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SYNOPSIS
Requires health benefits plans and carriers to meet certain requirements concerning network adequacy and mental health care.

CURRENT VERSION OF TEXT
As introduced.

(Sponsorship Updated As Of: 5/26/2022)
AN ACT concerning network adequacy and supplementing
P.L.1997, c.192 (C.26:2S-1 et seq.).

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

1. As used in this act:
“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, and shall include the State Health
Benefits Program, the School Employees’ Health Benefits Program,
the Medicaid program, and a Medicaid managed care organization.
“Covered person” means a person on whose behalf a carrier
offering the plan is obligated to pay benefits or provide services
pursuant to the health benefits plan.
“Health benefits plan” means a benefits plan which pays or
provides hospital and medical expense benefits for covered
services, and is delivered or issued for delivery in this State by or
through a carrier. Health benefits plan includes, but is not limited
to, Medicare supplement coverage and risk contracts to the extent
not otherwise prohibited by federal law. For the purposes of this
act, health benefits plan shall not include the following plans,
policies, or contracts: accident only, credit, disability, long-term
care, TRICARE supplement coverage, coverage arising out of a
workers’ compensation or similar law, automobile medical payment
insurance, personal injury protection insurance issued pursuant to
P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement
indemnity coverage.
“Medicaid” means the Medicaid program established pursuant to
P.L.1968, c.413 (C.30:4D-1 et seq.).
“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.
“Mental health provider” means professionals licensed in this
State to diagnose or treat mental health conditions.
“Network adequacy” means the adequacy of the provider
network with respect to the scope and type of health care benefits
provided by a carrier, the geographic service area covered by the
provider network, and access to hospital based and medical
specialists pursuant to the standards in the regulations promulgated
pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18) and in the
existing contract between a managed care organization and the
Division of Medical Assistance and Health Services in the
Department of Human Services.
“Telehealth” means the same as that term is defined by section 1
"Telemedicine" means the same as that term is defined by section 1 of P.L.2017, c.117 (C.45:1-61).

2. a. The Commissioner of Banking and Insurance or the Commissioner of Human Services, as appropriate, shall, in determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, approve a network for a health benefits plan only if the plan has a sufficient number of mental health providers to ensure that 100 percent of the covered persons have access to:

   (1) an in-network mental health provider that can provide services delivered in person, within 15 miles of the covered person’s residence, within the geographic boundaries of the State, and within 30 days of the initial request by the covered person; or

   (2) if in-person delivery pursuant to paragraph (1) of this subsection is not available, an in-network or out-of-network mental health provider that can provide services delivered through telemedicine or telehealth within 30 days of the initial request by the covered person.

   (a) A carrier that provides coverage for out-of-network mental health care services delivered through telemedicine or telehealth pursuant to paragraph (2) of this subsection shall provide coverage on the same basis as when the services are delivered through in-person contact and consultation in New Jersey and at a provider reimbursement rate of not less than the corresponding Medicaid provider reimbursement rate. Reimbursement payments under this section may be provided either to the individual practitioner who delivered the reimbursable services, or to the agency, facility, or organization that employs the individual practitioner who delivered the reimbursable services, as appropriate.

   (b) A carrier shall not charge any deductible, copayment, or coinsurance for a mental health care service, delivered through telemedicine or telehealth pursuant to paragraph (2) of this subsection, in an amount that exceeds the deductible, copayment, or coinsurance amount that is applicable to an in-person, in-network consultation.

   b. An entity providing or administering a self-funded health benefits plan which is subject to the "Employee Retirement Income Security Act of 1974" (29 U.S.C. s.1001 et seq.) may elect to meet the requirements of this act.

3. A carrier that violates any provision of this act shall be liable for the penalties provided pursuant to section 16 of P.L.1997, c.192 (C.26:2S-16).

4. The Commissioner of Banking and Insurance, in conjunction with the Commissioner of Human Services, shall adopt rules and
regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act.

5. This act shall take effect on the first day of the third month next following the date of enactment, except that the Commissioner of Banking and Insurance and the Commissioner of Human Services may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

STATEMENT

This bill requires carriers to take certain action to ensure that health benefits plans meet certain network adequacy requirements and mental health care. Under the bill, “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, and includes the State Health Benefits Program, the School Employees’ Health Benefits Program, the Medicaid program, and a Medicaid managed care organization.

The bill requires the Commissioner of Banking and Insurance or the Commissioner of Human Services, as appropriate, to approve a network for a health benefits plan only if the plan meets certain requirements concerning access to mental health providers. Under the bill a plan is required to have a sufficient number of mental health providers to ensure that 100 percent of the covered persons have access to either in-network mental health providers that can provide services delivered in person and within certain geographic and temporal requirements, or access to in-network or out-of-network mental health providers that can provide services delivered through telemedicine or telehealth.

A plan that provides access to in-network or out-of-network mental health providers that can provide services delivered through telemedicine or telehealth is required to provide coverage for out-of-network mental health care services delivered through telemedicine or telehealth on the same basis as when the services are delivered through in-person contact and consultation in New Jersey and at a provider reimbursement rate of not less than the corresponding Medicaid provider reimbursement rate. Reimbursement payments are to be provided either to the individual practitioner who delivered the reimbursable services, or to the agency, facility, or organization that employs the individual practitioner who delivered the reimbursable services, as appropriate.

In addition, a carrier is not to charge any deductible, copayment, or
coinsurance for a mental health care service, delivered through telemedicine or telehealth, in an amount that exceeds the deductible, copayment, or coinsurance amount that is applicable to an in-person, in-network consultation.