52:14-17.29d

LEGISLATIVE HISTORY CHECK

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LAWS OF: **1999** **CHAPTER:** 441

NJSA: 52:14-17.29d (Required State Health Benefits commission to provide certain services)

BILL NO: A3588 (Substituted for S2277)

SPONSOR(S): Vandervalk and Quigley

DATE INTRODUCED: November 15, 1999

COMMITTEE: **ASSEMBLY:** Health**;** Appropriations

SENATE: -------

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** January 10, 2000

SENATE: January 10, 2000

DATE OF APPROVAL: January 18, 2000

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL: First Reprint
(Amendments during passage denoted by superscript numbers)

A3588

SPONSORS STATEMENT: (Begins on page 3 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes 12-2-99 (Health)
Yes 1-6-00 (Appropriations)

SENATE: No

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: Yes

S2277

SPONSORS STATEMENT: (Begins on page 3 of original bill) Yes
Bill and Sponsors Statement identical to A3588

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: Yes (1-4-00)
Identical to Legislative Fiscal Estimate for A3588
Yes (1-18-00)
Identical to Fiscal Estimate for A3588 & 1-4-00 Fiscal Estimate for S2277

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: No

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES:

§§1, 2
C.52:14-17.29d
&
52:14-17.29e

P.L. 1999, CHAPTER 441, ***approved January 18, 2000***
Assembly, No. 3588 ***(First Reprint)***

AN ACT concerning coverage for biologically-based mental illness in the State Health Benefits Program and [1]amending and[1] supplementing P.L.1961, c.49 [1]**[**(C.52:14-17.25 et seq.)**]**[1].

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

1. [1](New section)[1] As used in this act:

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

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

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

2. [1](New section)[1] a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness 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.

c. The commission shall provide notice to employees regarding the

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AHL committee amendments adopted December 2, 1999.

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.

[1]3. Section 5 of P.L.1961, c.49 (C.52:14-17.29) is amended to read as follows:

5. (A) The contract or contracts purchased by the commission pursuant to section 4 shall provide separate coverages or policies as follows:

(1) Basic benefits which shall include:

(a) Hospital benefits, including outpatient;

(b) Surgical benefits;

(c) Inpatient medical benefits;

(d) Obstetrical benefits; and

(e) Services rendered by an extended care facility or by a home health agency and for specified medical care visits by a physician during an eligible period of such services, without regard to whether the patient has been hospitalized, to the extent and subject to the conditions and limitations agreed to by the commission and the carrier or carriers.

Basic benefits shall be substantially equivalent to those available on a group remittance basis to employees of the State and their dependents under the subscription contracts of the New Jersey "Blue Cross" and "Blue Shield" Plans. Such basic benefits shall include benefits for:

(i) Additional days of inpatient medical service;

(ii) Surgery elsewhere than in a hospital;

(iii) X-ray, radioactive isotope therapy and pathology services;

(iv) Physical therapy services;

(v) Radium or radon therapy services;

and the extended basic benefits shall be subject to the same conditions and limitations, applicable to such benefits, as are set forth in "Extended Outpatient Hospital Benefits Rider," Form 1500, 71(9-66), and in "Extended Benefit Rider" (as amended), Form MS 7050J(9-66) issued by the New Jersey "Blue Cross" and "Blue Shield" Plans, respectively, and as the same may be amended or superseded, subject to filing by the Commissioner of Insurance; and

