ASSEMBLY, No. 4549



STATE OF NEW JERSEY

217th LEGISLATURE



INTRODUCED JANUARY 30, 2017

Sponsored by:

Assemblywoman AMY H. HANDLIN

District 13 (Monmouth)

SYNOPSIS

Establishes primary health care plan with optional riders in SEHBP for school employees; requires contribution by school employees for health care benefits.

CURRENT VERSION OF TEXT

As introduced.



An Act concerning the New Jersey School Employees’ Health Benefits Program, supplementing P.L.2007, c.103 and P.L.1979, c.391 (C.18A:16-12 et seq.), amending various parts of the statutory law, and repealing section 36 of P.L.2007, c.103.

Be It Enacted by the Senate and General Assembly of the State of New Jersey:

1. (New section) a. (1) The School Employees’ Health Benefits Program shall consist of the Essential Benefits Primary Plan, set forth in subsection b. of this section, extended benefits riders, set forth in subsection c. of this section, and alternative coverage under a health maintenance organization plan, pursuant to subsection d. of this section. The Essential Benefits Primary Plan shall be available to all full-time, active employees, qualified retirees, and their dependents as provided for in P.L.2007, c.103 (C.52:14-17.46.1 et seq.).

(2) In the case of employees not subject to a collective negotiations agreement, the benefits provided pursuant to this section shall be available to the employees no later than 90 days following the effective date of P.L. , c. (pending before the Legislature as this bill).

(3) In the case of employees subject to a collective negotiations agreement, the benefits provided pursuant to this section shall be available to the employees on the effective date of the first collective negotiations agreement entered into between a bargaining unit and an employer following the effective date of P.L. , c. (pending before the Legislature as this bill).

b. The benefits provided under the Essential Benefits Primary Plan shall consist of:

(1) 90 days inpatient and outpatient hospital expenses, subject to a copayment set by the commission of no less than $250 per hospital visit;

(2) outpatient and ambulatory surgery, subject to a copayment set by the commission of no less than $100 per surgery;

(3) physicians’ fees connected with inpatient or outpatient hospital care, including, but not limited to, general acute care, surgery, and organ transplants;

(4) physicians’ fees connected with outpatient and ambulatory surgery;

(5) anesthesia and the administration of anesthesia;

(6) maternity benefits, including delivery room fees;

(7) coverage for newborns;

(8) treatment for complications of pregnancy;

(9) inpatient diagnostics tests and a $2,000 annual allowance, in the aggregate, for outpatient diagnostic tests for each covered person, including, but not limited to, pap smears, mammography, and prostate examinations and related diagnostic testing upon such terms and conditions established by the commission;

(10) intravenous solutions, blood, and blood plasma;

(11) oxygen and the administration of oxygen;

(12) radiation and x-ray therapy;

(13) laboratory fees incident to treatment in a hospital;

(14) inpatient physical therapy and hydrotherapy;

(15) up to 30 annual visits for outpatient physical therapy for each covered person, which shall include a per visit copayment determined by the commission;

(16) operating room fees;

(17) fees for a special care unit;

(18) treatment room fees;

(19) emergency room services for medically necessary treatment, subject to a $100 copayment per visit;

(20) pharmaceuticals dispensed in a hospital;

(21) dressings;

(22) splints and crutches;

(23) treatment for biologically-based mental illness, as defined in subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5), which shall include up to 90 days of inpatient stay, subject to a copayment set by the commission of no less than $250 per stay;

(24) treatment for alcohol and substance abuse, which shall include up to 30 days of inpatient or outpatient care, subject to a copayment set by the commission of no less than $250 per visit;

(25) up to $800 annually per covered person for wellness and preventative care, subject to an annual deductible and a per service copayment set by the commission;

(26) up to $800 annually per covered person, in the aggregate, for physician office visits for a diagnosed illness or injury, subject to a copayment set by the commission;

(27) diabetic self-management education;

(28) dialysis;

(29) chemotherapy;

(30) hearing aids for certain persons 15 years old or younger; and

(31) childhood immunizations and lead screening.

c. (1) The School Employees’ Health Benefits Commission shall develop extended benefits riders, which shall contain groupings of benefits that enhance the benefits offered in the Essential Benefits Primary Plan or provide additional benefits not included in the Essential Benefits Primary Plan. Extended benefits riders shall be offered to employees under terms and conditions established in P.L.2007, c.103 (C.52:14-17.46.1 et seq.) and by the commission pursuant to that act.

The extended benefits riders may:

(a) contain enhancements to the benefits in the Essential Benefits Primary Plan set forth in subsection b. of this section;

(b) provide increased coverage limits, lower deductibles, and lower copayments; and

(c) provide benefits in addition to those benefits in the Essential Benefits Primary Plan set forth in subsection b. of this section.

(2) The commission shall determine which additional benefits in the extended benefits riders to offer, which may include, but shall not be limited to: reimbursements for additional office visits; additional diagnostic tests; acupuncture; audiology services; chiropractic care; durable medical equipment; home health care; home hemophilia treatment; nutritional counseling; specialized pain management; private duty nursing; scalp hair prostheses; orthotics; shock therapy; allergy testing and related diagnostic and therapy services; skilled nursing facility charges; hospice care; speech therapy; occupational therapy; ambulance and other transportation charges; treatments for infertility; benefits for therapeutic treatment of inherited metabolic disease; forms of alternative medicine; and treatment for non-biologically-based mental illness.

(3) The commission shall establish such deductibles, copayments, and coinsurance for each extended benefits rider that it establishes. The deductible, copayment, and coinsurance need not be the same for every extended benefits rider that the commission establishes.

(4) Each employee may elect one or more of the available extended benefits riders. The commission shall formulate all groupings of additional benefits in the extended benefits riders in a manner that avoids adverse or duplicative selections by employees to the greatest extent possible. The groupings of enhanced or additional benefits may be subject to copayments and deductibles set by the commission applicable to the extended benefits riders, as a whole, or to individual benefits included within each extended benefits rider. Each employee may elect one or more of the available extended benefits riders offered by the employer in accordance with the terms and conditions established in P.L.2007, c.103 (C.52:14-17.46.1 et seq.) and by the commission pursuant to that act.

d. In addition to the Essential Benefits Primary Plan, the commission shall offer school employees and retirees a choice of standard health maintenance organization plans.

e. In the aggregate, benefits provided under the Essential Benefits Primary Plan and offered as extended benefits riders shall at least equal the benefit value of benefits of the School Employees’ Health Benefits Plan that are provided on the effective date of P.L.   , c. (pending before the Legislature as this bill).

