ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, No. 2077

STATE OF NEW JERSEY

213th LEGISLATURE

ADOPTED MARCH 3, 2008

Sponsored by:
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Assemblywoman VALERIE VAINIERI HUTTLE
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Co-Sponsored by:
Assemblywoman Wagner, Assemblymen Coutinho, Vas and Assemblywoman Voss

SYNOPSIS

Revises statutory mental health coverage requirements and requires all health insurers and SHBP to cover treatment for alcoholism and other substance-use disorders under same terms and conditions as for other diseases or illnesses.

CURRENT VERSION OF TEXT

Substitute as adopted by the Assembly Health and Senior Services Committee.

(Sponsorship Updated As Of: 6/6/2008)

AN ACT concerning health care coverage for mental health services and alcoholism and other substance-use disorders and revising parts of the statutory law.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.1999, c.106 (C.17:48-6v) is amended to read as follows:

1. a. (1) Every individual and group hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract.

In addition, the hospital service corporation contract shall provide coverage for serious non-biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract; however, coverage for treatment of alcoholism and other substance-use disorders shall be subject to the provisions of section 1 of P.L.1977, c.115 (C.17:48-6a).

(2) As used in this section:

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Serious non-biologically-based mental illness" means a mental or nervous condition that is primarily treated with psychotherapy or psychotropic medication but is not caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the function of the person with the illness, including, but not limited to, dysthymic disorder, post-traumatic stress disorder, borderline personality disorder, bulimia, anorexia and other eating disorders, and other illnesses found in the Diagnostic and Statistical Manual of Mental Disorders as determined by regulation of the Commissioner of

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

Banking and Insurance, in consultation with the Commissioner of Health and Senior Services.

"Same terms and conditions" means that the hospital service corporation cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which a hospital service corporation determines:

(1) whether a mental health care service meets the medical necessity standard as established by the hospital service corporation; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the contract.

c. Notwithstanding any other provision of law to the contrary, the coverage required pursuant to this section may be subject to utilization review as performed by the hospital service corporation or its designated utilization review organization.

d. The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

e. Notwithstanding the provisions of subsection a. of this section to the contrary:

(1) The financial requirements applicable to coverage for mental illness as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the contract, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, and the contract may not establish separate cost-sharing requirements that are applicable only with respect to coverage for mental illness; and

(2) The treatment limitations applicable to coverage for mental illness shall be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the contract, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(cf: P.L.1999, c.106, s.1)

2. Section 2 of P.L.1999, c.106 (C.17:48A-7u) is amended to read as follows:

2. a. (1) Every individual and group medical service corporation contract that provides hospital or medical expense benefits that is delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide

1 coverage for biologically-based mental illness under the same terms
2 and conditions as provided for any other sickness under the
3 contract.
4 In addition, the medical service corporation contract shall
5 provide coverage for serious non-biologically-based mental illness
6 under the same terms and conditions as provided for any other
7 sickness under the contract; however, coverage for treatment of
8 alcoholism and other substance-use disorders shall be subject to the
9 provisions of section 1 of P.L.1977, c.117 (C.17:48A-7a).
10 (2) As used in this section:
11 "Biologically-based mental illness" means a mental or nervous
12 condition that is caused by a biological disorder of the brain and
13 results in a clinically significant or psychological syndrome or
14 pattern that substantially limits the functioning of the person with
15 the illness, including but not limited to, schizophrenia,
16 schizoaffective disorder, major depressive disorder, bipolar
17 disorder, paranoia and other psychotic disorders, obsessive-
18 compulsive disorder, panic disorder and pervasive developmental
19 disorder or autism.
20 "Serious non-biologically-based mental illness" means a mental
21 or nervous condition that is primarily treated with psychotherapy or
22 psychotropic medication but is not caused by a biological disorder
23 of the brain and results in a clinically significant or psychological
24 syndrome or pattern that substantially limits the function of the
25 person with the illness, including, but not limited to, dysthymic
26 disorder, post-traumatic stress disorder, borderline personality
27 disorder, bulimia, anorexia and other eating disorders, and other
28 illnesses found in the Diagnostic and Statistical Manual of Mental
29 Disorders as determined by regulation of the Commissioner of
30 Banking and Insurance, in consultation with the Commissioner of
31 Health and Senior Services.
32 "Same terms and conditions" means that the medical service
33 corporation cannot apply different copayments, deductibles or
34 benefit limits, including day or visit limits or annual or lifetime
35 dollar limits, to biologically-based or other mental health benefits,
36 as applicable, than those applied to other medical or surgical
37 benefits.
38 b. Nothing in this section shall be construed to change the
39 manner in which a medical service corporation determines:
40 (1) whether a mental health care service meets the medical
41 necessity standard as established by the medical service
42 corporation; or
43 (2) which providers shall be entitled to reimbursement for
44 providing services for mental illness under the contract.
45 c. Notwithstanding any other provision of law to the contrary,
46 the coverage required pursuant to this section may be subject to
47 utilization review as performed by the medical service corporation
48 or its designated utilization review organization.

d. The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

e. Notwithstanding the provisions of subsection a. of this section to the contrary:

(1) The financial requirements applicable to coverage for mental illness as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the contract, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, and the contract may not establish separate cost-sharing requirements that are applicable only with respect to coverage for mental illness; and

(2) The treatment limitations applicable to coverage for mental illness shall be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the contract, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(cf: P.L.1999, c.106, s.2)

3. Section 3 of P.L.1999, c.106 (C.17:48E-35.20) is amended to read as follows:

3. (1) a. Every individual and group health service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract.

In addition, the health service corporation contract shall provide coverage for serious non-biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract; however, coverage for treatment of alcoholism and other substance-use disorders shall be subject to the provisions of section 34 of P.L.1985, c.236 (C.17:48E-34).

(2) As used in this section:

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Serious non-biologically-based mental illness" means a mental or nervous condition that is primarily treated with psychotherapy or psychotropic medication but is not caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the function of the person with the illness, including, but not limited to, dysthymic disorder, post-traumatic stress disorder, borderline personality disorder, bulimia, anorexia and other eating disorders, and other illnesses found in the Diagnostic and Statistical Manual of Mental Disorders as determined by regulation of the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services.

"Same terms and conditions" means that the health service corporation cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which the health service corporation determines:

(1) whether a mental health care service meets the medical necessity standard as established by the health service corporation; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the contract.

c. Notwithstanding any other provision of law to the contrary, the coverage required pursuant to this section may be subject to utilization review as performed by the health service corporation or its designated utilization review organization.

d. The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

e. Notwithstanding the provisions of subsection a. of this section to the contrary:

(1) The financial requirements applicable to coverage for mental illness as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the contract, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, and the contract may not establish separate cost-sharing requirements that are applicable only with respect to coverage for mental illness; and

(2) The treatment limitations applicable to coverage for mental illness shall be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the contract, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or

duration of treatment.
(cf: P.L.1999, c.106, s.3)

4. Section 4 of P.L.1999, c.106 (C.17B:26-2.1s) is amended to read as follows:

4. (1) a. Every individual health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to chapter 26 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract.

In addition, the individual health insurance policy shall provide coverage for serious non-biologically-based mental illness under the same terms and conditions as provided for any other sickness under the policy; however, coverage for treatment of alcoholism and other substance-use disorders shall be subject to the provisions of section 1 of P.L.1977, c.118 (C.17B:26-2.1).

(2) As used in this section:

“Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

“Serious non-biologically-based mental illness” means a mental or nervous condition that is primarily treated with psychotherapy or psychotropic medication but is not caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the function of the person with the illness, including, but not limited to, dysthymic disorder, post-traumatic stress disorder, borderline personality disorder, bulimia, anorexia and other eating disorders, and other illnesses found in the Diagnostic and Statistical Manual of Mental Disorders as determined by regulation of the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services.

