

# ASSEMBLY, No. 4498

## STATE OF NEW JERSEY 217th LEGISLATURE

INTRODUCED JANUARY 19, 2017

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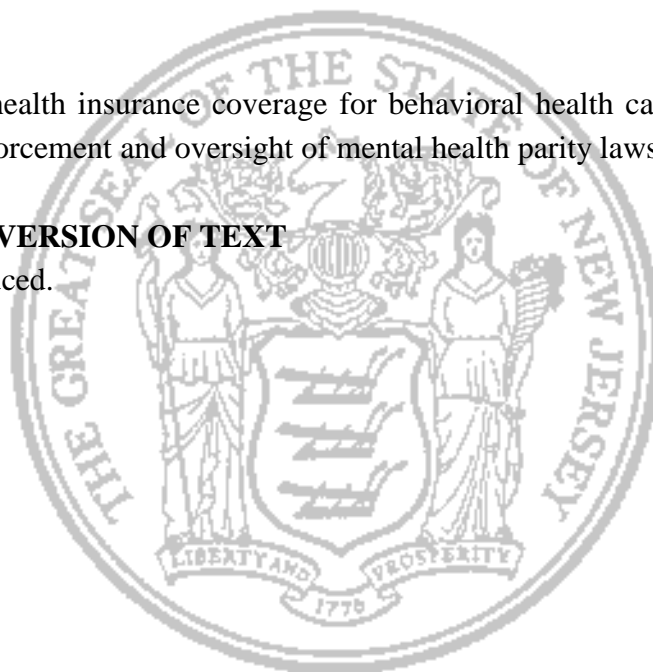
**Assemblymen Johnson and Benson**

**SYNOPSIS**

Expands health insurance coverage for behavioral health care services and enhances enforcement and oversight of mental health parity laws.

**CURRENT VERSION OF TEXT**

As introduced.



**(Sponsorship Updated As Of: 1/31/2017)**

1 AN ACT concerning health insurance coverage for behavioral health  
2 care services and amending various parts of the statutory law and  
3 supplementing P.L.1997, c.192 (C.26:2S-1 et al.).  
4

5 **BE IT ENACTED** by the Senate and General Assembly of the State  
6 of New Jersey:  
7

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

10 1. a. (1) Every individual and group hospital service  
11 corporation contract that provides hospital or medical expense  
12 benefits and is delivered, issued, executed or renewed in this State  
13 pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for  
14 issuance or renewal in this State by the Commissioner of Banking  
15 and Insurance, on or after the effective date of this act shall provide  
16 coverage for **【biologically-based mental illness】** medically  
17 necessary behavioral health care services under the same terms and  
18 conditions as provided for any other sickness under the contract and  
19 shall meet the requirements of the federal Paul Wellstone and Pete  
20 Domenici Mental Health Parity and Addiction Equity Act of 2008,  
21 42 U.S.C. 18031(j), and any amendments to, and federal guidance  
22 or regulations issued under that act, including 45 C.F.R. Parts 146  
23 and 147 and 45 C.F.R. 156.115(a)(3). **【"Biologically-based mental**  
24 illness"】

25 (2) As used in this section:

26 "Behavioral health care services" means **【a mental or nervous**  
27 condition that is caused by a biological disorder of the brain and  
28 results in a clinically significant or psychological syndrome or  
29 pattern that substantially limits the functioning of the person with  
30 the illness, including but not limited to, schizophrenia,  
31 schizoaffective disorder, major depressive disorder, bipolar  
32 disorder, paranoia and other psychotic disorders, obsessive-  
33 compulsive disorder, panic disorder and pervasive developmental  
34 disorder or autism**】** procedures or services rendered by a health care  
35 provider or health care facility for the treatment of mental illness,  
36 emotional disorders, or drug or alcohol abuse.

37 "Medically necessary" means health care services and supplies  
38 provided by a health care provider appropriate to the evaluation and  
39 treatment of disease, condition, illness or injury, consistent with the  
40 applicable standard of care, including the evaluation of  
41 experimental or investigational services, procedures, drugs or  
42 devices.

43 "Same terms and conditions" means that the hospital service  
44 corporation cannot apply different copayments, deductibles or  
45 benefit limits to **【biologically-based mental health】** behavioral

**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 care services benefits than those applied to other medical or  
2 surgical benefits.

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

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

8 (2) which providers shall be entitled to reimbursement for  
9 providing services for mental illness under the contract. **】** (Deleted  
10 by amendment, P.L. , c. )(pending before the Legislature as  
11 this bill)

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

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

16

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

19 2. a. (1) Every individual and group medical service  
20 corporation contract that provides hospital or medical expense  
21 benefits that is delivered, issued, executed or renewed in this State  
22 pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for  
23 issuance or renewal in this State by the Commissioner of Banking  
24 and Insurance, on or after the effective date of this act shall provide  
25 coverage for **【biologically-based mental illness】** medically  
26 necessary behavioral health care services under the same terms and  
27 conditions as provided for any other sickness under the contract and  
28 shall meet the requirements of the federal Paul Wellstone and Pete  
29 Domenici Mental Health Parity and Addiction Equity Act of 2008,  
30 42 U.S.C. 18031(j), and any amendments to, and federal guidance  
31 or regulations issued under that act, including 45 C.F.R. Parts 146  
32 and 147 and 45 C.F.R. 156.115(a)(3). **【"Biologically-based mental**  
33 illness"】

34 (2) As used in this section:

35 "Behavioral health care services" means **【a mental or nervous**  
36 condition that is caused by a biological disorder of the brain and  
37 results in a clinically significant or psychological syndrome or  
38 pattern that substantially limits the functioning of the person with  
39 the illness, including but not limited to, schizophrenia,  
40 schizoaffective disorder, major depressive disorder, bipolar  
41 disorder, paranoia and other psychotic disorders, obsessive-  
42 compulsive disorder, panic disorder and pervasive developmental  
43 disorder or autism**】** procedures or services rendered by a health care  
44 provider or health care facility for the treatment of mental illness,  
45 emotional disorders, or drug or alcohol abuse.

