A STUDY OF NEW JERSEY ASSEMBLY BILL 1141

REQUIRES HEALTH INSURANCE COVERAGE FOR ANNUAL MENTAL HEALTH SCREENING

Report to the New Jersey Assembly

September 18, 2023



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Appendix I Assembly Bill No. 1141

Appendix II Review Request for Assembly Bill No. 1141

INTRODUCTION

The Mandated Health Benefits Advisory Commission (MHBAC) has been asked to review A1141 (see Appendix I for a copy of the legislation), a bill that requires health insurers (health, hospital, and medical service corporations, commercial individual and group health 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, not referencing the School Employees' Health Benefits Programⁱ) to provide coverage for an "annual mental health screening." The same bill from last session was referred to the MHBAC and the Commission issued <u>a report</u>. This 2023 report effectively incorporates that prior report and includes some updated information and references.

Specifically, A1141 amends various parts of statutory law requiring health insurance coverage consistent with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. s.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. s.156.115(a)(3) to mental health parity under the federal by noting that such coverage "shall include, but not be limited to, an annual screening for mental health conditions." The bill does not define what is intended by an "annual screening for mental health conditions."

If enacted, it is not clear if the bill will change the current state of coverage for the state-regulated markets in New Jersey as similar benefits are already covered under health benefits plans. Coverage for preventive services and screening in commercial and self-funded health plans is also governed by existing federal and state laws. Specifically, the Patient Protection and Affordable Care Act (ACA), Section 2713, amending the Public Health Services Act, and implementing regulations, mandate coverage, requiring group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage to provide coverage of certain preventive services. For purposes of screening, the ACA requires coverage of evidence-based items or services that have an "A" or "B" recommendation rating from the United States Preventive Services Task Force (USPSTF), based on clear empirical evidence of their efficacy. The latest USPSTF does not include a general screening for mental or behavioral health. The USPSTF does have A and B recommendations for the following screenings related to behavioral health:

- Screening for unhealthy alcohol use
- Screening for unhealthy drug use
- Screening for tobacco use for adults, including pregnant women
- Screening for adult depression
- Screening for perinatal depression
- Screening for major depressive disorder in adolescents

Recommendations not meeting the "A" or "B" rating include the following:

- Screening for Autism spectrum disorder in young children
- Screening for Suicide Risk in Adolescents, Adults and Older Adults

The federal coverage requirements from the ACA have been the subject of legal challenges, which may serve to limit federal insurance coverage requirements.

However, for purposes of A1141 which pertain to state-regulated and administered coverage, New Jersey also enacted its own, state-based version of this ACA coverage requirement with the passage of P.L. 2019, c.360. That state law tracks the ACA's mandated coverage requirements, including mandate coverage, without cost sharing, for "evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force." No challenges have been asserted against New Jersey's law or its inclusion of coverage requirements linked to the decisions of the Unites State Preventive Services Task Force. Therefore, certain aspects of the "annual screening for mental health conditions" mandated by A1141 may already be required under New Jersey law.

The Mandated Health Benefits Advisory Commission Act (N.J.S.A. 17B:27D-1 <u>et seq.</u>) tasks the Commission with providing an independent analysis of the social, medical, and financial impact of proposed legislation referred to it for review. The Act does not ask the Commission to recommend whether or not to enact the legislation, and the Commission does not do so here. The MHBAC prepared this report using its own resources, including staff from the New Jersey Department of Banking and Insurance. Commission members contributed their professional expertise, on a voluntary basis, in helping to shape the presentation of this report, analyzing published research, and drafting and editing its various sections. The MHBAC has sought to include information from a number of reputable sources that it found credible but recognizes that opinions and analyses may differ.

LEGISLATIVE HISTORY

In the Assembly, A1141 was introduced on January 11, 2022, and was referred to the Assembly Financial Institutions and Insurance Committee. The same bill was introduced in the last two legislative sessions (A376 on January 14, 2020, and A5989 on November 25, 2019). As of the date of the issuance of this report, the Assembly has not considered any version of the bill.

In the Senate, S2790, the Senate version of A1141, was introduced June 6, 2022, and was referred to the Senate Commerce Committee. The same bill was introduced in the last legislative session (S1240 on January 14, 2020). The Senate has not considered any versions of the bill.

There have not been any fiscal notes published for any of the bills.

SOCIAL IMPACT

Prevalence of Mental Illness and Substance Abuse in Adults

The National Institute of Mental Health (NIMH) estimates that 51.5 million adults over the age of 18, or 20.6% of the population suffer from a mental illness. NIMH differentiates between Any Mental Illness (AMI) and Serious Mental Illness (SMI), the former defined as ... "a mental, behavioral, or emotional disorder which can be varied in its impact," and the latter as "a mental, behavioral or emotional disorder resulting in serious functional impairment which substantially interferes with or limits one or more major life activities." ii

The prevalence of AMI is higher among females (24.5%) than males (16.3%) and occurs most frequently in young adults 18 to 25 years of age, and among those reporting two or more races, demographically. In 2019, 43.8% of U.S. adults with AMI and 65.5% of the 13.1 million Americans with SMI received mental health treatment, among them, more adults older than 26 than those aged 18 to 25, and about half of those identifying as female, gay, lesbian, bisexual and transgender, or non-Hispanic whites. Data from the 2019 National Comorbidity Survey of Adolescents Aged 13-19, determined that 49.5% of this population had AMI and 22% had SMI based on DSM-IV criteria. iii

The National Alliance for Mental Illness (NAMI) delineates the frequency of mental illness in U.S. adults aged 18 and older by condition:^{iv}

