

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 1865

STATE OF NEW JERSEY
218th LEGISLATURE

ADOPTED JUNE 17, 2019

Sponsored by:

Senator LORETTA WEINBERG

District 37 (Bergen)

Senator THOMAS H. KEAN, JR.

District 21 (Morris, Somerset and Union)

Co-Sponsored by:

Senator Cunningham

SYNOPSIS

Requires health insurers to provide plans that limit patient cost-sharing concerning certain prescription drug coverage.

CURRENT VERSION OF TEXT

Substitute as adopted by the Senate Commerce Committee.



(Sponsorship Updated As Of: 10/25/2019)

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

3

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

6

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

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

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

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

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

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

47 b. The provisions of this section shall apply to all contracts in
48 which the hospital service corporation has reserved the right to
49 change the premium.

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

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

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

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

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

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

41 b. The provisions of this section shall apply to all contracts in
42 which the medical service corporation has reserved the right to
43 change the premium.
44

45 3. a. Notwithstanding any other provision of law to the
46 contrary, a health service corporation that offers a contract that
47 provides benefits for expenses incurred in the purchase of
48 prescription drugs and is delivered, issued, executed, or renewed in
49 this State, shall ensure that at least 25 percent of all plans, or at

1 least one plan if the corporation offers less than four plans, offered
2 by the corporation in each rating area and in each of the bronze,
3 silver, gold, and platinum levels of coverage, in the individual
4 market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in
5 the small employer market pursuant to P.L.1992, c.162
6 (C.17B:27A-17), shall conform with the following:

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

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

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

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

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

36 b. The provisions of this section shall apply to all contracts in
37 which the health service corporation has reserved the right to
38 change the premium.

39
40 4. a. Notwithstanding any other provision of law to the
41 contrary, an insurer that offers an individual health insurance policy
42 that provides benefits for expenses incurred in the purchase of
43 prescription drugs and is delivered, issued, executed, or renewed in
44 this State, shall ensure that at least 25 percent of all plans, or at
45 least one plan if the carrier offers less than four plans, offered by
46 the carrier in each rating area and in each of the bronze, silver, gold,
47 and platinum levels of coverage, in the individual market pursuant
48 to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall conform with the
49 following:

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

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

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

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

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

30 b. The provisions of this section shall apply to all policies in
31 which the insurer has reserved the right to change the premium.
32

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

39 b. The provisions of the section shall apply to all policies in
40 which the insurer has reserved the right to change the premium.
41

42 6. a. Notwithstanding any other provision of law to the
43 contrary, a carrier that offers an individual health benefits plan
44 that provides benefits for expenses incurred in the purchase of
45 prescription drugs and is delivered, issued, executed, or renewed in
46 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall
47 ensure that: at least 25 percent of all plans, or at least one plan if the
48 carrier offers less than four plans, offered by the carrier in each

1 rating area and in each of the bronze, silver, gold, and platinum
2 levels of coverage, in the individual market pursuant to P.L.1992,
3 c.161 (C.17B:27A-2 et seq.), shall conform with the following:

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

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

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

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

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

34 b. The provisions of this section shall apply to those health
35 benefits plans in which the carrier has reserved the right to change
36 the premium.

37
38 7. a. Notwithstanding any other provision of law to the
39 contrary, a carrier that offers a small employer health benefits plan
40 that provides benefits for expenses incurred in the purchase of
41 prescription drugs and is delivered, issued, executed, or renewed in
42 this State, pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), shall
43 ensure that at least 25 percent of all plans, or at least one plan if the
44 carrier offers less than four plans, offered by the carrier in each
45 rating area and in each of the bronze, silver, gold, and platinum
46 levels of coverage, in the small employer market pursuant to
47 P.L.1992, c.162 (C.17B:27A-17 et seq.), shall conform with the
48 following:

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

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

12 (c) a health benefits plan that meets the requirements of a
13 catastrophic plan, as defined in 45 C.F.R. s.156.155, shall be
14 exempt from the requirements of subparagraphs (a) and (b) of this
15 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; and

20 (3) for prescription drug benefits offered in conjunction with a
21 high-deductible health plan, the plan shall not provide prescription
22 drug benefits until the expenditures applicable to the deductible
23 under the plan have met the amount of the minimum annual
24 deductibles in effect for self-only and family coverage under section
25 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C.
26 223(c)(2)(A)(i)) for self-only and family coverage, respectively.
27 Once the foregoing expenditure amount has been met under the
28 plan, coverage for prescription drug benefits shall begin, and the
29 limit on out-of-pocket expenditures for prescription drug benefits
30 shall be as specified in paragraph (1) of this subsection.