46 "Medically necessary" means health care services and supplies  
47 provided by a health care provider appropriate to the evaluation and  
48 treatment of disease, condition, illness or injury, consistent with the

1 applicable standard of care, including the evaluation of  
2 experimental or investigational services, procedures, drugs or  
3 devices.

4 "Same terms and conditions" means that the medical service  
5 corporation cannot apply different copayments, deductibles or  
6 benefit limits to **【biologically-based mental health】** behavioral  
7 health care services benefits than those applied to other medical or  
8 surgical benefits.

9 b. **【Nothing in this section shall be construed to change the**  
10 **manner in which a medical service corporation determines:**

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

14 (2) which providers shall be entitled to reimbursement for  
15 providing services for mental illness under the contract. **【** Deleted  
16 by amendment, P.L. , c.  )(pending before the Legislature as  
17 this bill)

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

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

22

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

25 3. a. (1) Every individual and group health service corporation  
26 contract that provides hospital or medical expense benefits and is  
27 delivered, issued, executed or renewed in this State pursuant to  
28 P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or  
29 renewal in this State by the Commissioner of Banking and  
30 Insurance, on or after the effective date of this act shall provide  
31 coverage for **【biologically-based mental illness】** medically  
32 necessary behavioral health care services under the same terms and  
33 conditions as provided for any other sickness under the contract and  
34 shall meet the requirements of the federal Paul Wellstone and Pete  
35 Domenici Mental Health Parity and Addiction Equity Act of 2008,  
36 42 U.S.C. 18031(j), and any amendments to, and federal guidance  
37 or regulations issued under that act, including 45 C.F.R. Parts 146  
38 and 147 and 45 C.F.R. 156.115(a)(3). **【"Biologically-based mental**  
39 illness"】

40 (2) As used in this section:

41 "Behavioral health care services" means **【**a mental or nervous  
42 condition that is caused by a biological disorder of the brain and  
43 results in a clinically significant or psychological syndrome or  
44 pattern that substantially limits the functioning of the person with  
45 the illness, including but not limited to, schizophrenia,  
46 schizoaffective disorder, major depressive disorder, bipolar  
47 disorder, paranoia and other psychotic disorders, obsessive-  
48 compulsive disorder, panic disorder and pervasive developmental

1 disorder or autism】 procedures or services rendered by a health care  
2 provider or health care facility for the treatment of mental illness,  
3 emotional disorders, or drug or alcohol abuse.

4 “Medically necessary” means health care services and supplies  
5 provided by a health care provider appropriate to the evaluation and  
6 treatment of disease, condition, illness or injury, consistent with the  
7 applicable standard of care, including the evaluation of  
8 experimental or investigational services, procedures, drugs or  
9 devices.

10 "Same terms and conditions" means that the health service  
11 corporation cannot apply different copayments, deductibles or  
12 benefit limits to **【biologically-based mental health】 behavioral**  
13 **health care services** benefits than those applied to other medical or  
14 surgical benefits.

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

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

20 (2) which providers shall be entitled to reimbursement for  
21 providing services for mental illness under the contract.】 (Deleted  
22 by amendment, P.L. , c. )(pending before the Legislature as  
23 this bill)

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

27 (cf: P.L.1999, c.106, s.3)

28

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

31 4. a. (1) Every individual health insurance policy that provides  
32 hospital or medical expense benefits and is delivered, issued,  
33 executed or renewed in this State pursuant to chapter 26 of Title  
34 17B of the New Jersey Statutes, or approved for issuance or renewal  
35 in this State by the Commissioner of Banking and Insurance, on or  
36 after the effective date of this act shall provide coverage for  
37 **【biologically-based mental illness】** medically necessary behavioral  
38 health care services under the same terms and conditions as  
39 provided for any other sickness under the contract and shall meet  
40 the requirements of the federal Paul Wellstone and Pete Domenici  
41 Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C.  
42 18031(j), and any amendments to, and federal guidance or  
43 regulations issued under that act, including 45 C.F.R. Parts 146 and  
44 147 and 45 C.F.R. 156.115(a)(3). **【"Biologically-based mental**  
45 **illness"】**

46 (2) As used in this section:

47 “Behavioral health care services” means 【a mental or nervous  
48 condition that is caused by a biological disorder of the brain and

1 results in a clinically significant or psychological syndrome or  
2 pattern that substantially limits the functioning of the person with  
3 the illness, including but not limited to, schizophrenia,  
4 schizoaffective disorder, major depressive disorder, bipolar  
5 disorder, paranoia and other psychotic disorders, obsessive-  
6 compulsive disorder, panic disorder and pervasive developmental  
7 disorder or autism] procedures or services rendered by a health care  
8 provider or health care facility for the treatment of mental illness,  
9 emotional disorders, or drug or alcohol abuse.