(2) Major medical expense benefits which shall provide benefit payments for reasonable and necessary eligible medical expenses for hospitalization, surgery, medical treatment and other related services and supplies to the extent they are not covered by basic benefits. The commission may, by regulation, determine what types of services and supplies shall be included as "eligible medical services" under the major medical expense benefits coverage as well as those which shall be excluded from or limited under such coverage. Benefit payments for major medical expense benefits shall be equal to a percentage of the reasonable charges for eligible medical services incurred by a covered employee or an employee's covered dependent, during a calendar year as exceed a deductible for such calendar year of $100.00 subject to the maximums hereinafter provided and to the other terms and conditions authorized by this act. The percentage shall be 80% of the first $2,000.00 of charges for eligible medical services incurred subsequent to satisfaction of the deductible and 100% thereafter. There shall be a separate deductible for each calendar year for (a) each enrolled employee and (b) all enrolled dependents of such employee. Not more than $1,000,000.00 shall be paid for major medical expense benefits with respect to any one person for the entire period of such person's coverage under the plan, whether continuous or interrupted except that this maximum may be reapplied to a covered person in amounts not to exceed $2,000.00 a year. Maximums of $10,000.00 per calendar year and $20,000.00 for the entire period of the person's coverage under the plan shall apply to eligible expenses incurred because of mental illness or functional nervous disorders, and such may be reapplied to a covered person, except as provided in P.L. , c. (C.)(pending before the Legislature as this bill). The same provisions shall apply for retired employees and their dependents. Under the conditions agreed upon by the commission and the carriers as set forth in the contract, the deductible for a calendar year may be satisfied in whole or in part by eligible charges incurred during the last three months of the prior calendar year.

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

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

Benefits under the contract or contracts purchased as authorized by this act shall include those for the treatment of alcoholism where such treatment is prescribed by a physician and shall also include treatment while confined in or as an outpatient of a licensed hospital or residential treatment program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation. No benefits shall be provided beyond those stipulated in the contracts held by the State Health Benefits Commission.

(C) The rates charged for any contract purchased under the authority of this act shall reasonably and equitably reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound. The rates charged shall be determined by the carrier on accepted group rating principles with due regard to the experience, both past and contemplated, under the contract. The commission shall have the right to particularize subgroups for experience purposes and rates. No increase in rates shall be retroactive.

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

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

(F) The commission may purchase a contract or contracts to provide drug prescription and other health care benefits or authorize the purchase of a contract or contracts to provide drug prescription and other health care benefits as may be required to implement a duly

executed collective negotiations agreement or as may be required to implement a determination by a public employer to provide such benefit or benefits to employees not included in collective negotiations units.[1]

(cf: P.L.1989, c.48, s.1)

[1][**[**3.**]** 4.[1] This act shall take effect immediately.

Requires State Health Benefits Program to provide certain mental health benefits under same terms and conditions as for other illnesses and diseases.

ASSEMBLY, No. 3588

STATE OF NEW JERSEY

208th LEGISLATURE

INTRODUCED NOVEMBER 15, 1999

Sponsored by:
Assemblywoman CHARLOTTE VANDERVALK
District 39 (Bergen)
Assemblywoman JOAN M. QUIGLEY
District 32 (Bergen and Hudson)

SYNOPSIS

Requires State Health Benefits Program to provide certain mental health benefits under same terms and conditions as for other illnesses and diseases.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning coverage for biologically-based mental illness in the State Health Benefits Program and supplementing P.L.1961, c.49 (C.52:14-17.25 et seq.).

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

1. As used in this act:

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

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

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

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

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.

3. This act shall take effect immediately.

STATEMENT

This bill would require that the State Health Benefits Commission provide the same coverage for biologically-based mental illness to persons covered under the State Health Benefits Program as that required for other health insurers and health maintenance organizations under P.L.1999, c.106.

Specifically, the bill:

- requires that coverage be provided for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract;
- defines "biologically-based mental illness" as 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;
- defines "same terms and conditions" to mean that a health insurance carrier cannot apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits;
- stipulates that its provisions shall not be construed to change the manner in which a health insurance carrier determines:
  -- whether a mental health care service meets the medical necessity standard as established by the carrier; or
  -- which health care providers shall be entitled to reimbursement for providing services for mental illness under the contract; and
- requires the State Health Benefits Commission to provide notice to employees regarding the coverage required by this bill in accordance with the provisions of the bill and regulations adopted by the Commissioner of Health and Senior Services.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY, No. 3588

with committee amendments

STATE OF NEW JERSEY

DATED: DECEMBER 2, 1999

The Assembly Health Committee reports favorably and with committee amendments Assembly Bill No. 3588.

