Sponsored by:
Senator NIA H. GILL
District 34 (Essex and Passaic)
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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.
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. A hospital service corporation 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.
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.

2. a. A medical service corporation 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) 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.
3. a. A health service corporation 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) 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;
(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.

6. a. An individual health benefits plan that provides hospital or medical expense benefits shall provide coverage under every plan 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 plan with respect to 
self-only coverage or coverage other than self-only coverage for a 
plan 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 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. Notwithstanding any law to the contrary, a 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.

e. 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.

f. 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.

g. 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.

7. a. A small employer health benefits plan that provides hospital or medical expense benefits shall provide coverage under every plan 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 plan with respect to self-only coverage or coverage other than self-only coverage for a plan 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 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) 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.

9. This act shall take effect on January 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.