Sponsorship Updated As Of: 3/15/2016

SENATE, No. 814

STATE OF NEW JERSEY
217th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2016 SESSION

Sponsored by:
Senator LORETTA WEINBERG
District 37 (Bergen)
Senator THOMAS H. KEAN, JR.
District 21 (Morris, Somerset and Union)

SYNOPSIS
Requires health insurers to limit patient cost-sharing and provide appeal process concerning certain prescription drug coverage.

CURRENT VERSION OF TEXT
As reported by the Senate Commerce Committee with technical review.

(Sponsorship Updated As Of: 3/15/2016)
AN ACT concerning health benefits coverage for prescription drugs
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. Notwithstanding any other provision of law to the
contrary, every hospital service corporation contract that provides
benefits for expenses incurred in the purchase of prescription drugs
and is delivered, issued, executed, or renewed in this State pursuant
to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or
renewal in this State by the Commissioner of Banking and
Insurance, on or after the effective date of this act, shall conform
with the following:

   (1) (a) except as provided for in subparagraphs (b) and (c) of
this paragraph, limit a covered person’s out-of-pocket financial
responsibility, including any copayment or coinsurance, for
prescription drugs, including specialty drugs, to no more than $100
per month for each prescription drug for up to a 30-day supply of
any single drug;

   (b) a hospital service corporation contract that is required to
provide a bronze level of coverage, as defined in 45 C.F.R.
s.156.140, shall ensure that any required enrollee cost-sharing,
including any copayment or coinsurance, does not exceed $200 per
month for each prescription drug for up to a 30-day supply of any
single drug; and

   (c) a hospital service corporation contract that meets the
requirements of a catastrophic plan, as defined in 45 C.F.R.
s.156.155, shall be exempt from the requirements of subparagraphs
(a) and (b) of this paragraph;

   (2) except as provided in paragraph (3) of this subsection, the
limits described in paragraph (1) of this subsection shall apply at
any point in the benefit design, including before and after any
applicable deductible is reached;

   (3) for prescription drug benefits offered in conjunction with a
high-deductible health plan, not provide prescription drug benefits
until the expenditures applicable to the deductible under the plan
have met the amount of the minimum annual deductibles in effect
for self-only and family coverage under section 223(c)(2)(A)(i) of
the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(ii)) for
self-only and family coverage, respectively. Once the foregoing
expenditure amount has been met under the plan, coverage for
prescription drug benefits shall begin, and the limit on out-of-
pocket expenditures for prescription drug benefits shall be as
specified in paragraph (1) of this subsection; and

   (4) implement an exceptions process that allows enrollees to
request an exception to any formulary, which exception shall permit
a nonformulary drug to be deemed covered under the formulary if
the prescribing physician determines that the formulary drug for
treatment of the same condition either would not be as effective for
the enrollee or would have adverse effects for the enrollee, or both.
If an enrollee is denied such an exception, that denial shall be
deaemed an adverse determination that will be subject to appeal
under the carrier’s internal appeal process and section 11 of

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

2. a. Notwithstanding any other provision of law to the
contrary, every medical service corporation contract that provides
benefits for expenses incurred in the purchase of prescription drugs
and is delivered, issued, executed, or renewed in this State pursuant
to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or
renewal in this State by the Commissioner of Banking and
Insurance, on or after the effective date of this act, shall conform
with the following:

1) (a) except as provided for in subparagraphs (b) and (c) of
this paragraph, limit a covered person’s out-of-pocket financial
responsibility, including any copayment or coinsurance, for
prescription drugs, including specialty drugs, to no more than $100
per month for each prescription drug for up to a 30-day supply of
any single drug;

(b) a medical service corporation contract that is required to
provide a bronze level of coverage, as defined in 45 C.F.R.
s.156.140, shall ensure that any required enrollee cost-sharing,
including any copayment or coinsurance, does not exceed $200 per
month for each prescription drug for up to a 30-day supply of
any single drug; and

(c) a medical service corporation contract that meets the
requirements of a catastrophic plan, as defined in 45 C.F.R.
s.156.155, shall be exempt from the requirements of subparagraphs
(a) and (b) of this paragraph;