As amended by the committee, this bill would require that the State Health Benefits Commission provide the same coverage for biologically-based mental illness to persons covered under the State Health Benefits Program as that required for other health insurers and health maintenance organizations under P.L.1999, c.106.

Specifically, the bill:

- requires that coverage be provided for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract;
- defines "biologically-based mental illness" as 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;
- defines "same terms and conditions" to mean that a health insurance carrier cannot apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits;
- stipulates that its provisions shall not be construed to change the manner in which a health insurance carrier determines:
  -- whether a mental health care service meets the medical necessity standard as established by the carrier; or
  -- which health care providers shall be entitled to reimbursement for providing services for mental illness under the contract; and
- requires the State Health Benefits Commission to provide notice to employees regarding the coverage required by this bill in accordance with the provisions of the bill and regulations adopted by the Commissioner of Health and Senior Services.

The committee amended the bill to clarify that its provisions are an

exception to the provisions in N.J.S.A.52:14-17.29, which currently provides for annual and lifetime caps on eligible expenses incurred because of mental illness or functional nervous disorders (a category which is broader than the biologically-based mental illnesses addressed in this bill) that are lower than for major medical expense benefits.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 3588

STATE OF NEW JERSEY

DATED: JANUARY 6, 2000

The Assembly Appropriations Committee reports favorably Assembly Bill No. 3588 (1R).

Assembly Bill No. 3588 (1R) requires that the State Health Benefits Commission provide the same coverage for biologically-based mental illness to persons covered under the State Health Benefits Program (SHBP) as that required for other health insurers and health maintenance organizations under P.L.1999, c.106.

The bill requires that coverage be provided for "biologically-based mental illness" under the same terms and conditions as provided for any other sickness under the contract; the bill defines "biologically-based mental illness" as 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. The bill defines "same terms and conditions" to mean that a health insurance carrier cannot apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits. The bill states that it does not change the manner in which a health insurance carrier determines medical necessity or entitlement to reimbursement. The bill requires that the State Health Benefits Commission notify employees regarding the coverage required by this bill.

FISCAL IMPACT:

The SHBP offers employees a choice of coverage under several health maintenance organizations (HMOs), a self-funded fee-for-service major medical and surgical plan (Traditional Plan), and a point-of-service plan (NJ PLUS).

The Division of Pension and Benefits in the Department of the Treasury has indicated that all SHBP HMO plans currently meet the requirements of the federal Mental Health Parity Act (Title VII of Pub.L.104-204) and meet the requirements of the bill.

The Traditional Plan and NJ Plus have annual and aggregate lifetime benefit limits on expenses incurred expenses that do not meet the requirements of the federal Mental Health Parity Act (for which a

federal mental health parity exemption has been filed for 1999 and 2000). The cost impact, if any, of the bill on these plans cannot be estimated at this time.

Because the Traditional Plan and NJ PLUS do currently provide mental health benefits, any cost effect would be due to the incremental effect of raising the current limits, and cannot be determined from currently available cost information. Further, the "biologically-based mental illness" definition used under the bill is narrower than the definition of mental health expenditures used under the federal legislation, and federal data are not useful for estimating the effects of the bill.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

ASSEMBLY, No. 3588

STATE OF NEW JERSEY

208th LEGISLATURE

DATED: JANUARY 18, 2000

BILL SUMMARY

Assembly Bill No. 3588 (1R) of 1999 requires that the State Health Benefits Commission provide to persons covered under the State Health Benefits Program (SHBP) the same coverage for biologically-based mental illness as that required for other health insurers and health maintenance organizations under P.L.1999, c.106.

