

CHAPTER 472
(CORRECTED COPY)

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:

C.17:48-6uu Hospital service corporation to provide certain coverage for prescription drugs.

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

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

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

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the contract shall 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. s.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.

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

C.17:48A-7rr Medical service corporation to provide certain coverage for prescription drugs.

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

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

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

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the contract shall 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. s.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.

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

C.17:48E-35.45 Health service corporation to provide certain coverage for prescription drugs.

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

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

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

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the contract shall 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. s.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.

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.

C.17B:26-2.1nn Individual health insurance policy to provide certain coverage for prescription drugs.

4. a. Notwithstanding any other provision of law to the contrary, an insurer that offers an 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, shall ensure that at least 25 percent of all plans, or at least one plan if the carrier offers less than four plans, offered by the carrier in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall conform with the following:

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

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

(c) a 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 applicable deductible is reached; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the policy shall 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. s.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.

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

C.17B:27-46.1uu Group health insurance policy to provide certain coverage for prescription drugs.

5. a. Notwithstanding any other provision of law to the contrary, an insurer that offers a

group 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, shall ensure that the insurer offers at least two plans in the large group market pursuant to N.J.S.17B:27-26 et seq.

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

C.17B:27A-7.28 Individual health benefits plan to provide certain coverage for prescription drugs.

6. a. Notwithstanding any other provision of law to the contrary, a carrier that offers an individual health benefits plan 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.1992, c.161 (C.17B:27A-2 et seq.), shall ensure that: at least 25 percent of all plans, or at least one plan if the carrier offers less than four plans, offered by the carrier in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall conform with the following:

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

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

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall 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. s.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.

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.

C.17B:27A-19.32 Small employer health benefits plan to provide certain coverage for prescription drugs.

7. a. Notwithstanding any other provision of law to the contrary, a carrier that offers a small employer health benefits plan 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.1992, c.162 (C.17B:27A-17 et seq.), shall ensure that at least 25 percent of all plans, or at least one plan if the carrier offers less than four plans, offered by the carrier in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), shall conform with the following:

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

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

(c) a 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall 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. s.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.

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.

C.26:2J-4.46 Health maintenance organization to provide certain coverage for prescription drugs.

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

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

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

(c) an agreement 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; and

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall 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. s.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.

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

9. This act shall take effect as follows:

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

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

Approved January 21, 2020.