10 "Medically necessary" means health care services and supplies  
11 provided by a health care provider appropriate to the evaluation and  
12 treatment of disease, condition, illness or injury, consistent with the  
13 applicable standard of care, including the evaluation of  
14 experimental or investigational services, procedures, drugs or  
15 devices.

16 "Same terms and conditions" means that the insurer cannot apply  
17 different copayments, deductibles or benefit limits to [biologically-  
18 based mental health] behavioral health care services benefits than  
19 those applied to other medical or surgical benefits.

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

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

24 (2) which providers shall be entitled to reimbursement for  
25 providing services for mental illness under the policy.] (Deleted by  
26 amendment, P.L. , c. ) (pending before the Legislature as this  
27 bill)

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

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

31

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

34 5. a. (1) Every group health insurance policy that provides  
35 hospital or medical expense benefits and is delivered, issued,  
36 executed or renewed in this State pursuant to chapter 27 of Title  
37 17B of the New Jersey Statutes, or approved for issuance or renewal  
38 in this State by the Commissioner of Banking and Insurance, on or  
39 after the effective date of this act shall provide benefits for  
40 [biologically-based mental illness] medically necessary behavioral  
41 health care services under the same terms and conditions as  
42 provided for any other sickness under the policy and shall meet the  
43 requirements of the federal Paul Wellstone and Pete Domenici  
44 Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C.  
45 18031(j), and any amendments to, and federal guidance or  
46 regulations issued under that act, including 45 C.F.R. Parts 146 and  
47 147 and 45 C.F.R. 156.115(a)(3). ["Biologically-based mental  
48 illness"]

1       (2) As used in this section:

2       "Behavioral health care services" means [a mental or nervous  
3 condition that is caused by a biological disorder of the brain and  
4 results in a clinically significant or psychological syndrome or  
5 pattern that substantially limits the functioning of the person with  
6 the illness, including but not limited to, schizophrenia,  
7 schizoaffective disorder, major depressive disorder, bipolar  
8 disorder, paranoia and other psychotic disorders, obsessive-  
9 compulsive disorder, panic disorder and pervasive developmental  
10 disorder or autism] procedures or services rendered by a health care  
11 provider or health care facility for the treatment of mental illness,  
12 emotional disorders, or drug or alcohol abuse.

13       "Medically necessary" means health care services and supplies  
14 provided by a health care provider appropriate to the evaluation and  
15 treatment of disease, condition, illness or injury, consistent with the  
16 applicable standard of care, including the evaluation of  
17 experimental or investigational services, procedures, drugs or  
18 devices.

19       "Same terms and conditions" means that the insurer cannot apply  
20 different copayments, deductibles or benefit limits to [biologically-  
21 based mental health] behavioral health care services benefits than  
22 those applied to other medical or surgical benefits.

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

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

27       (2) which providers shall be entitled to reimbursement for  
28 providing services for mental illness under the policy.] (Deleted by  
29 amendment, P.L. , c. ) (pending before the Legislature as this  
30 bill)

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

33 (cf: P.L.1999, c.106, s.5)

34

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

37       6. a. (1) Every individual health benefits plan that provides  
38 hospital or medical expense benefits and is delivered, issued,  
39 executed or renewed in this State pursuant to P.L.1992, c.161  
40 (C.17B:27A-2 et seq.) or approved for issuance or renewal in this  
41 State on or after the effective date of this act shall provide benefits  
42 for [biologically-based mental illness] medically necessary  
43 behavioral health care services under the same terms and conditions  
44 as provided for any other sickness under the health benefits plan  
45 and shall meet the requirements of the federal Paul Wellstone and  
46 Pete Domenici Mental Health Parity and Addiction Equity Act of  
47 2008, 42 U.S.C. 18031(j), and any amendments to, and federal  
48 guidance or regulations issued under that act, including 45 C.F.R.

1 Parts 146 and 147 and 45 C.F.R. 156.115(a)(3). ["Biologically-  
2 based mental illness"]

3 (2) As used in this section:

4 "Behavioral health care services" means [a mental or nervous  
5 condition that is caused by a biological disorder of the brain and  
6 results in a clinically significant or psychological syndrome or  
7 pattern that substantially limits the functioning of the person with  
8 the illness, including but not limited to, schizophrenia,  
9 schizoaffective disorder, major depressive disorder, bipolar  
10 disorder, paranoia and other psychotic disorders, obsessive-  
11 compulsive disorder, panic disorder and pervasive developmental  
12 disorder or autism] procedures or services rendered by a health care  
13 provider or health care facility for the treatment of mental illness,  
14 emotional disorders, or drug or alcohol abuse.

15 "Medically necessary" means health care services and supplies  
16 provided by a health care provider appropriate to the evaluation and  
17 treatment of disease, condition, illness or injury, consistent with the  
18 applicable standard of care, including the evaluation of  
19 experimental or investigational services, procedures, drugs or  
20 devices.

21 "Same terms and conditions" means that the plan cannot apply  
22 different copayments, deductibles or benefit limits to **["biologically-**  
23 **based mental health] behavioral health care services** benefits than  
24 those applied to other medical or surgical benefits.