2. (New section) The amount of contribution to be paid by school employees for health care benefits coverage for the Essential Benefits Primary Plan or a health maintenance organization for the employee and any dependent shall be as follows:

for family coverage or its equivalent -

an employee who earns less than $25,000 shall pay 3 percent of the cost of coverage;

an employee who earns $25,000 or more but less than $30,000 shall pay 4 percent of the cost of coverage;

an employee who earns $30,000 or more but less than $35,000 shall pay 5 percent of the cost of coverage;

an employee who earns $35,000 or more but less than $40,000 shall pay 6 percent of the cost of coverage;

an employee who earns $40,000 or more but less than $45,000 shall pay 7 percent of the cost of coverage;

an employee who earns $45,000 or more but less than $50,000 shall pay 9 percent of the cost of coverage;

an employee who earns $50,000 or more but less than $55,000 shall pay 12 percent of the cost of coverage;

an employee who earns $55,000 or more but less than $60,000 shall pay 14 percent of the cost of coverage;

an employee who earns $60,000 or more but less than $65,000 shall pay 17 percent of the cost of coverage;

an employee who earns $65,000 or more but less than $70,000 shall pay 19 percent of the cost of coverage;

an employee who earns $70,000 or more but less than $75,000 shall pay 22 percent of the cost of coverage;

an employee who earns $75,000 or more but less than $80,000 shall pay 23 percent of the cost of coverage;

an employee who earns $80,000 or more but less than $85,000 shall pay 24 percent of the cost of coverage;

an employee who earns $85,000 or more but less than $90,000 shall pay 26 percent of the cost of coverage;

an employee who earns $90,000 or more but less than $95,000 shall pay 28 percent of the cost of coverage;

an employee who earns $95,000 or more but less than $100,000 shall pay 29 percent of the cost of coverage;

an employee who earns $100,000 or more but less than $110,000 shall pay 32 percent of the cost of coverage;

an employee who earns $110,000 or more shall pay 35 percent of the cost of coverage;

for individual coverage or its equivalent -

an employee who earns less than $20,000 shall pay 4.5 percent of the cost of coverage;

an employee who earns $20,000 or more but less than $25,000 shall pay 5.5 percent of the cost of coverage;

an employee who earns $25,000 or more but less than $30,000 shall pay 7.5 percent of the cost of coverage;

an employee who earns $30,000 or more but less than $35,000 shall pay 10 percent of the cost of coverage;

an employee who earns $35,000 or more but less than $40,000 shall pay 11 percent of the cost of coverage;

an employee who earns $40,000 or more but less than $45,000 shall pay 12 percent of the cost of coverage;

an employee who earns $45,000 or more but less than $50,000 shall pay 14 percent of the cost of coverage;

an employee who earns $50,000 or more but less than $55,000 shall pay 20 percent of the cost of coverage;

an employee who earns $55,000 or more but less than $60,000 shall pay 23 percent of the cost of coverage;

an employee who earns $60,000 or more but less than $65,000 shall pay 27 percent of the cost of coverage;

an employee who earns $65,000 or more but less than $70,000 shall pay 29 percent of the cost of coverage;

an employee who earns $70,000 or more but less than $75,000 shall pay 32 percent of the cost of coverage;

an employee who earns $75,000 or more but less than $80,000 shall pay 33 percent of the cost of coverage;

an employee who earns $80,000 or more but less than $95,000 shall pay 34 percent of the cost of coverage;

an employee who earns $95,000 or more shall pay 35 percent of the cost of coverage;

for a covered person with child or spouse coverage or its equivalent -

an employee who earns less than $25,000 shall pay 3.5 percent of the cost of coverage;

an employee who earns $25,000 or more but less than $30,000 shall pay 4.5 percent of the cost of coverage;

an employee who earns $30,000 or more but less than $35,000 shall pay 6 percent of the cost of coverage;

an employee who earns $35,000 or more but less than $40,000 shall pay 7 percent of the cost of coverage;

an employee who earns $40,000 or more but less than $45,000 shall pay 8 percent of the cost of coverage;

an employee who earns $45,000 or more but less than $50,000 shall pay 10 percent of the cost of coverage;

an employee who earns $50,000 or more but less than $55,000 shall pay 15 percent of the cost of coverage;

an employee who earns $55,000 or more but less than $60,000 shall pay 17 percent of the cost of coverage;

an employee who earns $60,000 or more but less than $65,000 shall pay 21 percent of the cost of coverage;

an employee who earns $65,000 or more but less than $70,000 shall pay 23 percent of the cost of coverage;

an employee who earns $70,000 or more but less than $75,000 shall pay 26 percent of the cost of coverage;

an employee who earns $75,000 or more but less than $80,000 shall pay 27 percent of the cost of coverage;

an employee who earns $80,000 or more but less than $85,000 shall pay 28 percent of the cost of coverage;

an employee who earns $85,000 or more but less than $100,000 shall pay 30 percent of the cost of coverage;

an employee who earns $100,000 or more shall pay 35 percent of the cost of coverage.

Base salary shall be used to determine what an employee earns for the purposes of this provision.

As used in this section, "cost of coverage" means the annual cost of coverage attributable to the coverage selected by the covered person under the Essential Benefits Primary Plan or health maintenance organization as set forth in section 1 of P.L. , c.    (C.        ) (pending before the Legislature as this bill) for medical and prescription drug plan coverage, but not for dental, vision, or other health care benefits; extended benefits riders established and made available pursuant to subsection c. section 1 of P.L. , c. (C. ) (pending before the Legislature as this bill); or the annual cost of health care coverage attributable to the coverage selected by the covered person for health care, prescription drug, dental, vision, or for any other health care benefits provided pursuant to P.L.1979, c.391 (C.18A:16-12 et seq.), N.J.S.40A:10-16 et seq., or any other law adopted by a local board of education, local unit or agency thereof, including a county college, when the employer is not a participant in the School Employees' Health Benefits Program.

b. With respect to any extended benefits rider elected by a person, as provided in subsection c. section 1 of P.L. , c.    (C.        ) (pending before the Legislature as this bill), the cost of coverage for each rider shall be calculated on the basis of the aggregate loss experience for each rider, plus administrative costs, and the level of contribution by the person shall be the same as established for the Essential Benefits Primary Plan pursuant to subsection a. of this section.

