ASSEMBLY, No. 968

STATE OF NEW JERSEY

214th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2010 SESSION

Sponsored by:
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District 37 (Bergen)
Assemblywoman VALERIE VAINIERI HUTTLE
District 37 (Bergen)
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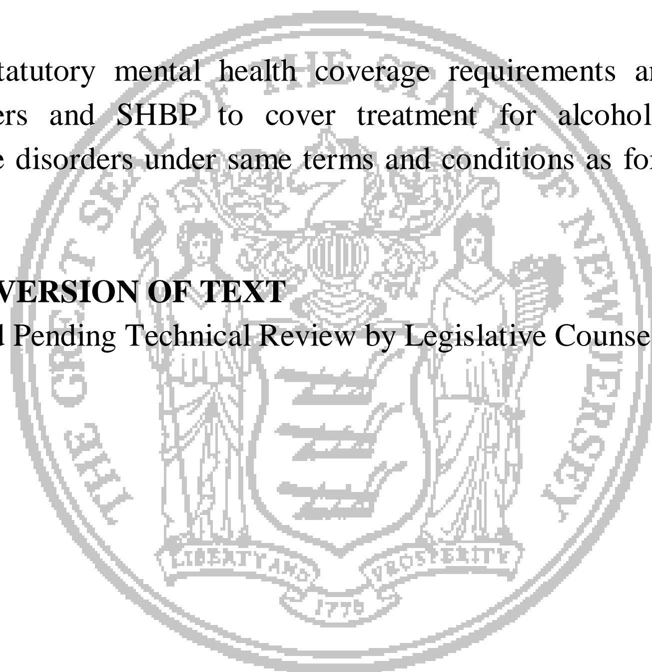
Assemblywoman Wagner, Assemblyman Coutinho and Assemblywoman Voss

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

Introduced Pending Technical Review by Legislative Counsel



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 Banking and Insurance, in consultation with 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.

1 Health and Senior Services.
2 "Same terms and conditions" means that the hospital service
3 corporation cannot apply different copayments, deductibles or
4 benefit limits, including day or visit limits or annual or lifetime
5 dollar limits, to biologically-based or other mental health benefits,
6 as applicable, than those applied to other medical or surgical
7 benefits.
8 b. Nothing in this section shall be construed to change the
9 manner in which a hospital service corporation determines:
10 (1) whether a mental health care service meets the medical
11 necessity standard as established by the hospital service
12 corporation; or
13 (2) which providers shall be entitled to reimbursement for
14 providing services for mental illness under the contract.
15 c. Notwithstanding any other provision of law to the contrary,
16 the coverage required pursuant to this section may be subject to
17 utilization review as performed by the hospital service corporation
18 or its designated utilization review organization.
19 d. The provisions of this section shall apply to all contracts in
20 which the hospital service corporation has reserved the right to
21 change the premium.
22 e. Notwithstanding the provisions of subsection a. of this section
23 to the contrary:
24 (1) The financial requirements applicable to coverage for mental
25 illness as provided in this section shall be no more restrictive than
26 the financial requirements applied to substantially all medical and
27 surgical benefits covered by the contract, including deductibles,
28 copayments, coinsurance, out-of-pocket expenses, and annual and
29 lifetime limits, and the contract may not establish separate cost-
30 sharing requirements that are applicable only with respect to
31 coverage for mental illness; and
32 (2) The treatment limitations applicable to coverage for mental
33 illness shall be no more restrictive than the treatment limitations
34 applied to substantially all medical and surgical benefits covered by
35 the contract, including limits on the frequency of treatment, number
36 of visits, days of coverage, or other similar limits on the scope or
37 duration of treatment.
38 (cf: P.L.1999, c.106, s.1)
39
40 2. Section 2 of P.L.1999, c.106 (C.17:48A-7u) is amended to
41 read as follows:
42 2. a. (1) Every individual and group medical service
43 corporation contract that provides hospital or medical expense
44 benefits that is delivered, issued, executed or renewed in this State
45 pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for
46 issuance or renewal in this State by the Commissioner of Banking
47 and Insurance, on or after the effective date of this act shall provide
48 coverage for biologically-based mental illness under the same terms

and conditions as provided for any other sickness under the contract.

In addition, the medical 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.117 (C.17:48A-7a).

(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 medical 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 medical service corporation determines:

(1) whether a mental health care service meets the medical necessity standard as established by the medical 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 medical service corporation or its designated utilization review organization.

