A STUDY OF NEW JERSEY SENATE BILL 4018

REQUIRES HEALTH INSURANCE AND MEDICAID COVERAGE FOR SCREENING, PREVENTION, AND TREATMENT SERVICES OF BEHAVIORAL HEALTH ISSUES AFFECTING CHILDREN

Report to the New Jersey Senate

November 7, 2025

Mandated Health Benefits Advisory Commission

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INTRODUCTION

The Mandated Health Benefits Advisory Commission (MHBAC) has been asked to review S4018 (see Appendix I for a copy of the legislation), a bill that requires health insurance and Medicaid coverage for screening, prevention, and treatment services of behavioral health issues affecting children. The bill would apply to health insurers, including health service corporations, hospital service corporations, 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 (SHBP) and School Employees' Health Benefits Program (SEHBP), and the State Medicaid program.[*]

Specifically, S4018 requires carriers and the State Medicaid program "to accept and reimburse claims for screening, prevention, and treatment using an at-risk diagnosis." The term "at-risk diagnosis" is defined to mean "a diagnosis made after consideration of factors influencing behavioral health and child development, such as family circumstances or life challenges, that does not lead to a formal mental health diagnosis and instead, promotes preventive care." The sponsor statement indicates that allowing providers to bill for an "at-risk diagnosis" authorizes them to use an alternative set of billing codes, without having to establish a formal mental health diagnosis, to provide appropriate screening, prevention, and treatment services to patients who are 18 years of age or younger.

Existing New Jersey coverage requirements for mental and behavioral health services for children and adolescents include mental health parity protections, coverage for adolescent depression screenings, and coverage of preventive health services. Under the State's mental health parity law, P.L.2019, c.58, insurance carriers must "provide coverage for mental health conditions and substance use disorders under the same terms and conditions as provided for any other sickness…."[i] New Jersey insurers must also meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as well as any amendments, guidance, or regulations issued under that act. Under New Jersey's mental health parity law, insurers cannot apply more restrictive utilization review requirements or copayments, deductibles, or benefit limits to mental health conditions or substance use disorder benefits than those applied to other medical or surgical benefits.[ii]

Furthermore, the federal Affordable Care Act requires health insurance carriers to provide coverage for certain preventative health services for children, including a variety of behavioral health services.[iii] New Jersey state law, P.L.2019, c.320, effectively mirrors these federal coverage requirements for state-regulated plans. Moreover, New Jersey state law, P.L.2021, c.73, expands on this by expressly requiring coverage for screenings for adolescent depression. Specifically,

[*] Pursuant to the Mandated Health Benefits Advisory Commission Act (N.J.S.A. 17B:27D-1 *et seq.*), the Commission's review is limited to the application of mandates to the commercial market. Accordingly, this report does not directly address how the coverage mandate would potentially impact the Medicaid program.

insurance carriers are required to "provide coverage for expenses incurred in screening adolescents between the ages of 12 and 18 for major depressive disorder…" so long as that screening for adolescents receives an "A" or "B" rating from the United States Preventive Services Task Force.[iv] This law also eliminates any form of cost sharing, such as copayments, deductibles, or coinsurance, on covered persons receiving adolescent depression screenings.[v]

The Mandated Health Benefits Advisory Commission Act (N.J.S.A. 17B:27D-1 *et seq.*) 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 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.

MEDICAL EVIDENCE

Behavioral disorders can be described as a "set of behaviors that cause negative emotional symptoms when left untreated."[vi] Children may experience a variety of behavioral problems, such as ADHD, anxiety, depression, oppositional defiant disorder (ODD), and conduct disorder (CD), all of which are categorized as internalizing or externalizing issues.[vii,viii] ODD and CD are known as disruptive behavior disorders and are two of the most common behavior issues diagnosed in children.[ix] ODD occurs when a "child displays a pattern of an angry or cranky mood, defiant or combative behavior, and vindictiveness toward people in authority."[x] CD is defined as "children showing an ongoing pattern of aggression toward others, and serious violations of rules and social norms at home, in school, and with peers."[xi] Common indications of behavioral issues include the child frequently exhibiting anger or lost temper, fighting, trouble resisting temptation, self-harming behavior, bullying others, and panic attacks.[xii,xiii] Mental Health Center Kids notes other symptoms can include academic underachievement, social withdrawal, changes in appetite and weight, and substance use.[xiv]

