# ASSEMBLY, No. 4498

# STATE OF NEW JERSEY

## 217th LEGISLATURE

INTRODUCED JANUARY 19, 2017

**Sponsored by:**
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**District 19 (Middlesex)**
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**District 7 (Burlington)**
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**District 17 (Middlesex and Somerset)**
**Assemblywoman JOANN DOWNEY**
**District 11 (Monmouth)**

**Co-Sponsored by:**
**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)**

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

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

(2) As used in this section:

"Behavioral health care services" 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**]** procedures or services rendered by a health care provider or health care facility for the treatment of mental illness, emotional disorders, or drug or alcohol abuse.

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

"Same terms and conditions" means that the hospital service corporation cannot apply different copayments, deductibles or 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.**

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

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

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

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

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

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

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

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

(2) As used in this section:

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

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

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

"Same terms and conditions" means that the medical service corporation cannot apply different copayments, deductibles or benefit limits to **[**biologically-based mental health**]** behavioral health care services benefits 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.**]** (Deleted by amendment, P.L. , c. )(pending before the Legislature as this bill)

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

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

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

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

(2) As used in this section:

"Behavioral health care services" 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**]** procedures or services rendered by a health care provider or health care facility for the treatment of mental illness, emotional disorders, or drug or alcohol abuse.

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

"Same terms and conditions" means that the health service corporation cannot apply different copayments, deductibles or benefit limits to **[**biologically-based mental health**]** behavioral health care services benefits 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.**]** (Deleted by amendment, P.L. , c. )(pending before the Legislature as this bill)

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

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

(2) As used in this section:

"Behavioral health care services" 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**]** procedures or services rendered by a health care provider or health care facility for the treatment of mental illness, emotional disorders, or drug or alcohol abuse.

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

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

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

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

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

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

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

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

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

(2) As used in this section:

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

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

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

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

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

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

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

(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] medically necessary behavioral health care services under the same terms and conditions as provided for any other sickness under the health benefits plan and shall meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance or regulations issued under that act, including 45 C.F.R.

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

(2) As used in this section:

"Behavioral health care services" 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**]** procedures or services rendered by a health care provider or health care facility for the treatment of mental illness, emotional disorders, or drug or alcohol abuse.

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

"Same terms and conditions" means that the plan cannot apply different copayments, deductibles or benefit limits to **[**biologically-based mental health**]** behavioral health care services benefits 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.**]** (Deleted by amendment, P.L. , c. ) (pending before the Legislature as this bill)

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

(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**]** medically necessary behavioral health care services under the same terms and conditions as provided for any other sickness under the health benefits plan and shall meet the requirements of the federal Paul Wellstone and

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

(2) As used in this section:

"Behavioral health care services" 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**]** procedures or services rendered by a health care provider or health care facility for the treatment of mental illness, emotional disorders, or drug or alcohol abuse.

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

"Same terms and conditions" means that the plan cannot apply different copayments, deductibles or benefit limits to **[**biologically-based mental health**]** behavioral health care services benefits 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.**]** (Deleted by amendment, P.L. , c. ) (pending before the Legislature as this bill)

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

(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 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 **[**biologically-based mental illness**]** medically necessary behavioral health care

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

(2) As used in this section:

"Behavioral health care services" 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**]** procedures or services rendered by a health care provider or health care facility for the treatment of mental illness, emotional disorders, or drug or alcohol abuse.

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

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

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

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

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

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

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

9. 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"**]** "Behavioral health care services" 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**]** procedures or services rendered by a health care provider or health care facility for the treatment of mental illness, emotional disorders, or drug or alcohol abuse.

"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.

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

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

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

10. 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**]** medically necessary behavioral health care services under the same terms and conditions as provided for any other sickness 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.**]** (Deleted by amendment, P.L. , c. )(pending before the Legislature as this bill)

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 mental illness, shall promptly notify that person of the coverage required by this section.
(cf: P.L.1999, c.441, s.2)

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

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

“Benefit limits” includes both quantitative treatment limitations and non-quantitative treatment limitations.

"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 or any entity contracted to administer health benefits in connection with the State Health Benefits Program or School Employees’ Health Benefits Program.

“Classification of benefits” means inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, prescription drug benefits, and emergency care benefits; these classifications of benefits are the only classifications that may be used.

“Department” means the Department of Banking and Insurance.

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

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

(2) Formulary design for prescription drugs;

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

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

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

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

(7) Exclusions based on failure to complete a course of treatment;

(8) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;

(9) In and out of network geographic limitations;

(10) Limitations on inpatient services for situations where the participant is a threat to self or others;

(11) Exclusions for court-ordered and involuntary holds;

(12) Experimental treatment limitations;

(13) Service coding;

(14) Exclusions for services provided by a licensed professional who provides behavioral health care services;

(15) Network adequacy; and

(16) Provider reimbursement rates.

b. A carrier shall not impose a non-quantitative treatment limitation with respect to a behavioral health care service in any classification of benefits unless, under the terms of the policy that provides hospital or medical expense benefits as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the NQTL to behavioral health care service benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical or surgical benefits in the same classification.

c. A carrier providing access to out-of-network providers for medical or surgical benefits within a classification, shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for behavioral health care services benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical or surgical benefits.

d. A carrier shall approve a request for an in-plan exception if the carrier’s network does not have any providers who are qualified, accessible and available to perform the specific medically necessary service. A carrier shall communicate the availability of in-plan exceptions:

(1) on its website where lists of network providers are displayed; and

(2) to beneficiaries when they call the carrier to inquire about network providers.

e. For any utilization review or benefit determination for the treatment of a substance use disorder, including but not limited to prior authorization and medical necessity determinations, the clinical review criteria shall be the most recent Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine. No

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

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

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

(1) The frequency with which the carrier required prior authorization for all prescribed procedures, services, or medications for mental health benefits during the previous calendar year, the frequency with which the carrier required prior authorization for all prescribed procedures, services, or medications for substance use disorder benefits during the previous calendar year, and the frequency with which the carrier required prior authorization for all prescribed procedures, services, or medications for medical and surgical benefits during the previous calendar year. A carrier shall submit this information separately for inpatient in-network and out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits, and prescription drug benefits; frequency shall be expressed as a percentage, with total prescribed procedures, services, or medications within each classification of benefits as the denominator and the overall number of times prior authorization was required for any prescribed procedures, services, or medications within each corresponding classification of benefits as the numerator.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STATEMENT

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

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

The bill also removes certain provisions of the statutes that provide that nothing in those statutes 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 or to be participating providers, as appropriate, for mental health services under the policy or contract.

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

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

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

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