"Same terms and conditions" means that the insurer cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which the insurer determines:

(1) whether a mental health care service meets the medical necessity standard as established by the insurer; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the policy.

c. Notwithstanding any other provision of law to the contrary, the coverage required pursuant to this section may be subject to utilization review as performed by the insurer or its designated utilization review organization.

d. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

e. Notwithstanding the provisions of subsection a. of this section to the contrary:

(1) The financial requirements applicable to coverage for mental illness as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the policy, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, and the policy may not establish separate cost-sharing requirements that are applicable only with respect to coverage for mental illness; and

(2) The treatment limitations applicable to coverage for mental illness shall be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the policy, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(cf: P.L.1999, c.106, s.4)

5. Section 5 of P.L.1999, c.106 (C.17B:27-46.1v) is amended to read as follows:

5. a. (1) Every group health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide benefits for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the policy.

In addition, the group health insurance policy shall provide coverage for serious non-biologically-based mental illness under the same terms and conditions as provided for any other sickness under the policy; however, coverage for treatment of alcoholism and other substance-use disorders shall be subject to the provisions of section 1 of P.L.1977, c.116 (C.17B:27-46.1).

(2) As used in this section:

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or

pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Serious non-biologically-based mental illness" means a mental or nervous condition that is primarily treated with psychotherapy or psychotropic medication but is not caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the function of the person with the illness, including, but not limited to, dysthymic disorder, post-traumatic stress disorder, borderline personality disorder, bulimia, anorexia and other eating disorders, and other illnesses found in the Diagnostic and Statistical Manual of Mental Disorders as determined by regulation of the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services.

"Same terms and conditions" means that the insurer cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which the insurer determines:

(1) whether a mental health care service meets the medical necessity standard as established by the insurer; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the policy.

c. Notwithstanding any other provision of law to the contrary, the coverage required pursuant to this section may be subject to utilization review as performed by the insurer or its designated utilization review organization.

d. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

e. Notwithstanding the provisions of subsection a. of this section to the contrary:

(1) The financial requirements applicable to coverage for mental illness as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the policy, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, and the policy may not establish separate cost-sharing requirements that are applicable only with respect to coverage for mental illness; and

(2) The treatment limitations applicable to coverage for mental illness shall be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by

1 the policy, including limits on the frequency of treatment, number
2 of visits, days of coverage, or other similar limits on the scope or
3 duration of treatment.
4 (cf: P.L.1999, c.106, s.5)
5
6 6. Section 6 of P.L.1999, c.106 (C.17B:27A-7.5) is amended to
7 read as follows:
8 6. a. (1) Every individual health benefits plan that provides
9 hospital or medical expense benefits and is delivered, issued,
10 executed or renewed in this State pursuant to P.L.1992, c.161
11 (C.17B:27A-2 et seq.) or approved for issuance or renewal in this
12 State on or after the effective date of this act shall provide benefits
13 for biologically-based mental illness under the same terms and
14 conditions as provided for any other sickness under the health
15 benefits plan.
16 In addition, the health benefits plan shall provide benefits for
17 serious non-biologically-based mental illness under the same terms
18 and conditions as provided for any other sickness under the plan;
19 however, coverage for treatment of alcoholism and other substance-
20 use disorders shall be subject to the provisions of section 14 of
21 P.L. , c. (C.)(pending before the Legislature as this bill).
22 (2) As used in this section:
23 "Biologically-based mental illness" means a mental or nervous
24 condition that is caused by a biological disorder of the brain and
25 results in a clinically significant or psychological syndrome or
26 pattern that substantially limits the functioning of the person with
27 the illness, including but not limited to, schizophrenia,
28 schizoaffective disorder, major depressive disorder, bipolar
29 disorder, paranoia and other psychotic disorders, obsessive-
30 compulsive disorder, panic disorder and pervasive developmental
31 disorder or autism.
32 "Serious non-biologically-based mental illness" means a mental
33 or nervous condition that is primarily treated with psychotherapy or
34 psychotropic medication but is not caused by a biological disorder
35 of the brain and results in a clinically significant or psychological
36 syndrome or pattern that substantially limits the function of the
37 person with the illness, including, but not limited to, dysthymic
38 disorder, post-traumatic stress disorder, borderline personality
39 disorder, bulimia, anorexia and other eating disorders, and other
40 illnesses found in the Diagnostic and Statistical Manual of Mental
41 Disorders as determined by regulation of the Commissioner of
42 Banking and Insurance, in consultation with the Commissioner of
43 Health and Senior Services.
44 "Same terms and conditions" means that the carrier cannot apply
45 different copayments, deductibles or benefit limits, including day or
46 visit limits or annual or lifetime dollar limits, to biologically-based
47 or other mental health benefits, as applicable, than those applied to
48 other medical or surgical benefits.

1 b. Nothing in this section shall be construed to change the
2 manner in which the carrier determines:
3 (1) whether a mental health care service meets the medical
4 necessity standard as established by the carrier; or
5 (2) which providers shall be entitled to reimbursement for
6 providing services for mental illness under the plan.
7 c. Notwithstanding any other provision of law to the contrary,
8 the coverage required pursuant to this section may be subject to
9 utilization review as performed by the carrier or its designated
10 utilization review organization.
11 d. The provisions of this section shall apply to all health benefits
12 plans in which the carrier has reserved the right to change the
13 premium.
14 e. Notwithstanding the provisions of subsection a. of this section
15 to the contrary:
16 (1) The financial requirements applicable to coverage for mental
17 illness as provided in this section shall be no more restrictive than
18 the financial requirements applied to substantially all medical and
19 surgical benefits covered by the plan, including deductibles,
20 copayments, coinsurance, out-of-pocket expenses, and annual and
21 lifetime limits, and the plan may not establish separate cost-sharing
22 requirements that are applicable only with respect to coverage for
23 mental illness; and
24 (2) The treatment limitations applicable to coverage for mental
25 illness shall be no more restrictive than the treatment limitations
26 applied to substantially all medical and surgical benefits covered by
27 the plan, including limits on the frequency of treatment, number of
28 visits, days of coverage, or other similar limits on the scope or
29 duration of treatment.
30 (cf: P.L.1999, c.106, s.6)
31
32 7. Section 7 of P.L.1999, c.106 (C.17B:27A-19.7) is amended to
33 read as follows:
34 7. a. (1) Every small employer health benefits plan that
35 provides hospital or medical expense benefits and is delivered,
36 issued, executed or renewed in this State pursuant to P.L.1992,
37 c.162 (C.17B:27A-17 et seq.) or approved for issuance or renewal
38 in this State on or after the effective date of this act shall provide
39 benefits for biologically-based mental illness under the same terms
40 and conditions as provided for any other sickness under the health
41 benefits plan.
42 In addition, the health benefits plan shall provide benefits for
43 serious non-biologically-based mental illness under the same terms
44 and conditions as provided for any other sickness under the plan;
45 however, coverage for treatment of alcoholism and other substance-
46 use disorders shall be subject to the provisions of section 15 of
47 P.L. , c. (C.)(pending before the Legislature as this bill).
48 (2) As used in this section:

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Serious non-biologically-based mental illness" means a mental or nervous condition that is primarily treated with psychotherapy or psychotropic medication but is not caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the function of the person with the illness, including, but not limited to, dysthymic disorder, post-traumatic stress disorder, borderline personality disorder, bulimia, anorexia and other eating disorders, and other illnesses found in the Diagnostic and Statistical Manual of Mental Disorders as determined by regulation of the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services.