The causes of behavior disorders are unclear, but it is known that biological and environmental factors such as genetics, neurobiological differences, personality, and family all contribute to the development of such disorders in children.[xv] For example, regarding the influence of family, a review focusing on parent-child relational health emphasized that a child's development is "embedded within a complex system of relationships."[xvi] The most influential relationship is between parent and child; when that relationship is compromised with inconsistency and negative parenting styles, behavior issues are likely to develop.[xvii] Studies suggest that recognizing this

complexity can help providers better understand children's behavioral issues and improve screening and intervention efforts.[xviii]

The process of diagnosing childhood behavioral issues includes psychological tests and observations about present and past behavior patterns by a psychiatrist.[xix] There are three main categories of testing: intellectual assessments, personality tests, and clinical assessments. Intellectual assessments measure cognitive ability and IQ; personality tests analyze emotional, social, and behavioral patterns; and clinical assessments focus on dysfunctional behavior and the severity of physiological issues, such as congenital defect or traumatic brain injury.[xx]

If behavioral health issues are left untreated, it can lead to potential long-term problems that extend into adulthood, such as violent and suicidal behaviors, substance abuse, and depression, as well as other health challenges like cancer, diabetes, and heart disease.[xxi] Furthermore, there is a possibility that similar challenges can be passed to the next generation if children's behavioral health issues are not managed and treated.[xxii]

SOCIAL IMPACT

Children who have behavioral health issues often face difficulties in other areas of their lives, such as in school and in their relationships with peers and family. Specifically, students with behavioral issues tend to struggle academically.[xxiii] One study examining children with behavioral problems found deficits in math, reading, and writing, particularly among children who exhibited externalizing behaviors.[xxiv] A meta-analysis also revealed that children with internalizing behavior issues, also have a higher risk of academic failure.[xxv]

Studies have also associated behavioral issues with low social competence. For example, children displaying externalizing behaviors, such as being disruptive, often struggle with emotion regulation, adaptive problem-solving skills, internalization of rules, and developing empathy.[xxvi] In a meta-analysis, researchers found that, on average, as behavioral problems increase, social competence tends to decrease.[xxvii] Social competence is essential for both present and future success in society.[xxviii] Therefore, experts recommend that more attention to improving children's social competence skills be incorporated into existing intervention programs.[xxix]

Parents of children with behavioral problems often experience high levels of anxiety and frustration.[xxx] Multiple studies report that parents of children with behavioral issues report elevated stress levels, with the number of behavioral issues directly influencing the amount of stress reported.[xxxi,xxxii] Parental stress can lead to more strain on the parent-child relationship, reducing effective parenting, and creating "a self-perpetuating cycle of parental stress and child's behavioral difficulties".[xxxiii]

Studies recommend that parents or guardians seek professional help as soon as behavioral issues are identified, noting that early intervention can help address problematic behaviors, which can lead to improved academic success, better social relationships, and healthier family dynamics.[xxxiv,xxxv]

Expanding coverage to a range of health care services and interventions for children without a behavioral health diagnosis will likely require additional provider resources to meet the potential increase in demand for services resulting from expanded coverage. This could exacerbate current access challenges caused by existing shortages in the behavioral health care provider workforce.[xxxvi] The New Jersey Department of Children and Families suggested, in connection with a 2022 Social and Behavioral Health Access Workforce Analysis, that "New Jersey, like the rest of the nation, is facing challenges related to a workforce shortage in its critical social services and behavioral health sectors. State-contracted service providers are struggling to retain or recruit new staff to fill vacancies. Workers are moving from job to job within the field, or in some cases, are leaving the social services or behavioral health fields altogether." [xxxvii]

OTHER STATES

No other states have enacted or introduced legislation similar to S4018, which expands commercial insurance coverage for screening, prevention, and treatment services for behavioral health issues affecting children with an at-risk diagnosis.

To date, state action on such coverage in the rest of the country has focused on Medicaid programs, with Oregon, Colorado, New York, California, and Massachusetts adopting policies to expand coverage for early identification and treatment of mental health needs in children. Guidelines from the Medicaid programs of Minnesota and Wisconsin are typical of state instructions for billing for behavioral health services that require a mental health diagnosis. In contrast, the billing guidelines for Oregon, New York, California, and Massachusetts include the use of additional codes that facilitate Medicaid coverage for behavioral health services with an at-risk diagnosis. Across states that facilitate access to this coverage through Medicaid, the stated purpose of extending coverage for behavioral health issues with an at-risk diagnosis is generally identified as permitting children access to care earlier in the treatment process, to improve behavioral health outcomes.