25 b. **["Nothing in this section shall be construed to change the**  
26 **manner in which the carrier determines:**

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

29 (2) which providers shall be entitled to reimbursement for  
30 providing services for mental illness under the plan. **]** (Deleted by  
31 amendment, P.L. , c. ) (pending before the Legislature as this  
32 bill)

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

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

37

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

40 7. a. (1) Every small employer health benefits plan that  
41 provides hospital or medical expense benefits and is delivered,  
42 issued, executed or renewed in this State pursuant to P.L.1992,  
43 c.162 (C.17B:27A-17 et seq.) or approved for issuance or renewal  
44 in this State on or after the effective date of this act shall provide  
45 benefits for [biologically-based mental illness] medically necessary  
46 behavioral health care services under the same terms and conditions  
47 as provided for any other sickness under the health benefits plan  
48 and shall meet the requirements of the federal Paul Wellstone and



1 Pete Domenici Mental Health Parity and Addiction Equity Act of  
2 2008, 42 U.S.C. 18031(j), and any amendments to, and federal  
3 guidance or regulations issued under that act, including 45 C.F.R.  
4 Parts 146 and 147 and 45 C.F.R. 156.115(a)(3). **["Biologically-**  
5 **based mental illness"]**

6 (2) As used in this section:

7 "Behavioral health care services" means [a mental or nervous  
8 condition that is caused by a biological disorder of the brain and  
9 results in a clinically significant or psychological syndrome or  
10 pattern that substantially limits the functioning of the person with  
11 the illness, including but not limited to, schizophrenia,  
12 schizoaffective disorder, major depressive disorder, bipolar  
13 disorder, paranoia and other psychotic disorders, obsessive-  
14 compulsive disorder, panic disorder and pervasive developmental  
15 disorder or autism] procedures or services rendered by a health care  
16 provider or health care facility for the treatment of mental illness,  
17 emotional disorders, or drug or alcohol abuse.

18 "Medically necessary" means health care services and supplies  
19 provided by a health care provider appropriate to the evaluation and  
20 treatment of disease, condition, illness or injury, consistent with the  
21 applicable standard of care, including the evaluation of  
22 experimental or investigational services, procedures, drugs or  
23 devices.

24 "Same terms and conditions" means that the plan cannot apply  
25 different copayments, deductibles or benefit limits to **[biologically-**  
26 **based mental health]** behavioral health care services benefits than  
27 those applied to other medical or surgical benefits.

28 b. **["Nothing in this section shall be construed to change the**  
29 **manner in which the carrier determines:**

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

32 (2) which providers shall be entitled to reimbursement for  
33 providing services for mental illness under the health benefits  
34 plan.] (Deleted by amendment, P.L. , c. ) (pending before the  
35 Legislature as this bill)

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

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

40

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

43 8. a. (1) Every enrollee agreement delivered, issued, executed,  
44 or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et  
45 seq.) or approved for issuance or renewal in this State by the  
46 Commissioner of Banking and Insurance, on or after the effective  
47 date of this act shall provide health care services for **[biologically-**  
48 **based mental illness]** medically necessary behavioral health care

1 services under the same terms and conditions as provided for any  
2 other sickness under the agreement and shall meet the requirements  
3 of the federal Paul Wellstone and Pete Domenici Mental Health  
4 Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and  
5 any amendments to, and federal guidance or regulations issued  
6 under that act, including 45 C.F.R. Parts 146 and 147 and 45 C.F.R.  
7 156.115(a)(3). ["Biologically-based mental illness"]

8 (2) As used in this section:

9 "Behavioral health care services" means [a mental or nervous  
10 condition that is caused by a biological disorder of the brain and  
11 results in a clinically significant or psychological syndrome or  
12 pattern that substantially limits the functioning of the person with  
13 the illness, including but not limited to, schizophrenia,  
14 schizoaffective disorder, major depressive disorder, bipolar  
15 disorder, paranoia and other psychotic disorders, obsessive-  
16 compulsive disorder, panic disorder and pervasive developmental  
17 disorder or autism] procedures or services rendered by a health care  
18 provider or health care facility for the treatment of mental illness,  
19 emotional disorders, or drug or alcohol abuse.

20 "Medically necessary" means health care services and supplies  
21 provided by a health care provider appropriate to the evaluation and  
22 treatment of disease, condition, illness or injury, consistent with the  
23 applicable standard of care, including the evaluation of  
24 experimental or investigational services, procedures, drugs or  
25 devices.

26 "Same terms and conditions" means that the health maintenance  
27 organization cannot apply different copayments, deductibles, or  
28 health care services limits to **["biologically-based mental"]**  
29 behavioral health care services than those applied to other medical  
30 or surgical health care services.

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

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

36 (2) which providers shall be entitled to reimbursement or to be  
37 participating providers, as appropriate, for mental health services  
38 under the enrollee agreement. **["Deleted by amendment,**  
39 P.L. , c. ) (pending before the Legislature as this bill)

40 c. The provisions of this section shall apply to enrollee  
41 agreements in which the health maintenance organization has  
42 reserved the right to change the premium.

43 (cf: P.L.2012, c.17, s.271)

44

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

47 1. As used in this act:

1       **["Biologically-based mental illness"]** “Behavioral health care  
2 services” means **[a mental or nervous condition that is caused by a**  
3 **biological disorder of the brain and results in a clinically significant**  
4 **or psychological syndrome or pattern that substantially limits the**  
5 **functioning of the person with the illness including, but not limited**  
6 **to, schizophrenia, schizoaffective disorder, major depressive**  
7 **disorder, bipolar disorder, paranoia and other psychotic disorders,**  
8 **obsessive-compulsive disorder, panic disorder and pervasive**  
9 **developmental disorder or autism]** procedures or services rendered  
10 by a health care provider or health care facility for the treatment of  
11 mental illness, emotional disorders, or drug or alcohol abuse.

