SENATE, No. 1865

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED FEBRUARY 15, 2018

Sponsored by:
Senator LORETTA WEINBERG
District 37 (Bergen)
Senator THOMAS H. KEAN, JR.
District 21 (Morris, Somerset and Union)

SYNOPSIS

Requires health insurers to limit patient cost-sharing and provide appeal process concerning certain prescription drug coverage.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 4/6/2018)

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, every hospital service corporation contract 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.1938, c.366 (C.17:48-1 et seq.), 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 conform with the following:

(1) (a) except as provided for in subparagraphs (b) and (c) of this paragraph, 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 $100 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a hospital service corporation contract that is required to provide a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required enrollee cost-sharing, including any copayment or coinsurance, does not exceed $200 per month for each prescription drug for up to a 30-day supply of any single drug; and

(c) a hospital service corporation 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;

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, 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; and

(4) implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if

1 the prescribing physician determines that the formulary drug for
2 treatment of the same condition either would not be as effective for
3 the enrollee or would have adverse effects for the enrollee, or both.
4 If an enrollee is denied such an exception, that denial shall be
5 deemed an adverse determination that will be subject to appeal
6 under the carrier's internal appeal process and section 11 of
7 P.L.1997, c.192 (C.26:2S-11).
8 b. The provisions of this section shall apply to all contracts in
9 which the hospital service corporation has reserved the right to
10 change the premium.
11
12 2. a. Notwithstanding any other provision of law to the
13 contrary, every medical service corporation contract that provides
14 benefits for expenses incurred in the purchase of prescription drugs
15 and is delivered, issued, executed, or renewed in this State pursuant
16 to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or
17 renewal in this State by the Commissioner of Banking and
18 Insurance, on or after the effective date of this act, shall conform
19 with the following:
20 (1) (a) except as provided for in subparagraphs (b) and (c) of
21 this paragraph, limit a covered person's out-of-pocket financial
22 responsibility, including any copayment or coinsurance, for
23 prescription drugs, including specialty drugs, to no more than $100
24 per month for each prescription drug for up to a 30-day supply of
25 any single drug;
26 (b) a medical service corporation contract that is required to
27 provide a bronze level of coverage, as defined in 45 C.F.R.
28 s.156.140, shall ensure that any required enrollee cost-sharing,
29 including any copayment or coinsurance, does not exceed $200 per
30 month for each prescription drug for up to a 30-day supply of any
31 single drug; and
32 (c) a medical service corporation contract that meets the
33 requirements of a catastrophic plan, as defined in 45 C.F.R.
34 s.156.155, shall be exempt from the requirements of subparagraphs
35 (a) and (b) of this paragraph;
36 (2) except as provided in paragraph (3) of this subsection, the
37 limits described in paragraph (1) of this subsection shall apply at
38 any point in the benefit design, including before and after any
39 applicable deductible is reached;
40 (3) for prescription drug benefits offered in conjunction with a
41 high-deductible health plan, not provide prescription drug benefits
42 until the expenditures applicable to the deductible under the plan
43 have met the amount of the minimum annual deductibles in effect
44 for self-only and family coverage under section 223(c)(2)(A)(i) of
45 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
46 self-only and family coverage, respectively. Once the foregoing
47 expenditure amount has been met under the plan, coverage for
48 prescription drug benefits shall begin, and the limit on out-of-