"Same terms and conditions" means that the carrier cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which the carrier determines:

(1) whether a mental health care service meets the medical necessity standard as established by the carrier; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the health benefits plan.

c. Notwithstanding any other provision of law to the contrary, the coverage required pursuant to this section may be subject to utilization review as performed by the carrier or its designated utilization review organization.

d. The provisions of this section shall apply to all health benefits plans in which the carrier has reserved the right to change the premium.

e. Notwithstanding the provisions of subsection a. of this section to the contrary:

(1) The financial requirements applicable to coverage for mental illness as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the plan, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, and the plan may not establish separate cost-sharing requirements that are applicable only with respect to coverage for

1 mental illness; and
2 (2) The treatment limitations applicable to coverage for mental
3 illness shall be no more restrictive than the treatment limitations
4 applied to substantially all medical and surgical benefits covered by
5 the plan, including limits on the frequency of treatment, number of
6 visits, days of coverage, or other similar limits on the scope or
7 duration of treatment.
8 (cf: P.L.1999, c.106, s.7)
9
10 8. Section 8 of P.L.1999, c.106 (C.26:2J-4.20) is amended to
11 read as follows:
12 8. a. (1) Every [enrollee agreement] contract delivered, issued,
13 executed or renewed in this State pursuant to P.L.1973, c.337
14 (C.26:2J-1 et seq.) or approved for issuance or renewal in this State
15 by the Commissioner of [Health and Senior Services] Banking and
16 Insurance, on or after the effective date of this act shall provide
17 health care services for biologically-based mental illness under the
18 same terms and conditions as provided for any other sickness under
19 the [agreement] contract.
20 In addition, the contract shall provide health care services for
21 serious non-biologically-based mental illness under the same terms
22 and conditions as provided for any other sickness under the
23 contract; however, coverage for treatment of alcoholism and other
24 substance-use disorders shall be subject to the provisions of section
25 16 of P.L. , c. (C.)(pending before the Legislature as this
26 bill).
27 (2) As used in this section:
28 "Biologically-based mental illness" means a mental or nervous
29 condition that is caused by a biological disorder of the brain and
30 results in a clinically significant or psychological syndrome or
31 pattern that substantially limits the functioning of the person with
32 the illness, including but not limited to, schizophrenia,
33 schizoaffective disorder, major depressive disorder, bipolar
34 disorder, paranoia and other psychotic disorders, obsessive-
35 compulsive disorder, panic disorder and pervasive developmental
36 disorder or autism.
37 "Serious non-biologically-based mental illness" means a mental
38 or nervous condition that is primarily treated with psychotherapy or
39 psychotropic medication but is not caused by a biological disorder
40 of the brain and results in a clinically significant or psychological
41 syndrome or pattern that substantially limits the function of the
42 person with the illness, including, but not limited to, dysthymic
43 disorder, post-traumatic stress disorder, borderline personality
44 disorder, bulimia, anorexia and other eating disorders, and other
45 illnesses found in the Diagnostic and Statistical Manual of Mental
46 Disorders as determined by regulation of the Commissioner of
47 Banking and Insurance, in consultation with the Commissioner of

Health and Senior Services.

"Same terms and conditions" means that the health maintenance organization cannot apply different copayments, deductibles or health care services limits, including day or visit limits or annual or lifetime dollar limits, to biologically-based or other mental health care services, as applicable, than those applied to other medical or surgical health care services.

b. Nothing in this section shall be construed to change the manner in which a health maintenance organization determines:

(1) whether a mental health care service meets the medical necessity standard as established by the health maintenance organization; or

(2) which providers shall be entitled to reimbursement or to be participating providers, as appropriate, for mental health services under the [enrollee agreement] contract.

c. Notwithstanding any other provision of law to the contrary, the mental health care services required pursuant to this section may be subject to utilization review as performed by the health maintenance organization or its designated utilization review organization.

d. The provisions of this section shall apply to enrollee agreements] contracts in which the health maintenance organization has reserved the right to change the premium.

e. Notwithstanding the provisions of subsection a. of this section to the contrary:

(1) The financial requirements applicable to mental health care services as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the contract, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, and the contract may not establish separate cost-sharing requirements that are applicable only with respect to mental health care services; and

(2) The treatment limitations applicable to mental health care services shall be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the contract, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(cf: P.L.1999, c.106, s.8)

9. Section 9 of P.L.1999, c.106 (C.34:11A-15) is amended to read as follows:

9. An employer in this State who provides health benefits coverage to his employees or their dependents for treatment of biologically-based or other mental illness shall [annually], [and] upon request of an employee [at other times during the year],

1 notify his employees whether the employees' coverage for treatment
2 of [biologically-based] mental illness is subject to the requirements
3 of this act.
4 (cf: P.L.1999, c.106, s.9)
5
6 10. Section 1 of P.L.1977, c.117 (C.17:48A-7a) is amended to
7 read as follows:
8 1. No group or individual contract providing hospital or medical
9 expense benefits shall be delivered, issued, executed or renewed in
10 this State, or approved for issuance or renewal in this State by the
11 Commissioner of Banking and Insurance, on or after the effective
12 date of this act, unless such contract provides benefits to any
13 subscriber or other person covered thereunder for expenses incurred
14 in connection with the treatment of alcoholism [when such
15 treatment is prescribed by a doctor of medicine] and other
16 substance-use disorders. Such benefits shall be provided [to the
17 same extent] under the same terms and conditions as provided for
18 any other [sickness] disease or illness under the contract.
19 "Treatment of alcoholism and other substance-use disorders"
20 includes, but is not limited to, any of the following items or services
21 provided for treatment of alcoholism or other substance-use
22 disorders: inpatient or outpatient treatment, including
23 detoxification, screening and assessment, case management,
24 medication management, psychiatric consultations and individual,
25 group and family counseling, and relapse prevention; non-hospital
26 residential treatment; and prevention services, including health
27 education and individual and group counseling to encourage the
28 reduction of risk factors for alcoholism or other substance-use
29 disorders.
30 "Same terms and conditions" means that the medical service
31 corporation cannot apply different copayments, deductibles or
32 benefit limits, including day or visit limits or annual or lifetime
33 dollar limits, to alcoholism and other substance-use disorder
34 treatment services than those applied to other medical or surgical
35 expense benefits.
36 Every contract shall include such benefits for the treatment of
37 alcoholism and other substance-use disorders as are hereinafter set
38 forth:
39 a. Inpatient or outpatient care in a [licensed hospital] health
40 care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et
41 seq.);
42 b. Treatment at a detoxification facility licensed pursuant to
43 [P.L.1975, c.305] section 8 of P.L.1975, c.305 (C.26:2B-14);
44 c. [Confinement as an inpatient or outpatient at a licensed,
45 certified, or state approved residential treatment facility, under a
46 program which meets minimum standards of care equivalent to
47 those prescribed by the Joint Commission on Hospital

Accreditation] Participation as an inpatient at a residential facility licensed by the Division of Addiction Services in the Department of Human Services or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Human Services; and

d. Treatment provided by a physician or other appropriately trained, licensed health care professional.

Treatment [or confinement] at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other [sickness] disease or illness under the contract.

Nothing in this section shall be construed to prohibit the medical service corporation from determining if the treatment of alcoholism and other substance-use disorders is medically necessary.

Nothing in this section shall be construed to change the manner in which the medical service corporation determines which health care providers shall be entitled to reimbursement for providing treatment services under the contract.

Notwithstanding any other provision of law to the contrary, the coverage required pursuant to this section may be subject to utilization review as performed by the medical service corporation or its designated utilization review organization.