d. The provisions of this section shall apply to all contracts in

1 which the medical service corporation has reserved the right to
2 change the premium.
3 e. Notwithstanding the provisions of subsection a. of this section
4 to the contrary:
5 (1) The financial requirements applicable to coverage for mental
6 illness as provided in this section shall be no more restrictive than
7 the financial requirements applied to substantially all medical and
8 surgical benefits covered by the contract, including deductibles,
9 copayments, coinsurance, out-of-pocket expenses, and annual and
10 lifetime limits, and the contract may not establish separate cost-
11 sharing requirements that are applicable only with respect to
12 coverage for mental illness; and
13 (2) The treatment limitations applicable to coverage for mental
14 illness shall be no more restrictive than the treatment limitations
15 applied to substantially all medical and surgical benefits covered by
16 the contract, including limits on the frequency of treatment, number
17 of visits, days of coverage, or other similar limits on the scope or
18 duration of treatment.
19 (cf: P.L.1999, c.106, s.2)
20
21 3. Section 3 of P.L.1999, c.106 (C.17:48E-35.20) is amended to
22 read as follows:
23 3. (1) a. Every individual and group health service corporation
24 contract that provides hospital or medical expense benefits and is
25 delivered, issued, executed or renewed in this State pursuant to
26 P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or
27 renewal in this State by the Commissioner of Banking and
28 Insurance, on or after the effective date of this act shall provide
29 coverage for biologically-based mental illness under the same
30 terms and conditions as provided for any other sickness under the
31 contract.
32 In addition, the health service corporation contract shall provide
33 coverage for serious non-biologically-based mental illness under the
34 same terms and conditions as provided for any other sickness under
35 the contract; however, coverage for treatment of alcoholism and
36 other substance-use disorders shall be subject to the provisions of
37 section 34 of P.L.1985, c.236 (C.17:48E-34).
38 (2) As used in this section:
39 "Biologically-based mental illness" means a mental or nervous
40 condition that is caused by a biological disorder of the brain and
41 results in a clinically significant or psychological syndrome or
42 pattern that substantially limits the functioning of the person with
43 the illness, including but not limited to, schizophrenia,
44 schizoaffective disorder, major depressive disorder, bipolar
45 disorder, paranoia and other psychotic disorders, obsessive-
46 compulsive disorder, panic disorder and pervasive developmental
47 disorder or autism.
48 “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

1 providing services for mental illness under the policy.
2 c. Notwithstanding any other provision of law to the contrary,
3 the coverage required pursuant to this section may be subject to
4 utilization review as performed by the insurer or its designated
5 utilization review organization.
6 d. The provisions of this section shall apply to all policies in
7 which the insurer has reserved the right to change the premium.
8 e. Notwithstanding the provisions of subsection a. of this section
9 to the contrary:
10 (1) The financial requirements applicable to coverage for mental
11 illness as provided in this section shall be no more restrictive than
12 the financial requirements applied to substantially all medical and
13 surgical benefits covered by the policy, including deductibles,
14 copayments, coinsurance, out-of-pocket expenses, and annual and
15 lifetime limits, and the policy may not establish separate cost-
16 sharing requirements that are applicable only with respect to
17 coverage for mental illness; and
18 (2) The treatment limitations applicable to coverage for mental
19 illness shall be no more restrictive than the treatment limitations
20 applied to substantially all medical and surgical benefits covered by
21 the policy, including limits on the frequency of treatment, number
22 of visits, days of coverage, or other similar limits on the scope or
23 duration of treatment.
24 (cf: P.L.1999, c.106, s.4)
25
26 5. Section 5 of P.L.1999, c.106 (C.17B:27-46.1v) is amended to
27 read as follows:
28 5. a. (1) Every group health insurance policy that provides
29 hospital or medical expense benefits and is delivered, issued,
30 executed or renewed in this State pursuant to chapter 27 of Title
31 17B of the New Jersey Statutes, or approved for issuance or renewal
32 in this State by the Commissioner of Banking and Insurance, on or
33 after the effective date of this act shall provide benefits for
34 biologically-based mental illness under the same terms and
35 conditions as provided for any other sickness under the policy.
36 In addition, the group health insurance policy shall provide
37 coverage for serious non-biologically-based mental illness under the
38 same terms and conditions as provided for any other sickness under
39 the policy; however, coverage for treatment of alcoholism and other
40 substance-use disorders shall be subject to the provisions of section
41 1 of P.L.1977, c.116 (C.17B:27-46.1).
42 (2) As used in this section:
43 "Biologically-based mental illness" means a mental or nervous
44 condition that is caused by a biological disorder of the brain and
45 results in a clinically significant or psychological syndrome or
46 pattern that substantially limits the functioning of the person with
47 the illness, including but not limited to, schizophrenia,
48 schizoaffective disorder, major depressive disorder, bipolar

1 disorder, paranoia and other psychotic disorders, obsessive-
2 compulsive disorder, panic disorder and pervasive developmental
3 disorder or autism.
4 "Serious non-biologically-based mental illness" means a mental
5 or nervous condition that is primarily treated with psychotherapy or
6 psychotropic medication but is not caused by a biological disorder
7 of the brain and results in a clinically significant or psychological
8 syndrome or pattern that substantially limits the function of the
9 person with the illness, including, but not limited to, dysthymic
10 disorder, post-traumatic stress disorder, borderline personality
11 disorder, bulimia, anorexia and other eating disorders, and other
12 illnesses found in the Diagnostic and Statistical Manual of Mental
13 Disorders as determined by regulation of the Commissioner of
14 Banking and Insurance, in consultation with the Commissioner of
15 Health and Senior Services.
16 "Same terms and conditions" means that the insurer cannot apply
17 different copayments, deductibles or benefit limits, including day or
18 visit limits or annual or lifetime dollar limits, to biologically-based
19 or other mental health benefits, as applicable, than those applied to
20 other medical or surgical benefits.
21 b. Nothing in this section shall be construed to change the
22 manner in which the insurer determines:
23 (1) whether a mental health care service meets the medical
24 necessity standard as established by the insurer; or
25 (2) which providers shall be entitled to reimbursement for
26 providing services for mental illness under the policy.
27 c. Notwithstanding any other provision of law to the contrary,
28 the coverage required pursuant to this section may be subject to
29 utilization review as performed by the insurer or its designated
30 utilization review organization.
31 d. The provisions of this section shall apply to all policies in
32 which the insurer has reserved the right to change the premium.
33 e. Notwithstanding the provisions of subsection a. of this section
34 to the contrary:
35 (1) The financial requirements applicable to coverage for mental
36 illness as provided in this section shall be no more restrictive than
37 the financial requirements applied to substantially all medical and
38 surgical benefits covered by the policy, including deductibles,
39 copayments, coinsurance, out-of-pocket expenses, and annual and
40 lifetime limits, and the policy may not establish separate cost-
41 sharing requirements that are applicable only with respect to
42 coverage for mental illness; and
43 (2) The treatment limitations applicable to coverage for mental
44 illness shall be no more restrictive than the treatment limitations
45 applied to substantially all medical and surgical benefits covered by
46 the policy, including limits on the frequency of treatment, number
47 of visits, days of coverage, or other similar limits on the scope or