1 pocket expenditures for prescription drug benefits shall be as
2 specified in paragraph (1) of this subsection; and
3 (4) implement an exceptions process that allows enrollees to
4 request an exception to any formulary, which exception shall permit
5 a nonformulary drug to be deemed covered under the formulary if
6 the prescribing physician determines that the formulary drug for
7 treatment of the same condition either would not be as effective for
8 the enrollee or would have adverse effects for the enrollee, or both.
9 If an enrollee is denied such an exception, that denial shall be
10 deemed an adverse determination that will be subject to appeal
11 under the carrier's internal appeal process and section 11 of
12 P.L.1997, c.192 (C.26:2S-11).
13 b. The provisions of this section shall apply to all contracts in
14 which the medical service corporation has reserved the right to
15 change the premium.
16
17 3. a. Notwithstanding any other provision of law to the
18 contrary, every health service corporation contract that provides
19 benefits for expenses incurred in the purchase of prescription drugs
20 and is delivered, issued, executed, or renewed in this State pursuant
21 to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or
22 renewal in this State by the Commissioner of Banking and
23 Insurance, on or after the effective date of this act, shall conform
24 with the following:
25 (1) (a) except as provided for in subparagraphs (b) and (c) of
26 this paragraph, limit a covered person's out-of-pocket financial
27 responsibility, including any copayment or coinsurance, for
28 prescription drugs, including specialty drugs, to no more than $100
29 per month for each prescription drug for up to a 30-day supply of
30 any single drug;
31 (b) a health service corporation contract that is required to
32 provide a bronze level of coverage, as defined in 45 C.F.R.
33 s.156.140, shall ensure that any required enrollee cost-sharing,
34 including any copayment or coinsurance, does not exceed $200 per
35 month for each prescription drug for up to a 30-day supply of any
36 single drug; and
37 (c) a health service corporation contract that meets the
38 requirements of a catastrophic plan, as defined in 45 C.F.R.
39 s.156.155, shall be exempt from the requirements of subparagraphs
40 (a) and (b) of this paragraph;
41 (2) except as provided in paragraph (3) of this subsection, the
42 limits described in paragraph (1) of this subsection shall apply at
43 any point in the benefit design, including before and after any
44 applicable deductible is reached;
45 (3) for prescription drug benefits offered in conjunction with a
46 high-deductible health plan, not provide prescription drug benefits
47 until the expenditures applicable to the deductible under the plan
48 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; and

(4) implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the enrollee or would have adverse effects for the enrollee, or both. If an enrollee is denied such an exception, that denial shall be deemed an adverse determination that will be subject to appeal under the carrier's internal appeal process and section 11 of P.L.1997, c.192 (C.26:2S-11).

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, every 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 pursuant to chapter 26 of Title 17B of the New Jersey Statutes, 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 conform with the following:

(1) (a) except as provided for in subparagraphs (b) and (c) of this paragraph, 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 $100 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) an individual health insurance policy that is required to provide a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required enrollee cost-sharing, including any copayment or coinsurance, does not exceed $200 per month for each prescription drug for up to a 30-day supply of any single drug; and

(c) an individual health insurance 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

1 applicable deductible is reached;
2 (3) for prescription drug benefits offered in conjunction with a
3 high-deductible health plan, not provide prescription drug benefits
4 until the expenditures applicable to the deductible under the plan
5 have met the amount of the minimum annual deductibles in effect
6 for self-only and family coverage under section 223(c)(2)(A)(i) of
7 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
8 self-only and family coverage, respectively. Once the foregoing
9 expenditure amount has been met under the plan, coverage for
10 prescription drug benefits shall begin, and the limit on out-of-
11 pocket expenditures for prescription drug benefits shall be as
12 specified in paragraph (1) of this subsection; and
13 (4) implement an exceptions process that allows enrollees to
14 request an exception to any formulary, which exception shall permit
15 a nonformulary drug to be deemed covered under the formulary if
16 the prescribing physician determines that the formulary drug for
17 treatment of the same condition either would not be as effective for
18 the enrollee or would have adverse effects for the enrollee, or both.
19 If an enrollee is denied such an exception, that denial shall be
20 deemed an adverse determination that will be subject to appeal
21 under the carrier's internal appeal process and section 11 of
22 P.L.1997, c.192 (C.26:2S-11).
23 b. The provisions of this section shall apply to all policies in
24 which the insurer has reserved the right to change the premium.
25
26 5. a. Notwithstanding any other provision of law to the
27 contrary, every group health insurance policy that provides benefits
28 for expenses incurred in the purchase of prescription drugs and is
29 delivered, issued, executed, or renewed in this State pursuant to
30 chapter 27 of Title 17B of the New Jersey Statutes, or approved for
31 issuance or renewal in this State by the Commissioner of Banking
32 and Insurance, on or after the effective date of this act, shall
33 conform with the following:
34 (1) (a) except as provided for in subparagraphs (b) and (c) of
35 this paragraph, limit a covered person's out-of-pocket financial
36 responsibility, including any copayment or coinsurance, for
37 prescription drugs, including specialty drugs, to no more than $100
38 per month for each prescription drug for up to a 30-day supply of
39 any single drug;
40 (b) a group health insurance policy that is required to provide a
41 bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall
42 ensure that any required enrollee cost-sharing, including any
43 copayment or coinsurance, does not exceed $200 per month for
44 each prescription drug for up to a 30-day supply of any single drug;
45 and
46 (c) a group health insurance policy that meets the requirements
47 of a catastrophic plan, as defined in 45 C.F.R. s.156.155, shall be
48 exempt from the requirements of subparagraphs (a) and (b) of this