Notwithstanding the provisions of this section to the contrary:

(1) The financial requirements applicable to coverage for alcoholism and other substance-use disorders as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the contract, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, and the contract may not establish separate cost-sharing requirements that are applicable only with respect to coverage for alcoholism and other substance-use disorders; and

(2) The treatment limitations applicable to coverage for alcoholism and other substance-use disorders shall be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the contract, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(cf: P.L.1977, c.117, s.1)

11. Section 34 of P.L.1985, c.236 (C.17:48E-34) is amended to read as follows:

34. No group or individual contract providing health service coverage shall be delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State by the

1 commissioner, on or after the effective date of this act, unless the
2 contract provides benefits to any subscriber or other person covered
3 thereunder for expenses incurred in connection with treatment of
4 alcoholism [when the treatment is prescribed by a doctor of
5 medicine] and other substance-use disorders. Benefits shall be
6 provided [to the same extent] under the same terms and conditions
7 as provided for any other [sickness] disease or illness under the
8 contract.
9 "Treatment of alcoholism and other substance-use disorders"
10 includes, but is not limited to, any of the following items or services
11 provided for treatment of alcoholism or other substance-use
12 disorders: inpatient or outpatient treatment, including
13 detoxification, screening and assessment, case management,
14 medication management, psychiatric consultations and individual,
15 group and family counseling, and relapse prevention; non-hospital
16 residential treatment; and prevention services, including health
17 education and individual and group counseling to encourage the
18 reduction of risk factors for alcoholism or other substance-use
19 disorders.
20 "Same terms and conditions" means that the health service
21 corporation cannot apply different copayments, deductibles or
22 benefit limits, including day or visit limits or annual or lifetime
23 dollar limits, to alcoholism and other substance-use disorder
24 treatment services than those applied to other medical or surgical
25 expense benefits.
26 Every contract shall include benefits for the treatment of
27 alcoholism and other substance-use disorders as follows:
28 a. Inpatient or outpatient care in a health care facility licensed
29 pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);
30 b. Treatment at a detoxification facility licensed pursuant to
31 section 8 of P.L.1975, c.305 (C.26:2B-14);
32 c. [Confinement as an inpatient or outpatient at a licensed,
33 certified, or state approved residential treatment facility, under a
34 program which meets minimum standards of care equivalent to
35 those prescribed by the Joint Commission on Hospital
36 Accreditation] Participation as an inpatient at a residential facility
37 licensed by the Division of Addiction Services in the Department of
38 Human Services or as an outpatient in a State-approved outpatient
39 treatment facility that meets minimum standards of care as set forth
40 by the Department of Human Services; and
41 d. Treatment provided by a physician or other appropriately
42 trained, licensed health care professional.
43 Treatment [or confinement] at any facility shall not preclude
44 further or additional treatment at any other eligible facility, if the
45 benefit days used do not exceed the total number of benefit days
46 provided for any other [sickness] disease or illness under the
47 contract.

1 Nothing in this section shall be construed to prohibit the health
2 service corporation from determining if the treatment of alcoholism
3 and other substance-use disorders is medically necessary.
4 Nothing in this section shall be construed to change the manner
5 in which the health service corporation determines which health
6 care providers shall be entitled to reimbursement for providing
7 treatment services under the contract.
8 Notwithstanding any other provision of law to the contrary, the
9 coverage required pursuant to this section may be subject to
10 utilization review as performed by the health service corporation or
11 its designated utilization review organization.
12 Notwithstanding the provisions of this section to the contrary:
13 (1) The financial requirements applicable to coverage for
14 alcoholism and other substance-use disorders as provided in this
15 section shall be no more restrictive than the financial requirements
16 applied to substantially all medical and surgical benefits covered by
17 the contract, including deductibles, copayments, coinsurance, out-
18 of-pocket expenses, and annual and lifetime limits, and the contract
19 may not establish separate cost-sharing requirements that are
20 applicable only with respect to coverage for alcoholism and other
21 substance-use disorders; and
22 (2) The treatment limitations applicable to coverage for
23 alcoholism and other substance-use disorders shall be no more
24 restrictive than the treatment limitations applied to substantially all
25 medical and surgical benefits covered by the contract, including
26 limits on the frequency of treatment, number of visits, days of
27 coverage, or other similar limits on the scope or duration of
28 treatment.
29 (cf: P.L.1985, c.236, s.34)
30
31 12. Section 1 of P.L.1977, c.118 (C.17B:26-2.1) is amended to
32 read as follows:
33 1. No health insurance [contract] policy providing hospital or
34 medical expense benefits shall be delivered, issued, executed or
35 renewed in this State, or approved for issuance or renewal in this
36 State by the Commissioner of Banking and Insurance, on or after
37 the effective date of this act, unless such [contract] policy provides
38 benefits to any [subscriber] insured or other person covered
39 thereunder for expenses incurred in connection with the treatment
40 of alcoholism [when such treatment is prescribed by a doctor of
41 medicine] and other substance-use disorders. Such benefits shall
42 be provided [to the same extent] under the same terms and
43 conditions as provided for any other [sickness] disease or illness
44 under the [contract] policy.
45 "Treatment of alcoholism and other substance-use disorders"
46 includes, but is not limited to, any of the following items or services
47 provided for treatment of alcoholism or other substance-use

1 disorders: inpatient or outpatient treatment, including
2 detoxification, screening and assessment, case management,
3 medication management, psychiatric consultations and individual,
4 group and family counseling, and relapse prevention; non-hospital
5 residential treatment; and prevention services, including health
6 education and individual and group counseling to encourage the
7 reduction of risk factors for alcoholism or other substance-use
8 disorders.
9 "Same terms and conditions" means that the insurer cannot apply
10 different copayments, deductibles or benefit limits, including day or
11 visit limits or annual or lifetime dollar limits, to alcoholism and
12 other substance-use disorder treatment services than those applied
13 to other medical or surgical expense benefits.
14 Every [contract] policy shall include such benefits for the
15 treatment of alcoholism and other substance-use disorders as are
16 hereinafter set forth:
17 a. Inpatient or outpatient care in a [licensed hospital] health
18 care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et
19 seq.);
20 b. Treatment at a detoxification facility licensed pursuant to
21 [P.L.1975, c.305] section 8 of P.L.1975, c.305 (C.26:2B-14);
22 c. [Confinement as an inpatient or outpatient at a licensed,
23 certified, or state approved residential treatment facility, under a
24 program which meets minimum standards of care equivalent to
25 those prescribed by the Joint Commission on Hospital
26 Accreditation] Participation as an inpatient at a residential facility
27 licensed by the Division of Addiction Services in the Department of
28 Human Services or as an outpatient in a State-approved outpatient
29 treatment facility that meets minimum standards of care as set forth
30 by the Department of Human Services; and
31 d. Treatment provided by a physician or other appropriately
32 trained, licensed health care professional.
33 Treatment [or confinement] at any facility shall not preclude
34 further or additional treatment at any other eligible facility;
35 provided, however, that the benefit days used do not exceed the
36 total number of benefit days provided for any other [sickness]
37 disease or illness under the [contract] policy.
38 Nothing in this section shall be construed to prohibit the insurer
39 from determining if the treatment of alcoholism and other
40 substance-use disorders is medically necessary.
41 Nothing in this section shall be construed to change the manner
42 in which the insurer determines which health care providers shall be
43 entitled to reimbursement for providing treatment services under the
44 policy.
45 Notwithstanding any other provision of law to the contrary, the
46 coverage required pursuant to this section may be subject to
47 utilization review as performed by the insurer or its designated

1 utilization review organization.
2 Notwithstanding the provisions of this section to the contrary:
3 (1) The financial requirements applicable to coverage for
4 alcoholism and other substance-use disorders as provided in this
5 section shall be no more restrictive than the financial requirements
6 applied to substantially all medical and surgical benefits covered by
7 the policy, including deductibles, copayments, coinsurance, out-of-
8 pocket expenses, and annual and lifetime limits, and the policy may
9 not establish separate cost-sharing requirements that are applicable
10 only with respect to coverage for alcoholism and other substance-
11 use disorders; and
12 (2) The treatment limitations applicable to coverage for
13 alcoholism and other substance-use disorders shall be no more
14 restrictive than the treatment limitations applied to substantially all
15 medical and surgical benefits covered by the policy, including
16 limits on the frequency of treatment, number of visits, days of
17 coverage, or other similar limits on the scope or duration of
18 treatment.
19 (cf: P.L.1977, c.118, s.1)
20
21 13. Section 1 of P.L.1977, c.116 (C.17B:27-46.1) is amended to
22 read as follows:
23 1. No group health insurance [contract] policy providing
24 hospital or medical expense benefits shall be delivered, issued,
25 executed or renewed in this State, or approved for issuance or
26 renewal in this State by the Commissioner of Banking and
27 Insurance, on or after the effective date of this act, unless such
28 [contract] policy provides benefits to any [subscriber] insured or
29 other person covered thereunder for expenses incurred in
30 connection with the treatment of alcoholism [when such treatment
31 is prescribed by a doctor of medicine] and other substance-use
32 disorders. Such benefits shall be provided [to the same extent]
33 under the same terms and conditions as provided for any other
34 [sickness] disease or illness under the [contract] policy.
35 "Treatment of alcoholism and other substance-use disorders"
36 includes, but is not limited to, any of the following items or services
37 provided for treatment of alcoholism or other substance-use
38 disorders: inpatient or outpatient treatment, including
39 detoxification, screening and assessment, case management,
40 medication management, psychiatric consultations and individual,
41 group and family counseling, and relapse prevention; non-hospital
42 residential treatment; and prevention services, including health
43 education and individual and group counseling to encourage the
44 reduction of risk factors for alcoholism or other substance-use
45 disorders.
46 "Same terms and conditions" means that the insurer cannot apply
47 different copayments, deductibles or benefit limits, including day or