duration of treatment.
(cf: P.L.1999, c.106, s.5)

6. Section 6 of P.L.1999, c.106 (C.17B:27A-7.5) is amended to read as follows:

6. a. (1) Every individual 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.161 (C.17B:27A-2 et seq.) or approved for issuance or renewal in this State 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 health benefits plan.

In addition, the health benefits plan shall provide benefits for serious non-biologically-based mental illness under the same terms and conditions as provided for any other sickness under the plan; however, coverage for treatment of alcoholism and other substance-use disorders shall be subject to the provisions of section 14 of P.L. , c. (C.)(pending before the Legislature as this bill).

(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 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 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 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.

(cf: P.L.1999, c.106, s.6)

7. Section 7 of P.L.1999, c.106 (C.17B:27A-19.7) is amended to read as follows:

7. a. (1) 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.) or approved for issuance or renewal in this State 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 health benefits plan.

In addition, the health benefits plan shall provide benefits for serious non-biologically-based mental illness under the same terms and conditions as provided for any other sickness under the plan; however, coverage for treatment of alcoholism and other substance-use disorders shall be subject to the provisions of section 15 of P.L. , c. (C.)(pending before the Legislature as this bill).

(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 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 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.
(cf: P.L.1999, c.106, s.7)

8. Section 8 of P.L.1999, c.106 (C.26:2J-4.20) is amended to read as follows:

8. a. (1) Every [enrollee agreement] contract 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 [Health and Senior Services] Banking and Insurance, on or after the effective date of this act shall provide health care services for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the [agreement] contract.

In addition, the contract shall provide health care services 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 16 of P.L. , c. (C.)(pending before the Legislature as this bill).

(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 maintenance

1 organization cannot apply different copayments, deductibles or
2 health care services limits, including day or visit limits or annual or
3 lifetime dollar limits, to biologically-based or other mental health
4 care services, as applicable, than those applied to other medical or
5 surgical health care services.
6 b. Nothing in this section shall be construed to change the
7 manner in which a health maintenance organization determines:
8 (1) whether a mental health care service meets the medical
9 necessity standard as established by the health maintenance
10 organization; or
11 (2) which providers shall be entitled to reimbursement or to be
12 participating providers, as appropriate, for mental health services
13 under the [enrollee agreement] contract.
14 c. Notwithstanding any other provision of law to the contrary,
15 the mental health care services required pursuant to this section may
16 be subject to utilization review as performed by the health
17 maintenance organization or its designated utilization review
18 organization.
19 d. The provisions of this section shall apply to enrollee
20 agreements] contracts in which the health maintenance
21 organization has reserved the right to change the premium.
22 e. Notwithstanding the provisions of subsection a. of this section
23 to the contrary:
24 (1) The financial requirements applicable to mental health care
25 services as provided in this section shall be no more restrictive than
26 the financial requirements applied to substantially all medical and
27 surgical benefits covered by the contract, including deductibles,
28 copayments, coinsurance, out-of-pocket expenses, and annual and
29 lifetime limits, and the contract may not establish separate cost-
30 sharing requirements that are applicable only with respect to mental
31 health care services; and
32 (2) The treatment limitations applicable to mental health care
33 services shall be no more restrictive than the treatment limitations
34 applied to substantially all medical and surgical benefits covered by
35 the contract, including limits on the frequency of treatment, number
36 of visits, days of coverage, or other similar limits on the scope or
37 duration of treatment.
38 (cf: P.L.1999, c.106, s.8)
39
40 9. Section 9 of P.L.1999, c.106 (C.34:11A-15) is amended to
41 read as follows:
42 9. An employer in this State who provides health benefits
43 coverage to his employees or their dependents for treatment of
44 biologically-based or other mental illness shall [annually], [and]
45 upon request of an employee [at other times during the year],
46 notify his employees whether the employees' coverage for treatment
47 of [biologically-based] mental illness is subject to the requirements