The bill requires that coverage be provided for defined biologically-based mental illness under the same terms and conditions as provided for any other sickness under the SHBP contracts. Under the bill, "same terms and conditions" means that a health insurance carrier cannot apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits. The bill states that its provisions may not be construed to change the manner in which a carrier determines medical necessity or entitlement to reimbursement for services for mental illness. The bill amends current law to provide an exception to the current provisions of N.J.S.A.52:14-17.29, which state annual and lifetime caps, lower than those for major medical expenses benefits, on eligible expenses incurred because of mental illness or functional nervous disorders. The bill also requires the State Health Benefits Commission to provide notice to employees regarding the coverage required by this bill in accordance with the provisions of the bill and regulations adopted by the Commissioner of Health and Senior Services.

OFFICE OF LEGISLATIVE SERVICES COMMENTS

The SHBP is a multi-plan program offering public employees coverage under one of several health maintenance organizations (HMO), a fee-for-service plan (Traditional Plan) or a point-of-service plan (NJ PLUS). The Division of Pensions and Benefits in the Department of the Treasury has indicated that all SHBP HMO plans meet the requirement of the federal Mental Health Parity Act for

provision of parity in mental health benefits and the requirements of this legislation. The SHBP Plan Comparison Chart, provided to public employees during the annual open enrollment period, indicates that for mental health inpatient and outpatient services the HMOs usually limit the number of days as an inpatient and the number of visits as an outpatient per calendar year, 60 days and 30 visits, for example, and in some plans the amount of the copayment is larger than that required for other office visits. OLS understands that the limits on the number of stay days and visits do not fall under "copayments, deductibles or benefits limits," do not violate the federal act and would not violate the intent of this legislation, which is parallel to the federal act in that regard. The Office of Legislative Services (OLS) notes, however, that some mental health outpatient services copayments may need to be adjusted as a result of this legislation.

The SHBP has filed with the federal Health Care Financing Administration a mental health parity exemption for the calendar years 1998, 1999 and 2000 for the Traditional Plan and NJ PLUS, because both have mental health benefits limitations. N.J.S.A.52:14-17.29 establishes benefit limit maximums of $10,000 per calendar year and $20,000 for the entire period of a person's coverage under the Traditional Plan for eligible expenses incurred because of mental illness or functional nervous disorders. NJ PLUS has benefit limit maximums of $15,000 annually and $50,000 lifetime. The Traditional Plan pays in full hospital inpatient expenses for 365 days but pays in full inpatient mental health expenses for 20 days with the balance of days paid at 80% within the annual and lifetime maximums. Outpatient mental health expenses are paid the same as physician office visits, but within the maximums. NJ PLUS, too, has similar differences in payment of inpatient and outpatient expenses, with variation for out-of-network services, and day limits, all subject to the annual and lifetime maximums. This legislation would require adjustments to achieve parity in payment of biologically-based mental health expenses.

The Traditional Plan and NJ PLUS are self-insured health plans and actual experience under this legislation will determine any increase in expenses, as opposed to independent insurers who increase premiums to cover estimated risk exposure. OLS notes that there is no information available to indicate to what extent the requirements of this legislation will increase the expenses of the Traditional Plan and NJ PLUS beyond the expenses already incurred under the current terms of those plans, since some mental health benefits of a general nature, including this legislation's for biologically-based mental illness, are already provided by each of these SHBP plans.

Compliance with the requirement that the commission provide notice to employees regarding the bill's mental health benefits coverage can probably be achieved through the usual mailings or the yearly informational packet at no or minimal additional expense to the State.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67.

SENATE, No. 2277

STATE OF NEW JERSEY

208th LEGISLATURE

INTRODUCED NOVEMBER 15, 1999

Sponsored by:
Senator C. LOUIS BASSANO
District 21 (Essex and Union)
Senator RICHARD J. CODEY
District 27 (Essex)

SYNOPSIS

Requires State Health Benefits Program to provide certain mental health benefits under same terms and conditions as for other illnesses and diseases.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning coverage for biologically-based mental illness in the State Health Benefits Program and supplementing P.L.1961, c.49 (C.52:14-17.25 et seq.).

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

1. As used in this act:

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

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

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

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

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.

3. This act shall take effect immediately.

STATEMENT

This bill would require that the State Health Benefits Commission provide the same coverage for biologically-based mental illness to persons covered under the State Health Benefits Program as that required for other health insurers and health maintenance organizations under P.L.1999, c.106.