1 visit limits or annual or lifetime dollar limits, to alcoholism and
2 other substance-use disorder treatment services than those applied
3 to other medical or surgical expense benefits.
4 Every [contract] policy shall include such benefits for the
5 treatment of alcoholism and other substance-use disorders as are
6 hereinafter set forth:
7 a. Inpatient or outpatient care in a [licensed hospital] health
8 care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et
9 seq.);
10 b. Treatment at a detoxification facility licensed pursuant to
11 [P.L.1975, c. 305] section 8 of P.L.1975, c.305 (C.26:2B-14);
12 c. [Confinement as an inpatient or outpatient at a licensed,
13 certified, or state approved residential treatment facility, under a
14 program which meets minimum standards of care equivalent to
15 those prescribed by the Joint Commission on Hospital
16 Accreditation] Participation as an inpatient at a residential facility
17 licensed by the Division of Addiction Services in the Department of
18 Human Services or as an outpatient in a State-approved outpatient
19 treatment facility that meets minimum standards of care as set forth
20 by the Department of Human Services; and
21 d. Treatment provided by a physician or other appropriately
22 trained, licensed health care professional.
23 Treatment [or confinement] at any facility shall not preclude
24 further or additional treatment at any other eligible facility;
25 provided, however, that the benefit days used do not exceed the
26 total number of benefit days provided for any other [sickness]
27 disease or illness under the [contract] policy.
28 Nothing in this section shall be construed to prohibit the insurer
29 from determining if the treatment of alcoholism and other
30 substance-use disorders is medically necessary.
31 Nothing in this section shall be construed to change the manner
32 in which the insurer determines which health care providers shall be
33 entitled to reimbursement for providing treatment services under the
34 policy.
35 Notwithstanding any other provision of law to the contrary, the
36 coverage required pursuant to this section may be subject to
37 utilization review as performed by the insurer or its designated
38 utilization review organization.
39 Notwithstanding the provisions of this section to the contrary:
40 (1) The financial requirements applicable to coverage for
41 alcoholism and other substance-use disorders as provided in this
42 section shall be no more restrictive than the financial requirements
43 applied to substantially all medical and surgical benefits covered by
44 the policy, including deductibles, copayments, coinsurance, out-of-
45 pocket expenses, and annual and lifetime limits, and the policy may
46 not establish separate cost-sharing requirements that are applicable
47 only with respect to coverage for alcoholism and other substance-

1 use disorders; and
2 (2) The treatment limitations applicable to coverage for
3 alcoholism and other substance-use disorders shall be no more
4 restrictive than the treatment limitations applied to substantially all
5 medical and surgical benefits covered by the policy, including
6 limits on the frequency of treatment, number of visits, days of
7 coverage, or other similar limits on the scope or duration of
8 treatment.
9 (cf: P.L.1977, c.116, s.1)
10
11 14. (New section) Every individual health benefits plan that
12 provides hospital or medical expense benefits, and is delivered,
13 issued, executed or renewed in this State pursuant to P.L.1992,
14 c.161 (C.17B:27A-2 et seq.), on or after the effective date of this
15 act, shall provide coverage for expenses incurred in connection with
16 the treatment of alcoholism and other substance-use disorders.
17 Such benefits shall be provided under the same terms and
18 conditions as provided for any other disease or illness under the
19 plan.
20 "Treatment of alcoholism and other substance-use disorders"
21 includes, but is not limited to, any of the following items or services
22 provided for treatment of alcoholism or other substance-use
23 disorders: inpatient or outpatient treatment, including
24 detoxification, screening and assessment, case management,
25 medication management, psychiatric consultations and individual,
26 group and family counseling, and relapse prevention; non-hospital
27 residential treatment; and prevention services, including health
28 education and individual and group counseling to encourage the
29 reduction of risk factors for alcoholism or other substance-use
30 disorders.
31 "Same terms and conditions" means that the carrier cannot apply
32 different copayments, deductibles or benefit limits, including day or
33 visit limits or annual or lifetime dollar limits, to alcoholism and
34 other substance-use disorder treatment services than those applied
35 to other medical or surgical expense benefits.
36 Every plan shall include such benefits for the treatment of
37 alcoholism and other substance-use disorders as are hereinafter set
38 forth:
39 a. Inpatient or outpatient care in a health care facility licensed
40 pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);
41 b. Treatment at a detoxification facility licensed pursuant to
42 section 8 of P.L.1975, c.305 (C.26:2B-14);
43 c. Participation as an inpatient at a residential facility licensed
44 by the Division of Addiction Services in the Department of Human
45 Services or as an outpatient in a State-approved outpatient treatment
46 facility that meets minimum standards of care as set forth by the
47 Department of Human Services; and
48 d. Treatment provided by a physician or other appropriately

trained, licensed health care professional.

Treatment at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other disease or illness under the plan.

Nothing in this section shall be construed to prohibit the carrier from determining if the treatment of alcoholism and other substance-use disorders is medically necessary.

Nothing in this section shall be construed to change the manner in which the carrier determines which health care providers shall be entitled to reimbursement for providing treatment services under the plan.

Notwithstanding any other provision of law to the contrary, the coverage required pursuant to this section may be subject to utilization review as performed by the carrier or its designated utilization review organization.

Notwithstanding the provisions of this section to the contrary:

(1) The financial requirements applicable to coverage for alcoholism and other substance-use disorders as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the plan, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, and the plan may not establish separate cost-sharing requirements that are applicable only with respect to coverage for alcoholism and other substance-use disorders; and

(2) The treatment limitations applicable to coverage for alcoholism and other substance-use disorders shall be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the plan, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

15. (New section) Every small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), on or after the effective date of this act, shall provide coverage for expenses incurred in connection with the treatment of alcoholism and other substance-use disorders. Such benefits shall be provided under the same terms and conditions as provided for any other disease or illness under the plan.