2) except as provided in paragraph (3) of this subsection, the
limits described in paragraph (1) of this subsection shall apply at
any point in the benefit design, including before and after any
applicable deductible is reached;

3) for prescription drug benefits offered in conjunction with a
high-deductible health plan, not provide prescription drug benefits
until the expenditures applicable to the deductible under the plan
have met the amount of the minimum annual deductibles in effect
for self-only and family coverage under section 223(c)(2)(A)(i) of
the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(ii)) for
self-only and family coverage, respectively. Once the foregoing
expenditure amount has been met under the plan, coverage for
prescription drug benefits shall begin, and the limit on out-of-
pocket expenditures for prescription drug benefits shall be as specified in paragraph (1) of this subsection; and

(4) implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the enrollee or would have adverse effects for the enrollee, or both. If an enrollee is denied such an exception, that denial shall be deemed an adverse determination that will be subject to appeal under the carrier’s internal appeal process and section 11 of P.L.1997, c.192 (C.26:2S-11).

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

3. a. Notwithstanding any other provision of law to the contrary, every health service corporation contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall conform with the following:

(1) (a) except as provided for in subparagraphs (b) and (c) of this paragraph, limit a covered person’s out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $100 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a health service corporation contract that is required to provide a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required enrollee cost-sharing, including any copayment or coinsurance, does not exceed $200 per month for each prescription drug for up to a 30-day supply of any single drug; and

(c) a health service corporation contract that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, shall be exempt from the requirements of subparagraphs (a) and (b) of this paragraph;

(2) except as provided in paragraph (3) of this subsection, the limits described in paragraph (1) of this subsection shall apply at any point in the benefit design, including before and after any applicable deductible is reached;

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect
for self-only and family coverage under section 223(c)(2)(A)(i) of
the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
self-only and family coverage, respectively. Once the foregoing
expenditure amount has been met under the plan, coverage for
prescription drug benefits shall begin, and the limit on out-of-
pocket expenditures for prescription drug benefits shall be as
specified in paragraph (1) of this subsection; and
(4) implement an exceptions process that allows enrollees to
request an exception to any formulary, which exception shall permit
a nonformulary drug to be deemed covered under the formulary if
the prescribing physician determines that the formulary drug for
treatment of the same condition either would not be as effective for
the enrollee or would have adverse effects for the enrollee, or both.
If an enrollee is denied such an exception, that denial shall be
deemed an adverse determination that will be subject to appeal
under the carrier’s internal appeal process and section 11 of
4. a. Notwithstanding any other provision of law to the
contrary, every individual health insurance policy that provides
benefits for expenses incurred in the purchase of prescription drugs
and is delivered, issued, executed, or renewed in this State pursuant
to chapter 26 of Title 17B of the New Jersey Statutes, or approved
for issuance or renewal in this State by the Commissioner of
Banking and Insurance, on or after the effective date of this act,
shall conform with the following:
(1) (a) except as provided for in subparagraphs (b) and (c) of
this paragraph, limit a covered person’s out-of-pocket financial
responsibility, including any copayment or coinsurance, for
prescription drugs, including specialty drugs, to no more than $100
per month for each prescription drug for up to a 30-day supply of
any single drug;
(b) an individual health insurance policy that is required to
provide a bronze level of coverage, as defined in 45 C.F.R.
s.156.140, shall ensure that any required enrollee cost-sharing,
including any copayment or coinsurance, does not exceed $200 per
month for each prescription drug for up to a 30-day supply of any
single drug; and
(c) an individual health insurance policy that meets the
requirements of a catastrophic plan, as defined in 45 C.F.R.
s.156.155, shall be exempt from the requirements of subparagraphs
(a) and (b) of this paragraph;
(2) except as provided in paragraph (3) of this subsection, the
limits described in paragraph (1) of this subsection shall apply at
any point in the benefit design, including before and after any
applicable deductible is reached;

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(ii)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in paragraph (1) of this subsection; and

(4) implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the enrollee or would have adverse effects for the enrollee, or both. If an enrollee is denied such an exception, that denial shall be deemed an adverse determination that will be subject to appeal under the carrier’s internal appeal process and section 11 of P.L.1997, c.192 (C.26:2S-11).