3. (New section) a. The Essential Benefits Primary Plan and any extended benefits riders offered in connection with the plan may be provided through a network-preferred provider organization or organizations, a health maintenance organization, or any other delivery system selected by the commission. The School Employees’ Health Benefits Commission shall establish the level of coinsurance applicable to out-of-network treatment.

b. The benefits provided shall be for medically necessary services that are not deemed experimental, investigative, or otherwise ineligible by the commission. The commission, in consultation with the administrator, shall determine whether services are “eligible medical services” consistent with the best interests of the plan, participating employers, and the persons covered under the School Employees’ Health Benefits Program. Benefits for services provided pursuant to the “School Employees' Health Benefits Program Act,” sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11), shall be subject to limits or exclusions consistent with those that apply to benefits provided pursuant to the "New Jersey State Health Benefits Program Act," P.L.1961, c.49 (C.52:14-17.25 et seq.).

c. Benefits for the treatment of alcoholism shall be those prescribed by a physician and shall include treatment while confined in, or as an outpatient of, a licensed hospital or residential treatment program that meets the minimum standard of care prescribed by the Joint Commission on Hospital Accreditation. No benefits shall be provided beyond those stipulated in the health care plan established by the School Employees’ Health Benefits Commission.

d. Benefits for biologically based mental health conditions shall be subject to limits and exclusions consistent with those that apply to benefits for such services pursuant to section 2 of P.L.1999, c.441 (C.52:14-17.29e). Coverage provided under the “School Employees' Health Benefits Program Act,” sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11), shall include coverage for all services for which coverage is set forth in section 2 of P.L.1999, c.441 (C.52:14-17.29e) and in the same manner, whether through the Essential Benefits Primary Plan or through extended benefits riders.

4. (New section) a. Notwithstanding the provisions of subsection d. of section 13 of P.L.1983, c.362 (C.39:6A-4.3) or any other law to the contrary, an employee receiving health care coverage under the School Employees’ Health Benefits Program plan shall not be eligible to receive plan benefits as primary coverage for injuries suffered in an automobile accident in lieu of personal injury protection coverage under an automobile insurance policy.

b. With respect to any benefits paid under a School Employees’ Health Benefits Plan for which recovery is subsequently made in any legal proceeding or otherwise, the School Employees’ Health Benefits Commission shall have a lien on the recovery in the amount of the benefits paid to the employee or dependent under the plan and shall exercise that lien.

5. (New section) a. As used in this section:

“Administrator” means a pharmacy benefits manager or a third party administrator under an agreement or contract with the commission to administer the School Employee Prescription Drug Plan.

"Brand name" means the proprietary or trade name assigned to a drug product by the manufacturer or distributor of the drug product.

"Generic drug product" means prescription drug products and insulins that are approved and designated by the United States Food and Drug Administration as a therapeutic equivalent for reference-listed drug products. The term includes drug products listed in the New Jersey Generic Formulary by the Drug Utilization Review Council pursuant to the "Prescription Drug Price and Quality Stabilization Act," P.L.1977, c.240 (C.24:6E-1 et al.).

"Mail-order pharmacy" means a mail order program made available by the administrator for procuring prescription drugs.

"Other brands" means prescription drug products which are not preferred brands or generic drug products. A new drug product approved by the United States Food and Drug Administration, which is not a generic drug product, shall be included in this category until the plan administrator makes a determination concerning whether to include the new drug product in the list of preferred brands.

"Preferred brands" means brand name prescription drug products and insulins that the administrator determines to be a cost effective alternative for prescription drug products and insulins with comparable therapeutic efficacy within a therapeutic class, as defined or recognized in the United States Pharmacopeia or the American Hospital Formulary Service Drug Information, or by the American Society of Health Systems Pharmacists. A drug product for which there is no other therapeutically equivalent drug product shall be a preferred brand. Determinations of preferred brands by the administrator shall be subject to review and modification by the commission.

"Retail pharmacy" means a pharmacy, drug store, or other retail establishment located in this State at which prescription drugs are dispensed by a registered pharmacist under the laws of this State. Retail pharmacy may include a pharmacy, drug store, or other retail establishment located in another state at which prescription drug products are dispensed by a registered pharmacist under the laws of that state if the expense of the prescription drug products dispensed at that pharmacy, drug store, or other retail establishment are eligible for payment under the School Employee Prescription Drug Plan.

"School Employee Prescription Drug Plan" means the plan for providing payment for eligible prescription drug expenses of covered persons under the School Employees' Health Benefits Program and their dependents.

b. Employers that participate in the School Employees' Health Benefits Program may offer to their employees and eligible dependents:

(1) enrollment in the School Employee Prescription Drug Plan, (2) enrollment in another free-standing prescription drug plan, or

(3) election of prescription drug coverage under their health care coverage through the School Employees' Health Benefits Program plan or as otherwise determined by the commission.

c. A co-payment shall be required for each prescription drug expense if the employer chooses to participate in the School Employee Prescription Drug Plan. The initial amounts of the co-payments shall be the same as those in effect on July 1, 2007 for the employee prescription drug plan offered through the State Health Benefits Program.

d. If an employer elects to offer a free-standing prescription drug plan, the employee's share of the cost for this prescription drug plan may be determined by means of a binding collective negotiations agreement, including any agreements in force at the time the employer commences participation in the School Employees' Health Benefits Program.

e. If an employee declines the employer's offering of a free-standing prescription drug plan, no reimbursement for prescription drugs shall be provided through the School Employees' Health Benefits Program plan in which the employee is enrolled.

f. Except as federally or State mandated, an employee may not receive reimbursement for a prescription drug under the School Employees' Health Benefits Program if the prescription drug is not eligible for coverage under an employer's prescription drug plan.

g. If an employer declines to offer a free-standing prescription drug plan, then the employer shall offer prescription drug coverage under the School Employees' Health Benefits Program plan or in a manner otherwise determined by the commission. Any plan that has in-network and out-of-network coverage shall cover prescription drugs at 90 percent reimbursement for in-network care and at the reimbursement rate for out-of-network care applicable to health care coverage in the plan. The out-of-pocket amounts paid towards prescription drugs shall be combined with other out-of-pocket payments in calculating the out-of-pocket maximum costs permissible under the School Employees' Health Benefits Program plan.

h. Health care coverages through the School Employees' Health Benefits Program that only have in-network benefits shall include a prescription card with co-payment amounts the same as those in effect on July 1, 2007 for such coverages offered through the State Health Benefits Program or otherwise determined by the commission in consultation with the committee.

i. In the fifth year following the initial appointment of all of its members, the commission shall audit and review the prescription drug program established under this section and may make changes to the program by majority vote of the full authorized membership of the commission.

6. (New section) a. Notwithstanding the provisions of any other law to the contrary, public employees of the State and employers other than the State shall contribute, through the withholding of the contribution from their pay, salary, or other compensation, toward the cost of health care benefits coverage for the employees and any dependents provided under the School Employees' Health Benefits Program in an amount that shall be determined in accordance with section 2 of P.L. , c. (C. ) (pending before the Legislature as this bill).

The amount payable by any employee under this subsection shall not, under any circumstance, be less than the 1.5 percent of base salary that is provided for in subsection c. of section 6 of P.L.1996, c.8 (C.52:14-17.28b), subsection a. of section 7 of P.L.1964, c.125 (C.52:14-17.38), or subsection b. of section 39 of P.L.2007, c.103 (C.52:14-17.46.9). An employee who pays the contribution required under this subsection shall not be required also to pay the contribution of 1.5 percent of base salary under those subsections listed above.