31 b. The provisions of this section shall apply to those health
32 benefits plans in which the carrier has reserved the right to change
33 the premium.

34
35 8. a. Notwithstanding any other provision of law to the
36 contrary, a health maintenance organization that offers a contract
37 that provides benefits for expenses incurred in the purchase of
38 prescription drugs and is delivered, issued, executed, or renewed in
39 this State, shall ensure that at least 25 percent of all plans, or at
40 least one plan if the organization offers less than four plans, offered
41 by the organization in each rating area and in each of the bronze,
42 silver, gold, and platinum levels of coverage, in the individual
43 market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in
44 the small employer market pursuant to P.L.1992, c.162
45 (C.17B:27A-17), shall conform with the following:

46 (1) (a) an agreement that provides a silver, gold, or platinum
47 level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a
48 covered person's cost-sharing, including any copayment or
49 coinsurance, for prescription drugs, including specialty drugs, to no

1 more than \$150 per month for each prescription drug for up to a 30-
2 day supply of any single drug;

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

8 (c) an agreement that meets the requirements of a catastrophic
9 plan, as defined in 45 C.F.R. s.156.155, shall be exempt from the
10 requirements of subparagraphs (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; and

15 (3) for prescription drug benefits offered in conjunction with a
16 high-deductible health plan, the plan shall not provide prescription
17 drug benefits until the expenditures applicable to the deductible
18 under the plan have met the amount of the minimum annual
19 deductibles in effect for self-only and family coverage under section
20 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C.
21 223(c)(2)(A)(i)) for self-only and family coverage, respectively.
22 Once the foregoing expenditure amount has been met under the
23 plan, coverage for prescription drug benefits shall begin, and the
24 limit on out-of-pocket expenditures for prescription drug benefits
25 shall be as specified in paragraph (1) of this subsection.

26 b. The provisions of this section shall apply to all agreements
27 in which the health maintenance organization has reserved the right
28 to change the premium.

29

30 9. Notwithstanding any other provision of law to the contrary,
31 the State Health Benefits Commission shall ensure that every
32 contract that provides benefits for expenses incurred in the purchase
33 of prescription drugs, which is purchased by the commission shall
34 conform with the following:

35 a. the contract shall limit a covered person's out-of-pocket
36 financial responsibility, including any copayment or coinsurance,
37 for prescription drugs, including specialty drugs, to no more than
38 \$200 per month for each prescription drug for up to a 30-day supply
39 of any single drug;

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

44 c. for prescription drug benefits offered in conjunction with a
45 high-deductible health plan, the contract shall not provide
46 prescription drug benefits until the expenditures applicable to the
47 deductible under the plan have met the amount of the minimum
48 annual deductibles in effect for self-only and family coverage under
49 section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26

1 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage,
2 respectively. Once the foregoing expenditure amount has been met
3 under the plan, coverage for prescription drug benefits shall begin,
4 and the limit on out-of-pocket expenditures for prescription drug
5 benefits shall be as specified in subsection a. of this section.

6
7 10. Notwithstanding any other provision of law to the contrary,
8 the School Employees' Health Benefits Commission shall ensure
9 that every contract that provides benefits for expenses incurred in
10 the purchase of prescription drugs, which is purchased by the
11 commission shall conform with the following:

12 a. the contract shall limit a covered person's out-of-pocket
13 financial responsibility, including any copayment or coinsurance,
14 for prescription drugs, including specialty drugs, to no more than
15 \$200 per month for each prescription drug for up to a 30-day supply
16 of any single drug;

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

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

32
33 11. This act shall take effect as follows:

34 a. for large employer plans affected by section 5 of the act, the
35 act shall take effect immediately and shall apply to plans issued or
36 renewed on or after January 1 of the calendar year that begins 180
37 days after the date of enactment;

38 b. for individual and small employer plans affected by sections
39 1 through 4 and sections 6 through 8 of the act, the act shall take
40 effect immediately and apply to new plans or renewals issued on or
41 after January 1 of the calendar year that begins 270 days after the
42 date of enactment; and

43 c. for contracts purchased by the State Health Benefits Program
44 and the School Employees' Health Benefits Program affected by
45 sections 9 and 10 of this act, the act shall take effect on the 90th day
46 after the date of enactment and shall apply to contracts purchased
47 on or after that date.