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

1 thereunder for expenses incurred in connection with treatment of
2 alcoholism [when the treatment is prescribed by a doctor of
3 medicine] and other substance-use disorders. Benefits shall be
4 provided [to the same extent] under the same terms and conditions
5 as provided for any other [sickness] disease or illness under the
6 contract.
7 "Treatment of alcoholism and other substance-use disorders"
8 includes, but is not limited to, any of the following items or services
9 provided for treatment of alcoholism or other substance-use
10 disorders: inpatient or outpatient treatment, including
11 detoxification, screening and assessment, case management,
12 medication management, psychiatric consultations and individual,
13 group and family counseling, and relapse prevention; non-hospital
14 residential treatment; and prevention services, including health
15 education and individual and group counseling to encourage the
16 reduction of risk factors for alcoholism or other substance-use
17 disorders.
18 "Same terms and conditions" means that the health service
19 corporation cannot apply different copayments, deductibles or
20 benefit limits, including day or visit limits or annual or lifetime
21 dollar limits, to alcoholism and other substance-use disorder
22 treatment services than those applied to other medical or surgical
23 expense benefits.
24 Every contract shall include benefits for the treatment of
25 alcoholism and other substance-use disorders as follows:
26 a. Inpatient or outpatient care in a health care facility licensed
27 pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);
28 b. Treatment at a detoxification facility licensed pursuant to
29 section 8 of P.L.1975, c.305 (C.26:2B-14);
30 c. [Confinement as an inpatient or outpatient at a licensed,
31 certified, or state approved residential treatment facility, under a
32 program which meets minimum standards of care equivalent to
33 those prescribed by the Joint Commission on Hospital
34 Accreditation] Participation as an inpatient at a residential facility
35 licensed by the Division of Addiction Services in the Department of
36 Human Services or as an outpatient in a State-approved outpatient
37 treatment facility that meets minimum standards of care as set forth
38 by the Department of Human Services; and
39 d. Treatment provided by a physician or other appropriately
40 trained, licensed health care professional.
41 Treatment [or confinement] at any facility shall not preclude
42 further or additional treatment at any other eligible facility, if the
43 benefit days used do not exceed the total number of benefit days
44 provided for any other [sickness] disease or illness under the
45 contract.
46 Nothing in this section shall be construed to prohibit the health
47 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 health 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 health 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.1985, c.236, s.34)

12. Section 1 of P.L.1977, c.118 (C.17B:26-2.1) is amended to read as follows:

1. No health insurance [contract] policy 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] policy provides benefits to any [subscriber] insured 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] policy.

"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,

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

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

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

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

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

1 provided for any other disease or illness under the contract.
2 Nothing in this section shall be construed to prohibit the health
3 maintenance organization from determining if the treatment of
4 alcoholism and other substance-use disorders is medically
5 necessary.
6 Nothing in this section shall be construed to change the manner
7 in which the health maintenance organization determines which
8 health care providers shall be entitled to reimbursement for
9 providing treatment services under the contract.
10 Notwithstanding any other provision of law to the contrary, the
11 treatment services required pursuant to this section may be subject
12 to utilization review as performed by the health maintenance
13 organization or its designated utilization review organization.
14 Notwithstanding the provisions of this section to the contrary:
15 (1) The financial requirements applicable to treatment services
16 for alcoholism and other substance-use disorders as provided in this
17 section shall be no more restrictive than the financial requirements
18 applied to substantially all health care services provided under the
19 contract, including deductibles, copayments, coinsurance, out-of-
20 pocket expenses, and annual and lifetime limits, except that the
21 contract may not establish separate cost-sharing requirements that
22 are applicable only with respect to coverage for alcoholism and
23 other substance-use disorders; and
24 (2) The treatment limitations applicable to treatment services for
25 alcoholism and other substance-use disorders shall be no more
26 restrictive than the treatment limitations applied to substantially all
27 health care services provided under the contract, including limits on
28 the frequency of treatment, number of visits, days of coverage, or
29 other similar limits on the scope or duration of treatment.
30
31 17. (New section) An employer in this State who provides
32 health benefits coverage to his employees or their dependents for
33 treatment of alcoholism or other substance-use disorders shall, upon
34 request of an employee, notify his employees whether the
35 employees' coverage for treatment of alcoholism or other substance-
36 use disorders is subject to the requirements of section 1 of
37 P.L.1977, c.115 (C.17:48-6a), section 1 of P.L.1977, c.116
38 (C.17B:27-46.1); section 1 of P.L.1977, c.117 (C.17:48A-7a),
39 section 1 of P.L.1977, c.118 (C.17B:26-2.1), section 34 of
40 P.L.1985, c.236 (C.17:48E-34), or sections 14 through 16 of P.L. ,
41 c. (C.)(pending before the Legislature as this bill).
42
43 18. Section 5 of P.L.1961, c.49 (C.52:14-17.29) is amended to
44 read as follows:
45 5. (A) The contract or contracts purchased by the commission
46 pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-
47 17.28) shall provide separate coverages or policies as follows:
48 (1) Basic benefits which shall include:

1 (a) Hospital benefits, including outpatient;
2 (b) Surgical benefits;
3 (c) Inpatient medical benefits;
4 (d) Obstetrical benefits; and
5 (e) Services rendered by an extended care facility or by a home
6 health agency and for specified medical care visits by a physician
7 during an eligible period of such services, without regard to
8 whether the patient has been hospitalized, to the extent and subject
9 to the conditions and limitations agreed to by the commission and
10 the carrier or carriers.
11 Basic benefits shall be substantially equivalent to those available
12 on a group remittance basis to employees of the State and their
13 dependents under the subscription contracts of the New Jersey
14 "Blue Cross" and "Blue Shield" Plans. Such basic benefits shall
15 include benefits for:
16 (i) Additional days of inpatient medical service;
17 (ii) Surgery elsewhere than in a hospital;
18 (iii) X-ray, radioactive isotope therapy and pathology services;
19 (iv) Physical therapy services;
20 (v) Radium or radon therapy services;
21 and the extended basic benefits shall be subject to the same
22 conditions and limitations, applicable to such benefits, as are set
23 forth in "Extended Outpatient Hospital Benefits Rider," Form 1500,
24 71(9-66), and in "Extended Benefit Rider" (as amended), Form MS
25 7050J(9-66) issued by the New Jersey "Blue Cross" and "Blue
26 Shield" Plans, respectively, and as the same may be amended or
27 superseded, subject to filing by the Commissioner of Banking and
28 Insurance; and
29 (2) Major medical expense benefits which shall provide benefit
30 payments for reasonable and necessary eligible medical expenses
31 for hospitalization, surgery, medical treatment and other related
32 services and supplies to the extent they are not covered by basic
33 benefits. The commission may, by regulation, determine what types
34 of services and supplies shall be included as "eligible medical
35 services" under the major medical expense benefits coverage as
36 well as those which shall be excluded from or limited under such
37 coverage. Benefit payments for major medical expense benefits
38 shall be equal to a percentage of the reasonable charges for eligible
39 medical services incurred by a covered employee or an employee's
40 covered dependent, during a calendar year as exceed a deductible
41 for such calendar year of $100.00 subject to the maximums
42 hereinafter provided and to the other terms and conditions
43 authorized by this act. The percentage shall be 80% of the first
44 $2,000.00 of charges for eligible medical services incurred
45 subsequent to satisfaction of the deductible and 100% thereafter.
46 There shall be a separate deductible for each calendar year for (a)
47 each enrolled employee and (b) all enrolled dependents of such

1 employee. Not more than $1,000,000.00 shall be paid for major
2 medical expense benefits with respect to any one person for the
3 entire period of such person's coverage under the plan, whether
4 continuous or interrupted except that this maximum may be
5 reapplied to a covered person in amounts not to exceed $2,000.00 a
6 year. Maximums of $10,000.00 per calendar year and $20,000.00
7 for the entire period of the person's coverage under the plan shall
8 apply to eligible expenses incurred because of [mental illness or
9 functional nervous disorders] <u>any mental illness or functional</u>
10 <u>nervous disorder that is not biologically-based mental illness or</u>
11 <u>serious non-biologically-based mental illness as defined in section 1</u>
12 <u>of P.L.1999, c.441 (C.52:14-17.29d)</u>, and such may be reapplied to
13 a covered person, [except as provided] in <u>accordance with the</u>
14 <u>provisions of</u> P.L.1999, c.441 (C.52:14-17.29d et al.). The same
15 provisions shall apply for retired employees and their dependents.
16 Under the conditions agreed upon by the commission and the
17 carriers as set forth in the contract, the deductible for a calendar
18 year may be satisfied in whole or in part by eligible charges
19 incurred during the last three months of the prior calendar year.
20 Any service determined by regulation of the commission to be an
21 "eligible medical service" under the major medical expense benefits
22 coverage which is performed by a duly licensed practicing
23 psychologist within the lawful scope of his practice shall be
24 recognized for reimbursement under the same conditions as would
25 apply were such service performed by a physician.
26 (B) The contract or contracts purchased by the commission
27 pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-
28 17.28) shall include coverage for services and benefits that are at a
29 level that is equal to or exceeds the level of services and benefits set
30 forth in this subsection, provided that such services and benefits
31 shall include only those that are eligible medical services and not
32 those deemed experimental, investigative or otherwise not eligible
33 medical services. The determination of whether services or benefits
34 are eligible medical services shall be made by the commission
35 consistent with the best interests of the State and participating
36 employers, employees, and dependents. The following list of
37 services is not intended to be exclusive or to require that any limits
38 or exclusions be exceeded.
39 Covered services shall include:
40 (1) Physician services, including:
41 (a) Inpatient services, including:
42 (i) medical care including consultations;
43 (ii) surgical services and services related thereto; and
44 (iii) obstetrical services including normal delivery, cesarean
45 section, and abortion.
46 (b) Outpatient/out-of-hospital services, including:
47 (i) office visits for covered services and care;