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

5. a. Notwithstanding any other provision of law to the contrary, every group health insurance policy that provides benefits for expenses incurred in the purchase of prescription drugs 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 conform with the following:

(1) (a) except as provided for in subparagraphs (b) and (c) of this paragraph, limit a covered person’s out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $100 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a group health insurance policy that is required to provide a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required enrollee cost-sharing, including any copayment or coinsurance, does not exceed $200 per month for each prescription drug for up to a 30-day supply of any single drug; and

(c) a group health insurance policy that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, shall be exempt from the requirements of subparagraphs (a) and (b) of this
paragraph;

(2) except as provided in paragraph (3) of this subsection, the limits described in paragraph (1) of this subsection shall apply at any point in the benefit design, including before and after any applicable deductible is reached;

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in paragraph (1) of this subsection; and

(4) implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the enrollee or would have adverse effects for the enrollee, or both. If an enrollee is denied such an exception, that denial shall be deemed an adverse determination that will be subject to appeal under the carrier’s internal appeal process and section 11 of P.L.1997, c.192 (C.26:2S-11).

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

6. a. Notwithstanding any other provision of law to the contrary, an individual health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, renewed, or approved for issuance or renewal in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall conform with the following:

(1) (a) except as provided for in subparagraphs (b) and (c) of this paragraph, limit a covered person’s out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $100 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) an individual health benefits plan that is required to provide a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required enrollee cost-sharing, including any copayment or coinsurance, does not exceed $200 per month for each prescription drug for up to a 30-day supply of any single drug;
and

(c) an individual health benefits plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, shall be exempt from the requirements of subparagraphs (a) and (b) of this paragraph;

(2) except as provided in paragraph (3) of this subsection, the limits described in paragraph (1) of this subsection shall apply at any point in the benefit design, including before and after any applicable deductible is reached;

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in paragraph (1) of this subsection; and

(4) implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the enrollee or would have adverse effects for the enrollee, or both. If an enrollee is denied such an exception, that denial shall be deemed an adverse determination that will be subject to appeal under the carrier’s internal appeal process and section 11 of P.L.1997, c.192 (C.26:2S-11).

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

7. a. Notwithstanding any other provision of law to the contrary, a small employer health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, renewed, or approved for issuance or renewal 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 by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall conform with the following:

(1) (a) except as provided for in subparagraphs (b) and (c) of this paragraph, limit a covered person’s out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $100 per month for each prescription drug for up to a 30-day supply of any single drug;
(b) a small employer health benefits plan that is required to
provide a bronze level of coverage, as defined in 45 C.F.R.
s.156.140, shall ensure that any required enrollee cost-sharing,
including any copayment or coinsurance, does not exceed $200 per
month for each prescription drug for up to a 30-day supply of any
single drug; and
(c) a small employer health benefits plan that meets the
requirements of a catastrophic plan, as defined in 45 C.F.R.
s.156.155, shall be exempt from the requirements of subparagraphs
(a) and (b) of this paragraph;
(2) except as provided in paragraph (3) of this subsection, the
limits described in paragraph (1) of this subsection shall apply at
any point in the benefit design, including before and after any
applicable deductible is reached;
(3) for prescription drug benefits offered in conjunction with a
high-deductible health plan, not provide prescription drug benefits
until the expenditures applicable to the deductible under the plan
have met the amount of the minimum annual deductibles in effect
for self-only and family coverage under section 223(c)(2)(A)(i) of
the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(ii)) for
self-only and family coverage, respectively. Once the foregoing
expenditure amount has been met under the plan, coverage for
prescription drug benefits shall begin, and the limit on out-of-
pocket expenditures for prescription drug benefits shall be as
specified in paragraph (1) of this subsection; and
(4) implement an exceptions process that allows enrollees to
request an exception to any formulary, which exception shall permit
a nonformulary drug to be deemed covered under the formulary if
the prescribing physician determines that the formulary drug for
treatment of the same condition either would not be as effective for
the enrollee or would have adverse effects for the enrollee, or both.
If an enrollee is denied such an exception, that denial shall be
deemed an adverse determination that will be subject to appeal
under the carrier’s internal appeal process and section 11 of

b. The provisions of this section shall apply to those health
benefits plan in which the carrier has reserved the right to change
the premium.