• Schizophrenia: <1%: 1.5 million people

• Obsessive-Compulsive Disorder: 1.2%: 3 million people

• Borderline Personality Disorder: 1.4%: 3.5 million people

• Bipolar Disorder: 2.8%: 7 million people

• Post Traumatic Stress Disorder: 3.6% 9 million people

• Major Depressive Disorder: 7.8% 19.4 million people

• Anxiety Disorder: 19.1% 48 million people

Perinatal depression is a common and often unrecognized condition during pregnancy and the postpartum period affecting 10-20% of pregnant women. In 2018, the National Survey of Drug Use and Health determined that approximately 20.3 million people ages 12 and older had a substance abuse disorder, including 14.8 million with an alcohol use disorder, and 8.1 million with an illicit drug use disorder; the most common substance involved in illicit drug use was marijuana. Approximately 2.1 million Americans have an opioid use disorder, nearly 1 million

are addicted to methamphetamine, and about 34 million smoke cigarettes. Vii Obtaining treatment for these disorders, regardless of type, remains a challenge. For example, only 8% of those with alcohol use disorder had received treatment for their condition in 2018. Viii Treatment is complicated by a nationwide scarcity of mental health clinicians -- in 2019, for example, 60% of U.S. counties had no practicing psychiatrist -- and in some cases, by a lack of health insurance coverage: In 2019, 10.9% of U.S. adults with AMI had no insurance coverage, and 11.9% of U.S. adults with SMI had no insurance coverage. The average delay between the onset of mental illness symptoms and treatment in the U.S. is 11 years. In the cigarettes.

Mental health and substance abuse disorders add to the burden of care in the U.S: patients with these disorders are involved in 1 out of 8 emergency room visits/year, and mood disorders are the most common cause of hospitalizations for all people in the U.S. under age 45 (aside from pregnancy and birth). It is estimated that serious mental illness causes \$193.2 billion in lost revenue/year. The community impact of mental illness is reflected in the fact that 20.5% of those experiencing homelessness have a serious mental illness, 37% of those incarcerated in state and federal U.S. prisons have a diagnosed mental illness, and 70.4% of youths in the juvenile justice system and 41% of patients in the Veteran's Health Administration have serious mental illness.^x In 2018, 23.6% of adults with any mental illness perceived unmet need for their mental health care; the most common expressed reason for not receiving mental health services was that the cost of care was unaffordable.^{xi}

Between 1999 and 2006, suicide rates in the U.S. among all ages increased at about 1%/year; between 2006 and 2018, the rates increased at about 2%/year. Suicide is the 10th leading cause of death in the U.S. in all age groups, and the 2nd leading cause of death for ages 10 to 34. Between 1999-2018, the rates were highest for females between 45-64 and for males aged 75 and older. In 2018, suicide rates were higher in most rural communities than in most urban communities. ^{xii} Beyond the immediate risk for higher mortality, individuals with depression are at higher risk for some chronic diseases including cardiovascular disease, diabetes, Alzheimer's disease and osteoporosis. Conversely, patients with many chronic diseases are at higher risk for depression, including but not limited to: cancer, coronary artery disease, stroke, Parkinson's disease, HIV-AIDS, multiple sclerosis and rheumatoid arthritis. ^{xiii}

Prevalence of Mental and Behavioral Health Conditions in Children

A study using national survey data from 2015 found that roughly 4% of children ages 4 to 7 had serious emotional or behavioral difficulties, with 6% of children ages 8 to 10 having these serious problems, and 8% of children ages 11 to 14 having serious emotional or behavioral difficulties. Similar studies have found that among children ages 6 to 11, another 17% have less severe emotional or behavioral difficulties. Strong evidence establishes the negative impact of these emotional and behavioral problems on math and reading scores and school dropout rates. xiv

"Attention deficit hyperactivity disorders (ADHD), behavioral problems, anxiety and depression are the most commonly diagnosed mental health disorders in children." Other childhood mental and behavioral health disorders include oppositional-defiant disorders, obsessive-compulsive disorders, conduct disorders, Tourette's syndrome and post-traumatic stress disorders. Conditions that can be associated with mental health and behavioral disorders are autism spectrum disorders, developmental disorders, learning disorders, language disorders and disorders of substance abuse. **vii xviii xix** It is estimated that 20 to 25 percent of youth in the United States will meet criteria for a mental health disorder with severe impairment (defined by endorsement of "a lot" or "extreme" impairment in daily activities or "severe or very severe" distress) during their lifetime. *** The members of the MHBAC were sensitive to a number of social issues that might have an impact on the mental health status of children and adults in New Jersey, but found no direct empirical evidence or generalizable conclusions connecting those issues to the subject matter of A1141, insurance coverage for annual mental health screening. **xxi

MEDICAL EVIDENCE

The primary purpose of screening tests is to detect early disease or risk factors for disease in large numbers of apparently healthy individuals. The purpose of a diagnostic test is to establish the presence (or absence) of disease as a basis for a treatment decision in symptomatic or screen positive individuals (i.e., a confirmatory test). xxiii

Mental (or behavioral) health conditions are a large, and varied group of conditions as referenced in the current version of DSM-5. It is estimated that 8% of Americans aged 12 years and older suffer from depression, and a 2015 study estimated that 16.1 million adults had at least one major depressive episode in the previous year. XXIII A related study of anxiety disorders in adolescent and adult women found that 40% of women experience an anxiety disorder in their lifetimes, while 23% had suffered an anxiety disorder in the past year. The authors reported that there was insufficient empirical evidence to support a recommendation to screen all adolescent and adult women for anxiety disorders. XXIII

There are multiple screening tools employed in medical practice, each testing for different categories of the Behavioral Health conditions. Some examples of the most commonly used screening tools for adults are PHQ2 and PHQ9 for Depression screening, the Geriatric Depression Screening tool (GSD15), GAD7 for Anxiety, CAGE for substance abuse disorder, MMSE and SLUMS for cognitive decline and dementia, and the Edinburgh Postpartum Depression Scale (EPDS) in perinatal women.