1 paragraph;
2 (2) except as provided in paragraph (3) of this subsection, the
3 limits described in paragraph (1) of this subsection shall apply at
4 any point in the benefit design, including before and after any
5 applicable deductible is reached;
6 (3) for prescription drug benefits offered in conjunction with a
7 high-deductible health plan, not provide prescription drug benefits
8 until the expenditures applicable to the deductible under the plan
9 have met the amount of the minimum annual deductibles in effect
10 for self-only and family coverage under section 223(c)(2)(A)(i) of
11 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
12 self-only and family coverage, respectively. Once the foregoing
13 expenditure amount has been met under the plan, coverage for
14 prescription drug benefits shall begin, and the limit on out-of-
15 pocket expenditures for prescription drug benefits shall be as
16 specified in paragraph (1) of this subsection; and
17 (4) implement an exceptions process that allows enrollees to
18 request an exception to any formulary, which exception shall permit
19 a nonformulary drug to be deemed covered under the formulary if
20 the prescribing physician determines that the formulary drug for
21 treatment of the same condition either would not be as effective for
22 the enrollee or would have adverse effects for the enrollee, or both.
23 If an enrollee is denied such an exception, that denial shall be
24 deemed an adverse determination that will be subject to appeal
25 under the carrier's internal appeal process and section 11 of
26 P.L.1997, c.192 (C.26:2S-11).
27 b. The provisions of this section shall apply to all policies in
28 which the insurer has reserved the right to change the premium.
29
30 6. a. Notwithstanding any other provision of law to the
31 contrary, an individual health benefits plan that provides benefits
32 for expenses incurred in the purchase of prescription drugs and is
33 delivered, issued, executed, renewed, or approved for issuance or
34 renewal in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et
35 seq.), or approved for issuance or renewal in this State by the
36 Commissioner of Banking and Insurance, on or after the effective
37 date of this act, shall conform with the following:
38 (1) (a) except as provided for in subparagraphs (b) and (c) of
39 this paragraph, limit a covered person's out-of-pocket financial
40 responsibility, including any copayment or coinsurance, for
41 prescription drugs, including specialty drugs, to no more than $100
42 per month for each prescription drug for up to a 30-day supply of
43 any single drug;
44 (b) an individual health benefits plan that is required to provide
45 a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall
46 ensure that any required enrollee cost-sharing, including any
47 copayment or coinsurance, does not exceed $200 per month for
48 each prescription drug for up to a 30-day supply of any single drug;

and

(c) an individual 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;

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, 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; and

(4) implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the enrollee or would have adverse effects for the enrollee, or both. If an enrollee is denied such an exception, that denial shall be deemed an adverse determination that will be subject to appeal under the carrier's internal appeal process and section 11 of P.L.1997, c.192 (C.26:2S-11).

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 small employer health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, renewed, or approved for issuance or renewal in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), 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 conform with the following:

(1) (a) except as provided for in subparagraphs (b) and (c) of this paragraph, 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 $100 per month for each prescription drug for up to a 30-day supply of any single drug;

