SENATE, No. 3754

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED MAY 16, 2019

Sponsored by:
Senator STEPHEN M. SWEENEY
District 3 (Cumberland, Gloucester and Salem)
Senator STEVEN V. OROHO
District 24 (Morris, Sussex and Warren)
Senator DECLAN J. O'SCANLON, JR.
District 13 (Monmouth)

SYNOPSIS

Terminates SEHBP; terminates SHBP Plan Design Committee; transfers coverage from SEHBP to SHBP; requires certain plans with no employee or retiree contributions; imposes limit on health care benefits for public employees.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning health care benefits for public employees and retirees, amending and repealing various parts of the statutory law, and supplementing P.L.1961, c.49 (C.52:14-17.26 et seq.).

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

1. (New section) Any employer participating in the School Employees' Health Benefits Program, authorized by sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11), before the effective date of this act, P.L. , c. (pending before the Legislature as this bill), shall become a participating employer in the State Health Benefits Program, authorized by P.L.1961, c.49 (C.52:14-17.25 et seq.), on the effective date hereof. The State Health Benefits Commission and the Division of Pensions and Benefits in the Department of the Treasury shall provide for the transition required by this section and shall ensure that coverage is continued without interruption for eligible employees, retirees, and dependents under the School Employees' Health Benefits Program, whose benefits hereafter shall be provided through the State Health Benefits Program.

2. Section 2 of P.L.1979, c.391 (C.18A:16-13) is amended to read as follows:

2. a. Any local board of education may directly or indirectly through a trust fund or otherwise enter into contracts of group life, accidental death and dismemberment, hospitalization, medical, surgical, major medical expense, minimum premium insurance policy or health and accident insurance with any insurance company or companies authorized to do business in this State, or may contract with a nonprofit hospital service, medical service or health service corporation with respect to the benefits which they are authorized to provide respectively. Such contract or contracts shall provide any one or more of such coverages for the employees of the local board of education and may include their dependents. A local board of education may enter into a contract or contracts to provide drug prescription and other health care benefits, or enter into a contract or contracts to provide drug prescription and other health care benefits as may be required to implement a duly executed collective negotiations agreement, or as may be required to implement a determination by a local board of education to provide such benefit or benefits to employees not included in collective negotiations units. Nothing herein contained shall be deemed to authorize coverage of dependents of an employee under a group life insurance policy or to allow the issuance of a group life insurance

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

policy under which the entire premium is to be derived from funds contributed by the insured employee.

For purposes of this section, "minimum premium insurance policy" means a group insurance policy issued by an insurer licensed to do business in this State under which the policyholder agrees to directly fund specified claims of insureds covered under the policy, in lieu of payment of a portion of the premium.

b. (1) After the effective date of P.L. , c. (pending before the Legislature as this bill), a contract entered into by a local board of education in accordance with subsection a. of this section to provide any group health care benefit plan offering coverage for its employees shall not include any plan that exceeds an actuarial value of 80 percent, and shall include a plan that has an actuarial value of at least 60 but not greater than 62 percent. Notwithstanding any provision of law or regulation to the contrary that requires a contribution by an employee, an employee who selects the plan with an actuarial value of at least 60 but not greater than 62 percent shall not be required, by any method or means, to contribute toward the annual cost that is a premium or periodic charge for that plan, whether as a percentage of salary, percentage of premium or periodic charge, or another specified amount, except as may be required by a binding collective negotiations agreement entered into prior to the effective date of P.L. , c. (pending before the Legislature as this bill).

(2) Notwithstanding the provisions of any other law to the contrary, after the effective date of P.L. , c (pending before the Legislature as this bill), a contract entered into by a local board of education in accordance with subsection a. of this section to provide any group health care benefit plan offering coverage to its employees shall not include any plan that provides health care benefits, including, but not limited to, basic benefits, extended basic benefits, and major medical benefits, in which the level of benefits provided thereunder exceeds the level of benefits provided in the plan offered under the "New Jersey State Health Benefits Program Act," P.L.1961, c.49 (C.52:14-17.25 et seq.) which provides the highest level of benefits.

(3) This subsection 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.

“Actuarial value” means a percentage of medical expenses paid by a specific health benefit care plan for a standard population. The actuarial value for each health care benefit plan shall be certified by an actuary as having been calculated in accordance with generally accepted actuarial principles and methodologies.

(cf: P.L.1995, c.74, s.4)

3. Section 11 of P.L.2019, c.58 (C.26:2S-10.8) is amended to read as follows:

11. a. For the purposes of this section:

"Benefit limits" includes both quantitative treatment limitations and non-quantitative treatment limitations.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State or any entity contracted to administer health benefits in connection with the State Health Benefits Program **[**or School Employees' Health Benefits Program**]**.

"Classification of benefits" means the classifications of benefits found at 45 C.F.R. 146.136(c)(2)(ii)(A) and 45 C.F.R. s.146.136(c)(3)(iii).

"Department" means the Department of Banking and Insurance.

"Mental health condition" means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.

"Non-quantitative treatment limitations" or "NQTL" means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs shall include, but shall not be limited to:

(1) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(2) Formulary design for prescription drugs;

(3) For plans with multiple network tiers, such as preferred providers and participating providers, network tier design;

(4) Standards for provider admission to participate in a network, including reimbursement rates;

(5) Plan methods for determining usual, customary, and reasonable charges;

(6) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective, also known as fail-first policies or step therapy protocols;

(7) Exclusions based on failure to complete a course of treatment;

(8) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;

(9) In and out-of-network geographic limitations;

(10) Limitations on inpatient services for situations where the participant is a threat to self or others;

(11) Exclusions for court-ordered and involuntary holds;

(12) Experimental treatment limitations;

(13) Service coding;

(14) Exclusions for services provided by a licensed professional who provides mental health condition or substance use disorder services;

(15) Network adequacy; and

(16) Provider reimbursement rates.

"Substance use disorder" means a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

b. A carrier shall approve a request for an in-plan exception if the carrier's network does not have any providers who are qualified, accessible and available to perform the specific medically necessary service. A carrier shall communicate the availability of in-plan exceptions:

(1) on its website where lists of network providers are displayed; and

(2) to beneficiaries when they call the carrier to inquire about network providers.

c. A carrier that provides hospital or medical expense benefits through individual or group contracts shall submit an annual report to the department on or before March 1. The annual report shall contain, to the extent that the commissioner determines practicable, the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental health benefits, the process used to develop or select the medical necessity criteria for substance use disorder benefits, and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(2) Identification of all NQTLs that are applied to mental health benefits, all NQTLs that are applied to substance use disorder benefits, and all NQTLs that are applied to medical and surgical benefits, including, but not limited to, those listed in subsection a. of this section;

(3) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (1) of this subsection and for selected NQTLs identified in paragraph (2) of this subsection, as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and selected NQTLs to mental health condition and substance use disorder benefits are comparable to, and are no more stringently applied than the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and selected NQTLs, as written and in operation, to medical and surgical benefits. A determination of which selected NQTLs require analysis will be determined by the department; at a minimum, the results of the analysis shall entail the following,

provided that some NQTLs may not necessitate all of the steps described below:

(a) identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

(b) identify and define the specific evidentiary standards, if applicable, used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

(c) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, for mental health and substance use disorder benefits are comparable to and applied no more stringently than the processes and strategies used to design each NQTL as written for medical and surgical benefits;

(d) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental health and substance use disorder benefits are comparable to and applied no more stringently than the processes or strategies used to apply each NQTL in operation for medical and surgical benefits; and

(e) disclose the specific findings and conclusions reached by the carrier that the results of the analyses above indicate that the carrier is in compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. s.18031(j), and its implementing and related regulations, which includes 45 C.F.R. s.146.136, 45 C.F.R. s.147.160, and 45 C.F.R. s.156.115(a)(3); and

(4) Any other information necessary to clarify data provided in accordance with this section requested by the Commissioner of Banking and Insurance including information that may be proprietary or have commercial value, provided that no proprietary information shall be made publicly available by the department.

d. The department shall implement and enforce applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), any amendments to, and federal guidance or regulations issued under that act, including 45 C.F.R. Parts 146 and 147, 45 C.F.R. s.156.115(a)(3), P.L.1999, c.106 (C.17:48-6v et al.), and section 2 of P.L.1999, c.441 (C.52:14-17.29e), which includes:

(1) Ensuring compliance by individual and group contracts, policies, plans, or enrollee agreements delivered, issued, executed, or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), P.L.1940, c.74 (C.17:48A-1 et seq.), P.L.1985, c.236 (C.17:48E-1 et seq.), chapter 26 of Title 17B of the New Jersey Statutes (N.J.S.17B:26-1 et seq.), chapter 27 of Title 17B of the New Jersey Statutes (N.J.S.17B:27-26 et seq.), P.L.1992, c.161 (C.17B:27A-2 et seq.), P.L.1992, c.162 (C.17B:27A-17 et seq.), P.L.1973, c.337 (C.26:2J-1 et seq.), and P.L.1961, c.49 (C.52:14-

17.25 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance.