There is utility in identifying individuals with behavioral health conditions and engaging them in effective treatment. Screening tools are best utilized in the primary care (e.g., Family Medicine, General Internal Medicine, Pediatric, and in some cases, OBGYN) medical practice setting, where patients identified with behavioral health conditions might begin and/or be referred for early counseling and medication therapy. However, performing screening tests in these settings may be made difficult because of limitations in the primary care clinician's (i.e., Physicians, Nurse Practitioners and Physician Assistants in Family Medicine, Pediatrics, General Internal

Medicine, and in some cases Obstetrics and Gynecology) time. A time-motion study of nearly 1,000 primary care physician visits in 2018, found that the average face-to-face time physicians spend with patients is 11.2 minutes, including 9.2 minutes of physician to patient interaction, and 2 minutes of contributing to the Electronic Health Record (EHR); an additional 18. 6 minutes was spent on the EHR, outside of the patient visit. **xv* Some screening may be initiated by practice support staff, such as Medical Assistants, Social Workers, LPN/RNs, and Advanced Practice Clinicians; some screening tests are self-administered and can be completed by patients in the waiting area prior to an in-person visit.

Developmental surveillance is the process through which children with developmental delay or who are at risk for developmental delay are identified. It is an essential component of routine well-child care and consists of eliciting and attending to parental concerns, maintaining a developmental history, observing parent-child interactions, identifying risk and protective factors, collaborating with other professionals, and formulating findings and plans. Developmental-behavioral screening refers to the use of a standardized test to identify asymptomatic children at risk for a developmental disorder; children who screen positive should undergo developmental-behavioral evaluation. Screening enhances clinical impressions formed through developmental surveillance.

Ideally, screening tools should be valid and reliable, brief, and low-cost. A1141 mandates an annual screening for mental health conditions, suggesting a screening for overall mental health. Examples of such evidence-based tools to screen for overall mental health in adults and youth are in Tables 1 and 2.

Table 1: Adults, Overall Mental Health Tools

National Institutes of Health Patient Reported Outcomes Measurement Information System (PROMIS)	https://www.assessmentcenter.net/promisforms.aspx
Patient Health Questionnaires (PHQ)	http://www.phqscreeners.com/
Recovery Assessment Scale (RAS)	http://www.power2u.org/downloads/pn-55.pdf

From: From: Beidas, R., Stewart, R., Walsh, L, et.al. Free, brief and validated: standardized instruments for low-resource mental health settings. Cognitive and Behavioral Practice. 2015. Feb 1: 22(1): 5-19. Retrieved 1/28/21 from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4310476/

Table 2: Youth, Overall Mental Health Tools

Brief Problem Checklist (BPC)	http://www.childfirst.ucla.edu/Resources.html
The Ohio Scale-Youth, Parent, and Clinician versions	ude.uvb@selaoneb
Peabody Treatment Progress Battery (PTPB)	http://peabodv.vanderbilt.edu/research/center-evaluation- proaram- improvement-cepi/rea/ptpb 2nd ed downloa ds.php
Pediatric Symptom Checklist and Pediatric Symptom Checklist-Youth Report (PSC & Y-PSC)	http://www.massaeneral.ora/psvchiatrv/services/pschome.aspx
Strength and Difficulties Questionnaire (SDQ)	http://www.sdqinfo.ora/a0.html
Youth Top Problems (TP)	http://www.wih.harvard.edu/~iweisz/pdfs/2011c.pdf

From: Beidas, R., Stewart, R., Walsh, L, et.al. Free, brief and validated: standardized instruments for low-resource mental health settings. Cognitive and Behavioral Practice. 2015. Feb 1: 22(1): 5-19. Retrieved 1/28/21 from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4310476/

Given time constraints, primary care clinicians may be more likely to use screening tools for specific conditions, like anxiety, major depression (adult or youth), perinatal depression or substance abuse, than for overall mental health, particularly since those are conditions which fall within the USPSTF recommendations and, therefore, trigger insurance coverage under ACA and New Jersey law. Brief, validated screening tools to assess most of these conditions are summarized in several recent articles along with links to the resources for clinician's use. **xxvi xxvii**

The Edinburg Postnatal Depression Scale is an evidenced-based screening tool effective in determining depression in the perinatal period and is widely used in OBGYN practices in the U.S. xxviii

Choice of screening should be based on primary care clinician judgment, knowledge of the patient's social and medical conditions, as well as past history of any behavioral health diagnoses, in the context of presenting conditions. It is crucial that there is an available and effective network of behavioral health clinicians to support primary care clinicians. There is often need for prompt additional care of patients who have been identified with a behavioral health condition after screening and early treatment, or there could be the potential for harm to such patients. The patients are in line with those of other medical screens, false positive results are not uncommon. They further note: "This may be due in part to the sensitivity of brief screening instruments to nonspecific symptoms." The patients of the patients of the part to the sensitivity of brief screening instruments to nonspecific symptoms."