"Treatment of alcoholism and other substance-use disorders" includes, but is not limited to, any of the following items or services provided for treatment of alcoholism or other substance-use disorders: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual,

1 group and family counseling, and relapse prevention; non-hospital
2 residential treatment; and prevention services, including health
3 education and individual and group counseling to encourage the
4 reduction of risk factors for alcoholism or other substance-use
5 disorders.
6 "Same terms and conditions" means that the carrier cannot apply
7 different copayments, deductibles or benefit limits, including day or
8 visit limits or annual or lifetime dollar limits, to alcoholism and
9 other substance-use disorder treatment services than those applied
10 to other medical or surgical expense benefits.
11 Every plan shall include such benefits for the treatment of
12 alcoholism and other substance-use disorders as are hereinafter set
13 forth:
14 a. Inpatient or outpatient care in a health care facility licensed
15 pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);
16 b. Treatment at a detoxification facility licensed pursuant to
17 section 8 of P.L.1975, c.305 (C.26:2B-14);
18 c. Participation as an inpatient at a residential facility licensed
19 by the Division of Addiction Services in the Department of Human
20 Services or as an outpatient in a State-approved outpatient treatment
21 facility that meets minimum standards of care as set forth by the
22 Department of Human Services; and
23 d. Treatment provided by a physician or other appropriately
24 trained, licensed health care professional.
25 Treatment at any facility shall not preclude further or additional
26 treatment at any other eligible facility; provided, however, that the
27 benefit days used do not exceed the total number of benefit days
28 provided for any other disease or illness under the plan.
29 Nothing in this section shall be construed to prohibit the carrier
30 from determining if the treatment of alcoholism and other
31 substance-use disorders is medically necessary.
32 Nothing in this section shall be construed to change the manner
33 in which the carrier determines which health care providers shall be
34 entitled to reimbursement for providing treatment services under the
35 plan.
36 Notwithstanding any other provision of law to the contrary, the
37 coverage required pursuant to this section may be subject to
38 utilization review as performed by the carrier or its designated
39 utilization review organization.
40 Notwithstanding the provisions of this section to the contrary:
41 (1) The financial requirements applicable to coverage for
42 alcoholism and other substance-use disorders as provided in this
43 section shall be no more restrictive than the financial requirements
44 applied to substantially all medical and surgical benefits covered by
45 the plan, including deductibles, copayments, coinsurance, out-of-
46 pocket expenses, and annual and lifetime limits, and the plan may
47 not establish separate cost-sharing requirements that are applicable
48 only with respect to coverage for alcoholism and other substance-

use disorders; and

(2) The treatment limitations applicable to coverage for alcoholism and other substance-use disorders shall be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the plan, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

16. (New section) Every contract for health care services, which is delivered, issued, executed or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide health care services for the treatment of alcoholism and other substance-use disorders. Such health care services shall be provided under the same terms and conditions as provided for any other disease or illness under the contract.

"Treatment of alcoholism and other substance-use disorders" includes, but is not limited to, any of the following items or services provided for treatment of alcoholism or other substance-use disorders: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcoholism or other substance-use disorders.

"Same terms and conditions" means that the health maintenance organization cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to alcoholism and other substance-use disorder treatment services than those applied to other health care services.

Every contract shall include such health care services for the treatment of alcoholism and other substance-use disorders as are hereinafter set forth:

a. Inpatient or outpatient care in a health care facility licensed pursuant to P.L.1971, c. 136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to section 8 of P.L.1975, c.305 (C.26:2B-14);

c. Participation as an inpatient at a residential facility licensed by the Division of Addiction Services in the Department of Human Services or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Human Services; and

d. Treatment provided by a physician or other appropriately trained, licensed health care professional.

Treatment at any facility shall not preclude further or additional

1 treatment at any other eligible facility; provided, however, that the
2 benefit days used do not exceed the total number of benefit days
3 provided for any other disease or illness under the contract.
4 Nothing in this section shall be construed to prohibit the health
5 maintenance organization from determining if the treatment of
6 alcoholism and other substance-use disorders is medically
7 necessary.
8 Nothing in this section shall be construed to change the manner
9 in which the health maintenance organization determines which
10 health care providers shall be entitled to reimbursement for
11 providing treatment services under the contract.
12 Notwithstanding any other provision of law to the contrary, the
13 treatment services required pursuant to this section may be subject
14 to utilization review as performed by the health maintenance
15 organization or its designated utilization review organization.
16 Notwithstanding the provisions of this section to the contrary:
17 (1) The financial requirements applicable to treatment services
18 for alcoholism and other substance-use disorders as provided in this
19 section shall be no more restrictive than the financial requirements
20 applied to substantially all health care services provided under the
21 contract, including deductibles, copayments, coinsurance, out-of-
22 pocket expenses, and annual and lifetime limits, except that the
23 contract may not establish separate cost-sharing requirements that
24 are applicable only with respect to coverage for alcoholism and
25 other substance-use disorders; and
26 (2) The treatment limitations applicable to treatment services for
27 alcoholism and other substance-use disorders shall be no more
28 restrictive than the treatment limitations applied to substantially all
29 health care services provided under the contract, including limits on
30 the frequency of treatment, number of visits, days of coverage, or
31 other similar limits on the scope or duration of treatment.
32
33 17. (New section) An employer in this State who provides
34 health benefits coverage to his employees or their dependents for
35 treatment of alcoholism or other substance-use disorders shall, upon
36 request of an employee, notify his employees whether the
37 employees' coverage for treatment of alcoholism or other substance-
38 use disorders is subject to the requirements of section 1 of
39 P.L.1977, c.115 (C.17:48-6a), section 1 of P.L.1977, c.116
40 (C.17B:27-46.1); section 1 of P.L.1977, c.117 (C.17:48A-7a),
41 section 1 of P.L.1977, c.118 (C.17B:26-2.1), section 34 of
42 P.L.1985, c.236 (C.17:48E-34), or sections 14 through 16 of P.L. ,
43 c. (C.)(pending before the Legislature as this bill).
44
45 18. Section 5 of P.L.1961, c.49 (C.52:14-17.29) is amended to
46 read as follows:

1 5. (A) The contract or contracts purchased by the commission
2 pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-
3 17.28) shall provide separate coverages or policies as follows:
4 (1) Basic benefits which shall include:
5 (a) Hospital benefits, including outpatient;
6 (b) Surgical benefits;
7 (c) Inpatient medical benefits;
8 (d) Obstetrical benefits; and
9 (e) Services rendered by an extended care facility or by a home
10 health agency and for specified medical care visits by a physician
11 during an eligible period of such services, without regard to
12 whether the patient has been hospitalized, to the extent and subject
13 to the conditions and limitations agreed to by the commission and
14 the carrier or carriers.
15 Basic benefits shall be substantially equivalent to those available
16 on a group remittance basis to employees of the State and their
17 dependents under the subscription contracts of the New Jersey
18 "Blue Cross" and "Blue Shield" Plans. Such basic benefits shall
19 include benefits for:
20 (i) Additional days of inpatient medical service;
21 (ii) Surgery elsewhere than in a hospital;
22 (iii) X-ray, radioactive isotope therapy and pathology services;
23 (iv) Physical therapy services;
24 (v) Radium or radon therapy services;
25 and the extended basic benefits shall be subject to the same
26 conditions and limitations, applicable to such benefits, as are set
27 forth in "Extended Outpatient Hospital Benefits Rider," Form 1500,
28 71(9-66), and in "Extended Benefit Rider" (as amended), Form MS
29 7050J(9-66) issued by the New Jersey "Blue Cross" and "Blue
30 Shield" Plans, respectively, and as the same may be amended or
31 superseded, subject to filing by the Commissioner of Banking and
32 Insurance; and
33 (2) Major medical expense benefits which shall provide benefit
34 payments for reasonable and necessary eligible medical expenses
35 for hospitalization, surgery, medical treatment and other related
36 services and supplies to the extent they are not covered by basic
37 benefits. The commission may, by regulation, determine what types
38 of services and supplies shall be included as "eligible medical
39 services" under the major medical expense benefits coverage as
40 well as those which shall be excluded from or limited under such
41 coverage. Benefit payments for major medical expense benefits
42 shall be equal to a percentage of the reasonable charges for eligible
43 medical services incurred by a covered employee or an employee's
44 covered dependent, during a calendar year as exceed a deductible
45 for such calendar year of $100.00 subject to the maximums
46 hereinafter provided and to the other terms and conditions
47 authorized by this act. The percentage shall be 80% of the first

$2,000.00 of charges for eligible medical services incurred subsequent to satisfaction of the deductible and 100% thereafter. There shall be a separate deductible for each calendar year for (a) each enrolled employee and (b) all enrolled dependents of such employee. Not more than $1,000,000.00 shall be paid for major medical expense benefits with respect to any one person for the entire period of such person's coverage under the plan, whether continuous or interrupted except that this maximum may be reapplied to a covered person in amounts not to exceed $2,000.00 a year. Maximums of $10,000.00 per calendar year and $20,000.00 for the entire period of the person's coverage under the plan shall apply to eligible expenses incurred because of [mental illness or functional nervous disorders] any mental illness or functional nervous disorder that is not biologically-based mental illness or serious non-biologically-based mental illness as defined in section 1 of P.L.1999, c.441 (C.52:14-17.29d), and such may be reapplied to a covered person, [except as provided] in accordance with the provisions of P.L.1999, c.441 (C.52:14-17.29d et al.). The same provisions shall apply for retired employees and their dependents. Under the conditions agreed upon by the commission and the carriers as set forth in the contract, the deductible for a calendar year may be satisfied in whole or in part by eligible charges incurred during the last three months of the prior calendar year.

