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ASSEMBLY COMMITTEE SUBSTITUTE FOR

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STATE OF NEW JERSEY

218th LEGISLATURE

ADOPTED JUNE 13, 2019

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SYNOPSIS

Preserves certain requirements that health insurance plans cover essential health benefits.

CURRENT VERSION OF TEXT

As reported by the Senate Budget and Appropriations Committee on January 6, 2020, with amendments.

(Sponsorship Updated As Of: 1/14/2020)

AN ACT concerning health insurance benefits 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. An individual health benefits plan subject to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall provide coverage under every plan delivered, issued, executed or renewed in this State, on or after the effective date of this act, that meets the essential health benefits requirements provided by this section.

b. Pursuant to section 3 of P.L. , c. (C.)(pending before the Legislature as this bill), the commissioner shall define essential health benefits to include at least the following general categories and the items and services covered within the categories:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

(5) mental health and substance use disorder services, including behavioral health treatment;

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

(9) preventive and wellness services and chronic disease management; and

(10) pediatric services, including oral and vision care.

c. An individual health benefits plan shall provide for a level of coverage that is designed to provide benefits that are actuarially equivalent to:

(1) 60 percent of the full actuarial value of the benefits provided under the plan;

(2) 70 percent of the full actuarial value of the benefits provided under the plan; or

(3) 80 percent of the full actuarial value of the benefits provided under the plan.

d. The level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection b. of this section are provided to a standard population, and without regard to the actual population to which the plan may provide benefits.

e. The commissioner shall develop guidelines to provide for a de minimis variation in the actuarial calculations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

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 <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SBA committee amendments adopted January 6, 2020.

2. a. A small employer health benefits plan subject to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall provide coverage under every plan delivered, issued, executed or renewed in this State, on or after the effective date of this act, that meets the essential health benefits requirements provided by this section.

b. Pursuant to section 3 of P.L. , c. (C.)(pending before the Legislature as this bill), commissioner shall define essential health benefits to include at least the following general categories and the items and services covered within the categories:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

(5) mental health and substance use disorder services, including behavioral health treatment;

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

(9) preventive and wellness services and chronic disease management; and

(10) pediatric services, including oral and vision care.

c. A small employer health benefits plan shall provide for a level of coverage that is designed to provide benefits that are actuarially equivalent to:

(1) 60 percent of the full actuarial value of the benefits provided under the plan;

(2) 70 percent of the full actuarial value of the benefits provided under the plan; or

(3) 80 percent of the full actuarial value of the benefits provided under the plan.

d. The level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection b. of this section are provided to a standard population, and without regard to the actual population to which the plan may provide benefits.

e. The commissioner shall develop guidelines to provide for a de minimis variation in the actuarial calculations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

3. In defining the essential health benefits pursuant to P.L. , c. (C.)(pending before the Legislature as this bill), the commissioner shall:

a. ensure that the essential health benefits shall be at least as comprehensive as the essential health benefits required of plans subject to the essential health benefits requirements of the Affordable Care Act as of January 1, 2019;

b. ensure that the essential health benefits reflect an appropriate balance among the categories described in [1]**[**this act**]** P.L. , c. (C.) (pending before the Legislature as this bill)[1], so that benefits shall not be unduly weighted toward any category;

c. not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

d. take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

e. ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

f. [1]**[**provide that a contract, plan or policy shall not be considered to provide coverage for the essential health benefits pursuant to P.L. , c. (C.)(pending before the Legislature as this bill) unless it provides that:

(1) coverage for emergency department services shall be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have a contractual relationship with the plan; and

(2) if those services are provided out-of-network, the cost-sharing requirement, expressed as a copayment amount or coinsurance rate, is the same requirement that would apply if those services were provided in-network;

g.**]**[1] provide that if a stand-alone dental plan is offered through the exchange, another health plan offered through the exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required; and

[1]**[**h.**]** g.[1] periodically review the essential health benefits under P.L. , c. (C.)(pending before the Legislature as this bill), and provide a report to the Governor and the Legislature that provides:

(1) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(2) an assessment of whether the essential health benefits [1]**[**needs**]** need[1] to be modified or updated to account for changes in medical evidence or scientific advancement;

(3) information on how the essential health benefits will be modified to address any gaps in access or changes in the evidence base; and

(4) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in [1]**[**this act**]** P.L. , c. (C.) (pending before the Legislature as this bill)[1]; [1]**[**and

i.**]** h.[1] periodically update the essential health benefits to address any gaps in access to coverage or changes in the evidence base the commissioner identifies in the review conducted pursuant to this section[1]; and

i. establish limits on the dollar amounts of cost-sharing that may be imposed pursuant to a plan with respect to self-only coverage or coverage other than self-only coverage for a plan year. The limits initially established pursuant to this subsection shall not exceed the dollar amounts in effect under section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (42 U.S.C. s.18022), as those limits were in effect on June 1, 2020[1].

4. Notwithstanding any law to the contrary, a health benefits plan shall not impose:

(1) any lifetime limits on the dollar value of benefits for any individual insured pursuant to the plan; or

(2) any annual limits on the dollar value of essential health benefits.

[1]5. A carrier that offers a health benefits plan in this State shall provide that coverage for medically necessary services on an emergency or urgent basis shall be provided without imposing any requirement under the plan for prior authorization of the services or, if the services are provided by an out-of-network provider, any limitation on coverage that is more restrictive than if the services were provided by an in-network provider.[1]

[1]**[**5.**]** 6.[1] This act shall take effect on [1]**[**January**]** June[1] 1, 2020, except the commissioner may take any anticipatory administrative action in advance of that date as shall be necessary for the implementation of this act.