1 (b) a small employer health benefits plan that is required to
2 provide a bronze level of coverage, as defined in 45 C.F.R.
3 s.156.140, shall ensure that any required enrollee cost-sharing,
4 including any copayment or coinsurance, does not exceed $200 per
5 month for each prescription drug for up to a 30-day supply of any
6 single drug; and
7 (c) a small employer health benefits plan that meets the
8 requirements of a catastrophic plan, as defined in 45 C.F.R.
9 s.156.155, shall be exempt from the requirements of subparagraphs
10 (a) and (b) of this paragraph;
11 (2) except as provided in paragraph (3) of this subsection, the
12 limits described in paragraph (1) of this subsection shall apply at
13 any point in the benefit design, including before and after any
14 applicable deductible is reached;
15 (3) for prescription drug benefits offered in conjunction with a
16 high-deductible health plan, not provide prescription drug benefits
17 until the expenditures applicable to the deductible under the plan
18 have met the amount of the minimum annual deductibles in effect
19 for self-only and family coverage under section 223(c)(2)(A)(i) of
20 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
21 self-only and family coverage, respectively. Once the foregoing
22 expenditure amount has been met under the plan, coverage for
23 prescription drug benefits shall begin, and the limit on out-of-
24 pocket expenditures for prescription drug benefits shall be as
25 specified in paragraph (1) of this subsection; and
26 (4) implement an exceptions process that allows enrollees to
27 request an exception to any formulary, which exception shall permit
28 a nonformulary drug to be deemed covered under the formulary if
29 the prescribing physician determines that the formulary drug for
30 treatment of the same condition either would not be as effective for
31 the enrollee or would have adverse effects for the enrollee, or both.
32 If an enrollee is denied such an exception, that denial shall be
33 deemed an adverse determination that will be subject to appeal
34 under the carrier's internal appeal process and section 11 of
35 P.L.1997, c.192 (C.26:2S-11).
36 b. The provisions of this section shall apply to those health
37 benefits plan in which the carrier has reserved the right to change
38 the premium.
39
40 8. a. Notwithstanding any other provision of law to the
41 contrary, a health maintenance organization enrollee agreement that
42 provides coverage for the purchase of prescription drugs and is
43 delivered, issued, executed, or renewed in this State pursuant to
44 P.L.1973, c.337 (C.26:2J-1 et seq.), or approved for issuance or
45 renewal in this State by the Commissioner of Banking and
46 Insurance, on or after the effective date of this act, shall conform
47 with the following:
48 (1) (a) except as provided for in subparagraphs (b) and (c) of

1 this paragraph, limit a covered person's out-of-pocket financial
2 responsibility, including any copayment or coinsurance, for
3 prescription drugs, including specialty drugs, to no more than $100
4 per month for each prescription drug for up to a 30-day supply of
5 any single drug;
6 (b) a health maintenance organization enrollee agreement that is
7 required to provide a bronze level of coverage, as defined in 45
8 C.F.R. s.156.140, shall ensure that any required enrollee cost-
9 sharing, including any copayment or coinsurance, does not exceed
10 $200 per month for each prescription drug for up to a 30-day supply
11 of any single drug; and
12 (c) a health maintenance organization enrollee agreement that
13 meets the requirements of a catastrophic plan, as defined in 45
14 C.F.R. s.156.155, shall be exempt from the requirements of
15 subparagraphs (a) and (b) of this paragraph;
16 (2) except as provided in paragraph (3) of this subsection, the
17 limits described in paragraph (1) of this subsection shall apply at
18 any point in the benefit design, including before and after any
19 applicable deductible is reached;
20 (3) for prescription drug benefits offered in conjunction with a
21 high-deductible health plan, not provide prescription drug benefits
22 until the expenditures applicable to the deductible under the plan
23 have met the amount of the minimum annual deductibles in effect
24 for self-only and family coverage under section 223(c)(2)(A)(i) of
25 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
26 self-only and family coverage, respectively. Once the foregoing
27 expenditure amount has been met under the plan, coverage for
28 prescription drug benefits shall begin, and the limit on out-of-
29 pocket expenditures for prescription drug benefits shall be as
30 specified in paragraph (1) of this subsection; and
31 (4) implement an exceptions process that allows enrollees to
32 request an exception to any formulary, which exception shall permit
33 a nonformulary drug to be deemed covered under the formulary if
34 the prescribing physician determines that the formulary drug for
35 treatment of the same condition either would not be as effective for
36 the enrollee or would have adverse effects for the enrollee, or both.
37 If an enrollee is denied such an exception, that denial shall be
38 deemed an adverse determination that will be subject to appeal
39 under the carrier's internal appeal process and section 11 of
40 P.L.1997, c.192 (C.26:2S-11).
41 b. The provisions of this section shall apply to all agreements
42 in which the health maintenance organization has reserved the right
43 to change the premium.
44
45 9. Notwithstanding any other provision of law to the contrary,
46 the State Health Benefits Commission shall ensure that every
47 contract that provides benefits for expenses incurred in the purchase
48 of prescription drugs, which is purchased by the commission on or

