SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 562

STATE OF NEW JERSEY

218th LEGISLATURE

ADOPTED JUNE 3, 2019

Sponsored by:
Senator NIA H. GILL
District 34 (Essex and Passaic)
Senator TROY SINGLETON
District 7 (Burlington)

SYNOPSIS

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

CURRENT VERSION OF TEXT

Substitute as adopted by the Senate Commerce Committee.

1 **AN ACT** concerning health insurance benefits and supplementing
2 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. A hospital service corporation that provides hospital or
8 medical expense benefits shall provide coverage under every
9 contract delivered, issued, executed or renewed in this State, or
10 approved for issuance or renewal in this State by the Commissioner
11 of Banking and Insurance, on or after the effective date of this act,
12 that meets the essential health benefits requirements provided by
13 this section.
14 b. The commissioner shall define essential health benefits to
15 include at least the following general categories and the items and
16 services covered within the categories:
17 (1) ambulatory patient services;
18 (2) emergency services;
19 (3) hospitalization;
20 (4) maternity and newborn care;
21 (5) mental health and substance use disorder services, including
22 behavioral health treatment;
23 (6) prescription drugs;
24 (7) rehabilitative and habilitative services and devices;
25 (8) laboratory services;
26 (9) preventive and wellness services and chronic disease
27 management; and
28 (10) pediatric services, including oral and vision care.
29 c. (1) The cost-sharing incurred under a contract with respect
30 to self-only coverage or coverage other than self-only coverage for
31 a contract year beginning in 2020 shall not exceed the dollar
32 amounts in effect under section 1302 of the Patient Protection and
33 Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those
34 limits were in effect on January 1, 2020.
35 (2) The cost-sharing incurred under a contract for a contract
36 year beginning in 2021, and in each subsequent year, shall be
37 limited to:
38 (a) with respect to self-only coverage, an amount equal to the
39 product of the amount for self-only coverage determined for
40 contract year 2020 and the premium adjustment percentage
41 determined pursuant to paragraph (3) of this subsection; and
42 (b) with respect to coverage other than self-only coverage, twice
43 the amount in effect under subparagraph (a).
44 (3) The premium adjustment percentage for any calendar year
45 shall be the percentage by which the average per capita premium for
46 health insurance coverage in the United States for the preceding
47 calendar year exceeds the average per capita premium for 2020.

1 (4) As used in this section, "cost-sharing" includes deductibles,
2 copayments, or similar charges, and any other expenditure required
3 of an insured individual which is a qualified medical expense,
4 within the meaning of section 223(d)(2) of the Internal Revenue
5 Code of 1986 (26 U.S.C. s.223), with respect to essential health
6 benefits covered under the contract. "Cost-sharing" shall not
7 include premiums, balance billing amounts for non-network
8 providers, or spending for non-covered services.
9 d. Notwithstanding any law to the contrary, a contract shall not
10 impose:
11 (1) any lifetime limits on the dollar value of benefits for any
12 individual insured pursuant to the contract; or
13 (2) any annual limits on the dollar value of essential health
14 benefits.
15
16 2. a. A medical service corporation that provides hospital or
17 medical expense benefits shall provide coverage under every
18 contract delivered, issued, executed or renewed in this State, or
19 approved for issuance or renewal in this State by the Commissioner
20 of Banking and Insurance, on or after the effective date of this act,
21 that meets the essential health benefits requirements provided by
22 this section.
23 b. The commissioner shall define essential health benefits to
24 include at least the following general categories and the items and
25 services covered within the categories:
26 (1) ambulatory patient services;
27 (2) emergency services;
28 (3) hospitalization;
29 (4) maternity and newborn care;
30 (5) mental health and substance use disorder services, including
31 behavioral health treatment;
32 (6) prescription drugs;
33 (7) rehabilitative and habilitative services and devices;
34 (8) laboratory services;
35 (9) preventive and wellness services and chronic disease
36 management; and
37 (10) pediatric services, including oral and vision care.
38 c. (1) The cost-sharing incurred under a contract with respect
39 to self-only coverage or coverage other than self-only coverage for
40 a contract year beginning in 2020 shall not exceed the dollar
41 amounts in effect under section 1302 of the Patient Protection and
42 Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those
43 limits were in effect on January 1, 2020.
44 (2) The cost-sharing incurred under a contract for a contract
45 year beginning in 2021, and in each subsequent year, shall be
46 limited to:
47 (a) with respect to self-only coverage, an amount equal to the
48 product of the amount for self-only coverage determined for