(2) Detecting violations of the law by individual and group contracts, policies, plans, or enrollee agreements delivered, issued, executed, or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), P.L.1940, c.74 (C.17:48A-1 et seq.), P.L.1985, c.236 (C.17:48E-1 et seq.), chapter 26 of Title 17B of the New Jersey Statutes (N.J.S.17B:26-1 et seq.), chapter 27 of Title 17B of the New Jersey Statutes (N.J.S.17B:27-26 et seq.), P.L.1992, c.161 (C.17B:27A-2 et seq.), P.L.1992, c.162 (C.17B:27A-17 et seq.), P.L.1973, c.337 (C.26:2J-1 et seq.), and P.L.1961, c.49 (C.52:14-17.25 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance.

(3) Accepting, evaluating, and responding to complaints regarding violations.

(4) Maintaining and regularly reviewing for possible parity violations a publicly available consumer complaint log regarding mental health condition and substance use disorder coverage, provided that the names of specific carriers will be redacted and not disclosed on the complaint log.

(5) The commissioner shall adopt rules as may be necessary to effectuate any provisions of this section and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

e. Not later than May 1 of each year, the department shall issue a report to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1). The report shall:

(1) Describe the methodology the department is using to check for compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C s.18031(j), and any federal regulations or guidance relating to the compliance and oversight of that act.

(2) Describe the methodology the department is using to check for compliance with P.L.1999, c.106 (C.17:48-6v et al.) and section 2 of P.L.1999, c.441 (C.52:14-17.29e).

(3) Identify market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with parity in mental health and substance use disorder benefits under state and federal laws and summarize the results of such market conduct examinations. This shall include:

(a) The number of market conduct examinations initiated and completed;

(b) The benefit classifications examined by each market conduct examination;

(c) The subject matters of each market conduct examination, including quantitative and non-quantitative treatment limitations;

(d) A summary of the basis for the final decision rendered in each market conduct examination; and

(e) Individually identifiable information shall be excluded from the reports consistent with state and Federal privacy protections.

(4) Detail any educational or corrective actions the department has taken to ensure compliance with Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C s.18031(j), P.L.1999, c.106 (C.17:48-6v et al.) and section 2 of P.L.1999, c.441 (C.52:14-17.29e).

(5) Detail the department's educational approaches relating to informing the public about mental health condition and substance use disorder parity protections under State and federal law.

(6) Be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the department finds appropriate, posting the report on the department's website.

f. The department shall post on its Internet website a report disclosing the department's conclusions as to whether the analyses collected from the carriers as specified in paragraph (3) of subsection c. of this section demonstrate compliance with the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations, specifically including whether or not there is compliance with 45 C.F.R. 146.136(c)(4). The name and identity of carriers shall be confidential, shall not be made public by the department, and shall not be subject to public inspection.

(cf: P.L.2019, c.58, s.11)

4. N.J.S.40A:10-17 is amended to read as follows:

40A:10-17. a. Any local unit or agency thereof, herein referred to as employers, may:

[a.**]** (1) Enter into contracts of group life, accidental death and dismemberment, hospitalization, dental, medical, surgical, major medical expense, or health and accident insurance with any insurance company or companies authorized to do business in this State, or may contract with a nonprofit hospital service or medical service or dental service corporation with respect to the benefits which they are authorized to provide respectively. The contract or contracts shall provide any one or more of such coverages for the employees of such employer and may include their dependents;

[b.**]** (2) Enter into a contract or contracts to provide drug prescription and other health care benefits, or enter into a contract or contracts to provide drug prescription and other health care benefits as may be required to implement a duly executed collective negotiation agreement, or as may be required to implement a determination by a local unit to provide such benefit or benefits to employees not included in collective negotiations units;

[c.**]** (3) Enter into a contract with an insurance company authorized to do business in this State to provide to its employees on a group or individual basis, individual retirement annuities, as defined by section 408(b) of the Federal Internal Revenue Code of

1954 as amended (26 U.S.C. s.408(b)). The contract shall provide for coverage under these annuities of any employee of the employer and may provide for the establishment of annuities on behalf of the spouse of the employee.

Nothing herein contained shall be deemed to authorize coverage of dependents of an employee under a group life insurance policy or to allow the issuance of a group life insurance policy under which the entire premium is to be derived from funds contributed by the insured employees.

b. (1) After the effective date of P.L. , c. (pending before the Legislature as this bill), a contract entered into by an employer in accordance with subsection a. of this section to provide any group health care benefit plan offering coverage to its employees shall not include any plan that exceeds an actuarial value of 80 percent, and shall include a plan that has an actuarial value of at least 60 but not greater than 62 percent. Notwithstanding any provision of law or regulation to the contrary that requires a contribution by an employee or retiree, an employee or retiree who selects the plan with an actuarial value of at least 60 but not greater than 62 percent shall not be required, by any method or means, to contribute toward the annual cost that is a premium or periodic charge for that plan, whether as a percentage of salary or retirement allowance, percentage of premium or periodic charge, or another specified amount, except as may be required by a binding collective negotiations agreement entered into prior to the effective date of P.L. , c. (pending before the Legislature as this bill).

(2) Notwithstanding the provisions of any other law to the contrary, after the effective date of P.L. , c (pending before the Legislature as this bill), a contract entered into by an employer in accordance with subsection a. of this section to provide any group health care benefit plan offering coverage to its employees shall not include any plan that provides health care benefits, including, but not limited to, basic benefits, extended basic benefits, and major medical benefits, in which the level of benefits provided thereunder exceeds the level of benefits provided in the plan offered under the "New Jersey State Health Benefits Program Act," P.L.1961, c.49 (C.52:14-17.25 et seq.) which provides the highest level of benefits.

(3) This subsection 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; and to any county and municipality, any agency, board, commission, authority, and instrumentality of a local unit, any fire district, any county college, any entity created by a county or municipality, and any local authority as defined under the "Local Authorities Fiscal Control Law," P.L.1983, c.313 (C.40A:5A-1 et seq.).

For the purposes of this subsection, “actuarial value” means a percentage of medical expenses paid by a specific health care

benefit plan for a standard population. The actuarial value for each health care benefit plan shall be certified by an actuary as having been calculated in accordance with generally accepted actuarial principles and methodologies.

(cf: P.L.1983, c.445, s.2)

5. Section 2 of P.L.1961, c.49 (C.52:14-17.26) is amended to read as follows:

2. As used in P.L.1961, c.49 (C.52:14-17.26 et seq.):

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

(b) The term "commission" means the State Health Benefits Commission, created by section 3 of P.L.1961, c.49 (C.52:14-17.27).

(c) (1) The term "employee" means an appointive or elective officer, a full-time employee of the State of New Jersey, or a full-time employee of an employer other than the State 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 20.

(2) After the effective date of P.L.2010, c.2, the term "employee" means (i) a full-time appointive or elective officer whose hours of work are fixed at 35 or more per week, a full-time employee of the State, or a full-time employee of an employer other than the State 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, or (ii) an appointive or elective officer, an employee of the State, or an employee of an employer other than the State who has or is eligible for health benefits coverage provided under P.L.1961, c.49 (C.52:14-17.25 et seq.) or who had or was eligible for health benefits coverage provided under sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 et seq.) on ⟦that⟧ the effective date of P.L.2010, c.2 and continuously thereafter provided the officer or employee is covered by the definition in paragraph (1) of this subsection. For the purposes of this act an employee of Rutgers, The State University of New Jersey, shall be deemed to be an employee of the State, and an employee of the New Jersey Institute of Technology shall be considered to be an employee of the State during such time as the Trustees of the Institute are party to a contractual agreement with the State Treasurer for the provision of educational services. The term "employee" shall further mean, for purposes of this act, a former employee of the South Jersey Port Corporation, who is employed by a subsidiary corporation or other corporation, which has been established by the Delaware River Port Authority pursuant

to subdivision (m) of Article I of the compact creating the Delaware River Port Authority (R.S.32:3-2), as defined in section 3 of P.L.1997, c.150 (C.34:1B-146), and who is eligible for continued membership in the Public Employees' Retirement System pursuant to subsection j. of section 7 of P.L.1954, c.84 (C.43:15A-7).

For the purposes of this act 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 from the State is limited to reimbursement of necessary expenses actually incurred in the discharge of their official duties, provided, however, that the term "employee" shall include persons employed on an intermittent basis to whom the State has agreed to provide coverage under P.L.1961, c.49 (C.52:14-17.25 et seq.) in accordance with a binding collective negotiations agreement. An employee paid on a 10-month basis, pursuant to an annual contract, will 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 this act 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 within the meaning of this act shall be final and shall be binding on all parties.

(d) (1) The term "dependents" means an employee's spouse, partner in a civil union couple or an employee's domestic partner as defined in section 3 of P.L.2003, c.246 (C.26:8A-3), and the employee's unmarried children under the age of 23 years who live with the employee in a regular parent-child relationship. "Children" shall include stepchildren, legally adopted children and children placed by the Division of Child Protection and Permanency 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, partner in a civil union couple, domestic partner 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, partners in a civil union couple or domestic partners of retired persons who are otherwise eligible for the benefits under this act 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.