Minnesota's Medicaid billing guidelines state that, "To be eligible for mental health clinical care consultation, MHCP (Minnesota Health Care Programs) recipients must…[h]ave a diagnosis of mental illness determined by a diagnostic assessment."[xxxviii] Similarly, Wisconsin's Medicaid billing guidelines state, "A mental health clinical consultation is a communication from a mental health provider to coordinate services for a …Medicaid beneficiary…with an established mental health diagnosis."[xxxix]

The billing guidelines of Oregon's Medicaid program state, "Health care providers often see children who do not meet the full criteria for a mental health diagnosis, but who are experiencing conditions and family circumstances that place them at high risk for the development of significant mental health disorders."[xl] Since January 1, 2016, in such cases, health care providers in Oregon have billed Medicaid for children's behavioral health services using a series of codes that indicate the presence of factors that put the child "at risk" of a mental health disorder. Oregon's Medicaid program emphasizes, "The use of all these codes helps the state of Oregon address children's mental health needs early in an effort to reduce the development of serious mental health conditions."[xli]

In 2023, Colorado enacted SB23-174, which requires that the state's Medicaid managed care system and School Health Services Program provide access to limited behavioral health care services to beneficiaries under 21 years of age without requiring a mental health diagnosis.[xlii] The law specified that the limited services must include family therapy, group therapy, individual therapy, services related to prevention, promotion, education, or outreach, and evaluation, intake, case management, and treatment planning.[xliii]

New York's Medicaid guidelines for establishing medical necessity within its Community Psychiatric Supports and Treatment program also includes the "at risk" designation. New York's Medicaid program reimburses health care providers for behavioral health services with billing codes that indicate "the child/youth is at risk of development of a behavioral health diagnosis…."[xliv] In another New York Medicaid program, the Other Licensed Practitioner (OLP) program, behavioral health services are reimbursed without requiring a DSM (Diagnostic and Statistical Manual of Mental Disorders) diagnosis. As the billing guidelines for OLP state, "The clinical services provided under OLP…are intended to help prevent the progression of behavioral health needs through early identification and intervention…to children/youth…for whom behavioral health conditions have not yet been diagnosed…."[xlv]

Under its Medi-Cal Managed Care Plans and fee-for-service system, California covers some mental health services, including evaluations and individual, group and family psychotherapy to covered members with potential mental health disorders that have not yet been diagnosed. For children and youth, more specialized mental health services, including "targeted case management, crisis services, residential services, and a variety of specialty outpatient mental health services" are available to beneficiaries with a condition placing them "at high risk for a mental health disorder" due to experience of trauma.[xlvi] In addition, Medi-Cal managed care plans are required to provide medically necessary specialty mental health services for children and youth with needs beyond the services normally included in covered mental health benefits, even if "a suspected mental health disorder…has not yet been diagnosed."[xlvii]

In response to the COVID-19 pandemic and the perception that there were increased challenges to the behavioral health needs of children and adolescents, Massachusetts' Medicaid program (MassHealth) issued new guidelines to improve access to care for children and adolescents. The

program asserted, "[M]any of MassHealth's youngest members may be at risk of developing clinical behavioral health disorders and worsening health. Earlier identification and intervention are key to providing children [and] adolescents…with needed behavioral health supports to preserve and promote their well-being."[xlviii] The guidelines continued, "For many youth, short-term interventions in…group, individual, or family settings cultivate coping skills and strategies for symptoms of depression, anxiety, and other social/emotional concerns, which may prevent the development of behavioral health conditions."[xlix]

MassHealth's current guidelines, issued September 1, 2021, expanded eligibility for preventive behavioral health services in Medicaid managed care plans to members under age 21, even if those members do not "meet criteria for behavioral health diagnosis" or the criteria for medical necessity for behavioral health treatment.[l] Furthermore, the guidelines state that Medicaid managed care plans are not permitted to require a diagnostic assessment before members can access preventive behavioral services. MassHealth guidelines also identify the billing codes providers should use in circumstances where preventive behavioral health services were accessed in the absence of a behavioral health diagnosis.[li]

In summary, although some other states have expressly extended coverage for screening, prevention, and treatment services for behavioral health issues affecting children with an at-risk diagnosis, that coverage expansion is limited to the Medicaid programs in those states, and does not apply to commercial insurance carriers. Aside from that difference, S4018 would, similar to the Oregon, Colorado, New York, California, and Massachusetts Medicaid programs, require coverage for behavioral health care without a specific mental health diagnosis. This contrasts with the requirements of the Minnesota and Wisconsin programs, both of which condition coverage on a mental health diagnosis. This difference underscores the stated purpose of the Oregon, New York, and Massachusetts Medicaid programs, which is to ensure that children exhibiting signs and symptoms of behavioral health issues are afforded access to care and treatment before their behavioral health issues develop into more severe or complex conditions or begin to have more significant, adverse effects on the child's personal, academic, social, and medical well-being.