Any service determined by regulation of the commission to be an "eligible medical service" under the major medical expense benefits coverage which is performed by a duly licensed practicing psychologist within the lawful scope of his practice shall be recognized for reimbursement under the same conditions as would apply were such service performed by a physician.

(B) The contract or contracts purchased by the commission pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall include coverage for services and benefits that are at a level that is equal to or exceeds the level of services and benefits set forth in this subsection, provided that such services and benefits shall include only those that are eligible medical services and not those deemed experimental, investigative or otherwise not eligible medical services. The determination of whether services or benefits are eligible medical services shall be made by the commission consistent with the best interests of the State and participating employers, employees, and dependents. The following list of services is not intended to be exclusive or to require that any limits or exclusions be exceeded.

Covered services shall include:

(1) Physician services, including:

(a) Inpatient services, including:

(i) medical care including consultations;

(ii) surgical services and services related thereto; and

(iii) obstetrical services including normal delivery, cesarean section, and abortion.

(b) Outpatient/out-of-hospital services, including:

(i) office visits for covered services and care;

(ii) allergy testing and related diagnostic/therapy services;

(iii) dialysis center care;

(iv) maternity care;

(v) well child care;

(vi) child immunizations/lead screening;

(vii) routine adult physicals including pap, mammography, and prostate examinations; and

(viii) annual routine obstetrical/gynecological exam.

(2) Hospital services, both inpatient and outpatient, including:

(a) room and board;

(b) intensive care and other required levels of care;

(c) semi-private room;

(d) therapy and diagnostic services;

(e) surgical services or facilities and treatment related thereto;

(f) nursing care;

(g) necessary supplies, medicines, and equipment for care; and

(h) maternity care and related services.

(3) Other facility and services, including:

(a) approved treatment centers for medical emergency/accidental injury;

(b) approved surgical center;

(c) hospice;

(d) chemotherapy;

(e) diagnostic x-ray and lab tests;

(f) ambulance;

(g) durable medical equipment;

(h) prosthetic devices;

(i) foot orthotics;

(j) diabetic supplies and education; and

(k) oxygen and oxygen administration.

(4) All services for which coverage is required pursuant to P.L.1961, c.49 (C.52:14-17.25 et seq.), as amended and supplemented. Benefits under the contract or contracts purchased as authorized by the State Health Benefits Program shall include those for mental health services subject to limits and exclusions consistent with the provisions of the New Jersey State Health Benefits Program Act.

(C) The contract or contracts purchased by the commission pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall include the following provisions regarding reimbursements and payments:

(1) In the successor plan, the co-payment for doctor’s office visits shall be $10 per visit with a maximum out-of-pocket of $400

1 per individual and $1,000 per family for in-network services for
2 each calendar year. The out-of-network deductible shall be $100 per
3 individual and $250 per family for each calendar year, and the
4 participant shall receive reimbursement for out-of-network charges
5 at the rate of 80% of reasonable and customary charges, provided
6 that the out-of-pocket maximum shall not exceed $2,000 per
7 individual and $5,000 per family for each calendar year.
8 (2) In the State managed care plan that is required to be included
9 in a contract entered into pursuant to subsection c. of section 4 of
10 P.L.1961, c.49 (C.52:14-17.28), the co-payment for doctor's office
11 visits shall be $15 per visit. The participant shall receive
12 reimbursement for out-of-network charges at the rate of 70% of
13 reasonable and customary charges. The in-network and out-of-
14 network limits, exclusions, maximums, and deductibles shall be
15 substantially equivalent to those in the NJ PLUS plan in effect on
16 June 30, 2007, with adjustments to that plan pursuant to a binding
17 collective negotiations agreement or pursuant to action by the
18 commission, in its sole discretion, to apply such adjustments to
19 State employees for whom there is no majority representative for
20 collective negotiations purposes.
21 (3) "Reasonable and customary charges" means charges based
22 upon the 90th percentile of the usual, customary, and reasonable
23 (UCR) fee schedule determined by the Health Insurance
24 Association of America or a similar nationally recognized database
25 of prevailing health care charges.
26 (D) Benefits under the contract or contracts purchased as
27 authorized by this act may be subject to such limitations,
28 exclusions, or waiting periods as the commission finds to be
29 necessary or desirable to avoid inequity, unnecessary utilization,
30 duplication of services or benefits otherwise available, including
31 coverage afforded under the laws of the United States, such as the
32 federal Medicare program, or for other reasons.
33 Benefits under the contract or contracts purchased as authorized
34 by this act shall include those for the treatment of alcoholism
35 [where such treatment is prescribed by a physician and shall also
36 include treatment while confined in or as an outpatient of a licensed
37 hospital or residential treatment program which meets minimum
38 standards of care equivalent to those prescribed by the Joint
39 Commission on Hospital Accreditation. No benefits shall be
40 provided beyond those stipulated in the contracts held by the State
41 Health Benefits Commission] <u>or other substance-use disorders.</u>
42 <u>The benefits shall be provided in accordance with the provisions of</u>
43 <u>section 21 of P.L. , c. (C.)(pending before the Legislature as</u>
44 <u>this bill)</u>.
45 (E) The rates charged for any contract purchased under the
46 authority of this act shall reasonably and equitably reflect the cost
47 of the benefits provided based on principles which in the judgment

1 of the commission are actuarially sound. The rates charged shall be
2 determined by the carrier on accepted group rating principles with
3 due regard to the experience, both past and contemplated, under the
4 contract. The commission shall have the right to particularize
5 subgroups for experience purposes and rates. No increase in rates
6 shall be retroactive.
7 (F) The initial term of any contract purchased by the
8 commission under the authority of this act shall be for such period
9 to which the commission and the carrier may agree, but permission
10 may be made for automatic renewal in the absence of notice of
11 termination by the commission. Subsequent terms for which any
12 contract may be renewed as herein provided shall each be limited to
13 a period not to exceed one year.
14 (G) A contract purchased by the commission pursuant to
15 subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall
16 contain a provision that if basic benefits or major medical expense
17 benefits of an employee or of an eligible dependent under the
18 contract, after having been in effect for at least one month in the
19 case of basic benefits or at least three months in the case of major
20 medical expense benefits, is terminated, other than by voluntary
21 cancellation of enrollment, there shall be a 31-day period following
22 the effective date of termination during which such employee or
23 dependent may exercise the option to convert, without evidence of
24 good health, to converted coverage issued by the carriers on a direct
25 payment basis. Such converted coverage shall include benefits of
26 the type classified as "basic benefits" or "major medical expense
27 benefits" in subsection (A) hereof and shall be equivalent to the
28 benefits which had been provided when the person was covered as
29 an employee. The provision shall further stipulate that the employee
30 or dependent exercising the option to convert shall pay the full
31 periodic charges for the converted coverage which shall be subject
32 to such terms and conditions as are normally prescribed by the
33 carrier for this type of coverage.
34 (H) The commission may purchase a contract or contracts to
35 provide drug prescription and other health care benefits or authorize
36 the purchase of a contract or contracts to provide drug prescription
37 and other health care benefits as may be required to implement a
38 duly executed collective negotiations agreement or as may be
39 required to implement a determination by a public employer to
40 provide such benefit or benefits to employees not included in
41 collective negotiations units.
42 (I) The commission shall take action as necessary, in
43 cooperation with the School Employees' Health Benefits
44 Commission established pursuant to section 33 of P.L.2007, c.103
45 (C.52:14-17.46.3), to effectuate the purposes of the School
46 Employees' Health Benefits Program Act as provided in sections 31
47 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-

17.46.11) and to enable the School Employees' Health Benefits Commission to begin providing coverage to participants pursuant to the School Employees' Health Benefits Program Act as of July 1, 2008.