Developmental and behavioral surveillance is recommended for all children during preventive health care visits. In the United States, periodic developmental-behavioral screening is also recommended. USPSTF recommends and requires insurance coverage for screening for major depressive disorders (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The USPSTF also concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for MDD in children aged 11 or younger. *xxxi*

Developmental disabilities (also called developmental disorders) are a heterogeneous group of conditions caused by impairments in learning, language, behavior, or motor skills. Examples include intellectual disability, autism spectrum disorder, attention deficit hyperactivity disorder, cerebral palsy, and hearing impairment. Developmental screening refers to the use of a standardized test to identify asymptomatic children who are at risk for a developmental disorder; children who screen positive should undergo a developmental-behavioral evaluation.

The benefits of developmental-behavioral screening were demonstrated in a multicenter randomized trial that compared developmental screening using validated screening tests (Ages & Stages Questionnaire-II and Modified Checklist for Autism in Toddlers) with office assistance, validated tools without office assistance, and milestone-based developmental surveillance in 2103 children <30 months of age. xxxiv

Children who screen positive, but whose developmental-behavioral evaluation does not identify a developmental-behavioral condition, may benefit from more frequent follow-up, psychosocial supports, or primary care interventions. XXXV In a systematic review of 48 studies, several primary care interventions for children younger than three years were associated with reduction in developmental delay (Healthy Steps, Video Interaction Project), improved cognitive or language development (Parenting Intervention, Care For Development, Touchpoints), and improved

behavior (Incredible Years, Positive Parenting Program, Parent-Child Interaction Therapy, PriCARE, Video Interaction Project). xxxvi

One relatively new element in mental healthcare treatment is the expanded use of telemedicine. One study of 175 practicing and licensed mental healthcare providers found that the group of psychologists, mental health counselors, and psychiatrists use of telemedicine nearly doubled, both on a daily basis and as a proportion of all patients seen, as a result of their experiences during the COVID-19 pandemic. **xxxvii** These mental healthcare providers also reported greater comfort using telemedicine in their practices and planned to continue using telemedicine after the pandemic ended. A large study looking at claims data for more than 5 million commercially insured adults between January 5 and December 21, 2020, found that expanded mental telemedicine services were able to offset "a sharp decline in in-person care...generating overall higher service utilization rates for several mental health conditions compared with prepandemic levels." Higher mental health treatment utilization rates incorporating telemedicine were achieved for major depressive disorder, anxiety disorders, and adjustment disorders, in particular.

OTHER STATES

The MHBAC did not identify any other states with such broad proposed mandates on insurance coverage for mental and behavioral health screening. The National Alliance on Mental Illness (NAMI) established a number of specific areas in which states could make meaningful progress on mental health. These areas included:

- State Mental Health Budgets
- Medicaid and Medicaid Expansion
- Insurance Parity
- Workforce
- Children and Youth
- First Episode Psychosis: Early Intervention
- Inpatient and Crisis Care
- Civil Commitment and Court-Ordered

Treatment

- Criminal Justice
- Suicide Prevention
- Housing and Employment^{xxxix}

North Carolina, for example, chose to focus its legislative efforts on youth suicide prevention in 2019. Among the provisions contained in that legislative package was a proposal to expand mental health screenings of adolescents to identify those at greater risk of suicide.^{xl}

Another study examined state requirements for childhood screening and elementary school form reporting on a set of 7 variables intended to measure health barriers to learning. For the 50 states

and the District of Columbia, mandatory screening and school reporting was very low on all the measures, under 25% of all states, even for the measures with the highest number of state requirements. In a previous legislative session, New Jersey considered legislation, \$2835 (Singleton)/A3926, which would have required public schools to administer written screenings for depression for students in certain grades. The bill passed both houses, but was pocket vetoed. Only 10 states and the District of Columbia had any kind of mandatory testing and school reporting for mental health or well-being, roughly the same as the number requiring screenings and reporting for vision, hearing, dental pain, and asthma. The results are presented in Table 3.

Table 3. States Requiring Screening of Health Conditions that Interfere with Learning

	Vision	Hearing	Dental	Asthma	Mental Health/ Behavior	Lead	Hungei
California	✓	✓	✓			✓	
Connecticut	✓	✓	✓	✓	✓	✓	
D.C.	✓	✓	✓	✓	✓	✓	
Georgia	✓	✓	✓				
Hawaii	✓	✓	✓	✓	✓		
Illinois	✓	✓	✓	✓	✓	✓	
Kansas	✓	✓	✓	✓	✓	✓	
Kentucky	✓	✓	✓		✓		
Maryland			✓	✓	✓	✓	
Massachusetts	✓	✓	✓	✓	✓	✓	
North Carolina	✓	✓	✓	✓	✓	✓	
Pennsylvania	✓	✓	✓	✓	✓		
Rhode Island	✓			✓	✓	✓	

Source: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0190254

The authors point out, however, that approximately 19% of American children aged 6 to 11 did not have an annual checkup in the previous year.

DISCUSSION

Mental illness or mental health conditions/disorders refers to a wide range of disorders that can affect mood, thinking, and behavior. Examples of mental health illness include depression, anxiety disorders, schizophrenia and associated disorders, bipolar disorders, eating disorders, and addictive behaviors that can include substance abuse disorders. Developmental surveillance and screening for developmental/behavioral problems starts in childhood, however the development of mental illness can occur at any age.

The combination of developmental surveillance and screening for developmental-behavioral problems increases early identification, enabling early intervention, which is associated with improved outcomes. Early identification also permits earlier treatment of underlying medical conditions that present with developmental-behavioral problems. Perceived potential harms of screening include unnecessary referrals for developmental-behavioral evaluation, undue anxiety or stigma for families, missed or delayed diagnosis, and increased burden (e.g., time, documentation) for pediatric practices.

