

[First Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR
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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)

1 AN ACT concerning health benefits coverage for prescription drugs
2 and supplementing various parts of the statutory law.

3
4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6
7 1. a. Notwithstanding any other provision of law to the
8 contrary, a hospital service corporation that offers a contract that
9 provides benefits for expenses incurred in the purchase of
10 prescription drugs and is delivered, issued, executed, or renewed in
11 this State, shall ensure that at least 25 percent of all plans, or at
12 least one plan if the corporation offers less than four plans, offered
13 by the corporation in each rating area and in each of the bronze,
14 silver, gold, and platinum levels of coverage, in the individual
15 market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in
16 the small employer market pursuant to P.L.1992, c.162
17 (C.17B:27A-17), shall conform with the following:

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

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

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

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

36 (3) for prescription drug benefits offered in conjunction with a
37 high-deductible health plan, the contract shall not provide
38 prescription drug benefits until the expenditures applicable to the
39 deductible under the plan have met the amount of the minimum
40 annual deductibles in effect for self-only and family coverage under
41 section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26
42 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage,
43 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:

¹Assembly amendments adopted in accordance with Governor's
recommendations January 13, 2020.

1 under the plan, coverage for prescription drug benefits shall begin,
2 and the limit on out-of-pocket expenditures for prescription drug
3 benefits shall be as specified in paragraph (1) of this subsection.

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

7
8 2. a. Notwithstanding any other provision of law to the
9 contrary, a medical service corporation that offers a contract that
10 provides benefits for expenses incurred in the purchase of
11 prescription drugs and is delivered, issued, executed, or renewed in
12 this State, shall ensure that at least 25 percent of all plans, or at
13 least one plan if the corporation offers less than four plans, offered
14 by the corporation in each rating area and in each of the bronze,
15 silver, gold, and platinum levels of coverage, in the individual
16 market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in
17 the small employer market pursuant to P.L.1992, c.162
18 (C.17B:27A-17), shall conform with the following:

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

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

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

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

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

48 b. The provisions of this section shall apply to all contracts in

1 which the medical service corporation has reserved the right to
2 change the premium.

3
4 3. a. Notwithstanding any other provision of law to the
5 contrary, a health service corporation that offers a contract that
6 provides benefits for expenses incurred in the purchase of
7 prescription drugs and is delivered, issued, executed, or renewed in
8 this State, shall ensure that at least 25 percent of all plans, or at
9 least one plan if the corporation offers less than four plans, offered
10 by the corporation in each rating area and in each of the bronze,
11 silver, gold, and platinum levels of coverage, in the individual
12 market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in
13 the small employer market pursuant to P.L.1992, c.162
14 (C.17B:27A-17), shall conform with the following:

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

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

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

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

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

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

47
48 4. a. Notwithstanding any other provision of law to the

1 contrary, an insurer that offers an individual health insurance policy
2 that provides benefits for expenses incurred in the purchase of
3 prescription drugs and is delivered, issued, executed, or renewed in
4 this State, shall ensure that at least 25 percent of all plans, or at
5 least one plan if the carrier offers less than four plans, offered by
6 the carrier in each rating area and in each of the bronze, silver, gold,
7 and platinum levels of coverage, in the individual market pursuant
8 to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall conform with the
9 following:

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

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

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

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

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

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

41

42 5. a. Notwithstanding any other provision of law to the
43 contrary, an insurer that offers a group health insurance policy that
44 provides benefits for expenses incurred in the purchase of
45 prescription drugs and is delivered, issued, executed, or renewed in
46 this State, shall ensure that the insurer offers at least two plans in
47 the large group market pursuant to N.J.S.17B:27-26 et seq.

48 b. The provisions of the section shall apply to all policies in

1 which the insurer has reserved the right to change the premium.

2

3 6. a. Notwithstanding any other provision of law to the
4 contrary, a carrier that offers an individual health benefits plan
5 that provides benefits for expenses incurred in the purchase of
6 prescription drugs and is delivered, issued, executed, or renewed in
7 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall
8 ensure that: at least 25 percent of all plans, or at least one plan if the
9 carrier offers less than four plans, offered by the carrier in each
10 rating area and in each of the bronze, silver, gold, and platinum
11 levels of coverage, in the individual market pursuant to P.L.1992,
12 c.161 (C.17B:27A-2 et seq.), shall conform with the following:

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

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

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

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

32 (3) for prescription drug benefits offered in conjunction with a
33 high-deductible health plan, the plan shall not provide prescription
34 drug benefits until the expenditures applicable to the deductible
35 under the plan have met the amount of the minimum annual
36 deductibles in effect for self-only and family coverage under section
37 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C.
38 223(c)(2)(A)(i)) for self-only and family coverage, respectively.
39 Once the foregoing expenditure amount has been met under the
40 plan, coverage for prescription drug benefits shall begin, and the
41 limit on out-of-pocket expenditures for prescription drug benefits
42 shall be as specified in paragraph (1) of this subsection.

