

# ASSEMBLY, No. 2431

## STATE OF NEW JERSEY 218th LEGISLATURE

INTRODUCED FEBRUARY 1, 2018

**Sponsored by:**

**Assemblyman DANIEL R. BENSON**

**District 14 (Mercer and Middlesex)**

**Assemblywoman ANGELICA M. JIMENEZ**

**District 32 (Bergen and Hudson)**

**Assemblywoman BETTYLOU DECROCE**

**District 26 (Essex, Morris and Passaic)**

**Assemblyman TIM EUSTACE**

**District 38 (Bergen and Passaic)**

**Co-Sponsored by:**

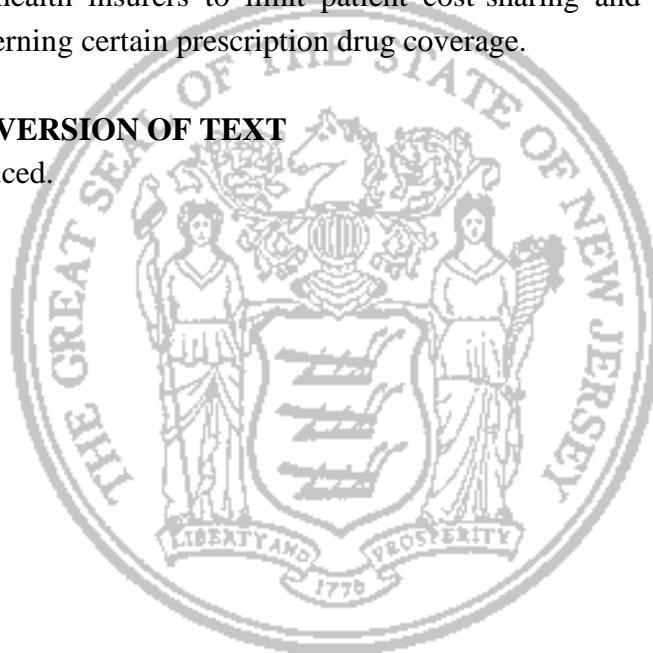
**Assemblywoman Vainieri Huttie, Assemblymen Mukherji, Bramnick,  
Assemblywoman Murphy, Assemblyman McKeon, Assemblywomen Jasey,  
Schepisi, Assemblymen Giblin, Dancer, Conaway and Johnson**

**SYNOPSIS**

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

**CURRENT VERSION OF TEXT**

As introduced.



**(Sponsorship Updated As Of: 1/25/2019)**

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

3

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

6

7 1. a. Notwithstanding any other provision of law to the  
8 contrary, every hospital service corporation contract that provides  
9 benefits for expenses incurred in the purchase of prescription drugs  
10 and is delivered, issued, executed, or renewed in this State pursuant  
11 to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or  
12 renewal in this State by the Commissioner of Banking and  
13 Insurance, on or after the effective date of this act, shall conform  
14 with the following:

15 (1) (a) except as provided for in subparagraphs (b) and (c) of  
16 this paragraph, limit a covered person's out-of-pocket financial  
17 responsibility, including any copayment or coinsurance, for  
18 prescription drugs, including specialty drugs, to no more than \$100  
19 per month for each prescription drug for up to a 30-day supply of  
20 any single drug;

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

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

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

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

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

1 the prescribing physician determines that the formulary drug for  
2 treatment of the same condition either would not be as effective for  
3 the enrollee or would have adverse effects for the enrollee, or both.  
4 If an enrollee is denied such an exception, that denial shall be  
5 deemed an adverse determination that will be subject to appeal  
6 under the carrier's internal appeal process and section 11 of  
7 P.L.1997, c.192 (C.26:2S-11).

