

ASSEMBLY, No. 988

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:

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SYNOPSIS

Preserves certain requirements that health insurance plans cover essential health benefits.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 **AN ACT** concerning health insurance benefits and supplementing
2 various parts of the statutory law.

3

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

6

7 1. a. An individual health benefits plan subject to P.L.1992,
8 c.161 (C.17B:27A-2 et seq.) shall provide coverage under every
9 plan delivered, issued, executed or renewed in this State, on or after
10 the effective date of this act, that meets the essential health benefits
11 requirements provided by this section.

12 b. Pursuant to section 3 of P.L. , c. (C.)(pending before
13 the Legislature as this bill), the commissioner shall define essential
14 health benefits to include at least the following general categories
15 and the items and services covered within the categories:

- 16 (1) ambulatory patient services;
- 17 (2) emergency services;
- 18 (3) hospitalization;
- 19 (4) maternity and newborn care;
- 20 (5) mental health and substance use disorder services, including
- 21 behavioral health treatment;
- 22 (6) prescription drugs;
- 23 (7) rehabilitative and habilitative services and devices;
- 24 (8) laboratory services;
- 25 (9) preventive and wellness services and chronic disease
- 26 management; and
- 27 (10) pediatric services, including oral and vision care.

28 c. An individual health benefits plan shall provide for a level of
29 coverage that is designed to provide benefits that are actuarially
30 equivalent to:

- 31 (1) 60 percent of the full actuarial value of the benefits provided
- 32 under the plan;
- 33 (2) 70 percent of the full actuarial value of the benefits provided
- 34 under the plan; or
- 35 (3) 80 percent of the full actuarial value of the benefits provided
- 36 under the plan.

37 d. The level of coverage of a plan shall be determined on the
38 basis that the essential health benefits described in subsection b. of
39 this section are provided to a standard population, and without
40 regard to the actual population to which the plan may provide
41 benefits.

42 e. The commissioner shall develop guidelines to provide for a
43 de minimis variation in the actuarial calculations used in
44 determining the level of coverage of a plan to account for
45 differences in actuarial estimates.

46

47 2. a. A small employer health benefits plan subject to
48 P.L.1992, c.162 (C.17B:27A-17 et seq.) shall provide coverage

1 under every plan delivered, issued, executed or renewed in this
2 State, on or after the effective date of this act, that meets the
3 essential health benefits requirements provided by this section.

4 b. Pursuant to section 3 of P.L. , c. (C.)(pending before
5 the Legislature as this bill), commissioner shall define essential
6 health benefits to include at least the following general categories
7 and the items and services covered within the categories:

- 8 (1) ambulatory patient services;
- 9 (2) emergency services;
- 10 (3) hospitalization;
- 11 (4) maternity and newborn care;
- 12 (5) mental health and substance use disorder services, including
13 behavioral health treatment;
- 14 (6) prescription drugs;
- 15 (7) rehabilitative and habilitative services and devices;
- 16 (8) laboratory services;
- 17 (9) preventive and wellness services and chronic disease
18 management; and
- 19 (10) pediatric services, including oral and vision care.

20 c. A small employer health benefits plan shall provide for a
21 level of coverage that is designed to provide benefits that are
22 actuarially equivalent to:

- 23 (1) 60 percent of the full actuarial value of the benefits provided
24 under the plan;
- 25 (2) 70 percent of the full actuarial value of the benefits provided
26 under the plan; or
- 27 (3) 80 percent of the full actuarial value of the benefits provided
28 under the plan.

29 d. The level of coverage of a plan shall be determined on the
30 basis that the essential health benefits described in subsection b. of
31 this section are provided to a standard population, and without
32 regard to the actual population to which the plan may provide
33 benefits.

34 e. The commissioner shall develop guidelines to provide for a
35 de minimis variation in the actuarial calculations used in
36 determining the level of coverage of a plan to account for
37 differences in actuarial estimates.

38
39 3. In defining the essential health benefits pursuant to
40 P.L. , c. (C.)(pending before the Legislature as this bill), the
41 commissioner shall:

42 a. ensure that the essential health benefits shall be at least as
43 comprehensive as the essential health benefits required of plans
44 subject to the essential health benefits requirements of the
45 Affordable Care Act as of January 1, 2019;

46 b. ensure that the essential health benefits reflect an appropriate
47 balance among the categories described in this act, so that benefits
48 shall not be unduly weighted toward any category;

- 1 c. not make coverage decisions, determine reimbursement
2 rates, establish incentive programs, or design benefits in ways that
3 discriminate against individuals because of their age, disability, or
4 expected length of life;
- 5 d. take into account the health care needs of diverse segments
6 of the population, including women, children, persons with
7 disabilities, and other groups;
- 8 e. ensure that health benefits established as essential not be
9 subject to denial to individuals against their wishes on the basis of
10 the individuals' age or expected length of life or of the individuals'
11 present or predicted disability, degree of medical dependency, or
12 quality of life;
- 13 f. provide that a contract, plan or policy shall not be
14 considered to provide coverage for the essential health benefits
15 pursuant to P.L. , c. (C.)(pending before the Legislature as
16 this bill) unless it provides that:
- 17 (1) coverage for emergency department services shall be
18 provided without imposing any requirement under the plan for prior
19 authorization of services or any limitation on coverage where the
20 provider of services does not have a contractual relationship with
21 the plan for the providing of services that is more restrictive than
22 the requirements or limitations that apply to emergency department
23 services received from providers who do have a contractual
24 relationship with the plan; and
- 25 (2) if those services are provided out-of-network, the cost-
26 sharing requirement, expressed as a copayment amount or
27 coinsurance rate, is the same requirement that would apply if those
28 services were provided in-network;
- 29 g. provide that if a stand-alone dental plan is offered through
30 the exchange, another health plan offered through the exchange
31 shall not fail to be treated as a qualified health plan solely because
32 the plan does not offer coverage of benefits offered through the
33 stand-alone plan that are otherwise required; and
- 34 h. periodically review the essential health benefits under
35 P.L. , c. (C.)(pending before the Legislature as this bill),
36 and provide a report to the Governor and the Legislature that
37 provides:
- 38 (1) an assessment of whether enrollees are facing any difficulty
39 accessing needed services for reasons of coverage or cost;
- 40 (2) an assessment of whether the essential health benefits needs
41 to be modified or updated to account for changes in medical
42 evidence or scientific advancement;
- 43 (3) information on how the essential health benefits will be
44 modified to address any gaps in access or changes in the evidence
45 base; and
- 46 (4) an assessment of the potential of additional or expanded
47 benefits to increase costs and the interactions between the addition