DISCUSSION/ FINANCIAL IMPACT

The definition of "at-risk diagnosis" in S4018 does not provide much guidance with regard to how the bill or the coverage requirement would apply, making it difficult to estimate the scope, cost, and potential effects of the coverage mandate that would be established under the bill. The fact that no other state has established a commercial coverage mandate for reimbursement of behavioral health care based on a diagnosis or determination that the patient is "at risk" also means there are no other studies, fiscal notes, or fiscal impact statements to support a fuller discussion of the potential financial impact of S4018. As described above, coverage already exists for mental health conditions under P.L.2019, c.58 and for certain adolescent screenings under P.L.2021, c.73.

For Colorado's enacted law regarding Medicaid behavioral health services, SB 23-174, a fiscal note reported, "Because the bill will not increase eligibility nor expand available services…no service cost increase is anticipated. The HCPF [Department of Health Care Policy and Financing] provides this level of mental health services to its membership under the behavioral health capitation program."[lii] The fiscal note explained that each Medicaid participant is assigned to a regional managed care organization "responsible for providing or arranging medically necessary behavioral health services."[liii] HCPF pays the regional managed care organizations a monthly capitation payment for each eligible Medicaid member, and the behavioral health services offered without requiring a mental health diagnosis would be included in this monthly capitation payment. As a result, no annual appropriation was anticipated pursuant to enacting this legislation.[liv]

As described above, studies have concluded that early access to children's behavioral health services leads to better outcomes, as measured in better social competence skills, improved academic success, better social relationships, and healthier family dynamics. These studies further conclude that reimbursing providers for care provided with an at-risk diagnosis, rather than waiting for a formal mental health diagnosis, can be more cost effective.

The Centers for Medicare & Medicaid Services (CMS) warns that the failure to provide effective behavioral health treatment for children and youth "could have costly and lifelong effects…."[lv] CMS asserts that young people who do not receive such care "face a range of problems in adulthood, including increased risk of criminal justice involvement and instability in employment and relationships."[lvi] CMS further posits that those costly and lifelong effects of "[u]ntreated behavioral health conditions in children can also have an adverse effect on health in adulthood…. including heart disease, cancer, diabetes, asthma, and kidney disease, as well as mental illness, suicide and substance abuse."[lvii]

The key to reducing the social and financial impact of these adverse outcomes, according to CMS, is early identification of behavioral health conditions in children and youth, which "may reduce or eliminate the effects of the condition if detected and treated early."[lviii] To this end, CMS encourages state Medicaid programs stop requiring a behavioral health diagnosis before beneficiaries can access care, so that children and youth can receive medically necessary behavioral health services as early as possible.[lix] As discussed above, in some states, such as California, New York, and Oregon, providers can bill Medicaid for behavioral health care screening, prevention, and treatment at an earlier stage, before a clear mental health diagnosis has been established.

An additional consideration is that the federal Patient Protection and Affordable Care Act requires states to defray the cost of any health insurance benefit mandate enacted after December 31, 2011, that is part of an insurance plan sold on a state exchange that is in addition to the state's essential health benefits (EHBs) and related to specific care, treatment, or services. ((P.L. 111-148 § 1311(d)(3) & 45 CFR 155.170). The state must then defray the cost of the additional mandates by making the appropriate payment directly to an enrollee or to the insurer on the enrollee's behalf

(45 CFR 155.170). A 2017 federal final rule (§ 19) changed the entity responsible for identifying mandates and receiving excess cost reports from the state's exchange to the state. Defrayment does not apply to the large group market. For more information on State-required benefits, please refer to this CMS FAQ on Defrayal of State Additional Required Benefits.[lx] As part of the HHS Notice of Benefit and Payment Parameters for 2025, for plan years beginning on or after January 1, 2027, CMS is proposing revisions to the standards for state selection of EHB-benchmark plans to address long-standing requests from states to improve, and reduce the burden of, the EHB-benchmark plan update process.[lxi] The process of updating the state's EHB-benchmark plan could create a pathway to adding benefits to the benchmark plan that may not trigger defrayal provided certain parameters are met. Thus, although this is a state-by-state analysis and no such analysis has been performed for New Jersey, a coverage mandate for behavioral health care for at-risk children may trigger the federal defrayment requirements.