The empirical evidence suggests that mental health screening and follow up referrals for mental health care for children and adults is inadequate. A survey of 33,653 primary care physicianpatient encounters, for example, showed less than 5% of adults were screened for depression. xliii Another study examined the screening and referral practices of a group of pediatric primary care clinicians before and after intensive training in their use. The authors reported that before the intervention, the primary care clinicians were using mental health screening for about 1% of their pediatric patients. This was consistent with their finding that, "[O]ver half of PCPs report never or rarely using a standardized [mental health] screening tool." While that percentage rose significantly with the intervention (to about 74%), it required 15 months of sustained training and intervention. The primary care clinicians identified a number of barriers to using mental health screening and referrals, including time constraints in patient appointments, insufficient reimbursements, inadequate referral resources, and a paucity of partnerships with mental health clinicians. xliv Psychiatric Advanced Practice Nurses in New Jersey describe reports from patients waiting 3 to 6 months for mental health care, with waits being the longest in underserved areas, like Cumberland County. xlv

Another study examined the outcomes when commercially insured adolescent patients were identified as requiring follow up care after a positive finding from a mental health screening. The findings were not encouraging. The researchers reported that even with a positive finding from a mental health screening, only 54% of the insured adolescent patients were referred for mental health treatment. Furthermore, only 67% of the patients who were referred accepted the referral. Finally, of that group of patients who accepted mental health treatment referrals, only 18% actually had face-to-face mental health appointments in the 180 days following their referrals. These findings suggest that the use of mental health screening tools and attention to referrals to follow up mental health care cannot guarantee that patients will seek the care they need, even with a positive finding from a mental health screening and commercial insurance coverage.

FINANCIAL IMPACT

In assessing the financial impact of the proposed mental health screening legislation, the Mandated Health Benefits Advisory Commission is limited by the absence of a fiscal note on this bill by New Jersey's Office of Legislative Services. Furthermore, since no other state has

proposed comparable legislation mandating insurance coverage for annual comprehensive mental and behavioral health screening, there are no other state models of the financial impact of such a bill.

The MHBAC estimates that the proposed insurance mandate would cover about 13% of New Jersey residents covered under regulated insurance plans and about 9% of residents covered under the State and School Employee Health Benefits Program. Current Federal insurance mandates for mental and behavioral health screenings are tied, through the Affordable Care Act, to the recommendations of the US Preventive Services Task Force (USPSTF). The USPSTF's A & B recommendations for mental and behavioral health screenings, therefore, are already covered. Any mental or behavioral health screenings beyond the existing insurance mandates, therefore, would be for screening tools not considered to have sufficient empirical evidence to justify their use, according to the USPSTF.

The language of A1141 is broad and general. The exact meaning of annual mental and behavioral health screenings, beyond those already covered under the ACA, is unclear. There are a variety of mental and behavioral health screening tools, for example, even for the same diagnostic purpose, each demanding differing amounts of time and expertise of primary care practitioners. Since the definition and intent of the expanded screenings is vague, it is impossible for the MHBAC to estimate a cost for this bill.

CONCLUSION

Balancing Social Impact, Medical Evidence, and Financial Impact

The literature clearly demonstrates that mental and behavioral health problems are a serious challenge to the wellbeing of children, adolescents, and adults in New Jersey and the United States. Existing mental and behavioral health insurance coverage mandates under the ACA and codified into New Jersey law are tied to the A & B recommendations of the USPSTF. The issue is defining precisely what is intended by A1141 in broadening annual mental and behavioral health screenings beyond the empirically proven and clearly defined screening tools currently covered. This lack of precision makes it difficult to assess which screening tools satisfy the bill's intentions and how healthcare providers can determine patient eligibility/insurance coverage for mental health screenings. This makes it impossible to quantify the financial impact of such an expanded insurance mandate.

The bill's emphasis on expanding the use of mental and behavioral health screenings also overlooks the impact of increased demands on primary care clinicians. The research finds that primary care clinicians are already under serious time constraints, in terms of the number of

minutes they can allocate in face-to-face meetings with patients. Some primary care clinicians report rarely using such mental and behavioral health screening tools and cite the barriers to using them consistently (e.g., time demands, documentation requirements, reimbursement rates/payments, limited mental health referral options, and a lack of familiarity with mental health colleagues).

It is not clear that an expanded insurance coverage mandate for screenings will actually result in better treatment and outcomes for patients suffering from mental and behavioral health problems. The empirical evidence does not suggest that significantly more patients will actually be screened for these conditions, and it is not clear that patients receiving positive mental and behavioral health screenings will actually receive referrals for further treatment. Furthermore, there is evidence that suggests that referrals don't necessarily lead to a majority of patients having face-to-face mental and behavioral health follow up appointments with care practitioners. In summation, increased evidence-based screening can not only identify specific mental health conditions, but it can give a better sense of their scope. Screening, however, does not establish a clear path to more widespread and effective treatment of the problems identified for a number of reasons described in this report, including an insufficient number of mental health clinicians.

ENDNOTES

¹ Subsection e. of N.J.S.A. 52:14-17.46.6 provides that "Coverage provided under the School Employees' Health Benefits Program Act shall include coverage for all services for which coverage is mandated in the State Health Benefits Program pursuant to P.L.1961, c.49 (C.52:14-17.25 et seq.)."