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

16       “Medically necessary” means health care services and supplies  
17 provided by a health care provider appropriate to the evaluation and  
18 treatment of disease, condition, illness or injury, consistent with the  
19 applicable standard of care, including the evaluation of  
20 experimental or investigational services, procedures, drugs or  
21 devices.

22       "Same terms and conditions" means that a carrier cannot apply  
23 different copayments, deductibles or benefit limits to **[biologically-**  
24 **based mental health]** behavioral health care services benefits than  
25 those applied to other medical or surgical benefits.

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

27

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

30       2. a. The State Health Benefits Commission shall ensure that  
31 every contract purchased by the commission on or after the  
32 effective date of this act that provides hospital or medical expense  
33 benefits shall provide coverage for **[biologically-based mental**  
34 **illness]** medically necessary behavioral health care services under  
35 the same terms and conditions as provided for any other sickness  
36 under the contract.

37       b. **[Nothing in this section shall be construed to change the**  
38 **manner in which a carrier determines:**

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

41       (2) which providers shall be entitled to reimbursement for  
42 providing services for mental illness under the contract. **]** (Deleted  
43 by amendment, P.L. , c. )(pending before the Legislature as  
44 this bill)

45       c. The commission shall provide notice to employees regarding  
46 the coverage required by this section in accordance with this  
47 subsection and regulations promulgated by the Commissioner of  
48 Health **[and Senior Services]** pursuant to the "Administrative

1 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice  
2 shall be in writing and prominently positioned in any literature or  
3 correspondence and shall be transmitted at the earliest of: (1) the  
4 next mailing to the employee; (2) the yearly informational packet  
5 sent to the employee; or (3) July 1, 2000. The commission shall  
6 also ensure that the carrier under contract with the commission,  
7 upon receipt of information that a covered person is receiving  
8 treatment for a biologically-based mental illness, shall promptly  
9 notify that person of the coverage required by this section.  
10 (cf: P.L.1999, c.441, s.2)

11

12 11. (New section) a. For the purposes of this section:

13 "Behavioral health care services" means procedures or services  
14 rendered by a health care provider or health care facility for the  
15 treatment of mental illness, emotional disorders, or drug or alcohol  
16 abuse.

17 "Benefit limits" includes both quantitative treatment limitations  
18 and non-quantitative treatment limitations.

19 "Carrier" means an insurance company, health service  
20 corporation, hospital service corporation, medical service  
21 corporation, or health maintenance organization authorized to issue  
22 health benefits plans in this State or any entity contracted to  
23 administer health benefits in connection with the State Health  
24 Benefits Program or School Employees' Health Benefits Program.

25 "Classification of benefits" means inpatient in-network benefits,  
26 inpatient out-of-network benefits, outpatient in-network benefits,  
27 outpatient out-of-network benefits, prescription drug benefits, and  
28 emergency care benefits; these classifications of benefits are the  
29 only classifications that may be used.

30 "Department" means the Department of Banking and Insurance.

31 "Non-quantitative treatment limitations" or "NQTL" means  
32 processes, strategies, or evidentiary standards, or other factors that  
33 are not expressed numerically, but otherwise limit the scope or  
34 duration of benefits for treatment. NQTLs shall include, but shall  
35 not be limited to:

36 (1) Medical management standards limiting or excluding  
37 benefits based on medical necessity or medical appropriateness, or  
38 based on whether the treatment is experimental or investigative;

39 (2) Formulary design for prescription drugs;

40 (3) For plans with multiple network tiers, such as preferred  
41 providers and participating providers, network tier design;

42 (4) Standards for provider admission to participate in a network,  
43 including reimbursement rates;

44 (5) Plan methods for determining usual, customary, and  
45 reasonable charges;

46 (6) Refusal to pay for higher-cost therapies until it can be shown  
47 that a lower-cost therapy is not effective, also known as fail-first  
48 policies or step therapy protocols;

- 1 (7) Exclusions based on failure to complete a course of  
2 treatment;
  - 3 (8) Restrictions based on geographic location, facility type,  
4 provider specialty, and other criteria that limit the scope or duration  
5 of benefits for services provided under the plan or coverage;
  - 6 (9) In and out of network geographic limitations;
  - 7 (10) Limitations on inpatient services for situations where the  
8 participant is a threat to self or others;
  - 9 (11) Exclusions for court-ordered and involuntary holds;
  - 10 (12) Experimental treatment limitations;
  - 11 (13) Service coding;
  - 12 (14) Exclusions for services provided by a licensed professional  
13 who provides behavioral health care services;
  - 14 (15) Network adequacy; and
  - 15 (16) Provider reimbursement rates.
- 16 b. A carrier shall not impose a non-quantitative treatment  
17 limitation with respect to a behavioral health care service in any  
18 classification of benefits unless, under the terms of the policy that  
19 provides hospital or medical expense benefits as written and in  
20 operation, any processes, strategies, evidentiary standards or other  
21 factors used in applying the NQTL to behavioral health care service  
22 benefits in the classification are comparable to, and are applied no  
23 more stringently than, the processes, strategies, evidentiary  
24 standards, or other factors used in applying the limitation with  
25 respect to medical or surgical benefits in the same classification.
- 26 c. A carrier providing access to out-of-network providers for  
27 medical or surgical benefits within a classification, shall use  
28 processes, strategies, evidentiary standards, or other factors in  
29 determining access to out-of-network providers for behavioral  
30 health care services benefits that are comparable to, and applied no  
31 more stringently than, the processes, strategies, evidentiary  
32 standards, or other factors in determining access to out-of-network  
33 providers for medical or surgical benefits.
- 34 d. A carrier shall approve a request for an in-plan exception if  
35 the carrier's network does not have any providers who are qualified,  
36 accessible and available to perform the specific medically necessary  
37 service. A carrier shall communicate the availability of in-plan  
38 exceptions:
- 39 (1) on its website where lists of network providers are  
40 displayed; and
  - 41 (2) to beneficiaries when they call the carrier to inquire about  
42 network providers.
- 43 e. For any utilization review or benefit determination for the  
44 treatment of a substance use disorder, including but not limited to  
45 prior authorization and medical necessity determinations, the  
46 clinical review criteria shall be the most recent Treatment Criteria  
47 for Addictive, Substance-Related, and Co-Occurring Conditions  
48 established by the American Society of Addiction Medicine. No