CONCLUSION

Behavioral health issues occurring in children can take a number of forms and are associated with a variety of biological and environmental factors. Behavioral health issues in children can adversely affect the child's academic performance and social life, and can further result in increased stress, anxiety, and frustration for the child's parents.

Studies have concluded that early intervention for childhood behavioral health issues, particularly during the period when the signs and symptoms of a behavioral health condition begin to manifest but those signs and symptoms do not support a formal mental health diagnosis, can help address problematic behaviors before they develop into more serious, and potentially more intractable, conditions. Studies have found that early intervention can lead to improved academic success, improved social relationships, and healthier family dynamics.

Although no other state has established a coverage mandate for behavioral health treatment for at risk children in the commercial insurance market, as S4018 would do, five states have established similar coverage requirements through their Medicaid programs. In the states that require Medicaid coverage for behavioral health issues without requiring a mental health diagnosis, the stated intent of those mandates is to ensure access to early intervention and treatment in order to maximize the potential benefit and efficacy of those interventions and treatments. To the extent that the expanded coverage mandate may increase demand for behavioral health services for children, there will likely need to be some level of increased capacity among behavioral health care providers, which could present access challenges given existing shortages in the behavioral health workforce. The Commission was unable to identify any studies into the cost of such coverage mandates or the estimated financial effects of requiring coverage for behavioral health care for at-risk children, and notes that any studies into the financial effects of Medicaid-based mandates may be of limited utility in reviewing a mandate applicable to the commercial market.

ENDNOTES

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SENATE, No. 4018

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED JANUARY 14, 2025

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator NICHOLAS P. SCUTARI
District 22 (Somerset and Union)

Co-Sponsored by:
Senator Diegnan

SYNOPSIS

Requires health insurance and Medicaid coverage for screening, prevention, and treatment services of behavioral health issues affecting children.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 1/30/2025)

AN ACT concerning insurance and Medicaid coverage for preventive care for developmental and behavioral needs in children and supplementing various parts of the statutory law.

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

1. a. A carrier that offers a health benefits plan in this State shall provide benefits to any subscriber for medical expenses incurred in screening, prevention, and treatment services of behavioral health issues in children. A carrier shall accept and reimburse claims for screening, prevention, and treatment using an at-risk diagnosis.

b. The benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract.

c. As used in this section:

"At-risk diagnosis" means a diagnosis made after consideration of factors influencing behavioral health and child development, such as family circumstances or life challenges, that does not lead to a formal mental health diagnosis and instead, promotes preventive care. Allowing providers to bill for an "at-risk diagnosis" authorizes providers to use an alternative code, including a Social Determinants of Health Z-code, to the codes of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, when billing for services, without a formal mental health diagnosis, for children who are 18 years of age or younger.

"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.

"Screening, prevention, and treatment" includes the prevention and early identification of mental health conditions, without a behavioral health diagnosis. Services may include, but are not limited to, screenings and individual, group, and family psychotherapy to individuals with potential mental health disorders not yet diagnosed.

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 and medical expense benefits shall provide benefits to any covered person for medical expenses incurred in the screening, prevention, and treatment services of behavioral health issues in children. The contract shall allow for acceptance and reimbursement of claims for screening, prevention, and treatment using an at-risk diagnosis.

b. The benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract.

c. As used in this section:

"At-risk diagnosis" means a diagnosis made after consideration of factors influencing behavioral health and child development, such as family circumstances or life challenges, that does not lead to a formal mental health diagnosis and instead, promotes preventive care. Allowing providers to bill for an "at-risk diagnosis" authorizes providers to use an alternative code, including a Social Determinants of Health Z-code, to the codes of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, when billing for services, without a formal mental health diagnosis, for children who are 18 years of age or younger.

"Screening, prevention, and treatment" includes the prevention and early identification of mental health conditions, without a behavioral health diagnosis. Services may include, but are not limited to, screenings and individual, group, and family psychotherapy to individuals with potential mental health disorders not yet diagnosed.