This section shall apply to employees for whom the employer has assumed a health care benefits payment obligation, to require that such employees pay, at a minimum, the amount of contribution specified in this section for health care coverage.

b. The contribution required pursuant to subsection a. of this section shall commence upon the effective date of P.L. , c.   (C.       ) (pending before the Legislature as this bill) for employees who do not have a majority representative for collective negotiations purposes or upon the expiration of any relevant collective negotiations agreement setting contributions in effect on the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill) for employees who do have a majority representative for collective negotiations purposes.

c. The provisions of law permitting the determination of an amount of contribution at the discretion of the employer or by means of a binding collective negotiations agreement, and by means of the application of the terms of such an agreement to employees who do not have a majority representative for collective negotiations purposes, or the modification of the respective payment obligations of the employer and those employees in a manner consistent with the terms of such an agreement, shall remain in effect with regard to contributions, whether as a share of the cost of coverage or otherwise, in addition to the contributions required under subsection a. of this section. All other provisions of law concerning contributions for health care benefits shall remain applicable to the extent not inconsistent with this section.

d. Paragraph (7) of subsection c. of P.L.1996, c.8 (C.52:14-17.28b) shall apply with regard to contributions specified and made under this section.

7. (New section) a. Notwithstanding the provisions of any other law to the contrary, a public employee of a local board of education shall contribute, through the withholding of the contribution from the employee’s pay, salary, or other compensation, toward the cost of health care benefits coverage for the employee and any dependent provided pursuant to P.L.1979, c.391 (C.18A:16-12 et seq.) in an amount that shall be determined in accordance with section 2 of P.L. , c. (C. ) (pending before the Legislature as this bill).

The amount payable by any employee under this subsection shall not, under any circumstance, be less than the 1.5 percent of base salary that is provided for in subsection b. of section 6 of P.L.1979, c.391 (C.18A:16-17). An employee who pays the contribution required under this subsection shall not also be required to pay the contribution of 1.5 percent of base salary under subsection b. of section 6 of P.L.1979, c.391 (C.18A:16-17).

This section shall apply to employees for whom the employer has assumed a health care benefits payment obligation pursuant to section 6 of P.L.1979, c.391 (C.18A:16-17), to require that such employees pay, at a minimum, the amount of contribution specified in this section for health care benefits coverage.

b. The contribution required pursuant to subsection a. of this section shall commence upon the effective date of P.L. , c.   (C.       ) (pending before the Legislature as this bill) for employees who do not have a majority representative for collective negotiations purposes or upon the expiration of any relevant collective negotiations agreement setting contributions in effect on the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill) for employees who do have a majority representative for collective negotiations purposes.

c. The provisions of law permitting the determination of an amount of contribution at the discretion of the employer or by means of a binding collective negotiations agreement, and by means of the application of the terms of such an agreement to employees who do not have a majority representative for collective negotiations purposes, or the modification of the respective payment obligations of the employer and those employees in a manner consistent with the terms of such an agreement, shall remain in effect with regard to contributions, whether as a share of the cost of coverage or otherwise, in addition to the contributions required under subsection a. of this section. All other provisions of law concerning contributions for health care benefits shall remain applicable to the extent not inconsistent with this section.

d. This section shall apply when the health care benefits are provided through self-insurance, the purchase of commercial insurance or reinsurance, an insurance fund or joint insurance fund, or in any other manner, or any combination thereof.

8. Section 32 of P.L.2007, c.103 (C.52:14-17.46.2) is amended to read as follows:

32. As used in the School Employees' Health Benefits Program Act, sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11):

a. The term "State" means the State of New Jersey.

b. The term "commission" means the School Employees' Health Benefits Commission, created by section 33 of P.L.2007, c.103 (C.52:14-17.46.3).

c. The term "employer" means local school district, regional school district, county vocational school district, county special services school district, jointure commission, educational services commission, State-operated school district, charter school, county college, any officer, board, or commission under the authority of the Commissioner of Education or of the State Board of Education, and any other public entity which is established pursuant to authority provided by Title 18A of the New Jersey Statutes, but excluding the State public institutions of higher education and excluding those public entities where the employer is the State of New Jersey.

d. (1) The term "employee" means a person employed in any full time capacity by an employer, and shall include persons defined as a school employee by the regulations of the State Health Benefits Commission in effect on the effective date of the School Employees' Health Benefits Program Act. "Full-time" shall have the same meaning as in the regulation of the State Health Benefits Commission regarding local coverage in effect on the effective date of the School Employees' Health Benefits Program Act.

(2) After the effective date of P.L.2010, c.2, the term "employee" means (a) a person employed in any full-time capacity by an employer who appears on a regular payroll and receives a salary or wages for an average of the number of hours per week as prescribed by the governing body of the participating employer which number of hours worked shall be considered full-time, determined by resolution, and not less than 25, and shall include persons defined as a school employee by the regulations of the State Health Benefits Commission in effect on the effective date of the School Employees' Health Benefits Program Act, or (b) a person employed in any full-time capacity by an employer who has or is eligible for health benefits coverage provided under P.L.1961, c.49 (C.52:14-17.25 et seq.) or sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 et seq.) on that effective date and continuously thereafter provided the person is covered by the definition in paragraph (1) of this subsection. The term "employee" shall not include persons employed on a short-term, seasonal, intermittent, or emergency basis, persons compensated on a fee basis, persons having less than two months of continuous service or persons whose compensation is limited to reimbursement of necessary expenses actually incurred in the discharge of their official duties. An employee paid on a 10-month basis, pursuant to an annual contract, shall be deemed to have satisfied the two-month waiting period if the employee begins employment at the beginning of the contract year. The term "employee" shall also not include retired persons who are otherwise eligible for benefits under the School Employees' Health Benefits Program but who, although they meet the age or disability eligibility requirement of Medicare, are not covered by Medicare Hospital Insurance, also known as Medicare Part A, and Medicare Medical Insurance, also known as Medicare Part B. A determination by the commission that a person is an eligible employee for the purposes of the School Employees' Health Benefits Program shall be final and binding on all parties.

e. The term "dependents" means an employee's spouse, domestic partner, or partner in a civil union couple, and unmarried children under the age of 23 years who live in a regular parent/child relationship. "Children" shall include stepchildren, legally adopted children and children placed by the Division of Youth and Family Services in the Department of Children and Families, provided they are reported for coverage and are wholly dependent upon the employee for support and maintenance. A spouse, domestic partner, partner in a civil union couple, or child enlisting or inducted into military service shall not be considered a dependent during the military service. The term "dependents" shall not include spouses, domestic partners, or partners in a civil union couple, of retired persons who are otherwise eligible for the benefits under the School Employees' Health Benefits Program but who, although they meet the age or disability eligibility requirement of Medicare, are not covered by Medicare Hospital Insurance, also known as Medicare Part A, and Medicare Medical Insurance, also known as Medicare Part B.