1 or expansion of benefits and reductions in existing benefits to meet
2 actuarial limitations described in this act; and

3 i. periodically update the essential health benefits to address
4 any gaps in access to coverage or changes in the evidence base the
5 commissioner identifies in the review conducted pursuant to this
6 section.

7
8 4. Notwithstanding any law to the contrary, a health benefits
9 plan shall not impose:

10 (1) any lifetime limits on the dollar value of benefits for any
11 individual insured pursuant to the plan; or

12 (2) any annual limits on the dollar value of essential health
13 benefits.

14
15 5. This act shall take effect on January 1, 2020, except the
16 commissioner may take any anticipatory administrative action in
17 advance of that date as shall be necessary for the implementation of
18 this act.

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20
21 STATEMEMNT

22
23 This bill requires certain health benefits plans to continue to offer
24 essential health benefits.

25 The bill requires individual and small employer health benefits
26 plans to provide coverage under every plan delivered, issued, executed
27 or renewed in this State that meets the essential health benefits
28 requirements provided by the bill.

29 The bill requires the Commissioner of Banking and Insurance to
30 define essential health benefits to include at least the following general
31 categories and the items and services covered within the categories:

32 (1) ambulatory patient services;

33 (2) emergency services;

34 (3) hospitalization;

35 (4) maternity and newborn care;

36 (5) mental health and substance use disorder services, including
37 behavioral health treatment;

38 (6) prescription drugs;

39 (7) rehabilitative and habilitative services and devices;

40 (8) laboratory services;

41 (9) preventive and wellness services and chronic disease
42 management; and

43 (10) pediatric services, including oral and vision care.

44 The bill requires individual and small employer health benefits
45 plans to provide for a level of coverage that is designed to provide
46 benefits that are actuarially equivalent to:

47 (1) 60 percent of the full actuarial value of the benefits provided
48 under the plan;

1 (2) 70 percent of the full actuarial value of the benefits provided
2 under the plan; or

3 (3) 80 percent of the full actuarial value of the benefits provided
4 under the plan.

5 Under the bill, the level of coverage of a plan is to be determined
6 on the basis that the essential health benefits are provided to a standard
7 population, and without regard to the actual population to which the
8 plan may provide benefits. The bill directs the commissioner to
9 develop guidelines to provide for a de minimis variation in the
10 actuarial calculations used in determining the level of coverage of a
11 plan to account for differences in actuarial estimates.

12 In defining the essential health benefits pursuant to the bill, the
13 commissioner is required to:

14 (1) ensure that the essential health benefits are at least as
15 comprehensive as the essential health benefits required of plans
16 subject to the essential health benefits requirements of the Affordable
17 Care Act as of January 1, 2019;

18 (2) ensure that the essential health benefits reflect an appropriate
19 balance among the categories described in the bill, so that benefits are
20 not be unduly weighted toward any category;

21 (3) not make coverage decisions, determine reimbursement rates,
22 establish incentive programs, or design benefits in ways that
23 discriminate against individuals because of their age, disability, or
24 expected length of life;

25 (4) take into account the health care needs of diverse segments of
26 the population, including women, children, persons with disabilities,
27 and other groups;

28 (5) ensure that health benefits established as essential not be
29 subject to denial to individuals against their wishes on the basis of the
30 individuals' age or expected length of life or of the individuals' present
31 or predicted disability, degree of medical dependency, or quality of
32 life;

33 (6) provide that a plan is not considered to provide coverage for
34 the essential health benefits unless it provides certain coverage for
35 emergency department services;

36 (7) provide that if a stand-alone dental plan is offered through the
37 exchange, another health plan offered through the exchange will not
38 fail to be treated as a qualified health plan solely because the plan does
39 not offer coverage of benefits offered through the stand-alone plan that
40 are otherwise required; and

41 (8) periodically review and update the essential health benefits,
42 and provide a report to the Governor and the Legislature that provides
43 certain information.

44 The bill also provides that, notwithstanding any law to the
45 contrary, a health benefits plan may not impose:

46 (1) any lifetime limits on the dollar value of benefits for any
47 individual insured pursuant to the plan; or

1 (2) any annual limits on the dollar value of essential health
2 benefits.

3 This provision applies to the following health insurers: health,
4 hospital and medical service corporations; commercial individual
5 and group health insurers; health maintenance organizations; and
6 health benefits plans issued pursuant to the New Jersey Individual
7 Health Coverage and Small Employer Health Benefits Programs.