3. a. The School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital and medical expense benefits shall provide benefits to any covered person for medical expenses incurred in the screening, prevention, and treatment services of behavioral health issues in children. The contract shall allow for acceptance and reimbursement of claims for screening, prevention, and treatment using an at-risk diagnosis.

b. The benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract.

c. As used in this section:

"At-risk diagnosis" means a diagnosis made after consideration of factors influencing behavioral health and child development, such as family circumstances or life challenges, that does not lead to a formal mental health diagnosis and instead, promotes preventive care. Allowing providers to bill for an "at-risk diagnosis" authorizes providers to use an alternative code, including a Social Determinants of Health Z-code, to the codes of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, when billing for services, without a formal mental health diagnosis, for children who are 18 years of age or younger.

"Screening, prevention, and treatment" includes the prevention and early identification of mental health conditions, without a behavioral health diagnosis. Services may include, but are not limited to, screenings and individual, group, and family

psychotherapy to individuals with potential mental health disorders not yet diagnosed.

4. a. Notwithstanding any law, rule, or regulation to the contrary, the Division of Medical Assistance and Health Services within the Department of Human Services, or a managed care organization that contracts with the division to provide medical services to beneficiaries of the NJ FamilyCare program, shall ensure the provision of benefits for medical expenses incurred in screening, prevention, and treatment services of behavioral health issues in children. The division or the managed care organization shall accept and reimburse claims for screening, prevention, and treatment using an at-risk diagnosis.

b. The department may take any administrative action necessary to effectuate the provisions of this section, including modifying or amending any applicable contract or promulgating, amending, or repealing any guidance, guidelines, or rules, which rules or amendments thereto shall be effective immediately upon filing with the Office of Administrative Law for a period not to exceed 12 months, and may, thereafter, be amended, adopted or readopted in accordance with the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

c. The Commissioner of Human Services shall apply for such State plan amendments or waivers as may be necessary to implement the provisions of this section and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program.

d. As used in this section:

"At-risk diagnosis" means a diagnosis made after consideration of factors influencing behavioral health and child development, such as family circumstances or life challenges, that does not lead to a formal mental health diagnosis and instead, promotes preventive care. Allowing providers to bill for an "at-risk diagnosis" authorizes providers to use an alternative code, including a Social Determinants of Health Z-code, to the codes of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, when billing for services, without a formal mental health diagnosis, for children who are 18 years of age or younger.

"Screening, prevention, and treatment" includes the prevention and early identification of mental health conditions, without a behavioral health diagnosis. Services may include, but are not limited to, screenings and individual, group, and family psychotherapy to individuals with potential mental health disorders not yet diagnosed.

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

STATEMENT

This bill 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, and the School Employees' Health Benefits Program) and the State Medicaid program to provide benefits to any covered person for medical expenses incurred relating to screening, prevention, and treatment of behavioral health issues in children. Carriers and the State Medicaid program are required to accept and reimburse claims for screening, prevention, and treatment using an at-risk diagnosis.

As used in the bill, an "at-risk diagnosis" is a diagnosis made after consideration of factors influencing behavioral health and child development, such as family circumstances or life challenges, that does not lead to a formal mental health diagnosis and instead, promotes preventive care. Allowing providers to bill for an "at-risk diagnosis" authorizes providers to use an alternative code, including a Social Determinants of Health Z-code, to the codes of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood when billing for services, without a formal mental health diagnosis for children who are 18 years of age or younger.

Appendix II

Liza Ackerman
Office of Legislative Services
Committee Aides
609-847-3845

NEW JERSEY LEGISLATURE

SENATE COMMERCE COMMITTEE

STATE HOUSE ANNEX · P.O. BOX 068 · TRENTON, NJ 08625-0068
www.njleg.gov

February 21, 2025

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

Dear Members of the Commission:

As the Chair of the Senate Commerce Committee, I respectfully request the Commission to review and prepare a written report of Senate Bill 4018, sponsored by Senators Vitale and Scutari. The bill would require health insurance and Medicaid coverage for screening, prevention, and treatment services of behavioral health issues affecting children.

If you have any questions, please do not hesitate to contact Allison Meyers or David Smith, Senate Commerce Committee Aides, at 609-847-3700. Thank you for your immediate attention to this matter.

Sincerely,

Joseph A. Lagana
Senator, 38th District

CC: Allison Meyers
Policy Analyst
Senate Majority Office

David Smith
Senior Policy Analyst
Senate Majority Office