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

11

12 2. a. Notwithstanding any other provision of law to the  
13 contrary, every medical service corporation contract that provides  
14 benefits for expenses incurred in the purchase of prescription drugs  
15 and is delivered, issued, executed, or renewed in this State pursuant  
16 to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or  
17 renewal in this State by the Commissioner of Banking and  
18 Insurance, on or after the effective date of this act, shall conform  
19 with the following:

20 (1) (a) except as provided for in subparagraphs (b) and (c) of this  
21 paragraph, limit a covered person's out-of-pocket financial  
22 responsibility, including any copayment or coinsurance, for  
23 prescription drugs, including specialty drugs, to no more than \$100  
24 per month for each prescription drug for up to a 30-day supply of  
25 any single drug;

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

32 (c) a medical service corporation contract that meets the  
33 requirements of a catastrophic plan, as defined in 45 C.F.R.  
34 s.156.155, shall be exempt from the requirements of subparagraphs  
35 (a) and (b) of this paragraph;

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

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

1 pocket expenditures for prescription drug benefits shall be as  
2 specified in paragraph (1) of this subsection; and

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

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

16  
17 3. a. Notwithstanding any other provision of law to the  
18 contrary, every health service corporation contract that provides  
19 benefits for expenses incurred in the purchase of prescription drugs  
20 and is delivered, issued, executed, or renewed in this State pursuant  
21 to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or  
22 renewal in this State by the Commissioner of Banking and  
23 Insurance, on or after the effective date of this act, shall conform  
24 with the following:

25 (1) (a) except as provided for in subparagraphs (b) and (c) of this  
26 paragraph, limit a covered person's out-of-pocket financial  
27 responsibility, including any copayment or coinsurance, for  
28 prescription drugs, including specialty drugs, to no more than \$100  
29 per month for each prescription drug for up to a 30-day supply of  
30 any single drug;

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

37 (c) a health service corporation contract that meets the  
38 requirements of a catastrophic plan, as defined in 45 C.F.R.  
39 s.156.155, shall be exempt from the requirements of subparagraphs  
40 (a) and (b) of this paragraph;

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

45 (3) for prescription drug benefits offered in conjunction with a  
46 high-deductible health plan, not provide prescription drug benefits  
47 until the expenditures applicable to the deductible under the plan  
48 have met the amount of the minimum annual deductibles in effect

1 for self-only and family coverage under section 223(c)(2)(A)(i) of  
2 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for  
3 self-only and family coverage, respectively. Once the foregoing  
4 expenditure amount has been met under the plan, coverage for  
5 prescription drug benefits shall begin, and the limit on out-of-  
6 pocket expenditures for prescription drug benefits shall be as  
7 specified in paragraph (1) of this subsection; and

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

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

21

22 4. a. Notwithstanding any other provision of law to the  
23 contrary, every individual health insurance policy that provides  
24 benefits for expenses incurred in the purchase of prescription drugs  
25 and is delivered, issued, executed, or renewed in this State pursuant  
26 to chapter 26 of Title 17B of the New Jersey Statutes, or approved  
27 for issuance or renewal in this State by the Commissioner of  
28 Banking and Insurance, on or after the effective date of this act,  
29 shall conform with the following:

30 (1) (a) except as provided for in subparagraphs (b) and (c) of this  
31 paragraph, limit a covered person's out-of-pocket financial  
32 responsibility, including any copayment or coinsurance, for  
33 prescription drugs, including specialty drugs, to no more than \$100  
34 per month for each prescription drug for up to a 30-day supply of  
35 any single drug;

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

42 (c) an individual health insurance policy that meets the  
43 requirements of a catastrophic plan, as defined in 45 C.F.R.  
44 s.156.155, shall be exempt from the requirements of subparagraphs  
45 (a) and (b) of this paragraph;

46 (2) except as provided in paragraph (3) of this subsection, the  
47 limits described in paragraph (1) of this subsection shall apply at  
48 any point in the benefit design, including before and after any

1 applicable deductible is reached;