1 contract year 2020 and the premium adjustment percentage
2 determined pursuant to paragraph (3) of this subsection; and
3 (b) with respect to coverage other than self-only coverage, twice
4 the amount in effect under subparagraph (a).
5 (3) The premium adjustment percentage for any calendar year
6 shall be the percentage by which the average per capita premium for
7 health insurance coverage in the United States for the preceding
8 calendar year exceeds the average per capita premium for 2020.
9 (4) As used in this section, "cost-sharing" includes deductibles,
10 copayments, or similar charges, and any other expenditure required
11 of an insured individual which is a qualified medical expense,
12 within the meaning of section 223(d)(2) of the Internal Revenue
13 Code of 1986 (26 U.S.C. s.223), with respect to essential health
14 benefits covered under the contract. "Cost-sharing" shall not
15 include premiums, balance billing amounts for non-network
16 providers, or spending for non-covered services.
17 d. Notwithstanding any law to the contrary, a contract shall not
18 impose:
19 (1) any lifetime limits on the dollar value of benefits for any
20 individual insured pursuant to the contract; or
21 (2) any annual limits on the dollar value of essential health
22 benefits.
23
24 3. a. A health service corporation that provides hospital or
25 medical expense benefits shall provide coverage under every
26 contract delivered, issued, executed or renewed in this State, or
27 approved for issuance or renewal in this State by the Commissioner
28 of Banking and Insurance, on or after the effective date of this act,
29 that meets the essential health benefits requirements provided by
30 this section.
31 b. The commissioner shall define essential health benefits to
32 include at least the following general categories and the items and
33 services covered within the categories:
34 (1) ambulatory patient services;
35 (2) emergency services;
36 (3) hospitalization;
37 (4) maternity and newborn care;
38 (5) mental health and substance use disorder services, including
39 behavioral health treatment;
40 (6) prescription drugs;
41 (7) rehabilitative and habilitative services and devices;
42 (8) laboratory services;
43 (9) preventive and wellness services and chronic disease
44 management; and
45 (10) pediatric services, including oral and vision care.
46 c. (1) The cost-sharing incurred under a contract with respect
47 to self-only coverage or coverage other than self-only coverage for
48 a contract year beginning in 2020 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 January 1, 2020.

(2) The cost-sharing incurred under a contract for a contract year beginning in 2021, and in each subsequent year, shall be limited to:

(a) with respect to self-only coverage, an amount equal to the product of the amount for self-only coverage determined for contract year 2020 and the premium adjustment percentage determined pursuant to paragraph (3) of this subsection; and

(b) with respect to coverage other than self-only coverage, twice the amount in effect under subparagraph (a).

(3) The premium adjustment percentage for any calendar year shall be the percentage by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2020.

(4) As used in this section, "cost-sharing" includes deductibles, copayments, or similar charges, and any other expenditure required of an insured individual which is a qualified medical expense, within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986 (26 U.S.C. s.223), with respect to essential health benefits covered under the contract. "Cost-sharing" shall not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

d. Notwithstanding any law to the contrary, a contract shall not impose:

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

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

4. a. An individual health insurer that provides hospital or medical expense benefits shall provide coverage under every policy delivered, issued, executed or renewed in this State, 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, that meets the essential health benefits requirements provided by this section.

b. 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. (1) The cost-sharing incurred under a policy with respect to self-only coverage or coverage other than self-only coverage for a policy year beginning in 2020 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 January 1, 2020.
(2) The cost-sharing incurred under a policy for a policy year beginning in 2021, and in each subsequent year, shall be limited to:
(a) with respect to self-only coverage, an amount equal to the product of the amount for self-only coverage determined for contract year 2020 and the premium adjustment percentage determined pursuant to paragraph (3) of this subsection; and
(b) with respect to coverage other than self-only coverage, twice the amount in effect under subparagraph (a).
(3) The premium adjustment percentage for any calendar year shall be the percentage by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2020.
(4) As used in this section, "cost-sharing" includes deductibles, copayments, or similar charges, and any other expenditure required of an insured individual which is a qualified medical expense, within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986 (26 U.S.C. s.223), with respect to essential health benefits covered under the policy. "Cost-sharing" shall not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.
d. Notwithstanding any law to the contrary, a policy shall not impose:
(1) any lifetime limits on the dollar value of benefits for any individual insured pursuant to the policy; or
(2) any annual limits on the dollar value of essential health benefits.