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ASSEMBLY, No. 1141

STATE OF NEW JERSEY

220th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2022 SESSION

Sponsored by:

Assemblyman CHRISTOPHER P. DEPHILLIPS District 40 (Bergen, Essex, Morris and Passaic) Assemblywoman NANCY F. MUNOZ District 21 (Morris, Somerset and Union)

Co-Sponsored by:

Assemblywomen Murphy, Dunn, Chaparro, Assemblymen McGuckin and Catalano

SYNOPSIS

Requires health insurance coverage for annual mental health screening.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



(Sponsorship Updated As Of: 5/11/2023)

AN ACT concerning insurance coverage of mental health screenings and amending various parts of the statutory law.

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

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- 1. Section 1 of P.L.1999, c.106 (C.17:48-6v) is amended to read as follows:
- 9 1. a. (1) Every individual and group hospital service 10 corporation contract that provides hospital or medical expense 11 benefits and is delivered, issued, executed or renewed in this State 12 pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for 13 issuance or renewal in this State by the Commissioner of Banking 14 and Insurance, on or after the effective date of this act shall provide 15 coverage for mental health conditions and substance use disorders 16 under the same terms and conditions as provided for any other 17 sickness under the contract and shall meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and 18 Addiction Equity Act of 2008, 42 U.S.C. s.18031(j), and any 19 20 amendments to, and federal guidance or regulations issued under 21 that act, including 45 C.F.R. Parts 146 and 147 and 45 C.F.R. 22 s.156.115(a)(3).
 - Coverage shall include, but not be limited to, an annual screening for mental health conditions.
 - (2) As used in this section:

"Mental health condition" means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.

"Same terms and conditions" means that the hospital service corporation cannot apply more restrictive non-quantitative limitations, such as utilization review and other criteria or more quantitative limitations such as copayments, deductibles, aggregate or annual limits or benefit limits to mental health condition and substance use disorder benefits than those applied to substantially all other medical or surgical benefits.

"Substance use disorder" means a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

- b. (Deleted by amendment, P.L.2019, c.58)
- 42 c. The provisions of this section shall apply to all contracts in 43 which the hospital service corporation has reserved the right to 44 change the premium.

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

- d. Nothing in this section shall reduce the requirement for a hospital service corporation to provide benefits pursuant to section 1 of P.L.2017, c.28 (C.17:48-6nn).
- 4 (cf: P.L.2019, c.58, s.1)

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- 6 2. Section 2 of P.L.1999, c.106 (C.17:48A-7u) is amended to read as follows:
- 8 2. a. (1) Every individual and group medical service 9 corporation contract that provides hospital or medical expense 10 benefits that is delivered, issued, executed or renewed in this State 11 pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for 12 issuance or renewal in this State by the Commissioner of Banking 13 and Insurance, on or after the effective date of this act shall provide coverage for mental health conditions and substance use disorders 14 15 under the same terms and conditions as provided for any other 16 sickness under the contract and shall meet the requirements of the 17 federal Paul Wellstone and Pete Domenici Mental Health Parity and 18 Addiction Equity Act of 2008, 42 U.S.C. s.18031(j), and any 19 amendments to, and federal guidance or regulations issued under 20 that act, including 45 s.C.F.R. Parts 146 and 147 and 45 C.F.R. 21 s.156.115(a)(3).
- Coverage shall include, but not be limited to, an annual
 screening for mental health conditions.
 - (2) As used in this section:

"Mental health condition" means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.

"Same terms and conditions" means that the medical service corporation cannot apply more restrictive non-quantitative limitations, such as utilization review and other criteria or more quantitative limitations such as copayments, deductibles, aggregate or annual limits or benefit limits to mental health condition and substance use disorder benefits than those applied to substantially all other medical or surgical benefits.

"Substance use disorder" means a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

- b. (Deleted by amendment, P.L.2019, c.58)
- 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.
- d. Nothing in this section shall reduce the requirement for a medical service corporation to provide benefits pursuant to section 2 of P.L.2017, c.28 (C.17:48A-7kk).
- 47 (cf: P.L.2019, c.58, s.2)

- 3. Section 3 of P.L.1999, c.106 (C.17:48E-35.20) is amended to read as follows:
- 3 3. a. (1) Every individual and group health service corporation 4 contract that provides hospital or medical expense benefits and is 5 delivered, issued, executed or renewed in this State pursuant to 6 P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or 7 renewal in this State by the Commissioner of Banking and 8 Insurance, on or after the effective date of this act shall provide 9 coverage for mental health conditions and substance use disorders under the same terms and conditions as provided for any other 10 11 sickness under the contract and shall meet the requirements of the 12 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. s.18031(j), and any 13
- 14 amendments to, and federal guidance or regulations issued under
- 15 that act, including 45 C.F.R. Parts 146 and 147 and 45 C.F.R.

16 s.156.115(a)(3).

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- 17 Coverage shall include, but not be limited to, an annual 18 screening for mental health conditions.
 - (2) As used in this section:

"Mental health condition" means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.

"Same terms and conditions" means that the health service corporation cannot apply more restrictive non-quantitative limitations, such as utilization review and other criteria or more quantitative limitations such as copayments, deductibles, aggregate or annual limits or benefit limits to mental health condition and substance use disorder benefits than those applied to substantially all other medical or surgical benefits.