1 additional criteria shall be used during utilization review or benefit  
2 determination for treatment of substance use disorders.

3 f. A carrier that provides coverage for prescription drugs may  
4 not exclude coverage for any Food and Drug Administration-  
5 approved forms of medication assisted treatment prescribed for the  
6 treatment of alcohol dependence or treatment of opioid dependence,  
7 if such treatment is medically necessary, according to most recent  
8 Treatment Criteria for Addictive, Substance-Related, and Co-  
9 Occurring Conditions established by the American Society of  
10 Addiction Medicine.

11 g. A carrier that provides hospital or medical expense benefits  
12 through individual or group contracts shall submit an annual report  
13 to the department on or before March 1 that contains the following  
14 information:

15 (1) The frequency with which the carrier required prior  
16 authorization for all prescribed procedures, services, or medications  
17 for mental health benefits during the previous calendar year, the  
18 frequency with which the carrier required prior authorization for all  
19 prescribed procedures, services, or medications for substance use  
20 disorder benefits during the previous calendar year, and the  
21 frequency with which the carrier required prior authorization for all  
22 prescribed procedures, services, or medications for medical and  
23 surgical benefits during the previous calendar year. A carrier shall  
24 submit this information separately for inpatient in-network and out-  
25 of-network benefits, outpatient in-network benefits, outpatient out-  
26 of-network benefits, emergency care benefits, and prescription drug  
27 benefits; frequency shall be expressed as a percentage, with total  
28 prescribed procedures, services, or medications within each  
29 classification of benefits as the denominator and the overall number  
30 of times prior authorization was required for any prescribed  
31 procedures, services, or medications within each corresponding  
32 classification of benefits as the numerator.

33 (2) A description of the process used to develop or select the  
34 medical necessity criteria for mental health benefits, the process  
35 used to develop or select the medical necessity criteria for substance  
36 use disorder benefits, and the process used to develop or select the  
37 medical necessity criteria for medical and surgical benefits.

38 (3) Identification of all NQTLs that are applied to mental health  
39 benefits, all NQTLs that are applied to substance use disorder  
40 benefits, and all NQTLs that are applied to medical and surgical  
41 benefits;

42 (4) The results of an analysis that demonstrates that for the  
43 medical necessity criteria described in paragraph (2) of this  
44 subsection and for each NQTL identified in paragraph (3) of this  
45 subsection, as written and in operation, the processes, strategies,  
46 evidentiary standards, or other factors used to apply the medical  
47 necessity criteria and each NQTL to behavioral health care benefits  
48 are comparable to, and are applied no more stringently than the  
49 processes, strategies, evidentiary standards, or other factors used to

1 apply the medical necessity criteria and each NQTL, as written and  
2 in operation, to medical and surgical benefits; at a minimum, the  
3 results of the analysis shall:

4 (a) identify the specific factors the carrier used in performing its  
5 NQTL analysis;

6 (b) identify and define the specific evidentiary standards relied  
7 on to evaluate the factors;

8 (c) describe how the evidentiary standards are applied to each  
9 service category for mental health benefits, substance use disorder  
10 benefits, medical benefits, and surgical benefits;

11 (d) disclose the results of the analyses of the specific evidentiary  
12 standards in each service category; and

13 (e) disclose the specific findings of the carrier in each service  
14 category and the conclusions reached with respect to whether the  
15 processes, strategies, evidentiary standards, or other factors used in  
16 applying the NQTL to mental health or substance use disorder  
17 benefits are comparable to, and applied no more stringently than,  
18 the processes, strategies, evidentiary standards, or other factors used  
19 in applying the NQTL with respect to medical and surgical benefits  
20 in the same classification.

21 (5) The rates of and reasons for denial of claims for inpatient in-  
22 network, inpatient out-of-network, outpatient in-network, outpatient  
23 out-of-network, prescription drug, and emergency care mental  
24 health services during the previous calendar year compared to the  
25 rates of and reasons for denial of claims in those same  
26 classifications of benefits for medical and surgical services during  
27 the previous calendar year.

28 (6) The rates of and reasons for denial of claims for inpatient in-  
29 network, inpatient out-of-network, outpatient in-network, outpatient  
30 out-of-network, prescription drug, and emergency care substance  
31 use disorder services during the previous calendar year compared to  
32 the rates of and reasons for denial of claims in those same  
33 classifications of benefits for medical and surgical services during  
34 the previous calendar year.

35 (7) A certification signed by the carrier's chief executive officer  
36 and chief medical officer that states that the carrier has completed a  
37 comprehensive review of the administrative practices of the carrier  
38 for the prior calendar year for, pursuant to  
39 P.L. , c. (C. )(pending before the Legislature as this bill),  
40 compliance with the necessary provisions of P.L.1999, c.106  
41 (C.17:48-6v et al.), the federal Paul Wellstone and Pete Domenici  
42 Mental Health Parity and Addiction Equity Act of 2008, and 42  
43 U.S.C. 18031(j).