(2) Notwithstanding the provisions of paragraph (1) of this subsection to the contrary and subject to the provisions of paragraph (3) of this subsection, for the purposes of an employer other

than the State that is participating in the State Health Benefits Program pursuant to section 3 of P.L.1964, c.125 (C.52:14-17.34), the term "dependents" means an employee's spouse or partner in a civil union couple and the employee's unmarried children under the age of 23 years who live with the employee in a regular parent-child relationship. "Children" shall include stepchildren, legally adopted children and children placed by the Division of Child Protection and Permanency 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, 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 or partners in a civil union couple of retired persons who are otherwise eligible for benefits under P.L.1961, c.49 (C.52:14-17.25 et seq.) 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.

(3) An employer other than the State that is participating in the State Health Benefits Program pursuant to section 3 of P.L.1964, c.125 (C.52:14-17.34) may adopt a resolution providing that the term "dependents" as defined in paragraph (2) of this subsection shall include domestic partners as provided in paragraph (1) of this subsection.

(e) The term "carrier" means a voluntary association, corporation or other organization, including a health maintenance organization as defined in section 2 of the "Health Maintenance Organizations Act," P.L.1973, c.337 (C.26:2J-2), which is lawfully engaged in providing or paying for or reimbursing the cost of, personal health services, 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.

(f) 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 (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.

(g) The term "State managed 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 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 under contracts with the State.

(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 "traditional plan" means a health care plan which provides basic benefits, extended basic benefits and major medical expense benefits as set forth in section 5 of P.L.1961, c.49 (C.52:14-17.29) by indemnifying eligible employees, retirees, and dependents for expenses for covered health care services and supplies through payments to providers or reimbursements to participants.

(j) The term "successor plan" means a State managed care plan that shall replace the traditional plan and that shall provide benefits as set forth in subsection (B) of section 5 of P.L.1961, c.49 (C.52:14-17.29) with provisions regarding reimbursements and payments as set forth in paragraph (1) of subsection (C) of section 5 of P.L.1961, c.49 (C.52:14-17.29).

(cf: P.L.2012, c.16, s.137)

6. Section 3 of P.L.1961, c.49 (C.52:14-17.27) is amended to read as follows:

3. a. There is hereby created a State Health Benefits Commission, consisting of **[**five**]** eleven members:

(1) the State Treasurer; the Commissioner of Banking and Insurance **[**;**]** , and the Chairperson of the Civil Service Commission, each serving ex officio;

(2) a member appointed by the Governor from among three persons nominated by the New Jersey League of Municipalities who shall be qualified by experience, education, or training in the review, administration, or design of health insurance plans for self-insured employers;

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

(4) a State employees' representative chosen by the Public Employee Committee of the AFL-CIO; [and the fifth member of the commission shall be]

(5) a local employees' representative chosen by the Public Employee Committee of the AFL-CIO;

(6) a member appointed by the Governor from among three persons nominated by the union, that is not affiliated with the AFL-CIO, that represents the greatest number of police officers in this State;

(7) a member appointed by the Governor from among three persons nominated by the New Jersey Education Association;

(8) a member appointed by the Governor from among three persons nominated by the education section of the New Jersey State AFL-CIO;

(9) a member appointed by the Governor who is a New Jersey resident, who shall be qualified by experience, education, or training in the field of actuarial science.

The treasurer shall be chairman of the commission, and the health benefits program authorized by P.L.1961, c.49 shall be administered in the Treasury Department. The Director of the Division of Pensions and Benefits shall be the secretary of the commission. The commission [and committee] shall establish a health benefits program for the employees of the State, the cost of which shall be paid as specified in section 6 of P.L.1961, c.49 (C.52:14-17.30). The commission [, in consultation with the committee,] shall establish rules and regulations as may be deemed reasonable and necessary for the administration of P.L.1961, c.49.

The Attorney General shall be the legal advisor of the commission [and committee].

The members of the commission [and committee] shall serve without compensation but shall be reimbursed for any necessary expenditures. The public employee members shall not suffer loss of salary or wages during service on the commission or committee.

The commission shall publish annually a report showing the fiscal transactions of the program for the preceding year and stating other facts pertaining to the plan. The commission shall submit the report to the Governor and furnish a copy to every employer for use of the participants and the public.

b. [There is established a State Health Benefits Plan Design Committee, composed of 12 members as follows:

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

three members who shall be appointed by the Public Employee Committee of the AFL-CIO;

one member who shall be appointed by the head of the union, that is not affiliated with the AFL-CIO, that represents the greatest number of police officers in this State;

one member who shall be appointed by the head of the union, that is not affiliated with the AFL-CIO, that represents the greatest number of firefighters in this State; and

one member who shall be appointed by the head of the State Troopers Fraternal Association.

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, three members shall serve for two years and until a successor is appointed and qualified, and two shall serve for one year and until a successor is appointed and qualified. Of the initial appointment by the head of the union representing the greatest number of police officers in the State, the member shall serve for two years and until a successor is appointed and qualified. Of the initial appointment by the head of the union representing the greatest number of firefighters in the State, the 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**]** commission 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**]** commission shall have the authority to create, modify, or terminate any plan or component, at its sole discretion. Any reference in law to the State Health Benefits **[**Commission**]** Plan Design Committee in the context of the creation, modification, or termination of a plan or plan component shall be deemed to apply to the **[**committee**]** commission.

[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 seven votes in the affirmative, the commission shall approve and implement the committee's decision.

If any matter before the committee receives six votes in the affirmative and six 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.45)

7. Section 4 of P.L.1961, c.49 (C.52:14-17.28) is amended to read as follows:

4. a. The commission shall negotiate with and arrange for the purchase, on such terms as it deems to be in the best interests of the State and its employees, from carriers licensed to operate in the State or in other jurisdictions, as appropriate, contracts providing hospital, surgical, obstetrical, and other covered health care services and benefits covering employees of the State and their dependents, and shall execute all documents pertaining thereto for and on behalf and in the name of the State.

b. Except for contracts entered into after June 30, 2007, the commission shall not enter into a contract under this act unless the benefits provided thereunder equal or exceed the minimum standards specified in section 5 of P.L.1961, c.49 (C.52:14-17.29) for the particular coverage which such contract provides, and unless coverage is available to all eligible employees and their dependents on the basis specified by section 7 of P.L.1961, c.49 (C.52:14-17.31), except that a State employee enrolled in the program on or after July 1, 2003 and all law enforcement officers employed by the State for whom there is a majority representative for collective negotiations purposes may not be eligible for coverage under the traditional plan as defined in section 2 of P.L.1961, c.49 (C.52:14-17.26) pursuant to a binding collective negotiations agreement or pursuant to the application by the commission, in its sole discretion, of the terms of any collective negotiations agreement binding on the State to State employees for whom there is no majority representative for collective negotiations purposes.

c. The commission shall not enter into a contract under P.L.1961, c.49 (C.52:14-17.25 et seq.) after June 30, 2007, unless the contract includes the successor plan, one or more health maintenance organization plans and a State managed care plan that shall be substantially equivalent to the NJ PLUS plan in effect on June 30, 2007, with adjustments to that plan pursuant to a binding collective negotiations agreement or pursuant to action by the commission, in its sole discretion, to apply such adjustments to State employees for whom there is no majority representative for collective negotiations purposes, and unless coverage is available to all eligible employees and their dependents on the basis specified by section 7 of P.L.1961, c.49 (C.52:14-17.31), except as provided in subsection d. of this section.

d. Eligibility for coverage under the successor plan may be limited pursuant to a binding collective negotiations agreement or

pursuant to the application by the commission, in its sole discretion, of the terms of any collective negotiations agreement binding on the State to State employees for whom there is no majority representative for collective negotiations purposes. Coverage under the successor plan and under the State managed care plan required to be included in a contract entered into pursuant to subsection c. of this section shall be made available in retirement to all State employees who accrued 25 years of nonconcurrent service credit in one or more State or locally-administered retirement systems before July 1, 2007. Coverage under the State managed care plan required to be included in a contract entered into pursuant to subsection c. of this section shall be made available in retirement to all State employees who accrue 25 years of nonconcurrent service credit in one or more State or locally-administered retirement systems on or after July 1, 2007.

e. Actions taken by the commission before the effective date of P.L.2007, c.103 in anticipation of entering into any contract pursuant to subsection c. of this section are hereby deemed to have been within the authority of the commission pursuant to P.L.1961, c.49 (C.52:14-17.25 et seq.).

f. After the effective date of P.L. , c. (pending before the Legislature as this bill), a contract entered into by the commission under P.L.1961, c.49 (C.52:14-17.25 et seq.) to provide health care benefit plans offering coverage under the program shall not include any plan that exceeds an actuarial value of 80 percent, and shall include a plan that has an actuarial value of at least 60 but not greater than 62 percent. Notwithstanding any provision of law or regulation to the contrary that requires a contribution by an employee or retiree, an employee or retiree who selects the plan with an actuarial value of at least 60 but not greater than 62 percent shall not be required, by any method or means, to contribute toward the annual cost that is a premium or periodic charge for that plan, whether as a percentage of salary or retirement allowance, percentage of premium or periodic charge, or another specified amount, except as may be required by a binding collective negotiations agreement entered into prior to the effective date of P.L. , c. (pending before the Legislature as this bill).