f. The term "carrier" means a **[**voluntary association, corporation or other organization, including but not limited to**]** an insurer licensed to do business in this State and a health maintenance organization as defined in section 2 of the "Health Maintenance Organizations Act," P.L.1973, c.337 (C.26:2J-2), or a third party administrator licensed pursuant to P.L.2001, c.267 (C.17B:27B-1 et seq.), which is lawfully engaged in **[**providing or paying for or reimbursing the cost of,**]** administering personal health services on behalf of an employer, including hospitalization, medical and surgical services **[**under insurance policies or contracts, membership or subscription contracts, or the like, in consideration of premiums or other periodic charges payable to the carrier**]**.

g. The term "hospital" means:

(1) an institution operated pursuant to law which is primarily engaged in providing on its own premises, for compensation from its patients, medical diagnostic and major surgical facilities for the care and treatment of sick and injured persons on an inpatient basis, and which provides such facilities under the supervision of a staff of physicians and with 24 hour a day nursing service by registered graduate nurses, or

(2) an institution not meeting all of the requirements of paragraph (1) but which is accredited as a hospital by the Joint Commission on Accreditation of Hospitals. In no event shall the term "hospital" include a convalescent nursing home or any institution or part thereof which is used principally as a convalescent facility, residential center for the treatment and education of children with mental disorders, rest facility, nursing facility or facility for the aged or for the care of drug addicts or alcoholics.

h. The term "Medicare" means the program established by the "Health Insurance for the Aged Act," Title XVIII of the "Social Security Act," Pub.L.89-97 (42 U.S.C. s.1395 et seq.), as amended, or its successor plan or plans.

i. The term "**[**managed**]** health care plan" means a health care plan under which comprehensive health care services and supplies are provided to eligible employees, retirees, and dependents: (1) through a group of doctors and other providers employed by the plan; or (2) through an individual practice association, preferred provider organization, or point of service plan under which services and supplies are furnished to plan participants through a network of doctors and other providers under contracts or agreements with the plan on a prepayment or reimbursement basis and which may provide for payment or reimbursement for services and supplies obtained outside the network. The plan **[**may**]** shall be provided **[**on an insured basis through contracts with carriers or**]** on a self-insured basis, and may be operated and administered by the State **[**or**]** , by carriers , or by other administrators of health care benefits plans under administrative services only contracts with the State.

j. The term "successor plan" means a **[**managed**]** health care plan that shall replace the "traditional plan," as defined in section 2 of P.L.1961, c.49 (C.52:14-17.26), and that shall provide benefits as set forth in **[**section 36 of P.L.2007, c.103 (C.52:14-17.46.6)**]** the Essential Benefits Primary Plan, established pursuant to subsection b. of section 1 of P.L. , c. (C. ) (pending before the Legislature as this bill), and any optional riders offered in connection with that plan, and provide out-of-network benefits to participants with a payment by the plan of **[**80%**]** 80 percent of reasonable and customary charges as set forth in section 37 of P.L.2007, c.103 (C.52:14-17.46.7) and as may be adjusted in accordance with section 40 of P.L.2007, c.103 (C.52:14-17.46.10).

k. The term “third party administrator” or “administrator” means a third party administrator licensed by the Department of Banking and Insurance or a carrier licensed or otherwise authorized to act as a third party administrator.

l. The term "reasonable and customary charges" means charges based upon the 90th percentile of the usual, customary, and reasonable (UCR) fee schedule determined by the Health Insurance Association of America or a similar nationally recognized database of prevailing health care charges.

m. The term “cost of coverage” means the actual cost of the health care benefits set forth in the plan, plus any anticipated loss development for the subsequent coverage period, as determined by the administrator or health maintenance organization, plus administrative costs paid to the administrator, pharmacy benefits manager, or any other ancillary organization engaged to manage the administration of the plan or plans.

(cf: P.L.2010, c.2, s.10)

9. Section 33 of P.L.2007, c.103 (C.52:14-17.46.3) is amended to read as follows:

33. a. There is hereby created a School Employees' Health Benefits Commission **[**,consisting**]** . The commission may periodically propose changes to the Essential Benefits Primary Plan. The Legislature shall approve, by law, any proposed changes to the Essential Benefits Primary Plan before the changes take effect. The commission shall have the sole authority to decide which proposed changes to the Essential Benefits Primary Plan are submitted to the Legislature for approval. The commission shall consist of nine members:

(1) the State Treasurer and the Commissioner of the Department of Banking and Insurance serving ex officio;

(2) **[**a member**]** two public members appointed by the Governor who **[**is a**]** are New Jersey **[**resident**]** residents and **[**is**]** qualified by experience, education, or training in the review, administration, or design of health **[**insurance**]** care plans for self-insured employers;

(3) a member appointed by the Governor from among three persons nominated by the New Jersey School Boards' Association, which member shall be qualified by experience, education, or training in the review, administration, or design of health **[**insurance**]** care plans for self-insured employers;

(4) three members appointed by the Governor from among five persons nominated by the New Jersey Education Association, of whom two shall be qualified by experience, education, or training in the review, administration, or design of health **[**insurance**]** care plans for self-insured employers;

(5) a member appointed by the Governor from among three persons nominated by the education section of the New Jersey State AFL-CIO, which member shall be qualified by experience, education, or training in the review, administration, or design of health **[**insurance**]** care plans for self-insured employers; and

(6) **[**a member appointed pursuant to subsection b. of this section who shall be the chairperson**]** the State Treasurer shall be the chairperson.

b. **[**The Governor shall appoint the chairperson from among three persons nominated jointly by at least six of the eight members appointed pursuant to subsection a. of this section.**]** (Deleted by amendment, P.L. , c. ) (pending before the Legislature as this bill)

c. If the Governor declines to make an appointment from among the persons nominated for membership, the Governor shall request that a new list of nominees be provided in compliance with subsection a. of this section. If the Governor declines to make an appointment from the new list, the process set forth in this subsection shall be repeated until the Governor makes an appointment from a list of nominees. **[**Except with respect to the appointment of the chairperson, if**]** If a new list of nominees is not submitted within 45 days of the Governor's request, the Governor shall make the appointment without the need to select from any list of nominees.

d. The initial terms of the members of the commission shall be as follows:

(1) the member appointed pursuant to paragraph (3) of subsection a. of this section and the two members appointed pursuant to paragraph (4) of subsection a. of this section who are required to be qualified by experience, education, or training shall serve for a term of three years; and

(2) the member appointed pursuant to paragraph (2) of subsection a. of this section, the member appointed pursuant to paragraph (4) of subsection a. of this section who is not required to be qualified by experience, education, or training, and the member appointed pursuant to paragraph (5) of subsection a. of this section shall serve for a term of two years **[**; and

(3) the chairperson shall serve for a term of six years**]**.