Specifically, the bill:

- requires that coverage be provided for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract;
- defines "biologically-based mental illness" as 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;
- defines "same terms and conditions" to mean that a health insurance carrier cannot apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits;
- stipulates that its provisions shall not be construed to change the manner in which a health insurance carrier determines:
  -- whether a mental health care service meets the medical necessity standard as established by the carrier; or
  -- which health care providers shall be entitled to reimbursement for providing services for mental illness under the contract; and
- requires the State Health Benefits Commission to provide notice to employees regarding the coverage required by this bill in accordance with the provisions of the bill and regulations adopted by the Commissioner of Health and Senior Services.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE, No. 2277

with committee amendments

STATE OF NEW JERSEY

DATED: DECEMBER 13, 1999

The Senate Budget and Appropriations Committee reports favorably and with committee amendments Senate Bill No. 2277.

This bill would require that the State Health Benefits Commission provide the same coverage for biologically-based mental illness to persons covered under the State Health Benefits Program (SHBP) as that required for other health insurers and health maintenance organizations under P.L.1999, c.106.

Specifically, the bill:

- requires that coverage be provided for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract;
- defines "biologically-based mental illness" as 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;
- defines "same terms and conditions" to mean that a health insurance carrier cannot apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits;
- stipulates that its provisions shall not be construed to change the manner in which a health insurance carrier determines:
  -- whether a mental health care service meets the medical necessity standard as established by the carrier; or
  -- which health care providers shall be entitled to reimbursement for providing services for mental illness under the contract; and
- requires the State Health Benefits Commission to provide notice to employees regarding the coverage required by this bill in accordance with the provisions of the bill and regulations adopted by the Commissioner of Health and Senior Services.

COMMITTEE AMENDMENTS

Committee amendments to the bill clarify that its provisions are an exception to the provisions in N.J.S.A.52:14-17.29, which currently provides for annual and lifetime caps under SHBP on eligible expenses incurred because of mental illness or functional nervous disorders (a category which is broader than the biologically-based mental illnesses addressed in this bill) that are lower than for major medical expense benefits.

As amended, this bill is identical to Assembly Bill No. 3588 (1R).

FISCAL IMPACT

The SHBP is a multi-plan program offering public employees coverage under one of several health maintenance organizations (HMO), a fee-for-service plan (Traditional Plan) or a point-of-service plan (NJ PLUS). The Division of Pensions and Benefits in the Department of the Treasury has indicated that all SHBP HMO plans meet the requirement of the federal Mental Health Parity Act for provision of parity in mental health benefits and the requirements of this legislation. The SHBP Plan Comparison Chart for employees indicates that for mental health inpatient and outpatient services the HMOs usually limit the number of days as an inpatient and the number of visits as an outpatient per calendar year, 60 days and 30 visits, for example, and in some plans the amount of the copayment is larger than that required for other office visits. OLS understands that the limits on the number of stay days and visits do not fall under "copayments, deductibles or benefits limits," do not violate the federal act and would not violate the intent of this legislation, which is parallel to the federal act in that regard. The Office of Legislative Services (OLS) notes, however, that some mental health outpatient services copayments may need to be adjusted as a result of this legislation.

The SHBP has filed with the appropriate federal agency a mental health parity exemption for 1999 and 2000 for the Traditional Plan and NJ PLUS, because both have mental health benefits limitations. N.J.S.A. 52:14-17.29 establishes benefit limit maximums of $10,000 per calendar year and $20,000 for the entire period of a person's coverage under the Traditional Plan for eligible expenses incurred because of mental illness or functional nervous disorders. NJ PLUS has benefit limit maximums of $15,000 annually and $50,000 lifetime. The Traditional Plan pays in full hospital inpatient expenses for 365 days but pays in full inpatient mental health expenses for 20 days with the balance of days paid at 80% within the annual and lifetime maximums. Outpatient mental health expenses are paid the same as physician office visits, but within the maximums. NJ PLUS, too, has similar differences in payment of inpatient and outpatient expenses, with variation for out-of-network services, and day limits, all subject to the annual and lifetime maximums. This legislation would require adjustments to achieve parity in payment of biologically-based mental health expenses.