"Actuarial value" means a percentage of medical expenses paid by a specific health care benefit plan for a standard population. The actuarial value for each health care benefit plan shall be certified by an actuary as having been calculated in accordance with generally accepted actuarial principles and methodologies.

This subsection shall apply also to an independent State authority that is not a participating employer in the program to the same extent as to an authority that is a participating employer, with the governing body of the authority responsible for compliance. As used in this paragraph, "independent State authority" means a public authority, board, commission, corporation, or other agency

or instrumentality of the State allocated in but not of a principal department of State government pursuant to Article V, Section IV, paragraph 1 of the New Jersey Constitution, or which is not subject to supervision or control by the department in which it is allocated, and a regional authority, but shall not include a college or university.

(cf: P.L.2007, c.103, s.21)

8. Section 5 of P.L.1961, c.49 (C.52:14-17.29) is amended to read as follows:

5. (A) The contract or contracts purchased by the commission pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall provide separate coverages or policies as follows:

(1) Basic benefits which shall include:

(a) Hospital benefits, including outpatient;

(b) Surgical benefits;

(c) Inpatient medical benefits;

(d) Obstetrical benefits; and

(e) Services rendered by an extended care facility or by a home health agency and for specified medical care visits by a physician during an eligible period of such services, without regard to whether the patient has been hospitalized, to the extent and subject to the conditions and limitations agreed to by the commission and the carrier or carriers.

Basic benefits shall be substantially equivalent to those available on a group remittance basis to employees of the State and their dependents under the subscription contracts of the New Jersey "Blue Cross" and "Blue Shield" Plans. Such basic benefits shall include benefits for:

(i) Additional days of inpatient medical service;

(ii) Surgery elsewhere than in a hospital;

(iii) X-ray, radioactive isotope therapy and pathology services;

(iv) Physical therapy services;

(v) Radium or radon therapy services;

and the extended basic benefits shall be subject to the same conditions and limitations, applicable to such benefits, as are set forth in "Extended Outpatient Hospital Benefits Rider," Form 1500, 71(9-66), and in "Extended Benefit Rider" (as amended), Form MS 7050J(9-66) issued by the New Jersey "Blue Cross" and "Blue Shield" Plans, respectively, and as the same may be amended or superseded, subject to filing by the Commissioner of Banking and Insurance; and

(2) Major medical expense benefits which shall provide benefit payments for reasonable and necessary eligible medical expenses for hospitalization, surgery, medical treatment and other related services and supplies to the extent they are not covered by basic benefits. The commission may, by regulation, determine what types

of services and supplies shall be included as "eligible medical services" under the major medical expense benefits coverage as well as those which shall be excluded from or limited under such coverage. Benefit payments for major medical expense benefits shall be equal to a percentage of the reasonable charges for eligible medical services incurred by a covered employee or an employee's covered dependent, during a calendar year as exceed a deductible for such calendar year of $100.00 subject to the maximums hereinafter provided and to the other terms and conditions authorized by this act. The percentage shall be 80% of the first $2,000.00 of charges for eligible medical services incurred subsequent to satisfaction of the deductible and 100% thereafter. There shall be a separate deductible for each calendar year for (a) each enrolled employee and (b) all enrolled dependents of such employee. Not more than $1,000,000.00 shall be paid for major medical expense benefits with respect to any one person for the entire period of such person's coverage under the plan, whether continuous or interrupted except that this maximum may be reapplied to a covered person in amounts not to exceed $2,000.00 a year. Maximums of $10,000.00 per calendar year and $20,000.00 for the entire period of the person's coverage under the plan shall apply to eligible expenses incurred because of mental illness or functional nervous disorders, and such may be reapplied to a covered person, except as provided in P.L.1999, c.441 (C.52:14-17.29d et al.). The same provisions shall apply for retired employees and their dependents. Under the conditions agreed upon by the commission and the carriers as set forth in the contract, the deductible for a calendar year may be satisfied in whole or in part by eligible charges incurred during the last three months of the prior calendar year.

Any service determined by regulation of the commission to be an "eligible medical service" under the major medical expense benefits coverage which is performed by a duly licensed practicing psychologist within the lawful scope of his practice shall be recognized for reimbursement under the same conditions as would apply were such service performed by a physician.

(B) The contract or contracts purchased by the commission pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall include coverage for services and benefits that are at a level that is equal to or exceeds the level of services and benefits set forth in this subsection, provided that such services and benefits shall include only those that are eligible medical services and not those deemed experimental, investigative or otherwise not eligible medical services. The determination of whether services or benefits are eligible medical services shall be made by the commission consistent with the best interests of the State and participating employers, employees, and dependents. The following list of

services is not intended to be exclusive or to require that any limits or exclusions be exceeded.

Covered services shall include:

(1) Physician services, including:

(a) Inpatient services, including:

(i) medical care including consultations;

(ii) surgical services and services related thereto; and

(iii) obstetrical services including normal delivery, cesarean section, and abortion.

(b) Outpatient/out-of-hospital services, including:

(i) office visits for covered services and care;

(ii) allergy testing and related diagnostic/therapy services;

(iii) dialysis center care;

(iv) maternity care;

(v) well child care;

(vi) child immunizations/lead screening;

(vii) routine adult physicals including pap, mammography, and prostate examinations; and

(viii) annual routine obstetrical/gynecological exam.

(2) Hospital services, both inpatient and outpatient, including:

(a) room and board;

(b) intensive care and other required levels of care;

(c) semi-private room;

(d) therapy and diagnostic services;

(e) surgical services or facilities and treatment related thereto;

(f) nursing care;

(g) necessary supplies, medicines, and equipment for care; and

(h) maternity care and related services.

(3) Other facility and services, including:

(a) approved treatment centers for medical emergency/accidental injury;

(b) approved surgical center;

(c) hospice;

(d) chemotherapy;

(e) diagnostic x-ray and lab tests;

(f) ambulance;

(g) durable medical equipment;

(h) prosthetic devices;

(i) foot orthotics;

(j) diabetic supplies and education; and

(k) oxygen and oxygen administration.

(4) All services for which coverage is required pursuant to P.L.1961, c.49 (C.52:14-17.25 et seq.), as amended and supplemented. Benefits under the contract or contracts purchased as authorized by the State Health Benefits Program shall include those for mental health services subject to limits and exclusions consistent with the provisions of the New Jersey State Health Benefits Program Act.

(C) The contract or contracts purchased by the commission pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall include the following provisions regarding reimbursements and payments:

(1) In the successor plan, the co-payment for doctor's office visits 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, and the participant shall receive reimbursement for out-of-network charges at the rate of 80% of reasonable and customary charges, provided that the out-of-pocket maximum shall not exceed $2,000 per individual and $5,000 per family for each calendar year.

(2) In the State managed care plan that is required to be included in a contract entered into pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28), the co-payment for doctor's office visits shall be $15 per visit. The participant shall receive reimbursement for out-of-network charges at the rate of 70% of reasonable and customary charges. The in-network and out-of-network limits, exclusions, maximums, and deductibles shall be substantially equivalent to those in the NJ PLUS plan in effect on June 30, 2007, with adjustments to that plan pursuant to a binding collective negotiations agreement or pursuant to action by the commission, in its sole discretion, to apply such adjustments to State employees for whom there is no majority representative for collective negotiations purposes.

(3) "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.

(D) Benefits under the contract or contracts purchased as authorized by this 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.

Benefits under the contract or contracts purchased as authorized by this act shall include those for the treatment of alcoholism where such treatment is prescribed by a physician and shall also include treatment while confined in or as an outpatient of a licensed hospital or residential treatment program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation. No benefits shall be provided beyond those stipulated in the contracts held by the State Health Benefits Commission.

(E) The rates charged for any contract purchased under the authority of this 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 shall be determined by the carrier on accepted group rating principles with due regard to the experience, both past and contemplated, under the contract. The commission shall have the right to particularize subgroups for experience purposes and rates. No increase in rates shall be retroactive.

(F) The initial term of any contract purchased by the commission under the authority of this act shall be for such period to which the commission and the carrier 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.

(G) A contract purchased by the commission pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall contain a provision that if basic benefits or major medical expense benefits of an employee or of an eligible dependent under the contract, after having been in effect for at least one month in the case of basic benefits or at least three months in the case of major medical expense benefits, is terminated, other than by voluntary cancellation of enrollment, there shall be a 31-day period following the effective date of termination during which such employee or dependent may exercise the option to convert, without evidence of good health, to converted coverage issued by the carriers on a direct payment basis. Such converted coverage shall include benefits of the type classified as "basic benefits" or "major medical expense benefits" in subsection (A) hereof and shall be equivalent to the benefits which had been provided when the person was covered as an employee. The provision shall further stipulate that the employee or dependent exercising the option to convert shall pay the full periodic charges for the converted coverage which shall be subject to such terms and conditions as are normally prescribed by the carrier for this type of coverage.