2 (3) for prescription drug benefits offered in conjunction with a  
3 high-deductible health plan, not provide prescription drug benefits  
4 until the expenditures applicable to the deductible under the plan  
5 have met the amount of the minimum annual deductibles in effect  
6 for self-only and family coverage under section 223(c)(2)(A)(i) of  
7 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for  
8 self-only and family coverage, respectively. Once the foregoing  
9 expenditure amount has been met under the plan, coverage for  
10 prescription drug benefits shall begin, and the limit on out-of-  
11 pocket expenditures for prescription drug benefits shall be as  
12 specified in paragraph (1) of this subsection; and

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

23 b. The provisions of this section shall apply to all policies in  
24 which the insurer has reserved the right to change the premium.  
25

26 5. a. Notwithstanding any other provision of law to the  
27 contrary, every group health insurance policy that provides benefits  
28 for expenses incurred in the purchase of prescription drugs and is  
29 delivered, issued, executed, or renewed in this State pursuant to  
30 chapter 27 of Title 17B of the New Jersey Statutes, or approved for  
31 issuance or renewal in this State by the Commissioner of Banking  
32 and Insurance, on or after the effective date of this act, shall  
33 conform with the following:

34 (1) (a) except as provided for in subparagraphs (b) and (c) of this  
35 paragraph, limit a covered person's out-of-pocket financial  
36 responsibility, including any copayment or coinsurance, for  
37 prescription drugs, including specialty drugs, to no more than \$100  
38 per month for each prescription drug for up to a 30-day supply of  
39 any single drug;

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

46 (c) a group health insurance policy that meets the requirements  
47 of a catastrophic plan, as defined in 45 C.F.R. s.156.155, shall be  
48 exempt from the requirements of subparagraphs (a) and (b) of this

1 paragraph;

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

6 (3) for prescription drug benefits offered in conjunction with a  
7 high-deductible health plan, not provide prescription drug benefits  
8 until the expenditures applicable to the deductible under the plan  
9 have met the amount of the minimum annual deductibles in effect  
10 for self-only and family coverage under section 223(c)(2)(A)(i) of  
11 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for  
12 self-only and family coverage, respectively. Once the foregoing  
13 expenditure amount has been met under the plan, coverage for  
14 prescription drug benefits shall begin, and the limit on out-of-  
15 pocket expenditures for prescription drug benefits shall be as  
16 specified in paragraph (1) of this subsection; and

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

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

29

30 6. a. Notwithstanding any other provision of law to the  
31 contrary, an individual health benefits plan that provides benefits  
32 for expenses incurred in the purchase of prescription drugs and is  
33 delivered, issued, executed, renewed, or approved for issuance or  
34 renewal in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et  
35 seq.), or approved for issuance or renewal in this State by the  
36 Commissioner of Banking and Insurance, on or after the effective  
37 date of this act, shall conform with the following:

38 (1) (a) except as provided for in subparagraphs (b) and (c) of this  
39 paragraph, limit a covered person's out-of-pocket financial  
40 responsibility, including any copayment or coinsurance, for  
41 prescription drugs, including specialty drugs, to no more than \$100  
42 per month for each prescription drug for up to a 30-day supply of  
43 any single drug;

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

1 and

2 (c) an individual health benefits plan that meets the  
3 requirements of a catastrophic plan, as defined in 45 C.F.R.  
4 s.156.155, shall be exempt from the requirements of subparagraphs  
5 (a) and (b) of this paragraph;

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

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

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

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

34

35 7. a. Notwithstanding any other provision of law to the  
36 contrary, a small employer health benefits plan that provides  
37 benefits for expenses incurred in the purchase of prescription drugs  
38 and is delivered, issued, executed, renewed, or approved for  
39 issuance or renewal in this State pursuant to P.L.1992, c.162  
40 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this  
41 State by the Commissioner of Banking and Insurance, on or after  
42 the effective date of this act, shall conform with the following:

43 (1) (a) except as provided for in subparagraphs (b) and (c) of this  
44 paragraph, limit a covered person's out-of-pocket financial  
45 responsibility, including any copayment or coinsurance, for  
46 prescription drugs, including specialty drugs, to no more than \$100  
47 per month for each prescription drug for up to a 30-day supply of  
48 any single drug;



1 (b) a small employer health benefits plan that is required to  
2 provide a bronze level of coverage, as defined in 45 C.F.R.  
3 s.156.140, shall ensure that any required enrollee cost-sharing,  
4 including any copayment or coinsurance, does not exceed \$200 per  
5 month for each prescription drug for up to a 30-day supply of any  
6 single drug; and

7 (c) a small employer health benefits plan that meets the  
8 requirements of a catastrophic plan, as defined in 45 C.F.R.  
9 s.156.155, shall be exempt from the requirements of subparagraphs  
10 (a) and (b) of this paragraph;

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

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

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

36 b. The provisions of this section shall apply to those health  
37 benefits plan in which the carrier has reserved the right to change  
38 the premium.

39

40 8. a. Notwithstanding any other provision of law to the  
41 contrary, a health maintenance organization enrollee agreement that  
42 provides coverage for the purchase of prescription drugs and is  
43 delivered, issued, executed, or renewed in this State pursuant to  
44 P.L.1973, c.337 (C.26:2J-1 et seq.), or approved for issuance or  
45 renewal in this State by the Commissioner of Banking and  
46 Insurance, on or after the effective date of this act, shall conform  
47 with the following:

48 (1) (a) except as provided for in subparagraphs (b) and (c) of this

1 paragraph, limit a covered person's out-of-pocket financial  
2 responsibility, including any copayment or coinsurance, for  
3 prescription drugs, including specialty drugs, to no more than \$100  
4 per month for each prescription drug for up to a 30-day supply of  
5 any single drug;

6 (b) a health maintenance organization enrollee agreement that is  
7 required to provide a bronze level of coverage, as defined in 45  
8 C.F.R. s.156.140, shall ensure that any required enrollee cost-  
9 sharing, including any copayment or coinsurance, does not exceed  
10 \$200 per month for each prescription drug for up to a 30-day supply  
11 of any single drug; and

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

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

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

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

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

44  
45 9. Notwithstanding any other provision of law to the contrary,  
46 the State Health Benefits Commission shall ensure that every  
47 contract that provides benefits for expenses incurred in the purchase  
48 of prescription drugs, which is purchased by the commission on or

1 after the effective date of this act, shall conform with the following:

2 a. limit a covered person's out-of-pocket financial responsibility,  
3 including any copayment or coinsurance, for prescription drugs,  
4 including specialty drugs, to no more than \$100 per month for each  
5 prescription drug for up to a 30-day supply of any single drug;

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

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

21 d. implement an exceptions process that allows enrollees to  
22 request an exception to any formulary, which exception shall permit  
23 a nonformulary drug to be deemed covered under the formulary if  
24 the prescribing physician determines that the formulary drug for  
25 treatment of the same condition either would not be as effective for  
26 the enrollee or would have adverse effects for the enrollee, or both.  
27 If an enrollee is denied such an exception, that denial shall be  
28 deemed an adverse determination that will be subject to appeal  
29 under the applicable appeal process established by the commission.  
30

31 10. Notwithstanding any other provision of law to the contrary,  
32 the School Employees' Health Benefits Commission shall ensure  
33 that every contract that provides benefits for expenses incurred in  
34 the purchase of prescription drugs, which is purchased by the  
35 commission on or after the effective date of this act, shall conform  
36 with the following:

37 a. limit a covered person's out-of-pocket financial  
38 responsibility, including any copayment or coinsurance, for  
39 prescription drugs, including specialty drugs, to no more than \$100  
40 per month for each prescription drug for up to a 30-day supply of  
41 any single drug;

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

46 c. for prescription drug benefits offered in conjunction with a  
47 high-deductible health plan, not provide prescription drug benefits  
48 until the expenditures applicable to the deductible under the plan

