or more employees and that is subject to this Article shall ~~offer~~ provide benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits under the health care plan generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes day and visit limits, 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(c) Chemical Dependency Parity Requirement For Health Care Plans Covering Less Than Ten Employees. -- Every health maintenance organization that writes a health care plan on a group basis covering less than 10 employees and that is subject to this Article shall provide benefits for the necessary care and treatment of chemical dependency. Benefits for chemical dependency shall be subject to the same limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors, and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage

of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(d) Case Management. -- A health maintenance organization may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(e) Medical Necessity. -- Nothing in this section prohibits a health maintenance organization from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the 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 utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

~~(c) Every group policy or group contract of insurance that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars ($8,000) is subject to the following conditions:~~

~~(1) The policy or contract shall provide, for each 12-month period, a minimum benefit of eight thousand dollars ($8,000) for the necessary care and treatment of chemical dependency.~~

~~(2) The policy or contract shall provide a minimum benefit of sixteen thousand dollars ($16,000) for~~

~~the necessary care and treatment of chemical dependency for the life of the policy or contract.~~

~~(d)~~(g) Provisions for benefits for necessary care and treatment of chemical dependency in group policies or group contracts of insurance shall provide benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of ~~General Statutes Chapter 131E:~~ Chapter 131E of the General Statutes:
   a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~ licensed facilities;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed ~~after July 1, 1984,~~ under Article 2 of Chapter 122C of the General Statutes: ~~Statutes Chapter 122C:~~
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed ~~after July 1, 1984,~~ under Article 2 of ~~General Statutes Chapter 122C.~~ Chapter 122C of the General Statutes.

~~Provided, however, that nothing in this subsection shall~~ This subsection does not prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(e) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group policy holder or group contract holder who rejects the coverage in writing.~~

~~(f)~~(h) Notwithstanding any other provision of this section or Article, any health maintenance organization subject to this Article that becomes a qualified health maintenance organization under Title XIII of the United States Public Health Service Act shall provide the benefits required under that federal Act, which shall be deemed to constitute compliance with the provisions of this section; and any health maintenance organization may provide that the benefits provided under this section must be obtained through providers affiliated with the health maintenance organization."

Section 10. Effective January 1, 2004, G.S. 58-67-70, as amended by Section 9 of this act, reads as rewritten:

"**§ 58-67-70. Coverage for chemical dependency treatment.**

(a) Definition. -- As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Chemical Dependency Parity ~~Requirement For Health Care Plans Covering 10 or More Employees.~~ Requirement. -- Every health maintenance organization that writes a health care plan on a group basis ~~covering 10 or more employees~~ and that is subject to this Article shall provide benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits under the health care plan generally. Benefits for chemical dependency shall be subject to the same limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes day and visit limits, 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

~~(c) Chemical Dependency Parity Requirement For Health Care Plans Covering Less Than 10 Employees. -- Every health maintenance organization that writes a health care plan on a group basis covering less than 10 employees and that is subject to this Article shall provide benefits for the necessary care and~~

~~treatment of chemical dependency. Benefits for chemical dependency shall be subject to the same limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.~~

(d) Case Management. -- A health maintenance organization may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(e) Medical Necessity. -- Nothing in this section prohibits a health maintenance organization from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the 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 utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

(g) Provisions for benefits for necessary care and treatment of chemical dependency in group policies or group contracts of

insurance shall provide benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of Chapter 131E of the General Statutes:
   a. Chemical dependency units in licensed facilities;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed under Article 2 of Chapter 122C of the General Statutes:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed under Article 2 of Chapter 122C of the General Statutes.

This subsection does not prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

(h) Notwithstanding any other provision of this section or Article, any health maintenance organization subject to this Article that becomes a qualified health maintenance organization under Title XIII of the United States Public Health Service Act shall provide the benefits required under that federal Act, which shall be deemed to constitute compliance with the provisions of this section; and any health maintenance organization may provide that the benefits provided under this section must be obtained through providers affiliated with the health maintenance organization."

Section 11. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against ~~the~~ mentally ill and 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~~ 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 edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) 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 of this manual.

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

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

~~(2) If the plan contains lifetime 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 plan, the HMO may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury~~

~~benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

~~(3) If the plan contains annual 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 plan, the HMO may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

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

~~(5) If the HMO offers two or more benefit package options under a plan, each package must comply with this subsection.~~

~~(6) This subsection does not apply to a health benefit plan if the HMO can demonstrate to the Commissioner that compliance will increase the cost of the plan by one percent (1%) or more.~~

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

~~(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 section applies only to group contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~"

Section 12. 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) Treatment of chemical dependency and mental illness in accordance with G.S. 58-51-50 and G.S. 58-3-220, respectively.

(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 13. The Legislative Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services shall study the issue of requiring mental illness and chemical dependency benefits in health benefit plans for groups with less than 10 employees in parity to physical illness benefits to the extent required under this act. The study may review the health benefits and the cost effectiveness of the parity requirements provided for in this act for these plans. In conducting the study, the Commission shall consult with the North Carolina Institute of Medicine and other interested entities. The Commission shall report its recommendations to the General Assembly upon the convening of the 2003 Regular Session.

Section 14. Sections 2, 5, 7, and 10 of this act are effective January 1, 2004, and apply to health benefit plans that are delivered, issued for delivery, or renewed on and after that date. The remainder of this act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2001. 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.