(H) The commission may purchase a contract or contracts to provide drug prescription and other health care benefits or authorize the purchase of a contract or contracts to provide drug prescription and other health care benefits as may be required to implement a duly executed collective negotiations agreement or as may be required to implement a determination by a public employer to provide such benefit or benefits to employees not included in collective negotiations units.

[(I) The commission shall take action as necessary, in cooperation with the School Employees' Health Benefits Commission established pursuant to section 33 of P.L.2007, c.103 (C.52:14-17.46.3), to effectuate the purposes of the School

Employees' Health Benefits Program Act as provided in sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11) and to enable the School Employees' Health Benefits Commission to begin providing coverage to participants pursuant to the School Employees' Health Benefits Program Act as of July 1, 2008.**]**

(J) Beginning January 1, 2012, the State Health Benefits **[**Plan Design Committee**]** Commission shall provide to employees the option to select one of at least three levels of coverage each for family, individual, individual and spouse, and individual and dependent, or equivalent categories, for each plan offered by the program differentiated by out of pocket costs to employees including co-payments and deductibles. Notwithstanding any other provision of law to the contrary, the **[**committee**]** commission shall have the sole discretion to set the amounts for maximums, co-pays, deductibles, and other such participant costs for all plans in the program. The **[**committee**]** commission shall also provide for a high deductible health plan that conforms with Internal Revenue Code Section 223.

There shall be appropriated annually for each State fiscal year, through the annual appropriations act, such amounts as shall be necessary as funding by the State as an employer, or as otherwise required, with regard to employees or retirees who have enrolled in a high deductible health plan that conforms with Internal Revenue Code Section 223.

(cf: P.L.2011, c.78, s.47)

9. Section 7 of P.L.1961, c.49 (C.52:14-17.31) is amended to read as follows:

7. The coverage provided solely for employees shall, subject to the provisions below, automatically become effective for all eligible employees from the first day on or after the effective date of the program on which they satisfy the definition of "employee" contained in this act. The commission shall establish the rules and regulations governing the enrollment and effective dates of coverage of dependents of employees it deems necessary or desirable. The rules and regulations shall not defer coverage with respect to any qualified dependent an employee has on the date the employee's employer becomes a participating employer, provided the employee was, immediately prior to the date, insured with respect to the dependent under a group insurance plan of the employer which was in effect immediately prior to the date. Under the rules and regulations established by the commission, each employee shall be given the opportunity to enroll for coverage for dependents as of the earliest date the employee becomes eligible for enrollment. With respect to the traditional plan, an employee may elect to enroll dependents for both basic coverage and major

medical expense coverage but may not enroll for either coverage alone.

In the event that the group health plan which covered an employee or dependents immediately prior to the date the employee's employer becomes a participating employer provides, after termination of coverage thereunder, any continuation of benefits, or would so provide in the absence of coverage pursuant to this act, no coverage shall be afforded pursuant to this act for any such expenses (i) which are covered, or which would be covered in the absence of coverage pursuant to this act, in whole or in part, by the prior insurance plan or (ii) which may be used in satisfaction of any deductible requirement under the prior insurance plan to establish entitlement to the continuation of benefits.

Each employee shall furnish the Division of Pensions and Benefits, in the prescribed form, the information necessary on account of the employee's own coverage and necessary to enroll dependents. Any employee not desiring coverage at the time the employee first becomes eligible, shall give the division written notice of that fact in the form prescribed by the division. The employee may not enroll thereafter except at the times and under the conditions prescribed by the commission.

Any person employed as a substitute teacher by a school district and who provides evidence of coverage under another health benefits program may waive coverage for the current school year on or after the date on which the person becomes an employee eligible for coverage.

Multiple coverage in the program as an employee, dependent, or retiree shall be prohibited and the prohibition shall be implemented in accordance with the rules and regulations promulgated by the commission. **[**The provisions of this paragraph shall be applicable to the State Health Benefits Program and to the School Employees' Health Benefits Program to the extent not inconsistent with the provisions of sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 et seq.)**]**.

(cf: P.L.2010, c.2, s.12)

10. Section 3 of P.L.1987, c.384 (C.52:14-17.32f) is amended to read as follows:

3. A qualified retiree from the Teachers' Pension and Annuity Fund (N.J.S.18A:66-1 et seq.) and dependents of a qualified retiree, but not including survivors, are eligible to participate in the State Health Benefits Program **[**until June 30, 2008, and beginning July 1, 2008, in the School Employees' Health Benefits Program**]**, regardless of whether the retiree's employer participated in the program.

A qualified retiree is a retiree who:

a. Retired on a benefit based on 25 or more years of service credit;

b. Retired on a disability pension based on fewer years of service credit; or

c. Elected deferred retirement based on 25 or more years of service credit and who receives a retirement allowance.

The program shall reimburse a qualified retiree who participates in the program for the premium charges under Part B of the federal Medicare program for the retiree and the retiree's spouse. A qualified retiree who retired under subsections a. and b. of this section prior to the effective date of this 1987 amendatory and supplementary act is eligible for the coverage if the retiree applies to the program for it within one year after the effective date, and a qualified retiree as defined under subsection c. of this section whose retirement allowance commenced prior to the effective date of this 1992 amendatory act is eligible for the coverage if the retiree applies to the program for it within one year after the effective date.

The premium or periodic charges for benefits provided to a qualified retiree and the dependents of the retiree, and the cost for reimbursement of Medicare premiums shall be paid by the State. An employee who becomes a member of the Teachers' Pension and Annuity Fund on or after the effective date of P.L.2010, c.2 shall pay as a qualified retiree 1.5 percent of the retiree's monthly retirement allowance, including any future cost-of-living adjustments, 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.)**]** P.L.1961, c.49 (52:14-17.26 et seq.) and the State shall pay the remainder of the premium or periodic charges for benefits provided to a qualified retiree and the dependents of the retiree, and the cost for reimbursement of Medicare premiums.

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

11. Section 2 of P.L.1992, c.126 (52:14-17.32f1) is amended to read as follows:

2. The provisions of section 3 of P.L.1987, c.384 (C.52:14-17.32f) shall apply to:

a. any employee of a board of education who retires on a benefit or benefits based in the aggregate upon 25 or more years of nonconcurrent service credit in one or more State or locally-administered retirement systems, or retires on a disability pension based upon fewer years of service credit in that system or systems, or elected deferred retirement based in the aggregate upon 25 or more years of nonconcurrent service credit in one or more State or locally-administered retirement systems and receives a retirement allowance from that system or systems;

b. any employee of a county college who retires on a benefit or benefits based in the aggregate upon 25 or more years of nonconcurrent service credit in one or more State or locally-administered retirement systems, or retires on a disability pension based upon fewer years of service credit in that system or systems,

or elected deferred retirement based in the aggregate upon 25 or more years of nonconcurrent service credit in one or more State or locally-administered retirement systems and receives a retirement allowance from that system or systems; or who receives a disability benefit pursuant to section 18 of P.L.1969, c.242 (C.18A:66-184); and

c. any employee of a county college who retires on a benefit based upon 10 or more years of service credit in the alternate benefit program P.L.1969, c.242 (C.18A:66-167 et seq.) and who has additional years of service credited in another defined contribution retirement program as an employee of a private institution of higher education which, under contract with a county government, provided services as a county college and subsequently merged with a county technical institute to become a county college, which additional years of service when added to the service credited in the alternate benefit program totals 25 or more years and any such employee who retired prior to the effective date of P.L.1999, c.382 if the employee applies to the program for coverage within one year after the effective date of P.L.1999, c.382.

The costs of the premium or periodic charges for the benefits and reimbursement of medicare premiums provided to a retiree and the dependents of the retiree under this section shall be paid by the State. An employee who becomes a member of a State or locally-administered retirement system on or after the effective date of P.L.2010, c.2 shall pay as a qualified retiree 1.5 percent of the retiree's monthly retirement allowance, including any future cost-of-living adjustments, 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.)**]** P.L.1961, c.49 (C.52:14-17.26 et seq.) and the State shall pay the remainder of the premium or periodic charges for benefits provided to a qualified retiree and the dependents of the retiree, and the cost for reimbursement of Medicare premiums.

(cf: P.L.2010, c.2, s.3)

12. Section 1 of P.L.1995, c.357 (C.52:14-17.32f2) is amended to read as follows:

1. The provisions of section 3 of P.L.1987, c.384 (C.52:14-17.32f) shall apply to any employee of a board of education who is a member of a pension fund created prior to January 5, 1996 under the provisions of article 2 of chapter 66 of Title 18A of the New Jersey Statutes (N.J.S.18A:66-94 et seq.) and who retires on a benefit based upon 25 or more years of service credit in the pension fund, or retires on a disability pension based upon fewer years of service credit in that pension fund, or elected deferred retirement based upon 25 or more years of service credit and receives a retirement allowance from that pension fund, except that the costs of the premium or periodic charges for the benefits and reimbursement of medicare premiums provided to a retiree and the

dependents of the retiree under this section shall be paid by the State. An employee who becomes a member of the pension fund on or after the effective date of P.L.2010, c.2 shall pay in retirement 1.5 percent of the retiree's monthly retirement allowance, including any future cost-of-living adjustments, 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.)**]** P.L.1961, c.49 (C.52:14-17.26 et seq.) and the State shall pay the remainder of the premium or periodic charges for benefits provided to a qualified retiree and the dependents of the retiree, and the cost for reimbursement of Medicare premiums.