1 after the effective date of this act, shall conform with the following:
2 a. limit a covered person's out-of-pocket financial
3 responsibility, including any copayment or coinsurance, for
4 prescription drugs, including specialty drugs, to no more than $100
5 per month for each prescription drug for up to a 30-day supply of
6 any single drug;
7 b. except as provided in subsection c. of this section, the limits
8 described in subsection a. of this section shall apply at any point in
9 the benefit design, including before and after any applicable
10 deductible is reached;
11 c. for prescription drug benefits offered in conjunction with a
12 high-deductible health plan, not provide prescription drug benefits
13 until the expenditures applicable to the deductible under the plan
14 have met the amount of the minimum annual deductibles in effect
15 for self-only and family coverage under section 223(c)(2)(A)(i) of
16 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
17 self-only and family coverage, respectively. Once the foregoing
18 expenditure amount has been met under the plan, coverage for
19 prescription drug benefits shall begin, and the limit on out-of-
20 pocket expenditures for prescription drug benefits shall be as
21 specified in subsection a. of this section; and
22 d. implement an exceptions process that allows enrollees to
23 request an exception to any formulary, which exception shall permit
24 a nonformulary drug to be deemed covered under the formulary if
25 the prescribing physician determines that the formulary drug for
26 treatment of the same condition either would not be as effective for
27 the enrollee or would have adverse effects for the enrollee, or both.
28 If an enrollee is denied such an exception, that denial shall be
29 deemed an adverse determination that will be subject to appeal
30 under the applicable appeal process established by the commission.
31
32 10. Notwithstanding any other provision of law to the contrary,
33 the School Employees' Health Benefits Commission shall ensure
34 that every contract that provides benefits for expenses incurred in
35 the purchase of prescription drugs, which is purchased by the
36 commission on or after the effective date of this act, shall conform
37 with the following:
38 a. limit a covered person's out-of-pocket financial
39 responsibility, including any copayment or coinsurance, for
40 prescription drugs, including specialty drugs, to no more than $100
41 per month for each prescription drug for up to a 30-day supply of
42 any single drug;
43 b. except as provided in subsection c. of this section, the limits
44 described in subsection a. of this section shall apply at any point in
45 the benefit design, including before and after any applicable
46 deductible is reached;
47 c. for prescription drug benefits offered in conjunction with a
48 high-deductible health plan, 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; and

d. implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the enrollee or would have adverse effects for the enrollee, or both. If an enrollee is denied such an exception, that denial shall be deemed an adverse determination that will be subject to appeal under the applicable appeal process established by the commission.

11. This act shall take effect on the 90th day after enactment and shall apply to policies or contracts issued or renewed on or after the effective date.

STATEMENT

This bill requires certain health insurers, under certain policies or contracts that provide coverage for prescription drugs, to place limitations on covered persons' cost sharing for prescription drugs. The bill's provisions apply to the following insurers and programs that provide coverage for prescription drugs under a policy or contract: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP).

Unless the plan or contract is required to provide bronze level of coverage or is a catastrophic plan under the federal Affordable Care Act, the bill requires insurers to ensure that plans 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 $100 per month for each prescription drug for up to a 30-day supply of any single drug. If the plan or contract is required to provide a bronze level of coverage, as defined in 45 C.F.R. s.156.140, the plan shall ensure that any required enrollee cost-sharing, including any copayment or

1 coinsurance, does not exceed $200 per month for each prescription
2 drug for up to a 30-day supply of any single drug. In the case of a
3 plan that meets the requirements of a catastrophic plan, as defined
4 in 45 C.F.R. s.156.155, it is exempt from these requirements.
5 In the case of high-deductible plans, these cost sharing limits
6 apply at any point in the benefit design, including before and after
7 any applicable deductible is reached. For prescription drug benefits
8 offered in conjunction with a high-deductible health plan, the plan
9 shall not provide prescription drug benefits until the expenditures
10 applicable to the deductible under the plan have met the amount of
11 the minimum annual deductibles in effect for self-only and family
12 coverage under section 223(c)(2)(A)(i) of the federal Internal
13 Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family
14 coverage, respectively. Once the foregoing expenditure amount has
15 been met under the plan, coverage for prescription drug benefits
16 shall begin, and the limit on out-of-pocket expenditures for
17 prescription drug benefits would be as specified in the bill.
18 The bill also requires the plans to implement an exceptions
19 process that allows enrollees to request an exception to any
20 formulary, which exception shall permit a nonformulary drug to be
21 deemed covered under the formulary if the prescribing physician
22 determines that the formulary drug for treatment of the same
23 condition either would not be as effective for the enrollee or would
24 have adverse effects for the enrollee, or both. If an enrollee is
25 denied such an exception, that denial is deemed an adverse
26 determination that will be subject to appeal.