1 (ii) allergy testing and related diagnostic/therapy services;
2 (iii) dialysis center care;
3 (iv) maternity care;
4 (v) well child care;
5 (vi) child immunizations/lead screening;
6 (vii) routine adult physicals including pap, mammography, and
7 prostate examinations; and
8 (viii) annual routine obstetrical/gynecological exam.
9 (2) Hospital services, both inpatient and outpatient, including:
10 (a) room and board;
11 (b) intensive care and other required levels of care;
12 (c) semi-private room;
13 (d) therapy and diagnostic services;
14 (e) surgical services or facilities and treatment related thereto;
15 (f) nursing care;
16 (g) necessary supplies, medicines, and equipment for care; and
17 (h) maternity care and related services.
18 (3) Other facility and services, including:
19 (a) approved treatment centers for medical
20 emergency/accidental injury;
21 (b) approved surgical center;
22 (c) hospice;
23 (d) chemotherapy;
24 (e) diagnostic x-ray and lab tests;
25 (f) ambulance;
26 (g) durable medical equipment;
27 (h) prosthetic devices;
28 (i) foot orthotics;
29 (j) diabetic supplies and education; and
30 (k) oxygen and oxygen administration.
31 (4) All services for which coverage is required pursuant to
32 P.L.1961, c.49 (C.52:14-17.25 et seq.), as amended and
33 supplemented. Benefits under the contract or contracts purchased as
34 authorized by the State Health Benefits Program shall include those
35 for mental health services subject to limits and exclusions
36 consistent with the provisions of the New Jersey State Health
37 Benefits Program Act.
38 (C) The contract or contracts purchased by the commission
39 pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-
40 17.28) shall include the following provisions regarding
41 reimbursements and payments:
42 (1) In the successor plan, the co-payment for doctor's office
43 visits shall be $10 per visit with a maximum out-of-pocket of $400
44 per individual and $1,000 per family for in-network services for
45 each calendar year. The out-of-network deductible shall be $100 per
46 individual and $250 per family for each calendar year, and the
47 participant shall receive reimbursement for out-of-network charges

at the rate of 80% of reasonable and customary charges, provided that the out-of-pocket maximum shall not exceed $2,000 per individual and $5,000 per family for each calendar year.

(2) In the State managed care plan that is required to be included in a contract entered into pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28), the co-payment for doctor's office visits shall be $15 per visit. The participant shall receive reimbursement for out-of-network charges at the rate of 70% of reasonable and customary charges. The in-network and out-of-network limits, exclusions, maximums, and deductibles shall be substantially equivalent to those in the NJ PLUS plan in effect on June 30, 2007, with adjustments to that plan pursuant to a binding collective negotiations agreement or pursuant to action by the commission, in its sole discretion, to apply such adjustments to State employees for whom there is no majority representative for collective negotiations purposes.

(3) "Reasonable and customary charges" means charges based upon the 90th percentile of the usual, customary, and reasonable (UCR) fee schedule determined by the Health Insurance Association of America or a similar nationally recognized database of prevailing health care charges.

(D) Benefits under the contract or contracts purchased as authorized by this act may be subject to such limitations, exclusions, or waiting periods as the commission finds to be necessary or desirable to avoid inequity, unnecessary utilization, duplication of services or benefits otherwise available, including coverage afforded under the laws of the United States, such as the federal Medicare program, or for other reasons.

Benefits under the contract or contracts purchased as authorized by this act shall include those for the treatment of alcoholism [where such treatment is prescribed by a physician and shall also include treatment while confined in or as an outpatient of a licensed hospital or residential treatment program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation. No benefits shall be provided beyond those stipulated in the contracts held by the State Health Benefits Commission] or other substance-use disorders. The benefits shall be provided in accordance with the provisions of section 21 of P.L. , c. (C.)(pending before the Legislature as this bill).

(E) The rates charged for any contract purchased under the authority of this act shall reasonably and equitably reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound. The rates charged shall be determined by the carrier on accepted group rating principles with due regard to the experience, both past and contemplated, under the

contract. The commission shall have the right to particularize subgroups for experience purposes and rates. No increase in rates shall be retroactive.

(F) The initial term of any contract purchased by the commission under the authority of this act shall be for such period to which the commission and the carrier may agree, but permission may be made for automatic renewal in the absence of notice of termination by the commission. Subsequent terms for which any contract may be renewed as herein provided shall each be limited to a period not to exceed one year.

(G) A contract purchased by the commission pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall contain a provision that if basic benefits or major medical expense benefits of an employee or of an eligible dependent under the contract, after having been in effect for at least one month in the case of basic benefits or at least three months in the case of major medical expense benefits, is terminated, other than by voluntary cancellation of enrollment, there shall be a 31-day period following the effective date of termination during which such employee or dependent may exercise the option to convert, without evidence of good health, to converted coverage issued by the carriers on a direct payment basis. Such converted coverage shall include benefits of the type classified as "basic benefits" or "major medical expense benefits" in subsection (A) hereof and shall be equivalent to the benefits which had been provided when the person was covered as an employee. The provision shall further stipulate that the employee or dependent exercising the option to convert shall pay the full periodic charges for the converted coverage which shall be subject to such terms and conditions as are normally prescribed by the carrier for this type of coverage.

(H) The commission may purchase a contract or contracts to provide drug prescription and other health care benefits or authorize the purchase of a contract or contracts to provide drug prescription and other health care benefits as may be required to implement a duly executed collective negotiations agreement or as may be required to implement a determination by a public employer to provide such benefit or benefits to employees not included in collective negotiations units.

(I) The commission shall take action as necessary, in cooperation with the School Employees' Health Benefits Commission established pursuant to section 33 of P.L.2007, c.103 (C.52:14-17.46.3), to effectuate the purposes of the School Employees' Health Benefits Program Act as provided in sections 31 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 [sickness] disease or illness under the contract.