44 (8) Any other information necessary to clarify data provided in  
45 accordance with this section requested by the Commissioner of the  
46 Department of Banking and Insurance including information that  
47 may be proprietary or have commercial value; the commissioner  
48 shall not certify any contract of a carrier that fails to submit all data  
49 as required by this section.

1 h. (1) The department may, at the request of the Attorney  
2 General, or in its own discretion, hold a public hearing relative to a  
3 carrier's annual report submitted pursuant to subsection g. of this  
4 section.

5 (2) The department shall post on its Internet website a summary  
6 of the aggregate data from all carriers, submitted pursuant to  
7 subsection g. of this section, regarding the rates of and reasons for  
8 denial of claims for inpatient in-network, inpatient out-of-network,  
9 outpatient in-network, outpatient out-of-network, prescription drug,  
10 and emergency care mental health and substance use disorder  
11 services during the previous calendar year compared to the rates of  
12 and reasons for denial of claims in those same classifications of  
13 benefits for medical and surgical services during the previous  
14 calendar year. The department shall also make available the  
15 percentage of in-plan exceptions granted of those requested for  
16 mental health and substance use disorder services for both inpatient  
17 and outpatient out-of-network services compared to the percentage  
18 of in-plan exceptions granted of those requested for medical and  
19 surgical inpatient and outpatient out-of-network services.

20 i. The department shall implement and enforce applicable  
21 provisions of the Paul Wellstone and Pete Domenici Mental Health  
22 Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), any  
23 amendments to, and federal guidance or regulations issued under  
24 that act, including 45 C.F.R. Parts 146 and 147, 45 C.F.R.  
25 156.115(a)(3), P.L.1999, c.106 (C.17:48-6v et al.), and section 2 of  
26 P.L.1999, c.441 (C.52:14-17.29e), which includes:

27 (1) Ensuring compliance by individual and group contracts,  
28 policies, plans, or enrollee agreements delivered, issued, executed,  
29 or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et  
30 seq.), P.L.1940, c.74 (C.17:48A-1 et seq.), P.L.1985, c.236  
31 (C.17:48E-1 et seq.), chapter 26 of Title 17B of the New Jersey  
32 Statutes (N.J.S.17B:26-1 et seq.), chapter 27 of Title 17B of the  
33 New Jersey Statutes (N.J.S.17B:27-26 et seq.), P.L.1992, c.161  
34 (C.17B:27A-2 et seq.), P.L.1992, c.162 (C.17B:27A-17 et seq.),  
35 P.L.1973, c.337 (C.26:2J-1 et seq.), and P.L.1961, c.49 (C.52:14-  
36 17.25 et seq.), or approved for issuance or renewal in this State by  
37 the Commissioner of Banking and Insurance.

38 (2) Detecting violations of the law by individual and group  
39 contracts, policies, plans, or enrollee agreements delivered, issued,  
40 executed, or renewed in this State pursuant to P.L.1938, c.366  
41 (C.17:48-1 et seq.), P.L.1940, c.74 (C.17:48A-1 et seq.), P.L.1985,  
42 c.236 (C.17:48E-1 et seq.), chapter 26 of Title 17B of the New  
43 Jersey Statutes (N.J.S.17B:26-1 et seq.), chapter 27 of Title 17B of  
44 the New Jersey Statutes (N.J.S.17B:27-26 et seq.), P.L.1992, c.161  
45 (C.17B:27A-2 et seq.), P.L.1992, c.162 (C.17B:27A-17 et seq.),  
46 P.L.1973, c.337 (C.26:2J-1 et seq.), and P.L.1961, c.49 (C.52:14-  
47 17.25 et seq.), or approved for issuance or renewal in this State by  
48 the Commissioner of Banking and Insurance.



1 (3) Accepting, evaluating, and responding to complaints  
2 regarding violations.

3 (4) Maintaining and regularly reviewing for possible parity  
4 violations a publically available consumer complaint log regarding  
5 behavioral health care coverage.

6 (5) Conducting parity compliance market conduct examinations  
7 of individual and group contracts, policies, plans, or enrollee  
8 agreements delivered, issued, executed, or renewed in this State  
9 pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), P.L.1940, c.74  
10 (C.17:48A-1 et seq.), P.L.1985, c.236 (C.17:48E-1 et seq.), chapter  
11 26 of Title 17B of the New Jersey Statutes (N.J.S.17B:26-1 et seq.),  
12 chapter 27 of Title 17B of the New Jersey Statutes (N.J.S.17B:27-  
13 26 et seq.), P.L.1992, c.161 (C.17B:27A-2 et seq.), P.L.1992, c.162  
14 (C.17B:27A-17 et seq.), P.L.1973, c.337 (C.26:2J-1 et seq.), and  
15 P.L.1961, c.49 (C.52:14-17.25 et seq.), or approved for issuance or  
16 renewal in this State by the Commissioner of Banking and  
17 Insurance, including but not limited to reviews of network  
18 adequacy, reimbursement rates, denials, and prior authorizations.

19 (6) The commissioner shall adopt rules as may be necessary to  
20 effectuate any provisions of the Paul Wellstone and Pete Domenici  
21 Mental Health Parity and Addiction Equity Act of 2008 that relate  
22 to the business of insurance.