5. a. A group health insurer that provides hospital or medical expense benefits shall provide coverage under every policy delivered, issued, executed or renewed in this State, 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, that meets the essential health benefits requirements provided by this section.
b. 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;

1 (3) hospitalization;
2 (4) maternity and newborn care;
3 (5) mental health and substance use disorder services, including
4 behavioral health treatment;
5 (6) prescription drugs;
6 (7) rehabilitative and habilitative services and devices;
7 (8) laboratory services;
8 (9) preventive and wellness services and chronic disease
9 management; and
10 (10) pediatric services, including oral and vision care.
11 c. (1) The cost-sharing incurred under a policy with respect to
12 self-only coverage or coverage other than self-only coverage for a
13 policy year beginning in 2020 shall not exceed the dollar amounts
14 in effect under section 1302 of the Patient Protection and
15 Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those
16 limits were in effect on January 1, 2020.
17 (2) The cost-sharing incurred under a policy for a policy year
18 beginning in 2021, and in each subsequent year, shall be limited to:
19 (a) with respect to self-only coverage, an amount equal to the
20 product of the amount for self-only coverage determined for
21 contract year 2020 and the premium adjustment percentage
22 determined pursuant to paragraph (3) of this subsection; and
23 (b) with respect to coverage other than self-only coverage, twice
24 the amount in effect under subparagraph (a).
25 (3) The premium adjustment percentage for any calendar year
26 shall be the percentage by which the average per capita premium for
27 health insurance coverage in the United States for the preceding
28 calendar year exceeds the average per capita premium for 2020.
29 (4) As used in this section, "cost-sharing" includes deductibles,
30 copayments, or similar charges, and any other expenditure required
31 of an insured individual which is a qualified medical expense,
32 within the meaning of section 223(d)(2) of the Internal Revenue
33 Code of 1986 (26 U.S.C. s.223), with respect to essential health
34 benefits covered under the policy. "Cost-sharing" shall not include
35 premiums, balance billing amounts for non-network providers, or
36 spending for non-covered services.
37 d. Notwithstanding any law to the contrary, a policy shall not
38 impose:
39 (1) any lifetime limits on the dollar value of benefits for any
40 individual insured pursuant to the policy; or
41 (2) any annual limits on the dollar value of essential health
42 benefits.
43
44 6. a. An individual health benefits plan that provides hospital
45 or medical expense benefits shall provide coverage under every
46 plan delivered, issued, executed or renewed in this State, or
47 approved for issuance or renewal in this State by the Commissioner
48 of Banking and Insurance, on or after the effective date of this act,

1 that meets the essential health benefits requirements provided by
2 this section.
3 b. The commissioner shall define essential health benefits to
4 include at least the following general categories and the items and
5 services covered within the categories:
6 (1) ambulatory patient services;
7 (2) emergency services;
8 (3) hospitalization;
9 (4) maternity and newborn care;
10 (5) mental health and substance use disorder services, including
11 behavioral health treatment;
12 (6) prescription drugs;
13 (7) rehabilitative and habilitative services and devices;
14 (8) laboratory services;
15 (9) preventive and wellness services and chronic disease
16 management; and
17 (10) pediatric services, including oral and vision care.
18 c. (1) The cost-sharing incurred under a plan with respect to
19 self-only coverage or coverage other than self-only coverage for a
20 plan year beginning in 2020 shall not exceed the dollar amounts in
21 effect under section 1302 of the Patient Protection and Affordable
22 Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those limits
23 were in effect on January 1, 2020.
24 (2) The cost-sharing incurred under a plan for a plan year
25 beginning in 2021, and in each subsequent year, shall be limited to:
26 (a) with respect to self-only coverage, an amount equal to the
27 product of the amount for self-only coverage determined for
28 contract year 2020 and the premium adjustment percentage
29 determined pursuant to paragraph (3) of this subsection; and
30 (b) with respect to coverage other than self-only coverage, twice
31 the amount in effect under subparagraph (a).
32 (3) The premium adjustment percentage for any calendar year
33 shall be the percentage by which the average per capita premium for
34 health insurance coverage in the United States for the preceding
35 calendar year exceeds the average per capita premium for 2020.
36 (4) As used in this section, "cost-sharing" includes deductibles,
37 copayments, or similar charges, and any other expenditure required
38 of an insured individual which is a qualified medical expense,
39 within the meaning of section 223(d)(2) of the Internal Revenue
40 Code of 1986 (26 U.S.C. s.223), with respect to essential health
41 benefits covered under the plan. "Cost-sharing" shall not include
42 premiums, balance billing amounts for non-network providers, or
43 spending for non-covered services.
44 d. Notwithstanding any law to the contrary, a plan shall not
45 impose:
46 (1) any lifetime limits on the dollar value of benefits for any
47 individual insured pursuant to the plan; or