In addition, the commission shall ensure that every such contract

shall provide coverage for serious non-biologically-based mental illness under the same terms and conditions as provided for any other disease or illness under the contract.

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

Notwithstanding the provisions 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, except that 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.

c. The commission shall provide notice to employees regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health and Senior Services pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of: (1) the next mailing to the employee; (2) the yearly informational packet sent to the employee; or (3) July 1, 2000. The commission shall also ensure that the carrier under contract with the commission, upon receipt of information that a covered person is receiving treatment for a biologically-based or other mental illness, shall promptly notify that person of the coverage required by this section.

(cf: P.L.1999, c.441, s.2)

21. (New section) The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of P.L. , c. (C.)(pending before the 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

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

1 section shall be no more restrictive than the financial requirements
2 applied to substantially all medical and surgical benefits under the
3 contract, including deductibles, copayments, coinsurance, out-of-
4 pocket expenses, and annual and lifetime limits, except that the
5 contract may not establish separate cost-sharing requirements that
6 are applicable only with respect to coverage for alcoholism and
7 other substance-use disorders; and
8 (2) The treatment limitations applicable to alcoholism and other
9 substance-use disorders shall be no more restrictive than the
10 treatment limitations applied to substantially all medical and
11 surgical benefits under the contract, including limits on the
12 frequency of treatment, number of visits, days of coverage, or other
13 similar limits on the scope or duration of treatment.
14
15 22. Section 1 of P.L.1977, c.115 (C.17:48-6a) is amended to
16 read as follows:
17 1. No group or individual contract providing hospital or medical
18 expense benefits shall be delivered, issued, executed or renewed in
19 this State, or approved for issuance or renewal in this State by the
20 Commissioner of Banking and Insurance on or after the effective
21 date of this act, unless such contract provides benefits to any
22 subscriber or other person covered thereunder for expenses incurred
23 in connection with the treatment of alcoholism [when such
24 treatment is prescribed by a doctor of medicine] and other
25 substance-use disorders. Such benefits shall be provided [to the
26 same extent] under the same terms and conditions as provided for
27 any other [sickness] disease or illness under the contract.
28 "Treatment of alcoholism and other substance-use disorders"
29 includes, but is not limited to, any of the following items or services
30 provided for treatment of alcoholism or other substance-use
31 disorders: inpatient or outpatient treatment, including
32 detoxification, screening and assessment, case management,
33 medication management, psychiatric consultations and individual,
34 group and family counseling, and relapse prevention; non-hospital
35 residential treatment; and prevention services, including health
36 education and individual and group counseling to encourage the
37 reduction of risk factors for alcoholism or other substance-use
38 disorders.
39 "Same terms and conditions" means that the medical service
40 corporation cannot apply different copayments, deductibles or
41 benefit limits, including day or visit limits or annual or lifetime
42 dollar limits, to alcoholism and other substance-use disorder
43 treatment services than those applied to other medical or surgical
44 expense benefits.
45 Every contract shall include such benefits for the treatment of
46 alcoholism and other substance-use disorders as are hereinafter set
47 forth:

1 a. Inpatient or outpatient care in a [licensed hospital] health
2 care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et
3 seq.);
4 b. Treatment at a detoxification facility licensed pursuant to
5 [P.L.1975, c.305] section 8 of P.L.1975, c.305 (C.26:2B-14);
6 c. [Confinement as an inpatient or outpatient at a licensed,
7 certified, or state approved residential treatment facility, under a
8 program which meets minimum standards of care equivalent to
9 those prescribed by the Joint Commission on Hospital
10 Accreditation] Participation as an inpatient at a residential facility
11 licensed by the Division of Addiction Services in the Department of
12 Human Services or as an outpatient in a State-approved outpatient
13 treatment facility that meets minimum standards of care as set forth
14 by the Department of Human Services; and
15 d. Treatment provided by a physician or other appropriately
16 trained, licensed health care professional.
17 Treatment [or confinement] at any facility shall not preclude
18 further or additional treatment at any other eligible facility;
19 provided, however, that the benefit days used do not exceed the
20 total number of benefit days provided for any other [sickness]
21 disease or illness under the contract.
22 Nothing in this section shall be construed to prohibit the hospital
23 service corporation from determining if the treatment of alcoholism
24 and other substance-use disorders is medically necessary.
25 Nothing in this section shall be construed to change the manner
26 in which the hospital service corporation determines which health
27 care providers shall be entitled to reimbursement for providing
28 treatment services under the contract.
29 Notwithstanding any other provision of law to the contrary, the
30 coverage required pursuant to this section may be subject to
31 utilization review as performed by the hospital service corporation
32 or its designated utilization review organization.
33 Notwithstanding the provisions of this section to the contrary:
34 (1) The financial requirements applicable to coverage for
35 alcoholism and other substance-use disorders as provided in this
36 section shall be no more restrictive than the financial requirements
37 applied to substantially all medical and surgical benefits covered by
38 the contract, including deductibles, copayments, coinsurance, out-
39 of-pocket expenses, and annual and lifetime limits, except that the
40 contract may not establish separate cost-sharing requirements that
41 are applicable only with respect to coverage for alcoholism and
42 other substance-use disorders; and
43 (2) The treatment limitations applicable to coverage for
44 alcoholism and other substance-use disorders shall be no more
45 restrictive than the treatment limitations applied to substantially all
46 medical and surgical benefits covered by the contract, including
47 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.115, s.1)

23. This act shall take effect on the 90th day after enactment and shall apply to policies or contracts issued or renewed on or after the effective date, but shall remain inoperative until the enactment into law of P.L. , c. (C.) (pending before the Legislature as Assembly Bill No. 2255 of 2008).