(cf: P.L.2007, c.103, s.23)

19. Section 1 of P.L.1999, c.441 (C.52:14-17.29d) is amended to read as follows:

1. As used in this act:

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness including, but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Same terms and conditions" means that a carrier cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

"Serious non-biologically-based mental illness" means a mental or nervous condition that is primarily treated with psychotherapy or psychotropic medication but is not caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the function of the person with the illnesses, including, but not limited to, dysthymic disorder, post-traumatic stress disorder, borderline personality disorder, bulimia, anorexia and other eating disorders, and other illnesses found in the Diagnostic and Statistical Manual of Mental Disorders as determined by the State Health Benefits Commission, in consultation with the Commissioner of Health and Senior Services.

(cf: P.L.1999, c.441, s.1)

20. Section 2 of P.L.1999, c.441 (C.52:14-17.29e) is amended to read as follows:

2. a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other

1 [sickness] disease or illness under the contract.
2 In addition, the commission shall ensure that every such contract
3 shall provide coverage for serious non-biologically-based mental
4 illness under the same terms and conditions as provided for any
5 other disease or illness under the contract.
6 b. Nothing in this section shall be construed to change the
7 manner in which a carrier determines:
8 (1) whether a mental health care service meets the medical
9 necessity standard as established by the carrier; or
10 (2) which providers shall be entitled to reimbursement for
11 providing services for mental illness under the contract.
12 Notwithstanding any other provision of law to the contrary, the
13 coverage required pursuant to this section may be subject to
14 utilization review as performed by the carrier.
15 Notwithstanding the provisions of this section to the contrary:
16 (1) The financial requirements applicable to coverage for mental
17 illness as provided in this section shall be no more restrictive than
18 the financial requirements applied to substantially all medical and
19 surgical benefits covered by the contract, including deductibles,
20 copayments, coinsurance, out-of-pocket expenses, and annual and
21 lifetime limits, except that the contract may not establish separate
22 cost-sharing requirements that are applicable only with respect to
23 coverage for mental illness; and
24 (2) The treatment limitations applicable to coverage for mental
25 illness shall be no more restrictive than the treatment limitations
26 applied to substantially all medical and surgical benefits covered by
27 the contract, including limits on the frequency of treatment, number
28 of visits, days of coverage, or other similar limits on the scope or
29 duration of treatment.
30 c. The commission shall provide notice to employees regarding
31 the coverage required by this section in accordance with this
32 subsection and regulations promulgated by the Commissioner of
33 Health and Senior Services pursuant to the "Administrative
34 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice
35 shall be in writing and prominently positioned in any literature or
36 correspondence and shall be transmitted at the earliest of: (1) the
37 next mailing to the employee; (2) the yearly informational packet
38 sent to the employee; or (3) July 1, 2000. The commission shall
39 also ensure that the carrier under contract with the commission,
40 upon receipt of information that a covered person is receiving
41 treatment for a biologically-based or other mental illness, shall
42 promptly notify that person of the coverage required by this section.
43 (cf: P.L.1999, c.441, s.2)
44
45 21. (New section) The State Health Benefits Commission shall
46 ensure that every contract purchased by the commission on or after
47 the effective date of P.L. , c. (C.)(pending before the
48 Legislature as this bill) provides hospital or medical expense

benefits for the treatment of alcoholism and other substance-use disorders under the same terms and conditions as provided for any other disease or illness under the contract.

"Treatment of alcoholism and other substance-use disorders" includes, but is not limited to, any of the following items or services provided for treatment of alcoholism or other substance-use disorders: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcoholism or other substance-use disorders.

"Same terms and conditions" means that a carrier cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to alcoholism and other substance-use disorder treatment services than those applied to other medical or surgical expense benefits.

Every contract shall include such benefits for the treatment of alcoholism and other substance-use disorders as are hereinafter set forth:

a. Inpatient or outpatient care in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to section 8 of P.L.1975, c.305 (C.26:2B-14);

c. Participation as an inpatient at a residential facility licensed by the Division of Addiction Services in the Department of Human Services or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Human Services; and

d. Treatment provided by a physician or other appropriately trained, licensed health care professional.

Treatment at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other disease or illness under the contract.

Nothing in this section shall be construed to prohibit a carrier from determining if the treatment of alcoholism and other substance-use disorders is medically necessary.

Nothing in this section shall be construed to change the manner in which the carrier determines which health care providers shall be entitled to reimbursement for providing treatment services under the contract.

Notwithstanding any other provision of law to the contrary, the treatment services required pursuant to this section may be subject to utilization review as performed by the carrier.

Notwithstanding the provisions of this section to the contrary:

(1) The financial requirements applicable to treatment for alcoholism and other substance-use disorders as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits under the contract, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, except that the contract may not establish separate cost-sharing requirements that are applicable only with respect to coverage for alcoholism and other substance-use disorders; and

(2) The treatment limitations applicable to alcoholism and other substance-use disorders shall be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits under the contract, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

22. Section 1 of P.L.1977, c.115 (C.17:48-6a) is amended to read as follows:

1. No group or individual contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, unless such contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in connection with the treatment of alcoholism [when such treatment is prescribed by a doctor of medicine] and other substance-use disorders. Such benefits shall be provided [to the same extent] under the same terms and conditions as provided for any other [sickness] disease or illness under the contract.

"Treatment of alcoholism and other substance-use disorders" includes, but is not limited to, any of the following items or services provided for treatment of alcoholism or other substance-use disorders: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcoholism or other substance-use disorders.

"Same terms and conditions" means that the medical service corporation cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to alcoholism and other substance-use disorder treatment services than those applied to other medical or surgical expense benefits.

Every contract shall include such benefits for the treatment of

alcoholism and other substance-use disorders as are hereinafter set forth:

a. Inpatient or outpatient care in a [licensed hospital] health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to [P.L.1975, c.305] section 8 of P.L.1975, c.305 (C.26:2B-14);

c. [Confinement as an inpatient or outpatient at a licensed, certified, or state approved residential treatment facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation] Participation as an inpatient at a residential facility licensed by the Division of Addiction Services in the Department of Human Services or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Human Services; and

d. Treatment provided by a physician or other appropriately trained, licensed health care professional.

Treatment [or confinement] at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other [sickness] disease or illness under the contract.

Nothing in this section shall be construed to prohibit the hospital service corporation from determining if the treatment of alcoholism and other substance-use disorders is medically necessary.

Nothing in this section shall be construed to change the manner in which the hospital service corporation determines which health care providers shall be entitled to reimbursement for providing treatment services under the contract.

Notwithstanding any other provision of law to the contrary, the coverage required pursuant to this section may be subject to utilization review as performed by the hospital service corporation or its designated utilization review organization.

Notwithstanding the provisions of this section to the contrary:

(1) The financial requirements applicable to coverage for alcoholism and other substance-use disorders as provided in this section shall be no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the contract, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, except that the contract may not establish separate cost-sharing requirements that are applicable only with respect to coverage for alcoholism and other substance-use disorders; and

(2) The treatment limitations applicable to coverage for alcoholism and other substance-use disorders shall be no more restrictive than the treatment limitations applied to substantially all

1 medical and surgical benefits covered by the contract, including
2 limits on the frequency of treatment, number of visits, days of
3 coverage, or other similar limits on the scope or duration of
4 treatment.
5 (cf: P.L.1977, c.115, s.1)
6
7 23. This act shall take effect on the 90th day after enactment and
8 shall apply to policies or contracts issued or renewed on or after the
9 effective date, but shall remain inoperative until the enactment into
10 law of P.L. , c. (C.) (pending before the Legislature as
11 Assembly Bill No. 2255 of 2008).