An employee who retired prior to the effective date of **[**this act**]** P.L.1995, c.357 is eligible for the coverage if the employee applies to the program for it within one year after the effective date.

(cf: P.L.2010, c.2, s.4)

13. Section 3 of P.L.1964, c.125 (C.52:14-17.34) is amended to read as follows:

3. In order that the New Jersey State Health Benefits Program Act may be extended to include other public and school employees, participation by counties, municipalities, school districts public agencies or organizations as defined in section 71 of P.L.1954, c.84 (C.43:15A-71), including the New Jersey Turnpike Authority, the Interstate Environmental Commission, the Delaware River Basin Commission, New Jersey Housing and Mortgage Finance Agency, New Jersey Educational Facilities Authority, New Jersey Meadowlands Commission and the Compensation Rating and Inspection Bureau, hereinafter defined as employers, is hereby authorized **[**, provided, however, that no such employer shall enroll for coverage under the State Health Benefits Program pursuant to P.L.1961, c.49 (C.52:14-17.25 et seq.) employees as defined in section 32 of P.L.2007, c.103 (C.52:14-17.46.2)**]**.

(cf: P.L.2007, c.103, s.28)

14. Section 4 of P.L.1964, c.125 (C.52:14-17.35) is amended to read as follows:

4. As used in this act and in the act to which this act is a supplement:

(a) The term "employer" means a county, municipality, school district, public agency or organization as defined in section 71 of P.L.1954, c.84 (C.43:15A-71), including the New Jersey Turnpike Authority, the Interstate Environmental Commission, the Delaware River Basin Commission, New Jersey Housing and Mortgage Finance Agency, New Jersey Educational Facilities Authority, New Jersey Meadowlands Commission and the Compensation Rating and Inspection Bureau. The term "employer" shall include a subsidiary corporation or other corporation established by the Delaware River Port Authority pursuant to subdivision (m) of Article I of the

compact creating the authority (R.S.32:3-2), as defined in section 3 of P.L.1997, c.150 (C.34:1B-146), except that only persons who are employees of the South Jersey Port Corporation on the effective date of P.L.1997, c.150 (C.34:1B-144 et al.) and are re-employed by the subsidiary or other corporation within 365 days of the effective date are eligible to participate in the program.

(b) The term "State Treasury" means the State agency responsible for the administration of the New Jersey State Health Benefits Program Act which is to be located in the Division of Pensions and Benefits in the Department of the Treasury.

(cf: P.L.2007, c.103, s.29)

15. Section 5 of P.L.1964, c.125 (C.52:14-17.36) is amended to read as follows:

5. a. The commission established by section 3 of chapter 49 of the laws of 1961, is hereby authorized to prescribe rules and regulations satisfactory to the carrier or carriers under which employers may participate in the health benefits program provided by that act. All provisions of that act will, except as expressly stated herein, be construed as to participating employers and to their employees and to dependents of such employees the same as for the State, employees of the State and dependents of such employees.

b. All changes in the provision of health care benefits through the program that are included in collective negotiations agreements between the State and its employees entered into on or after the effective date of P.L.2010, c.2 shall be made applicable by the commission to participating employers and their employees at the same time and in the same manner as to State employees. **[**This subsection shall be applicable to the State Health Benefits Program and to the School Employees' Health Benefits Program to the extent not inconsistent with the provisions of sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 et seq.)**]**.

(cf: P.L.2010, c.2, s.8)

16. Section 6 of P.L.1964, c.125 (C.52:14-17.37) is amended to read as follows:

6. a. Any employer eligible for participation in the program may elect such participation by the adoption of a resolution by its governing body, which would include the name and title of a certifying agent, and a certified copy of the resolution shall be filed with the commission. Any employer making such election shall become a participating employer under the program, subject to and in accordance with the rules and regulations of the commission relating thereto.

b. Notwithstanding the provisions of any other law to the contrary, the availability of plans within the program may be limited for employees of a participating employer other than the State pursuant to a binding collective negotiations agreement

between the employer and its employees or pursuant to the application by the employer, in its sole discretion, of the terms of any collective negotiations agreement binding on the employer to employees for whom there is no majority representative for collective negotiations purpose. The commission shall implement the terms of such an agreement, and the application of such terms, with regard to plan availability for employees of the employer. The commission may impose such restrictions on the terms as the commission may deem necessary to ensure the effective and efficient operation of the program. **[**This subsection shall apply to the State Health Benefits Program and the School Employees' Health Benefits Program.**]**

(cf: P.L.2010, c.2, s.7)

17. Section 5 of P.L.1993, c.8 (C.52:14-17.38b) is amended to read as follows:

5. Notwithstanding the provisions of any other law, rule, or regulation to the contrary, any local board of education may elect to participate in the State Health Benefits Program upon the termination of any contract in effect on the effective date of this amendatory and supplementary act, P.L.1993, c.8 (C.52:14-17.38b et al.), between the board of education and an insurance company writing insurance pursuant to Title 17B of the New Jersey Statutes, hospital service corporation, medical service corporation, health service corporation, or health maintenance organization to provide hospital and medical expense benefits. Such election shall be in accordance with the laws and regulations otherwise applicable to participation by employers other than the State in the program. If the board does not elect to participate in the State Health Benefits Program at that time, its eligibility to elect such participation thereafter shall be subject to the time period specified by the State Health Benefits Commission for participating again in the State Health Benefits Program after a participant's withdrawal from the program. **[**No such election shall be permitted after June 30, 2008**]**.

(cf: P.L.2007, c.103, s.30)

18. Section 3 of P.L.1993, c.8 (C.52:14-17.38c) is amended to read as follows:

3. With respect to any policy or contract between a local board of education and an insurance company writing insurance pursuant to Title 17B of the New Jersey Statutes, hospital service corporation, medical service corporation, health service corporation, or health maintenance organization which provides hospital or medical expense benefits:

a. upon the commencement of any policy or contract entered into after the effective date of this amendatory and supplementary act, P.L.1993, c.8 (C.52:14-17.38b et al.); or

b. in the case of any policy or contract in effect as of the effective date of this act, no earlier than the second anniversary date after the effective date of this act of any such policy or contract,

the insurance company, hospital service corporation, medical service corporation, health service corporation, or health maintenance organization shall annually pay to the State Health Benefits Program a surcharge in the form of a percentage of the claims paid by the insurance company, hospital service corporation, medical service corporation, health service corporation, or health maintenance organization which are attributable to the coverage of the employees of the board and their dependents for the time period from July 1 through the following June 30, except that if the commencement or the second anniversary date of the policy or contract occurs after July 1, the initial surcharge shall be prorated for the remainder of that year from July 1 through the following June 30. The surcharge shall be paid on or before December 31 of the time period for which it is payable in the manner prescribed hereinafter, except that if the commencement or second anniversary date of the policy or contract occurs on or after November 1, an estimated initial surcharge shall be paid no later than the end of the sixth month following the commencement or anniversary date of the policy or contract or July 1 following the commencement or anniversary date of the policy or contract, whichever is earlier, and the actual surcharge payable for the initial time period shall be determined and adjustments, if any, shall be made to the surcharge payable for the succeeding time period in the manner prescribed hereinafter.

The initial surcharge percentage for the time period July 1, 1993 through June 30, 1994 shall be 3.25%. The State Treasurer shall thereafter annually redetermine the surcharge percentage, which shall be the percentage of total claims paid for active employees and for retired employees receiving health care coverage under the State Health Benefits Program pursuant to section 3 of P.L.1987, c.384 (C.52:14-17.32f) or subsection a. of section 2 of P.L.1992, c.126 (C.52:14-17.32f1) who are not eligible for Medicare which is reasonably attributable to the excess claim cost for these retired employees. The State Treasurer shall annually provide an estimated surcharge percentage based upon the claims paid for the 12 months immediately preceding the time period for which the surcharge is payable. Except as otherwise provided herein in the case of the initial surcharge, each organization shall pay to the State Health Benefits Program an estimated surcharge on or before December 31 of the time period for which the surcharge is payable, which shall be the amount determined by multiplying the total claims paid by the organization for the coverage for the 12 months immediately preceding the time period for which the surcharge is payable by the estimated surcharge percentage. Within three months after the time period for which the surcharge is payable, the State Treasurer shall

determine the actual surcharge percentage for the time period based upon the actual claims experience for the period. The surcharge for the succeeding time period shall be increased or decreased, as appropriate, by the difference between the estimated surcharge paid and the surcharge due based upon the actual claims experience.

This section shall apply to any policy or contract in which the insurer has reserved the right to change the premium.