1 (2) any annual limits on the dollar value of essential health
2 benefits.
3 e. An individual health benefits plan shall provide for a level of
4 coverage that is designed to provide benefits that are actuarially
5 equivalent to:
6 (1) 60 percent of the full actuarial value of the benefits provided
7 under the plan;
8 (2) 70 percent of the full actuarial value of the benefits provided
9 under the plan; or
10 (3) 80 percent of the full actuarial value of the benefits provided
11 under the plan.
12 f. The level of coverage of a plan shall be determined on the
13 basis that the essential health benefits described in subsection b. of
14 this section are provided to a standard population, and without
15 regard to the actual population to which the plan may provide
16 benefits.
17 g. The commissioner shall develop guidelines to provide for a
18 de minimis variation in the actuarial calculations used in
19 determining the level of coverage of a plan to account for
20 differences in actuarial estimates.
21
22 7. a. A small employer health benefits plan that provides
23 hospital or medical expense benefits shall provide coverage under
24 every plan delivered, issued, executed or renewed in this State, or
25 approved for issuance or renewal in this State by the Commissioner
26 of Banking and Insurance, on or after the effective date of this act,
27 that meets the essential health benefits requirements provided by
28 this section.
29 b. The commissioner shall define essential health benefits to
30 include at least the following general categories and the items and
31 services covered within the categories:
32 (1) ambulatory patient services;
33 (2) emergency services;
34 (3) hospitalization;
35 (4) maternity and newborn care;
36 (5) mental health and substance use disorder services, including
37 behavioral health treatment;
38 (6) prescription drugs;
39 (7) rehabilitative and habilitative services and devices;
40 (8) laboratory services;
41 (9) preventive and wellness services and chronic disease
42 management; and
43 (10) pediatric services, including oral and vision care.
44 c. (1) The cost-sharing incurred under a plan with respect to
45 self-only coverage or coverage other than self-only coverage for a
46 plan year beginning in 2020 shall not exceed the dollar amounts in
47 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 January 1, 2020.

(2) The cost-sharing incurred under a plan for a plan year beginning in 2021, and in each subsequent year, shall be limited to:

(a) with respect to self-only coverage, an amount equal to the product of the amount for self-only coverage determined for contract year 2020 and the premium adjustment percentage determined pursuant to paragraph (3) of this subsection; and

(b) with respect to coverage other than self-only coverage, twice the amount in effect under subparagraph (a).

(3) The premium adjustment percentage for any calendar year shall be the percentage by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2020.

(4) As used in this section, "cost-sharing" includes deductibles, copayments, or similar charges, and any other expenditure required of an insured individual which is a qualified medical expense, within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986 (26 U.S.C. s.223), with respect to essential health benefits covered under the plan. "Cost-sharing" shall not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

d. A small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State 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 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.

e. 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.

f. 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.

8. a. A health maintenance organization that provides hospital or medical expense benefits shall provide coverage under every contract delivered, issued, executed or renewed in this State, 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, that meets the essential health benefits requirements provided by this section.

b. 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. (1) The cost-sharing incurred under a contract with respect to self-only coverage or coverage other than self-only coverage for a contract year beginning in 2020 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 January 1, 2020.

(2) The cost-sharing incurred under a contract for a contract year beginning in 2021, and in each subsequent year, shall be limited to:

(a) with respect to self-only coverage, an amount equal to the product of the amount for self-only coverage determined for contract year 2020 and the premium adjustment percentage determined pursuant to paragraph (3) of this subsection; and

(b) with respect to coverage other than self-only coverage, twice the amount in effect under subparagraph (a).

(3) The premium adjustment percentage for any calendar year shall be the percentage by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2020.

(4) As used in this section, "cost-sharing" includes deductibles, copayments, or similar charges, and any other expenditure required of an insured individual which is a qualified medical expense, within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986 (26 U.S.C. s.223), with respect to essential health benefits covered under the contract. "Cost-sharing" shall not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

d. Notwithstanding any law to the contrary, a contract shall not impose:

1 (1) any lifetime limits on the dollar value of benefits for any
2 individual insured pursuant to the contract; or
3 (2) any annual limits on the dollar value of essential health
4 benefits.
5
6 9. This act shall take effect on January 1, 2020, except the
7 commissioner may take any anticipatory administrative action in
8 advance of that date as shall be necessary for the implementation of
9 this act.