All subsequent terms shall be for three years **[**, except that the term of the chairperson shall be five years**]**. A member of the commission may be reappointed to succeeding terms without limit in the same manner as the original appointment. A vacancy occurring on the commission shall be filled in the same manner as the original appointment and only for the unexpired term.

e. There is established a School Employees' Health Benefits Plan Design Committee, composed of **[**six**]** seven members as follows:

three members who shall be appointed by the Governor as representatives of public employers whose employees are enrolled in the program;

two members who shall be appointed by the Governor upon the recommendation of the New Jersey Education Association; **[**and**]**

one member who shall be appointed by the Governor upon the recommendation of the education section of the New Jersey State AFL-CIO; and

one public member who shall be appointed by the Governor.

The members of the committee shall serve for a term of three years and until a successor is appointed and qualified. Of the initial appointments by the Governor, two members shall serve for two years and until a successor is appointed and qualified, and one shall serve for one year and until a successor is appointed and qualified. Of the initial appointments **[**by**]** of members of the New Jersey Education Association, one member shall serve for one year and until a successor is appointed and qualified.

The members of the committee shall select a chairperson from among the members, who shall serve for a term of one year, with no member serving more than one term as chairperson until all the members of the committee have served a term in a manner alternating among the employer representatives and employee representatives, unless the committee determines otherwise with regard to this process.

The committee shall **[**have the responsibility for and authority over the various plans and components of those plans, including for medical benefits, prescription benefits, dental, vision, and any other health care benefits, offered and administered by the program. The committee shall have the authority to create, modify, or terminate any plan or component, at its sole discretion. Any reference in law to the School Employees' Health Benefits Commission in the context of the creation, modification, or termination of a plan or plan component shall be deemed to apply to the committee**]** consult with the commission on the development and composition of extended benefits riders that employees and retirees may purchase in connection with the Essential Benefits Primary Plan. The commission, however, shall retain sole authority over the development and composition of extended benefits riders.

**[**The members of the committee shall have the same duty and responsibility to the program as do the members of the commission.

If any matter before the committee receives at least four votes in the affirmative, the commission shall approve and implement the committee's decision.

If any matter before the committee receives three votes in the affirmative and three votes in the negative or the committee otherwise reaches an impasse on a decision, the provisions of section 55 of P.L.2011, c.78 (C.52:14-17.27b) shall be followed.**]**

(cf: P.L.2011, c.78, s.46)

10. Section 35 of P.L.2007, c.103 (C.52:14-17.46.5) is amended to read as follows:

35. a. The commission shall **[**negotiate with and arrange for the purchase, on such terms as it deems in the best interests of the State, participating employers and those persons covered hereunder from carriers licensed to operate in the State or in other jurisdictions, as appropriate, contracts providing benefits required by the School Employees' Health Benefits Program Act, as specified in section 36 of P.L.2007, c.103 (C.52:14-17.46.6), or such benefits as the commission may determine to provide, so long as such modification of benefits is in the best interests of the State, participating employers and those persons covered hereunder, and is consistent with the provisions of section 40 of that act (C.52:14-17.46.10)**]** establish a health care plan covering school employees in accordance with the provisions of sections 1 through 5 of P.L. , c.    (C.  ) (pending before the Legislature as this bill) and P.L.2007, c.103 (C.52:14-17.46.1 et seq.), including the Essential Benefits Primary Plan, established pursuant to subsection b. of section 1 of P.L. , c. (C. ) (pending before the Legislature as this bill), any optional riders offered in connection with that plan, and alternative coverage under a health maintenance organization plan. The commission shall have authority to execute all documents pertaining thereto for and on behalf of the State. **[**The commission shall not enter into a contract under the School Employees' Health Benefits Program Act, unless the benefits provided thereunder are equal to or exceed the standards specified in section 36 of that act, or as such standards are modified pursuant to section 40 of that act.**]**

b. The **[**rates charged for any contract purchased**]** cost of coverage for health benefits plans provided under the authority of the School Employees' Health Benefits Program Act shall reasonably and equitably reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound. The **[**rates charged**]** cost of coverage shall be determined based upon **[**accepted group rating principles with due regard to**]** the loss experience, both past and **[**contemplated, under the contract**]** prospective, as well as the cost of administering the plan. The commission shall have the right to particularize subgroups for experience purposes and rates. No increase in rates shall be retroactive.

c. The commission shall be authorized to **[**accept an assignment of contract rights from or**]** enter into an agreement, contract, memorandum of understanding or other terms with the State Health Benefits Commission to ensure that coverage for eligible employees, retirees and dependents under the School Employees' Health Benefits Program whose benefits had been provided through the State Health Benefits Program is continued without interruption. The transition provided for in this subsection shall occur within one year of the effective date of the School Employees' Health Benefits Program Act, sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11).

d. Benefits **[**under the contract or contracts purchased as authorized by the School Employees' Health Benefits Program Act**]** may be subject to such limitations, exclusions, or waiting periods as the commission finds to be necessary or desirable to avoid inequity, unnecessary utilization, duplication of services or benefits otherwise available, including coverage afforded under the laws of the United States, such as the federal Medicare program, or for other reasons.

e. The **[**initial**]** term of any contract **[**purchased by the commission under the authority of the School Employees' Health Benefits Program Act**]** with an administrator of the plan or any health maintenance organization shall be for such period to which the commission and the **[**carrier**]** administrator or health maintenance organization may agree, but permission may be made for automatic renewal in the absence of notice of termination by the commission. Subsequent terms for which any contract may be renewed as herein provided shall each be limited to a period not to exceed one year.

(cf: P.L.2007, c.103, s.35)

11. Section 10 of P.L.2009, c.115 (C.52:14-17.46.6b) is amended to read as follows:

10. Notwithstanding any other provision of law to the contrary, the School Employees' Health Benefits Commission shall **[**ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall**]** provide coverage pursuant to the provisions of this section.

a. The **[**contract**]** health care plan shall provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.

b. When the covered person's primary diagnosis is autism or another developmental disability, the **[**contract**]** health care plan shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. When the covered person is under 21 years of age and the covered person's primary diagnosis is autism, the **[**contract**]** health care plan shall provide coverage for expenses incurred for medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed through a treatment plan, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the **[**contract**]** health care plan, but shall not be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions.

(2) The benefits provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum benefit amount for a covered person in any calendar year through 2011 shall be $36,000.