"Substance use disorder" means a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

- (Deleted by amendment, P.L.2019, c.58)
- The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.
- 39 d. Nothing in this section shall reduce the requirement for a health service corporation to provide benefits pursuant to section 3 40 of P.L.2017, c.28 (C.17:48E-35.38). 41
- 42 (cf: P.L.2019, c.58, s.3)

- 44 4. Section 4 of P.L.1999, c.106 (C.17B:26-2.1s) is amended to 45 read as follows:
- 46 4. a. (1) Every individual health insurance policy that 47 provides hospital or medical expense benefits and is delivered, 48 issued, executed or renewed in this State pursuant to chapter 26 of

- 1 Title 17B of the New Jersey Statutes, or approved for issuance or
- 2 renewal in this State by the Commissioner of Banking and
- 3 Insurance, on or after the effective date of this act shall provide
- 4 coverage for mental health conditions and substance use disorders
- 5 under the same terms and conditions as provided for any other
- 6 sickness under the contract and shall meet the requirements of the
- 7 federal Paul Wellstone and Pete Domenici Mental Health Parity and
- 8 Addiction Equity Act of 2008, 42 U.S.C. s.18031(j), and any
- 9 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.
- 11 s.156.115(a)(3).

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- 12 <u>Coverage shall include, but not be limited to, an annual</u> 13 <u>screening for mental health conditions.</u>
 - (2) As used in this section:

"Mental health condition" means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.

"Same terms and conditions" means that the insurer cannot apply more restrictive non-quantitative limitations, such as utilization review and other criteria or more quantitative limitations such as copayments, deductibles, aggregate or annual limits or benefit limits to mental health condition and substance use disorder benefits than those applied to substantially all other medical or surgical benefits.

"Substance use disorder" means a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

- b. (Deleted by amendment, P.L.2019, c.58)
- c. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.
- d. Nothing in this section shall reduce the requirement for an insurer to provide benefits pursuant to section 4 of P.L.2017, c.28 (C.17B:26-2.1hh).
- 36 (cf: P.L.2019, c.58, s.4)

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- 38 5. Section 5 of P.L.1999, c.106 (C.17B:27-46.1v) is amended 39 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 mental health conditions and substance use disorders 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 1
- 2 2008, 42 U.S.C. s.18031(j), and any amendments to, and federal
- 3 guidance or regulations issued under that act, including 45 C.F.R.
- 4 Parts 146 and 147 and 45 C.F.R. s.156.115(a)(3).
- 5 Benefits shall include, but not be limited to, an annual screening 6 for mental health conditions.
 - (2) As used in this section:

"Mental health condition" means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.

"Same terms and conditions" means that the insurer cannot apply more restrictive non-quantitative limitations, such as utilization review and other criteria or more quantitative limitations such as copayments, deductibles, aggregate or annual limits or benefit limits to mental health condition and substance use disorder benefits than those applied to substantially all other medical or surgical benefits.

- 19 "Substance use disorder" means a disorder defined to be consistent 20 with generally recognized independent standards of current medical practice referenced in the most current version of the Diagnostic 21
- 22 and Statistical Manual of Mental Disorders.
 - b. (Deleted by amendment, P.L.2019, c.59)
 - The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.
 - Nothing in this section shall reduce the requirement for an insurer to provide benefits pursuant to section 5 of P.L.2017, c.28 (C.17B:27-46.1nn).
- 29 (cf: P.L.2019, c.58, s.5)

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- 31 6. Section 2 of P.L.1999, c.106 (C.17B:27A-7.5) is amended to 32
- read as follows: 33 6. a. (1) Every individual health benefits plan that provides
- 34 hospital or medical expense benefits and is delivered, issued, 35 executed or renewed in this State pursuant to P.L.1992, c.161
- 36 (C.17B:27A-2 et seq.) or approved for issuance or renewal in this
- 37 State on or after the effective date of this act shall provide benefits
- 38 for mental health conditions and substance use disorders under the
- 39 same terms and conditions as provided for any other sickness under
- the health benefits plan and shall meet the requirements of the 40
- 41 federal Paul Wellstone and Pete Domenici Mental Health Parity and
- 42 Addiction Equity Act of 2008, 42 U.S.C. s.18031(j), and any
- 43 amendments to, and federal guidance or regulations issued under
- 44 that act, including 45 C.F.R. Parts 146 and 147 and 45 C.F.R.
- 45 s.156.115(a)(3).

- 46 Benefits shall include, but not be limited to, an annual screening 47 for mental health conditions.
 - (2) As used in this section:

"Mental health condition" means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.

"Same terms and conditions" means that the plan cannot apply more restrictive non-quantitative limitations, such as utilization review and other criteria or more quantitative limitations such as copayments, deductibles, aggregate or annual limits or benefit limits to mental health condition and substance use disorder benefits than those applied to substantially all other medical or surgical benefits.

"Substance use disorder" means a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

- b. (Deleted by amendment, P.L.2019, c.58)
- 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.
- d. Nothing in this section shall reduce the requirement for a plan to provide benefits pursuant to section 6 of P.L.2017, c.28 (C.17B:27A-7.21).
- 23 (cf: P.L.2019, c.58, s.6)

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- 7. Section 7 of P.L.1999, c.106 (C.17B:27A-19.7) is amended to read as follows:
- 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 mental health conditions and substance use disorders
- 33 under the same terms and conditions as provided for any other
- 34 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.
- 37 s.18031(j), and any amendments to, and federal guidance or
- 38 regulations issued under that act, including 45 C.F.R. Parts 146 and
- 39 147 and 45 C.F.R. s.156.115(a)(3).
- Benefits shall include, but not be limited to, an annual screening for mental health conditions.
 - (2) As used in this section:
 - "Mental health condition" means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.
- "Same terms and conditions" means that the plan cannot apply more restrictive non-quantitative limitations, such as utilization