The Traditional Plan and NJ PLUS are self-insured health plans and actual experience under this legislation will determine any increase in expenses, as opposed to independent insurers who increase premiums to cover estimated risk exposure. OLS notes that there is no information available to indicate to what extent the requirements of this legislation will increase the expenses of the Traditional Plan and NJ PLUS beyond the expenses already incurred under the current terms of those plans, since some mental health benefits of a general nature, including this legislation's for biologically-based mental illness, are already provided by each of these SHBP plans.

Compliance with the requirement that the commission provide notice to employees regarding the bill's mental health benefits coverage can probably be achieved through the usual mailings or the yearly informational packet at no or minimal additional expense to the State.

LEGISLATIVE FISCAL ESTIMATE

SENATE, No. 2277

STATE OF NEW JERSEY

208th LEGISLATURE

DATED: JANUARY 4, 2000

BILL SUMMARY

Senate Bill No. 2277 of 1999 requires that the State Health Benefits Commission provide to persons covered under the State Health Benefits Program (SHBP) the same coverage for biologically-based mental illness as that required for other health insurers and health maintenance organizations under P.L.1999, c.106.

The bill requires that coverage be provided for defined biologically-based mental illness under the same terms and conditions as provided for any other sickness under the SHBP contracts. Under the bill, "same terms and conditions" means that a health insurance carrier cannot apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits. The bill states that its provisions may not be construed to change the manner in which a carrier determines medical necessity or entitlement to reimbursement for services for mental illness. The bill also requires the State Health Benefits Commission to provide notice to employees regarding the coverage required by this bill in accordance with the provisions of the bill and regulations adopted by the Commissioner of Health and Senior Services.

OFFICE OF LEGISLATIVE SERVICES COMMENTS

The SHBP is a multi-plan program offering public employees coverage under one of several health maintenance organizations (HMO), a fee-for-service plan (Traditional Plan) or a point-of-service plan (NJ PLUS). The Division of Pensions and Benefits in the Department of the Treasury has indicated that all SHBP HMO plans meet the requirement of the federal Mental Health Parity Act for provision of parity in mental health benefits and the requirements of this legislation. The SHBP Plan Comparison Chart for employees indicates that for mental health inpatient and outpatient services the HMOs usually limit the number of days as an inpatient and the number of visits as an outpatient per calendar year, 60 days and 30 visits, for

example, and in some plans the amount of the copayment is larger than that required for other office visits. OLS understands that the limits on the number of stay days and visits do not fall under "copayments, deductibles or benefits limits," do not violate the federal act and would not violate the intent of this legislation, which is parallel to the federal act in that regard. The Office of Legislative Services (OLS) notes, however, that some mental health outpatient services copayments may need to be adjusted as a result of this legislation.

The SHBP has filed with the appropriate federal agency a mental health parity exemption for 1999 and 2000 for the Traditional Plan and NJ PLUS, because both have mental health benefits limitations. N.J.S.A. 52:14-17.29 establishes benefit limit maximums of $10,000 per calendar year and $20,000 for the entire period of a person's coverage under the Traditional Plan for eligible expenses incurred because of mental illness or functional nervous disorders. NJ PLUS has benefit limit maximums of $15,000 annually and $50,000 lifetime. The Traditional Plan pays in full hospital inpatient expenses for 365 days but pays in full inpatient mental health expenses for 20 days with the balance of days paid at 80% within the annual and lifetime maximums. Outpatient mental health expenses are paid the same as physician office visits, but within the maximums. NJ PLUS, too, has similar differences in payment of inpatient and outpatient expenses, with variation for out-of-network services, and day limits, all subject to the annual and lifetime maximums. This legislation would require adjustments to achieve parity in payment of biologically-based mental health expenses.