(b) Commencing on January 1, 2012, the maximum benefit amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum benefit amount shall apply to **[**a contract that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in**]** the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, the commission shall not be precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the **[**carrier**]** administrator to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The **[**carrier**]** administrator may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the **[**carrier**]** administrator and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of subsections b. and c. of this section shall not be construed as limiting benefits otherwise available to a covered person.

f. The provisions of subsections b. and c. of this section shall not be construed to require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program, or affect any requirement to provide those services; except that the benefits provided pursuant to those subsections shall include coverage for expenses incurred by participants in an individualized family service plan through a family cost share.

g. The coverage required under this section may be subject to utilization review, including periodic review, by the **[**carrier**]** administrator of the continued medical necessity of the specified therapies and interventions.

(cf: P.L.2009, c.115, s.10)

12. Section 10 of P.L.2011, c.188 (C.52:14-17.46.6c) is amended to read as follows:

10. a. The School Employees' Health Benefits Commission shall **[**ensure that every contract purchased on or after the effective date of this act that provides hospital or medical expense benefits shall**]** provide coverage for expenses for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells on a basis no less favorable than the **[**contract**]** health care plan provides for intravenously administered or injected anticancer medications.

b. Pursuant to subsection a. of this section, coverage for expenses for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells shall not be subject to any prior authorization, dollar limit, copayment, deductible or coinsurance provision that does not apply to intravenously administered or injected anticancer medications.

c. A School Employees' Health Benefits Commission **[**contract**]** health care plan shall not achieve compliance with the provisions of this section by imposing an increase in patient cost sharing, including any copayment, deductible or coinsurance, for anticancer medications, whether intravenously administered or injected or orally administered, that are covered under the **[**contract**]** health care plan as of the effective date of **[**this act**]** P.L.2011, c.188.

(cf: P.L.2011, c.188, s.10)

13. Section 10 of P.L.2013, c.50 (C.52:14-17.46.6d) is amended to read as follows:

10. The health care plan established by the School Employees' Health Benefits Commission shall **[**ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits that**]** include coverage for prescription eye drops**[**,**]** and shall provide coverage for expenses incurred for refills of prescription eye drops in accordance with the Guidance for Early Refill Edits of Topical Ophthalmic Products provided to Medicare Part D plan sponsors by the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services, provided that:

(1) the prescribing health care practitioner indicates on the original prescription that additional quantities of the prescription eye drops are needed; and

(2) the refill requested by the covered person does not exceed the number of additional quantities indicated on the original prescription by the prescribing health care practitioner.

(cf: P.L.2013, c.50, s.10)

14. Section 10 of P.L.2015, c.206 (C.52:14-17.46.6e) is amended to read as follows:

10. The School Employees' Health Benefits Commission shall **[**ensure that every contract under the School Employees' Health Benefits Program purchased on or after the effective date of this act, which provides benefits for pharmacy services, prescription drugs, or for participation in a prescription drug plan, shall,**]** on at least one occasion per year for each covered person:

(1) apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a network pharmacy for less than a 30 days' supply if the prescriber or pharmacist indicates the fill or refill is in the best interest of the covered person or is for the purpose of synchronizing the covered person's chronic medications;

(2) provide coverage for a drug prescribed for the treatment of a chronic illness dispensed in accordance with a plan among the covered person, the prescriber and the pharmacist to synchronize the refilling of multiple prescriptions for the covered person; and

(3) determine dispensing fees based exclusively on the total number of prescriptions dispensed; dispensing fees shall not be prorated or based on the number of the days' supply of medication prescribed or dispensed.

This section shall not apply to prescriptions for opioid analgesics. "Opioid analgesic" means a drug in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in immediate release or extended release form, and whether or not combined with other drug substances to form a single drug product or dosage form.

(cf: P.L.2015, c.206, s.10)

15. Section 37 of P.L.2007, c.103 (C.52:14-17.46.7) is amended to read as follows:

37. Beginning with the initial year of the School Employees' Health Benefits Program, the commission shall offer to participating employers and to qualified employees, retirees and dependents a managed care plan in which the office co-payment amount shall be $10 per visit with a maximum out-of-pocket of $400 per individual and $1,000 per family for in-network services for each calendar year. The out-of-network deductible shall be $100 per individual and $250 per family for each calendar year with the plan paying for **[**80%**]** 80 percent of reasonable and customary charges as defined herein up to an out-of-pocket maximum that shall not exceed $2,000 per individual and $5,000 per family for each calendar year. Beginning with the implementation of the Essential Benefits Primary Plan established by P.L. , c. (C. ) (pending before the Legislature as this bill), the office co-payment amount shall be $25 per visit with an annual maximum out-of-pocket cost of $500 for an individual and $1,100 for a family.

In the successor plan, the in-network out-of-pocket payments shall count toward the out-of-network out-of-pocket maximums. Any lifetime maximum for out-of-network services shall not be less than any maximums in effect under the State Health Benefits Program as of July 1, 2007. There shall be no lifetime maximum for in-network services.

The **[**carrier that administers**]** administrator of the successor plan shall make available to the plan participants through in-network and out-of-network providers access to physicians and hospitals sufficient in geographic scope and number to provide access to health care services that is substantially equivalent to the access to health care services available through the State Health Benefits Program as of July 1, 2007.

Beginning with the initial year of the School Employees' Health Benefits Program, the commission shall be authorized to offer to participating employers and qualified employees, retirees and dependents managed care plans in which the in-network per visit charge shall not exceed $15 per visit and the out of network reimbursement shall be **[**70%**]** 70 percent of the usual, reasonable and customary charges as defined herein, provided the in-network and out-of-network maximums and deductibles do not exceed the limits set forth above. Beginning with the implementation of the Essential Benefits Primary Plan established by P.L. , c. (C. ) (pending before the Legislature as this bill), the in-network per visit charge shall be $25 per visit and the out-of-network reimbursement shall be 70 percent of the reasonable and customary charges.

The amounts of maximums, co-pays, deductibles, and other participant costs shall be reviewed, as part of the fifth year audit undertaken pursuant to section 40 of P.L.2007, c.103 (C.52:14-17.46.10). The commission shall make changes in such amounts pursuant to section 40 by majority vote of the full authorized membership of the commission.

**[**Beginning January 1, 2012, the School Employees' Health Benefits Plan Design Committee shall have the sole discretion to set the amounts for maximums, co-pays, deductibles, and other such participant costs for all plans offered in the program, notwithstanding any other provision of law to the contrary.**]**

"Reasonable and customary charges" means, for any out-of-network payment made by a carrier, charges based upon the 90th percentile of the usual, customary, and reasonable (UCR) fee schedule determined by the Health Insurance Association of America or a similar nationally recognized database of prevailing health care charges.

Beginning with the initial year of the School Employees' Health Benefits Program, the commission shall offer to participating employers and qualified employees, retirees and dependents one or more health maintenance organization plans.