[Beginning July 1, 2008, a reference to the State Health Benefits Program in this section shall mean the School Employees' Health Benefits Program, established pursuant to sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11).**]**

(cf: P.L.2007, c.103, s.45)

19. Section 11 of P.L.2017, c.28 (C.24:21-15.2) is amended to read as follows:

11. a. A practitioner shall not issue an initial prescription for an opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41) in a quantity exceeding a five-day supply for treatment of acute pain. Any prescription for acute pain pursuant to this subsection shall be for the lowest effective dose of immediate-release opioid drug.

b. Prior to issuing an initial prescription of a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41) in a course of treatment for acute or chronic pain, a practitioner shall:

(1) take and document the results of a thorough medical history, including the patient's experience with non-opioid medication and non-pharmacological pain management approaches and substance abuse history;

(2) conduct, as appropriate, and document the results of a physical examination;

(3) develop a treatment plan, with particular attention focused on determining the cause of the patient's pain;

(4) access relevant prescription monitoring information under the Prescription Monitoring Program pursuant to section 8 of P.L.2015, c.74 (C. 45:1-46.1); and

(5) limit the supply of any opioid drug prescribed for acute pain to a duration of no more than five days as determined by the directed dosage and frequency of dosage.

c. No less than four days after issuing the initial prescription pursuant to subsection a. of this subsection, the practitioner, after consultation with the patient, may issue a subsequent prescription for the drug to the patient in any quantity that complies with applicable State and federal laws, provided that:

(1) the subsequent prescription would not be deemed an initial prescription under this section;

(2) the practitioner determines the prescription is necessary and appropriate to the patient's treatment needs and documents the rationale for the issuance of the subsequent prescription; and

(3) the practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction, or diversion and documents that determination.

d. Prior to issuing the initial prescription of a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41) in a course of treatment for acute pain and prior to issuing a prescription at the outset of a course of treatment for chronic pain, a practitioner shall discuss with the patient, or the patient's parent or guardian if the patient is under 18 years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including but not limited to:

(1) the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

(2) the reasons why the prescription is necessary;

(3) alternative treatments that may be available; and

(4) risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines or alcohol with opioids, can result in fatal respiratory depression.

The practitioner shall include a note in the patient's medical record that the patient or the patient's parent or guardian, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The Division of Consumer Affairs shall develop and make available to practitioners guidelines for the discussion required pursuant to this subsection.

e. Prior to the commencement of an ongoing course of treatment for chronic pain with a Schedule II controlled dangerous substance or any opioid, the practitioner shall enter into a pain management agreement with the patient.

f. When a Schedule II controlled dangerous substance or any other prescription opioid drug is continuously prescribed for three months or more for chronic pain, the practitioner shall:

(1) review, at a minimum of every three months, the course of treatment, any new information about the etiology of the pain, and the patient's progress toward treatment objectives and document the results of that review;

(2) assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with

physical and psychological dependence and document the results of that assessment;

(3) periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence and document with specificity the efforts undertaken;

(4) review the Prescription Drug Monitoring information in accordance with section 8 of P.L.2015, c.74 (C. 45:1-46.1); and

(5) monitor compliance with the pain management agreement and any recommendations that the patient seek a referral.

g. As used in this section:

"Acute pain" means pain, whether resulting from disease, accidental or intentional trauma, or other cause, that the practitioner reasonably expects to last only a short period of time. "Acute pain" does not include chronic pain, pain being treated as part of cancer care, hospice or other end of life care, or pain being treated as part of palliative care.

"Chronic pain" means pain that persists or recurs for more than three months.

"Initial prescription" means a prescription issued to a patient who:

(1) has never previously been issued a prescription for the drug or its pharmaceutical equivalent; or

(2) was previously issued a prescription for, or used or was administered the drug or its pharmaceutical equivalent, but the date on which the current prescription is being issued is more than one year after the date the patient last used or was administered the drug or its equivalent.

When determining whether a patient was previously issued a prescription for, or used or was administered a drug or its pharmaceutical equivalent, the practitioner shall consult with the patient and review the patient's medical record and prescription monitoring information.

"Pain management agreement" means a written contract or agreement that is executed between a practitioner and a patient, prior to the commencement of treatment for chronic pain using a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41), as a means to:

(1) prevent the possible development of physical or psychological dependence in the patient;

(2) document the understanding of both the practitioner and the patient regarding the patient's pain management plan;

(3) establish the patient's rights in association with treatment, and the patient's obligations in relation to the responsible use, discontinuation of use, and storage of Schedule II controlled

dangerous substances, including any restrictions on the refill of prescriptions or the acceptance of Schedule II prescriptions from practitioners;

(4) identify the specific medications and other modes of treatment, including physical therapy or exercise, relaxation, or psychological counseling, that are included as a part of the pain management plan;

(5) specify the measures the practitioner may employ to monitor the patient's compliance, including but not limited to random specimen screens and pill counts; and

(6) delineate the process for terminating the agreement, including the consequences if the practitioner has reason to believe that the patient is not complying with the terms of the agreement.

"Practitioner" means a medical doctor, doctor of osteopathy, dentist, optometrist, podiatrist, physician assistant, certified nurse midwife, or advanced practice nurse, acting within the scope of practice of their professional license pursuant to Title 45 of the Revised Statutes.

h. This section shall not apply to a prescription for a patient who is currently in active treatment for cancer, receiving hospice care from a licensed hospice or palliative care, or is a resident of a long term care facility, or to any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

i. Every policy, contract or plan delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, and every contract purchased by the **[**School Employees' Health Benefits Commission or**]** State Health Benefits Commission, on or after the effective date of this act, that provides coverage for prescription drugs subject to a co-payment, coinsurance or deductible shall charge a co-payment, coinsurance or deductible for an initial prescription of an opioid drug prescribed pursuant to this section that is either:

(1) proportional between the cost sharing for a 30-day supply and the amount of drugs the patient was prescribed; or

(2) equivalent to the cost sharing for a full 30-day supply of the opioid drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the 30-day supply.

(cf: P.L.2017, c.341, s.1)

20. Section 1 of P.L.2017, c.220 (C.26:2S-5.1) is amended to read as follows:

1. a. A carrier shall provide to subscribers written informational materials about organ and tissue donation and registration at each contract renewal. The materials shall be developed or approved by a federally designated organ procurement

organization, and shall inform subscribers as to how to make an anatomical gift, including information on the registration of a gift in the Donate Life New Jersey registry.

b. For purposes of this section, "carrier," as defined in P.L.1997, c.192 (C.26:2S-1 et al.), shall also include the State Health Benefits Program [and the School Employees' Health Benefits Program].

(cf: P.L.2017, c.220, s.1)

21. Section 3 of P.L.2018, c32 (C.26:2SS-3) is amended to read as follows:

3. As used in this act:

"Carrier" means an entity that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefits plan, including: an insurance company authorized to issue health benefits plans; a health maintenance organization; a health, hospital, or medical service corporation; a multiple employer welfare arrangement; the State Health Benefits Program [and the School Employees' Health Benefits Program]; or any other entity providing a health benefits plan. Except as provided under the provisions of this act, "carrier" shall not include any other entity providing or administering a self-funded health benefits plan.

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means a person on whose behalf a carrier is obligated to pay health care expense benefits or provide health care services.

"Department" means the Department of Banking and Insurance.

"Emergency or urgent basis" means all emergency and urgent care services including, but not limited to, the services required pursuant to N.J.A.C.11:24-5.3.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, "health benefits plan" shall not include the following plans, policies or contracts: Medicaid, Medicare, Medicare Advantage, accident only, credit, disability, long-term care, TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), a dental plan as defined pursuant to section 1 of P.L.2014, c.70 (C.26:2S-26) and hospital confinement indemnity coverage.

"Health care facility" means a general acute care hospital, satellite emergency department, hospital based off-site ambulatory care facility in which ambulatory surgical cases are performed, or

ambulatory surgery facility, licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Health care professional" means an individual, acting within the scope of his licensure or certification, who provides a covered service defined by the health benefits plan.

"Health care provider" or "provider" means a health care professional or health care facility.

"Inadvertent out-of-network services" means health care services that are: covered under a managed care health benefits plan that provides a network; and provided by an out-of-network health care provider in the event that a covered person utilizes an in-network health care facility for covered health care services and, for any reason, in-network health care services are unavailable in that facility. "Inadvertent out-of-network services" shall include laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.

"Knowingly, voluntarily, and specifically selected an out-of-network provider" means that a covered person chose the services of a specific provider, with full knowledge that the provider is out-of-network with respect to the covered person's health benefits plan, under circumstances that indicate that covered person had the opportunity to be serviced by an in-network provider, but instead selected the out-of-network provider. Disclosure by a provider of network status shall not render a covered person's decision to proceed with treatment from that provider a choice made "knowingly" pursuant to this definition.

"Medicaid" means the State Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Medical necessity" or "medically necessary" means or describes a health care service that a health care provider, exercising his or her prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the covered person's illness, injury, or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury, or disease.

"Medicare" means the federal Medicare program established pursuant to Pub.L.89-97 (42 U.S.C. s.1395 et seq.).

"Self-funded health benefits plan" or "self-funded plan" means a self-insured health benefits plan governed by the provisions of the federal "Employee Retirement Income Security Act of 1974," 29 U.S.C. s.1001 et seq.