8. a. Notwithstanding any other provision of law to the
contrary, a health maintenance organization enrollee agreement that
provides coverage for the purchase of prescription drugs and is
delivered, issued, executed, or renewed in this State pursuant to
P.L.1973, c.337 (C.26:2J-1 et seq.), or approved for issuance or
renewal in this State by the Commissioner of Banking and
Insurance, on or after the effective date of this act, shall conform
with the following:
(1) (a) except as provided for in subparagraphs (b) and (c) of
this paragraph, limit a covered person’s out-of-pocket financial
responsibility, including any copayment or coinsurance, for
prescription drugs, including specialty drugs, to no more than $100
per month for each prescription drug for up to a 30-day supply of
any single drug;
(b) a health maintenance organization enrollee agreement that is
required to provide a bronze level of coverage, as defined in 45
C.F.R. s.156.140, shall ensure that any required enrollee cost-
sharing, including any copayment or coinsurance, does not exceed
$200 per month for each prescription drug for up to a 30-day supply
of any single drug; and
(c) a health maintenance organization enrollee agreement that
meets the requirements of a catastrophic plan, as defined in 45
C.F.R. s.156.155, shall be exempt from the requirements of
subparagraphs (a) and (b) of this paragraph;
(2) except as provided in paragraph (3) of this subsection, the
limits described in paragraph (1) of this subsection shall apply at
any point in the benefit design, including before and after any
applicable deductible is reached;
(3) for prescription drug benefits offered in conjunction with a
high-deductible health plan, not provide prescription drug benefits
until the expenditures applicable to the deductible under the plan
have met the amount of the minimum annual deductibles in effect
for self-only and family coverage under section 223(c)(2)(A)(i) of
the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
self-only and family coverage, respectively. Once the foregoing
expenditure amount has been met under the plan, coverage for
prescription drug benefits shall begin, and the limit on out-of-
pocket expenditures for prescription drug benefits shall be as
specified in paragraph (1) of this subsection; and
(4) implement an exceptions process that allows enrollees to
request an exception to any formulary, which exception shall permit
a nonformulary drug to be deemed covered under the formulary if
the prescribing physician determines that the formulary drug for
treatment of the same condition either would not be as effective for
the enrollee or would have adverse effects for the enrollee, or both.
If an enrollee is denied such an exception, that denial shall be
deemed an adverse determination that will be subject to appeal
under the carrier’s internal appeal process and section 11 of
b. The provisions of this section shall apply to all agreements
in which the health maintenance organization has reserved the right
to change the premium.

9. Notwithstanding any other provision of law to the contrary,
the State Health Benefits Commission shall ensure that every
contract that provides benefits for expenses incurred in the purchase
of prescription drugs, which is purchased by the commission on or
after the effective date of this act, shall conform with the following:

a. limit a covered person’s out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $100 per month for each prescription drug for up to a 30-day supply of any single drug;

b. except as provided in subsection c. of this section, the limits described in subsection a. of this section shall apply at any point in the benefit design, including before and after any applicable deductible is reached;

c. for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in subsection a. of this section; and

d. implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the enrollee or would have adverse effects for the enrollee, or both.

If an enrollee is denied such an exception, that denial shall be deemed an adverse determination that will be subject to appeal under the applicable appeal process established by the commission.

10. Notwithstanding any other provision of law to the contrary, the School Employees’ Health Benefits Commission shall ensure that every contract that provides benefits for expenses incurred in the purchase of prescription drugs, which is purchased on or after the effective date of this act, shall conform with the following:

a. limit a covered person’s out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $100 per month for each prescription drug for up to a 30-day supply of any single drug;

b. except as provided in subsection c. of this section, the limits described in subsection a. of this section shall apply at any point in the benefit design, including before and after any applicable deductible is reached;

c. for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits
until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in subsection a. of this section; and

d. implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the enrollee or would have adverse effects for the enrollee, or both. If an enrollee is denied such an exception, that denial shall be deemed an adverse determination that will be subject to appeal under the applicable appeal process established by the commission.

11. This act shall take effect on the 90th day after enactment and shall apply to policies or contracts issued or renewed on or after the effective date.