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ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, No. 2431

STATE OF NEW JERSEY

218th LEGISLATURE

ADOPTED MARCH 18, 2019

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SYNOPSIS

Requires health insurers to provide plans that limit patient cost-sharing concerning certain prescription drug coverage.

CURRENT VERSION OF TEXT

As amended on January 13, 2020 by the General Assembly pursuant to the Governor's recommendations.

(Sponsorship Updated As Of: 12/17/2019)

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, a hospital service corporation that offers a contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, shall ensure that at least 25 percent of all plans, or at least one plan if the corporation offers less than four plans, offered by the corporation in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17), shall conform with the following:

(1) (a) a contract that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a contract that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the contract shall 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

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Assembly amendments adopted in accordance with Governor's recommendations January 13, 2020.

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.

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, a medical service corporation that offers a contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, shall ensure that at least 25 percent of all plans, or at least one plan if the corporation offers less than four plans, offered by the corporation in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17), shall conform with the following:

(1) (a) a contract that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a contract that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the contract shall 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.

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, a health service corporation that offers a contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, shall ensure that at least 25 percent of all plans, or at least one plan if the corporation offers less than four plans, offered by the corporation in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17), shall conform with the following:

(1) (a) a contract that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a contract that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the contract shall 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.

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

4. a. Notwithstanding any other provision of law to the

contrary, an insurer that offers an 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, shall ensure that at least 25 percent of all plans, or at least one plan if the carrier offers less than four plans, offered by the carrier in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall conform with the following:

(1) (a) a policy that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a policy that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the policy shall 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.

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, an insurer that offers a 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, shall ensure that the insurer offers at least two plans in the large group market pursuant to N.J.S.17B:27-26 et seq.

b. The provisions of the 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, a carrier that offers an individual health benefits plan 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.1992, c.161 (C.17B:27A-2 et seq.), shall ensure that: at least 25 percent of all plans, or at least one plan if the carrier offers less than four plans, offered by the carrier in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall conform with the following:

(1) (a) a health benefits plan that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a health benefits plan that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall 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.

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 carrier that offers a small employer health benefits plan 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.1992, c.162 (C.17B:27A-17 et seq.), shall ensure that at least 25 percent of all plans, or at least one plan if the carrier offers less than four plans, offered by the carrier in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), shall conform with the following:

(1) (a) a health benefits plan that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a health benefits plan that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall 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.

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.

8. a. Notwithstanding any other provision of law to the contrary, a health maintenance organization that offers a contract

that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, shall ensure that at least 25 percent of all plans, or at least one plan if the organization offers less than four plans, offered by the organization in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17), shall conform with the following:

(1) (a) an agreement that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) an agreement that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

(c) an 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall 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.

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.

[1]**[**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 shall conform with the following:

a. the contract shall 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 $200 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; and

c. for prescription drug benefits offered in conjunction with a high-deductible health plan, the contract shall 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.**]**[1]

[1]**[**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 by the commission shall conform with the following:

a. the contract shall 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 $200 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; and

c. for prescription drug benefits offered in conjunction with a high-deductible health plan, the contract shall 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.**]**[1]

[1]**[**11.**]** 9.[1] This act shall take effect as follows:

a. for large employer plans affected by section 5 of the act, the act shall take effect immediately and shall apply to plans issued or renewed on or after January 1 of the calendar year that begins 180 days after the date of enactment; [1]and[1]

b. for individual and small employer plans affected by sections 1 through 4 and sections 6 through 8 of the act, the act shall take effect immediately and apply to new plans or renewals issued on or after January 1 of the calendar year that begins 270 days after the date of enactment[1][; and] .[1]

[1][c. for contracts purchased by the State Health Benefits Program and the School Employees' Health Benefits Program affected by sections 9 and 10 of this act, the act shall take effect on the 90th day after the date of enactment and shall apply to contracts purchased on or after that date.][1]