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

1 7. a. Notwithstanding any other provision of law to the
2 contrary, a carrier that offers a small employer health benefits plan
3 that provides benefits for expenses incurred in the purchase of
4 prescription drugs and is delivered, issued, executed, or renewed in
5 this State, pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), shall
6 ensure that at least 25 percent of all plans, or at least one plan if the
7 carrier offers less than four plans, offered by the carrier in each
8 rating area and in each of the bronze, silver, gold, and platinum
9 levels of coverage, in the small employer market pursuant to
10 P.L.1992, c.162 (C.17B:27A-17 et seq.), shall conform with the
11 following:

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

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

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

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

31 (3) for prescription drug benefits offered in conjunction with a
32 high-deductible health plan, the plan shall not provide prescription
33 drug benefits until the expenditures applicable to the deductible
34 under the plan have met the amount of the minimum annual
35 deductibles in effect for self-only and family coverage under section
36 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C.
37 223(c)(2)(A)(i)) for self-only and family coverage, respectively.
38 Once the foregoing expenditure amount has been met under the
39 plan, coverage for prescription drug benefits shall begin, and the
40 limit on out-of-pocket expenditures for prescription drug benefits
41 shall be as specified in paragraph (1) of this subsection.

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

45
46 8. a. Notwithstanding any other provision of law to the
47 contrary, a health maintenance organization that offers a contract

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

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

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

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

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

28 (3) for prescription drug benefits offered in conjunction with a
29 high-deductible health plan, the plan shall not provide prescription
30 drug benefits until the expenditures applicable to the deductible
31 under the plan have met the amount of the minimum annual
32 deductibles in effect for self-only and family coverage under section
33 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C.
34 223(c)(2)(A)(i)) for self-only and family coverage, respectively.
35 Once the foregoing expenditure amount has been met under the
36 plan, coverage for prescription drug benefits shall begin, and the
37 limit on out-of-pocket expenditures for prescription drug benefits
38 shall be as specified in paragraph (1) of this subsection.

39 b. The provisions of this section shall apply to all agreements
40 in which the health maintenance organization has reserved the right
41 to change the premium.

42

43 ¹9. Notwithstanding any other provision of law to the contrary,
44 the State Health Benefits Commission shall ensure that every
45 contract that provides benefits for expenses incurred in the purchase
46 of prescription drugs, which is purchased by the commission shall
47 conform with the following:

48 a. the contract shall limit a covered person's out-of-pocket

1 financial responsibility, including any copayment or coinsurance,
2 for prescription drugs, including specialty drugs, to no more than
3 \$200 per month for each prescription drug for up to a 30-day supply
4 of any single drug;

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

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

20

21 ¹【10. Notwithstanding any other provision of law to the
22 contrary, the School Employees' Health Benefits Commission shall
23 ensure that every contract that provides benefits for expenses
24 incurred in the purchase of prescription drugs, which is purchased
25 by the commission shall conform with the following:

26 a. the contract shall limit a covered person's out-of-pocket
27 financial responsibility, including any copayment or coinsurance,
28 for prescription drugs, including specialty drugs, to no more than
29 \$200 per month for each prescription drug for up to a 30-day supply
30 of any single drug;

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

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

46

47 ¹【11.】9.¹ This act shall take effect as follows:

- 1 a. for large employer plans affected by section 5 of the act, the
2 act shall take effect immediately and shall apply to plans issued or
3 renewed on or after January 1 of the calendar year that begins 180
4 days after the date of enactment; ¹and¹
- 5 b. for individual and small employer plans affected by sections
6 1 through 4 and sections 6 through 8 of the act, the act shall take
7 effect immediately and apply to new plans or renewals issued on or
8 after January 1 of the calendar year that begins 270 days after the
9 date of enactment¹**;** and¹ **].**¹
- 10 ¹**[**c. for contracts purchased by the State Health Benefits Program
11 and the School Employees' Health Benefits Program affected by
12 sections 9 and 10 of this act, the act shall take effect on the 90th day
13 after the date of enactment and shall apply to contracts purchased
14 on or after that date.¹**]**¹