STATEMENT

This bill provides for expanded health insurance coverage for the treatment of mental illness and substance-use disorders.

Mental Health Coverage: The bill expands the mental health coverage provisions of P.L.1999, c.106 and P.L.1999, c.441 to require health insurers to provide coverage for serious non-biologically-based mental illness. This requirement would apply to: hospital, medical and health service corporations; individual and small employer and large group commercial health insurers; health maintenance organizations; and the State Health Benefits Program.

The current statutory mental health "parity" coverage requirement is limited to biologically-based mental illness (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).

The bill provides as follows:

- "Serious non-biologically-based mental illness" is defined to mean 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 regulation of the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services.

- The bill clarifies the definition of "same terms and conditions," and makes it consistent with the definition of that term as provided in the sections of the substitute concerning benefits for treatment of alcoholism and other substance-use disorders. The revised definition provides that an insurer cannot apply different copayments, deductibles or benefit limits, "including day or visit limits or annual or lifetime dollar limits," to mental health benefits than the insurer applies to other medical or surgical benefits.
- The provisions of P.L.1999, c.106 and P.L.1999, c.441, which provide that the mental health parity requirements in those laws are not to be construed to change the manner in which the carrier determines whether a mental health care service meets the medical necessity standard as established by the carrier, or which providers are entitled to reimbursement for providing services under the policy or contract, would also apply to the expanded mental health coverage in this substitute.
- Notwithstanding any other provision of law to the contrary, the coverage required for mental illness may be subject to utilization review as performed by the insurer.
- Notwithstanding the provisions of the bill to the contrary:

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

-- The treatment limitations applicable to mental illness are to be no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the policy or 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.

Coverage for Treatment of Alcoholism and Other Substance-Use Disorders: The bill also requires health insurers, as well as the State Health Benefits Program, to provide coverage for treatment of alcoholism and other substance-use disorders under the same terms and conditions as for other diseases or illnesses.

Specifically, the bill revises the existing statutory requirement to provide coverage for treatment of alcoholism that applies to hospital, medical and health service corporations, commercial health insurers, and the State Health Benefits Program (but currently not to individual and small employer health benefits plans and health maintenance organizations), to add coverage for treatment of other substance-use disorders and to specify the types

of benefits that must be covered. The bill extends the requirement to provide coverage for treatment of alcoholism to those health insurers that are not already mandated by State law to provide such coverage, and includes the requirement to provide coverage for treatment of other substance-use disorders.

The bill provides as follows:

- "Treatment of alcoholism and other substance-use disorders" is defined to include, but not be limited to, any of the following items or services provided for treatment of alcoholism and 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" is defined to mean that the insurer 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.
- All health insurance contracts or policies are to provide the following benefits:

  -- inpatient or outpatient care in a licensed health care facility;

  -- treatment at a State-licensed detoxification facility;

  -- participation as an inpatient at a State-licensed residential facility 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

  -- treatment provided by a physician or other appropriately trained, licensed health care professional.
- Treatment at any facility is not to preclude further or additional treatment at any other eligible facility if the benefit days used do not exceed the total number of benefit days provided for any other disease or illness under the contract or policy.
- The provisions of the bill are not to be construed to:

  -- prohibit an insurer from determining if the treatment of alcoholism and other substance-use disorders is medically necessary; or

  -- change the manner in which the insurer determines which health care providers are entitled to reimbursement for providing substance-use disorder treatment services under the policy or contract.

1 • Notwithstanding any other provision of law to the contrary, the
2 coverage required for substance-use disorders may be subject to
3 utilization review as performed by the insurer.
4 • Notwithstanding the provisions of the bill to the contrary:
5 -- The financial requirements applicable to coverage for
6 alcoholism and other substance-use disorders are to be no more
7 restrictive than the financial requirements applied to substantially
8 all medical and surgical benefits covered by the policy or contract,
9 including deductibles, copayments, coinsurance, out-of-pocket
10 expenses, and annual and lifetime limits, and the policy or contract
11 may not establish separate cost-sharing requirements that are
12 applicable only with respect to coverage for alcoholism and other
13 substance-use disorders; and
14 -- The treatment limitations applicable to coverage for
15 alcoholism and other substance-use disorders are to be no more
16 restrictive than the treatment limitations applied to substantially all
17 medical and surgical benefits covered by the policy or contract,
18 including limits on the frequency of treatment, number of visits,
19 days of coverage, or other similar limits on the scope or duration of
20 treatment.
21 **Effective Date:** The bill takes effect on the 90th day after the
22 date of enactment and applies to health insurance contracts and
23 policies issued or renewed on or after that date, but would remain
24 inoperative until the enactment into law of Assembly Bill No. 2255
25 of 2008 (Greenwald/Conaway), which is currently pending before
26 the General Assembly.