The Traditional Plan and NJ PLUS are self-insured health plans and actual experience under this legislation will determine any increase in expenses, as opposed to independent insurers who increase premiums to cover estimated risk exposure. OLS notes that there is no information available to indicate to what extent the requirements of this legislation will increase the expenses of the Traditional Plan and NJ PLUS beyond the expenses already incurred under the current terms of those plans, since some mental health benefits of a general nature, including this legislation's for biologically-based mental illness, are already provided by each of these SHBP plans.

Compliance with the requirement that the commission provide notice to employees regarding the bill's mental health benefits coverage can probably be achieved through the usual mailings or the yearly informational packet at no or minimal additional expense to the State.

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67.

LEGISLATIVE FISCAL ESTIMATE

SENATE, No. 2277

STATE OF NEW JERSEY

208th LEGISLATURE

DATED: JANUARY 18, 2000

BILL SUMMARY

Senate Bill No. 2277 of 1999 requires that the State Health Benefits Commission provide to persons covered under the State Health Benefits Program (SHBP) the same coverage for biologically-based mental illness as that required for other health insurers and health maintenance organizations under P.L.1999, c.106.

The bill requires that coverage be provided for defined biologically-based mental illness under the same terms and conditions as provided for any other sickness under the SHBP contracts. Under the bill, "same terms and conditions" means that a health insurance carrier cannot apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits. The bill states that its provisions may not be construed to change the manner in which a carrier determines medical necessity or entitlement to reimbursement for services for mental illness. The bill also requires the State Health Benefits Commission to provide notice to employees regarding the coverage required by this bill in accordance with the provisions of the bill and regulations adopted by the Commissioner of Health and Senior Services.

OFFICE OF LEGISLATIVE SERVICES COMMENTS

The SHBP is a multi-plan program offering public employees coverage under one of several health maintenance organizations (HMO), a fee-for-service plan (Traditional Plan) or a point-of-service plan (NJ PLUS). The Division of Pensions and Benefits in the Department of the Treasury has indicated that all SHBP HMO plans meet the requirement of the federal Mental Health Parity Act for provision of parity in mental health benefits and the requirements of this legislation. The SHBP Plan Comparison Chart for employees indicates that for mental health inpatient and outpatient services the HMOs usually limit the number of days as an inpatient and the number of visits as an outpatient per calendar year, 60 days and 30 visits, for

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The SHBP has filed with the appropriate federal agency a mental health parity exemption for 1999 and 2000 for the Traditional Plan and NJ PLUS, because both have mental health benefits limitations. N.J.S.A. 52:14-17.29 establishes benefit limit maximums of $10,000 per calendar year and $20,000 for the entire period of a person's coverage under the Traditional Plan for eligible expenses incurred because of mental illness or functional nervous disorders. NJ PLUS has benefit limit maximums of $15,000 annually and $50,000 lifetime. The Traditional Plan pays in full hospital inpatient expenses for 365 days but pays in full inpatient mental health expenses for 20 days with the balance of days paid at 80% within the annual and lifetime maximums. Outpatient mental health expenses are paid the same as physician office visits, but within the maximums. NJ PLUS, too, has similar differences in payment of inpatient and outpatient expenses, with variation for out-of-network services, and day limits, all subject to the annual and lifetime maximums. This legislation would require adjustments to achieve parity in payment of biologically-based mental health expenses.

The Traditional Plan and NJ PLUS are self-insured health plans and actual experience under this legislation will determine any increase in expenses, as opposed to independent insurers who increase premiums to cover estimated risk exposure. OLS notes that there is no information available to indicate to what extent the requirements of this legislation will increase the expenses of the Traditional Plan and NJ PLUS beyond the expenses already incurred under the current terms of those plans, since some mental health benefits of a general nature, including this legislation's for biologically-based mental illness, are already provided by each of these SHBP plans.

Compliance with the requirement that the commission provide notice to employees regarding the bill's mental health benefits coverage can probably be achieved through the usual mailings or the yearly informational packet at no or minimal additional expense to the State.

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67.