(cf: P.L.2011, c.78, s.49)

16. Section 39 of P.L.2007, c.103 (C.52:14-17.46.9) is amended to read as follows:

39. a. For each active covered employee and for the eligible dependents the employee may have enrolled at the employee's option, from funds appropriated therefor, the employer shall pay to the commission the **[**premium or periodic charges**]** cost of coverage for the benefits provided under the **[**contract**]** health care plan in amounts equal to the premium or periodic charges for the benefits provided under such a **[**contract**]** plan covering the employee and the employee's enrolled dependents.

b. The obligations of any employer to pay the **[**premium or periodic charges**]** cost of coverage for health benefits coverage provided under the School Employees' Health Benefits Program Act, sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11), may be determined by means of a binding collective negotiations agreement, including any agreement in force at the time the employer commences participation in the School Employees' Health Benefits Program. With respect to employees for whom there is no majority representative for collective negotiations purposes, the employer may, in its sole discretion, modify the respective payment obligations set forth in law for the employer and such employees in a manner consistent with the terms of any collective negotiations agreement binding on the employer.

Commencing on the effective date of P.L.2010, c.2 and upon the expiration of any applicable binding collective negotiations agreement in force on that effective date, employees shall pay 1.5 percent of base salary, through the withholding of the contribution, for health benefits coverage provided under P.L.2007, c.103 (C.52:14-17.46.1 et seq.), notwithstanding any other amount that may be required additionally pursuant to this subsection by means of a binding collective negotiations agreement or the modification of payment obligations by law.

c. There is hereby established a School Employee Health Benefits Program fund consisting of all contributions to **[**premiums and periodic charges**]** the cost of coverage remitted to the State treasury by participating employers for employee coverage. All such contributions shall be deposited in the fund and the fund shall be used to pay the portion of the **[**premium and periodic charges**]** cost of coverage attributable to employee and dependent coverage.

d. Notwithstanding any law to the contrary and except as provided by amendment by P.L.2010, c.2, and by P.L.2011, c.78, the payment in full of **[**premium or periodic charges**]** the cost of coverage for eligible retirees and their dependents pursuant to section 3 of P.L.1987, c.384 (C.52:14-17.32f), section 2 of P.L.1992, c.126 (C.52:14-17.32f1), or section 1 of P.L.1995, c.357 (C.52:14-17.32f2) shall be continued without alteration or interruption and there shall be no premium sharing or periodic charges for certain school employees in retirement once they have met the criteria for vesting for pension benefits, which criteria for purposes of this subsection only shall mean the criteria for vesting in the Teachers' Pension and Annuity Fund. **[**For purposes of this subsection, "premium sharing or periodic charges" shall mean payments by eligible retirees based upon a proportion of the premiums for health care benefits.**]**

(cf: P.L.2011, c.78, s.54)

17. Section 36 of P.L.2007, c.103 (C.52:14-17.46.6) is repealed.

18. This act shall take effect on the 180th day next following enactment, except the School Employees’ Health Benefits Commission may take any anticipatory administrative action in advance as shall be necessary for the implementation of this act.

STATEMENT

This bill makes a number of changes to the School Employees Health Benefits Program. In lieu of the present benefits currently in the plan, the bill divides the existing plan into several parts, permitting persons covered by the plan to elect the benefits they want. The core of the plan is an Essential Benefits Primary Plan, the benefits in which are statutory; it would be the default plan for all covered persons. The Essential Benefits Primary Plan is modeled after the indemnity plans most commonly purchased in the 1950s and 1960s. It contains the basic health benefits that the majority of people use most frequently; a similar policy sold in the commercial insurance market in New Jersey until very recently proved to be very successful because individuals were able to protect themselves at a lower cost than the cost of the other commercial policies. Under the provisions of the bill, no additions can be made to the statutory benefits listed in the Essential Benefits Primary Plan without the assent of the Legislature and the Governor by law.

As an adjunct to the Essential Benefits Primary Plan, the bill provides for the formulation of extended benefits riders, which would be groupings of additional benefits presently included in the School Employees’ Health Benefits Program and the State Health Benefits Plan, but which are not included in the Essential Benefits Primary Plan. These would include additional or enhanced benefits. The riders would be formulated by the State Health Benefits Commission with the assistance of the Health Benefits Design Committee. Each rider would be rated separately, based on its loss experience. Any new benefits added to the benefits plan, whether by negotiation or by statute, would be added to a plan rider. Riders are to be formulated as groupings of benefits in a manner that will avoid, to the extent possible, adverse selection with respect to the persons electing them.

The extent of coverage in the revised School Employees’ Health Benefits Program would be selected at the option of the covered person. If the covered person elected only the Essential Benefits Primary Plan, his contribution to his coverage would be reduced from his existing contribution because he would not be paying for benefits he may neither want, need, nor can afford. Taken together, the Essential Benefits Primary Plan and all of the extended benefits riders would contain all of the benefits now in the School Employees Health Benefits Program and the State Health Benefits Plan, giving covered persons the option of retaining their existing coverage and their contribution to the coverage would not be reduced from present levels. The bill renews the existing contribution percentages required under current law, which were due to expire in 2015. The cost of coverage of the respective parts of the plan would be based on the actual loss experience of the benefits of those parts, plus any anticipated loss development for the subsequent coverage period, and the cost of administration.

The bill adds two public members appointed by the Governor to the School Employees’ Health Benefits Commission. The State Treasurer would be the chairperson. The bill adds one public member, appointed by the Governor, to the School Employees’ Health Benefits Plan Design Committee. The role of the Design Committee would be a consultative one, collaborating with the commission on the development and composition of the extended benefits riders. The commission would retain the sole authority to submit to the Legislature proposed changes to the Essential Benefits Primary Plan.

The bill would prohibit any covered person from using the benefits in the School Employees’ Health Benefits Program in lieu of the personal injury protection coverage under an automobile insurance policy. Personal injury protection coverage, which provides medical benefits under the no-fault law, is one of the least expensive benefits in an automobile insurance policy, and these costs would no longer be paid by public money, which adds considerably to the cost of the school employees’ health benefits coverage.

The bill is intended not only to reduce the cost of the School Employees’ Health Benefits Program for the State and local governments, but to give employees choices as to their coverage, which can reduce their costs as well by permitting them to select the coverage which is best suited to their needs; it is likely that many will elect the Essential Benefits Primary package, with or without one or more riders, but will not prohibit any person from selecting the full package of benefits now offered under the current plan. It is the sponsor’s intent that, to the extent that the total average cost of coverage per covered person in the State plan is reduced, it would be possible for the State and local employers to avoid paying the “Cadillac” tax due to be levied in several years by the federal government pursuant to the Patient Protection and Affordable Care Act.

Finally, the bill makes a number of technical changes to existing law to accommodate the fact that the plan is a self-insured plan, rather than an insured plan as in the past. This consists primarily of changes in terminology to reflect the manner in which the plan is now administered.