(cf: P.L.2018, c.32, s.3)

22. Section 12 of P.L.2018, c.32 (C.26:2SS-12) is amended to read as follows:

12. On or before January 31 of each calendar year, the commissioner shall consult with the Department of the Treasury, the relevant professional and occupational licensing boards within the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Health, to obtain information to compile and make publicly available, on the department's website:

a. A list of all arbitrations filed pursuant to sections 10 and 11 of this act between January 1 and December 31 of the previous calendar year, including the percentage of all claims that were arbitrated.

(1) For each arbitration decision, the list shall include but not be limited to:

(a) an indication of whether the decision was in favor of the carrier or the out-of-network health care provider;

(b) the arbitration bids offered by each side and the award amount;

(c) the category and practice specialty of each out-of-network health care provider involved in an arbitration decision, as applicable; and

(d) a description of the service that was provided and billed for.

(2) The list of arbitration decisions shall not include any information specifically identifying the provider, carrier, or covered person involved in each arbitration decision.

b. The percentage of facilities and hospital-based professionals, by specialty, that are in-network for each carrier in this State as reported pursuant to subsection d. of section 7 of this act.

c. The number of complaints the department receives relating to out-of-network health care charges.

d. The number of and description of claims received by the State Health Benefits Program **[**and the School Employees' Health Benefits Program**]** for in-State emergency out-of-network health care and inadvertent out-of-network health care.

e. Annual trends on health benefits plan premium rates, total annual amount of spending on inadvertent and emergency out-of-network costs by carriers, and medical loss ratios in the State to the extent that the information is available.

f. The number of physician specialists practicing in the State in a particular specialty and whether they are in-network or out-of-network with respect to the carriers that administer the State Health Benefits Program, **[**the School Employees' Health Benefits Program,**]** the qualified health plans in the federally run health exchange in the State, and other health benefits plans offered in the State.

g. The results of the network audit required pursuant to section 16 of this act.

h. A summary of the information submitted to the department pursuant to subsection f. of section 6 of this act concerning the number of claims submitted by health care providers to carriers which are denied or down coded by the carrier and the reasons for the denials or down coding determinations.

i. Any other benchmarks or information obtained pursuant to this act that the commissioner deems appropriate to make publicly available to further the goals of the act.

(cf: P.L.2018, c.32, s.12)

23. Section 2 of P.L.2018, c.31 (C.54A:11-2) is amended to read as follows:

2. As used in this act:

"Affordable Care Act" means the federal "Patient Protection and Affordable Care Act," Pub.L.111-148, as amended by the federal "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, and any federal rules and regulations adopted pursuant thereto.

"Applicable individual" means the same as defined in 26 U.S.C. s.5000A(d)(1).

"Carrier" means any entity that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a hospital or health service corporation, a multiple employer welfare arrangement, an entity under contract with the State Health Benefits Program **[**or the School Employees' Health Benefits Program**]** to administer a health benefits plan, or any other entity providing a health benefits plan.

"Minimum essential coverage" means the same as defined in 26 U.S.C. s.5000A(f)(1).

(cf: P.L.2018, c.31, s.2)

24. (New section) Nothing in this act, P.L. , c. (pending before the Legislature as this bill), shall be construed to prohibit a local public entity from renegotiating the terms and conditions of employment set forth in a collective bargaining agreement in effect on the effective date of this act in order to account for any modification thereof attributable to this act.

25. Savings realized by a school district as a result of the implementation of paragraph (1) of subsection b. of section 2 of P.L.1979, c.391 (C.18A:16-13), as amended by P.L. , c. (pending before the Legislature as this bill), or as a result of the implementation of section 1 of P.L. , c. (C.) (pending before the Legislature as this bill) or of any renegotiations of a collective bargaining agreement pursuant to section 24 of P.L. , c. (C.) (pending before the Legislature as this bill), shall be used solely and exclusively by the school district for the purpose

of reducing the amount that is required to be raised by the local property tax levy by the school district for school district purposes. When a cap on the annual increase in the property tax levy for a school district is imposed by law, the savings realized pursuant to paragraph (1) of subsection b. of section 2 of P.L.1979, c.391 (C.18A:16-13), as amended by P.L. , c. (pending before the Legislature as this bill), shall be deducted from the adjusted tax levy for the previous budget year and the difference shall serve as the basis for calculating the adjusted tax levy for the next year.

The savings shall be calculated in the manner prescribed by Department of Education.

26. Savings realized by a local unit as a result of the implementation of paragraph (1) of subsection b. of N.J.S.40A:10-17 or subsection f. of section 4 of P.L.1961, c.49 (C.52:14-17.28), as amended by P.L. , c. (pending before the Legislature as this bill),), or as a result of the implementation of section 1 of P.L. , c. (C.) (pending before the Legislature as this bill) or of any renegotiations of a collective bargaining agreement pursuant to section 24 of P.L. , c. (C.) (pending before the Legislature as this bill), shall be used solely and exclusively by the local unit for the purpose of reducing the amount that is required to be raised by the local property tax levy by the local unit for local unit purposes. When a cap on the annual increase in the property tax levy for a local unit is imposed by law, the savings realized pursuant to paragraph (1) of subsection b. of N.J.S.40A:10-17 or subsection f. of section 4 of P.L.1961, c.49 (C.52:14-17.28), as amended by P.L. , c. (pending before the Legislature as this bill), shall be deducted from the adjusted tax levy for the previous budget year and the difference shall serve as the basis for calculating the adjusted tax levy for the next year.

The savings shall be calculated in the manner prescribed by the Department of Community Affairs.

27. The following sections of law are repealed:

Sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11);

Section 55 of P.L.2011, c.78 (C.52:14-17.27b);

Section 10 of P.L.2009, c.113 (52:14-17.46.6a);

Section 10 of P.L.2009, c.115 (C.52:14-17.46.6b);

Section 10 of P.L.2011, c.188 (C.52:14-17.46.6c);

Section 10 of P.L.2013, c.50 (C.52:14-17.46.6d);

Section 10 of P.L.2015, c.206 (C.52:14-17.46.6e);

Section 10 of P.L.2017, c.28 (C.52:14-17.46.6f);

Section 7 of P.L.2017, c.48 (C.52:14-17.46.6g);

Section 10 of P.L.2017, c.117 (C.52:14-17.46.6h);

Section 10 of P.L.2017, c.176 (C.52:14-17.46.6i);

Section 10 of P.L.2017, c.305 (C.52:14-17.46.6j); and

Section 10 of P.L.2017, c.309 (C.52:14-17.46.6k).

28. This act shall take effect on January 1, 2020, but the Department of the Treasury and the State Health Benefits Commission may take such anticipatory administrative action before that time as may be necessary to effectuate the purposes of this act.

STATEMENT

This bill terminates the School Employees' Health Benefits Program (SEHBP) as of January 1, 2020, and permits coverage for participants therein in the State Health Benefits Program (SHBP). Boards of education and other educational employers who have chosen to participate in SEHBP before that date will become participating employers in the SHBP. The State Health Benefits Commission and the Division of Pensions and Benefits in the Department of the Treasury will provide for the transition required by the bill and ensure that health care coverage for eligible employees, retirees, and dependents under the SEHBP, whose benefits will now be provided through SHBP, is continued without interruption. Prior to the creation of SEHBP in 2008, boards of education and other educational employers could participate in SHBP.

The bill modifies the membership of the State Health Benefits Commission to include representation for certain local and educational employees and increases the number of members on the committee who represent public employers in a reciprocal manner. The bill adds a member to the commission with expertise in actuarial science and a member qualified by experience, education, or training in the review, administration, or design of health insurance plans for self-insured employers. The bill also eliminates the State Health Benefits Plan Design Committee and transfers the committee's responsibility for plan design to the commission.

The bill also provides that health care benefits plans provided by the State, a county, a municipal, or a school district as an employer to its employees and retirees cannot exceed an actuarial value of 80 percent. This limit will apply to the contracts providing such plans entered into after the bill's effective date. The bill requires that all public employers offer to employees and retirees a plan with an actuarial of at least 60 but not greater than 62 percent, and, if an employee or retiree selects that plan, the bill bars the public employer from requiring the employee or retiree to make any contribution toward the annual cost of the plan. "Actuarial value" means a percentage of medical expenses paid by a specific health care benefit plan for a standard population. The actuarial value for each health care benefit plan must be certified by an actuary as

having been calculated in accordance with generally accepted actuarial principles and methodologies. These provisions apply to the SHBP and all plans offered by a State authority, a county, a municipality, or a school district outside of those programs, including though 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.

The bill prohibits a local government or school district that is not participating in the State Health Benefits Program from entering into a contract that provides health care benefits that exceed the highest level of benefits provided under the State Health Benefits Program.

The bill also specifies that the bill may not be construed to prohibit a local public entity from renegotiating the terms and conditions of employment in a collective bargaining agreement in order to account for any modification thereof attributable to the bill. Finally, the bill requires the savings realized by a local government or school district as a result of this bill to be used solely and exclusively for the purpose of reducing the amount that is required to be raised by the local property tax levy for the local government or school district.