1 have met the amount of the minimum annual deductibles in effect  
2 for self-only and family coverage under section 223(c)(2)(A)(i) of  
3 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for  
4 self-only and family coverage, respectively. Once the foregoing  
5 expenditure amount has been met under the plan, coverage for  
6 prescription drug benefits shall begin, and the limit on out-of-  
7 pocket expenditures for prescription drug benefits shall be as  
8 specified in subsection a. of this section; and

9 d. implement an exceptions process that allows enrollees to  
10 request an exception to any formulary, which exception shall permit  
11 a nonformulary drug to be deemed covered under the formulary if  
12 the prescribing physician determines that the formulary drug for  
13 treatment of the same condition either would not be as effective for  
14 the enrollee or would have adverse effects for the enrollee, or both.  
15 If an enrollee is denied such an exception, that denial shall be  
16 deemed an adverse determination that will be subject to appeal  
17 under the applicable appeal process established by the commission.  
18

19 11. This act shall take effect on the 90th day after enactment and  
20 shall apply to policies or contracts issued or renewed on or after the  
21 effective date.  
22  
23

#### 24 STATEMENT

25  
26 This bill requires certain health insurers, under certain policies or  
27 contracts that provide coverage for prescription drugs, to place  
28 limitations on covered persons' cost sharing for prescription drugs.  
29 The bill's provisions apply to the following insurers and programs  
30 that provide coverage for prescription drugs under a policy or  
31 contract: health, hospital and medical service corporations;  
32 commercial individual and group health insurers; health  
33 maintenance organizations; health benefits plans issued pursuant to  
34 the New Jersey Individual Health Coverage and Small Employer  
35 Health Benefits Programs; the State Health Benefits Program  
36 (SHBP) and the School Employees' Health Benefits Program  
37 (SEHBP).

38 Unless the plan or contract is required to provide bronze level of  
39 coverage or is a catastrophic plan under the federal Affordable Care  
40 Act, the bill requires insurers to ensure that plans limit a covered  
41 person's out-of-pocket financial responsibility, including any  
42 copayment or coinsurance, for prescription drugs, including  
43 specialty drugs, to no more than \$100 per month for each  
44 prescription drug for up to a 30-day supply of any single drug. If  
45 the plan or contract is required to provide a bronze level of  
46 coverage, as defined in 45 C.F.R. s.156.140, the plan shall ensure  
47 that any required enrollee cost-sharing, including any copayment or  
48 coinsurance, does not exceed \$200 per month for each prescription

1 drug for up to a 30-day supply of any single drug. In the case of a  
2 plan that meets the requirements of a catastrophic plan, as defined  
3 in 45 C.F.R. s.156.155, it is exempt from these requirements.

4 In the case of high-deductible plans, these cost sharing limits  
5 apply at any point in the benefit design, including before and after  
6 any applicable deductible is reached. For prescription drug benefits  
7 offered in conjunction with a high-deductible health plan, the plan  
8 shall not provide prescription drug benefits until the expenditures  
9 applicable to the deductible under the plan have met the amount of  
10 the minimum annual deductibles in effect for self-only and family  
11 coverage under section 223(c)(2)(A)(i) of the federal Internal  
12 Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family  
13 coverage, respectively. Once the foregoing expenditure amount has  
14 been met under the plan, coverage for prescription drug benefits  
15 shall begin, and the limit on out-of-pocket expenditures for  
16 prescription drug benefits would be as specified in the bill.

17 The bill also requires the plans to implement an exceptions  
18 process that allows enrollees to request an exception to any  
19 formulary, which exception shall permit a nonformulary drug to be  
20 deemed covered under the formulary if the prescribing physician  
21 determines that the formulary drug for treatment of the same  
22 condition either would not be as effective for the enrollee or would  
23 have adverse effects for the enrollee, or both. If an enrollee is  
24 denied such an exception, that denial is deemed an adverse  
25 determination that will be subject to appeal.