23 j. Not later than May 1 of each year, the department shall issue  
24 a report to the Legislature pursuant to section 2 of P.L.1991, c.164  
25 (C.52:14-19.1). The report shall:

26 (1) Cover the methodology the department is using to check for  
27 compliance with the federal Paul Wellstone and Pete Domenici  
28 Mental Health Parity and Addiction Equity Act of 2008  
29 (MHPAEA), 42 U.S.C 18031(j), and any federal regulations or  
30 guidance relating to the compliance and oversight of the MHPAEA  
31 and 42 U.S.C 18031(j).

32 (2) Cover the methodology the department is using to check for  
33 compliance with P.L.1999, c.106 (C.17:48-6v et al.) and section 2  
34 of P.L.1999, c.441 (C.52:14-17.29e).

35 (3) Identify market conduct examinations conducted or  
36 completed during the preceding 12-month period regarding  
37 compliance with parity in mental health and substance use disorder  
38 benefits under state and federal laws and summarize the results of  
39 such market conduct examinations. This shall include:

40 (a) The number of market conduct examinations initiated and  
41 completed;

42 (b) The benefit classifications examined by each market conduct  
43 examination;

44 (c) The subject matters of each market conduct examination,  
45 including quantitative and non-quantitative treatment limitations;

46 (d) A summary of the basis for the final decision rendered in  
47 each market conduct examination; and

48 (e) Individually identifiable information shall be excluded from  
49 the reports consistent with Federal privacy protections.

1 (4) Detail any educational or corrective actions the department  
2 has taken to ensure compliance with MHPAEA, 42 U.S.C 18031(j),  
3 P.L.1999, c.106 (C.17:48-6v et al.) and section 2 of P.L.1999, c.441  
4 (C.52:14-17.29e).

5 (5) Detail the department's educational approaches relating to  
6 informing the public about behavioral health care parity protections  
7 under State and federal law.

8 (6) Be written in non-technical, readily understandable language  
9 and shall be made available to the public by, among such other  
10 means as the department finds appropriate, posting the report on the  
11 department's website.

12

13 12. This act shall take effect on the 60th day after enactment and  
14 shall apply to all contracts and policies delivered, issued, executed  
15 or renewed on or after that date.

16

17

18

#### STATEMENT

19

20 This bill requires hospital, medical and health service  
21 corporations, commercial insurers, health maintenance  
22 organizations, health benefits plans issued pursuant to the New  
23 Jersey Individual Health Coverage and Small Employer Health  
24 Benefits Programs, the State Health Benefits Program, and the  
25 School Employees' Health Benefits Program, to provide coverage,  
26 for medically necessary behavioral health care services and to meet  
27 the requirements of the federal Paul Wellstone and Pete Domenici  
28 Mental Health Parity and Addiction Equity Act of 2008, which  
29 prevents certain health insurers that provide mental health or  
30 substance use disorder benefits from imposing less favorable  
31 benefit limitations on those benefits than on medical or surgical  
32 benefits, commonly referred to as mental health parity.

33 The bill amends several statutes, initially enacted in 1999, which  
34 require hospital, medical and health service corporations, individual  
35 and group health insurers and the State Health Benefits Program to  
36 provide coverage for biologically-based mental illness under the  
37 same terms and conditions as provided for any other sickness. The  
38 bill expands that coverage to include coverage for "behavioral  
39 health care services," which is defined as procedures or services  
40 rendered by a health care provider or health care facility for the  
41 treatment of mental illness, emotional disorders, or drug or alcohol  
42 abuse.

43 The bill also removes certain provisions of the statutes that  
44 provide that nothing in those statutes shall be construed to change  
45 the manner in which the insurer determines:

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

1 (2) which providers shall be entitled to reimbursement or to be  
2 participating providers, as appropriate, for mental health services  
3 under the policy or contract.

4 The bill also supplements the "Health Care Quality Act,"  
5 P.L.1997, c.192 (C.26:2S-1 et al.) to place certain restrictions on  
6 carriers to ensure parity with respect to imposing a non-quantitative  
7 treatment limitations, the use of out-of-network providers, and in-  
8 plan exceptions for behavioral health care services.

9 The bill further specifies that for any utilization review or benefit  
10 determination for the treatment of a substance use disorder,  
11 including but not limited to prior authorization and medical  
12 necessity determinations, the clinical review criteria shall be the  
13 most recent Treatment Criteria for Addictive, Substance-Related,  
14 and Co-Occurring Conditions established by the American Society  
15 of Addiction Medicine. No additional criteria shall be used during  
16 utilization review or benefit determination for treatment of  
17 substance use disorders.

18 In addition, the bill prohibits a carrier that provides coverage for  
19 prescription drugs from excluding coverage for any FDA-approved  
20 forms of medication assisted treatment prescribed for the treatment  
21 of alcohol dependence or treatment of opioid dependence, if such  
22 treatment is medically necessary, according to most recent  
23 Treatment Criteria for Addictive, Substance-Related, and Co-  
24 Occurring Conditions established by the American Society of  
25 Addiction Medicine.

26 The bill also requires carriers to submit an annual report to the  
27 Department of Banking and Insurance on or before March 1 that  
28 contains certain information concerning compliance with the bill's  
29 provisions. The bill also requires, not later than May 1 of each  
30 year, the Department of Banking and Insurance to issue a report to  
31 the Legislature pursuant to section of P.L.1991, c.164 (C.52:14-  
32 19.1) and to make that report available to the public. The report is  
33 to detail certain information relating to the department's oversight  
34 of the bill's provisions.