- review and other criteria or more quantitative limitations such as 1 2 copayments, deductibles, aggregate or annual limits or benefit
- 3 limits to mental health condition and substance use disorder
- 4 benefits than those applied to substantially all other medical or 5 surgical benefits.
 - "Substance use disorder" means a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.
 - b. (Deleted by amendment, P.L.2019, c.58)
- 11 The provisions of this section shall apply to all health 12 benefits plans in which the carrier has reserved the right to change the premium. 13
- 14 d. Nothing in this section shall reduce the requirement for a 15 plan to provide benefits pursuant to section 7 of P.L.2017, c.28 16 (C.17B:27A-19.25).
- 17 (cf: P.L.2019, c.58, s.7)

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- 19 8. Section 8 of P.L.1999, c.106 (C.26:2J-4.20) is amended to
- 20 read as follows: 8. a. (1) Every enrollee agreement delivered, issued, executed, 21
- 22 or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et
- 23 seq.) or approved for issuance or renewal in this State by the 24 Commissioner of Banking and Insurance, on or after the effective
- 25 date of this act shall provide health care services for mental health
- 26 conditions and substance use disorders under the same terms and
- 27 conditions as provided for any other sickness under the agreement
- 28 and shall meet the requirements of the federal Paul Wellstone and 29
- Pete Domenici Mental Health Parity and Addiction Equity Act of 30 2008, 42 U.S.C. s.18031(j), and any amendments to, and federal
- 31 guidance or regulations issued under that act, including 45 C.F.R.
- 32 Parts 146 and 147 and 45 C.F.R. s.156.115(a)(3).
- 33 Health care services shall include, but not be limited to, an 34 annual screening for mental health conditions.
 - (2) As used in this section:
 - "Mental health condition" means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.
 - "Same terms and conditions" means that the health maintenance organization cannot apply more restrictive non-quantitative limitations, such as utilization review and other criteria or more quantitative limitations such as copayments, deductibles,, aggregate or annual limits or health care services limits to mental health condition and substance use disorder services than those applied to substantially all other medical or surgical health care services.
- 47 "Substance use disorder" means a disorder defined to be 48 consistent with generally recognized independent standards of

1 current medical practice referenced in the most current version of 2 the Diagnostic and Statistical Manual of Mental Disorders.

- b. (Deleted by amendment, P.L.2019, c.58)
- 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.
 - d. Nothing in this section shall reduce the requirement for a health maintenance organization to provide benefits pursuant to section 8 of P.L.2017, c.28 (C.26:2J-4.39).

10 (cf: P.L.2019, c.58, s.8)

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- 9. Section 2 of P.L.1999, c.441 (C.52:14-17.29e) is amended to read as follows:
- 14 2. a. The State Health Benefits Commission shall ensure that 15 every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense 16 17 benefits shall provide coverage for mental health conditions and 18 substance use disorders under the same terms and conditions as 19 provided for any other sickness under the contract and shall meet the requirements of the federal Paul Wellstone and Pete Domenici 20 Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 21 22 s.18031(j), and any amendments to, and federal guidance or 23 regulations issued under that act, including 45 C.F.R. Parts 146 and 24 147 and 45 C.F.R. s.156.115(a)(3).
 - Coverage shall include, but not be limited to, an annual screening for mental health conditions.
- 27 b. The commission shall provide notice to employees regarding 28 the coverage required by this section in accordance with this 29 subsection and regulations promulgated by the Commissioner of 30 Health pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice shall be in writing and 31 32 prominently positioned in any literature or correspondence and shall 33 be transmitted at the earliest of: (1) the next mailing to the 34 employee; (2) the yearly informational packet sent to the employee; 35 or (3) July 1, 2000. The commission shall also ensure that the 36 carrier under contract with the commission, upon receipt of 37 information that a covered person is receiving treatment for a 38 mental health condition or substance use disorder, shall promptly 39 notify that person of the coverage required by this section.
 - c. Nothing in this section shall reduce the requirement for a carrier to provide benefits pursuant to section 9 of P.L.2017, c.28 (C.52:14-17.29u).
- 43 (cf: P.L.2019, c.58, s.10)

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10. This act shall take effect on the 90th day next following the date of enactment and shall apply to all contracts and policies delivered, issued, executed or renewed on or after that date.

A1141 DEPHILLIPS, N.MUNOZ

1	STATEMENT
2	
3	This bill requires health insurers (health, hospital, and medical
4	service corporations, commercial individual and group health
5	insurers, health maintenance organizations, health benefits plans
6	issued pursuant to the New Jersey Individual Health Coverage and
7	Small Employer Health Benefits Programs, and the State Health
8	Benefits Program) to provide coverage for an annual mental health
9	screening.
10	The provisions of the bill will take effect 90 days after the date
11	of enactment and will apply to all health benefits plans issued or
12	renewed on or after that date.



NEW JERSEY GENERAL ASSEMBLY

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COMMITTEES
FINANCIAL INSTITUTIONS
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BUDGET
ENVIRONMENT AND
SOLID WASTE
JUDICIARY
INTERGOVERNMENTAL
RELATIONS COMMISSION

April 4, 2023

New Jersey Mandated Health Benefits Advisory Commission P.O. Box 325 Trenton, NJ 08625

Dear Members of the Commission:

As the Chairman of the Assembly Financial Institutions and Insurance Committee, I respectfully request the Commission review and prepare a written report of A1141 which Requires health insurance coverage for annual mental health screening.

If you have any questions, please do not hesitate to contact Mark Iaconelli, Jr., Esq., Deputy General Counsel, at 609-847-3500.

Thank you for your immediate attention to this matter.

Sincerely,

John F. McKeon

CC: Mark Iaconelli, Jr., Esq., Deputy General Counsel, Assembly Majority Office