17B:27A-7.26; 17B:27A-19.30 et al
LEGISLATIVE HISTORY CHECKLIST

Compiled by the NJ State Law Library

LAWS OF: 2019 **CHAPTER:** 354

NJSA: 17B:27A-7.26; 17B:27A-19.30 et al (Preserves certain requirements that health insurance plans cover essential health benefits.)

BILL NO: A5248 (Substituted for S562)

SPONSOR(S) Herb Conaway and others

DATE INTRODUCED: 5/13/2019

COMMITTEE: **ASSEMBLY:** Appropriations

SENATE: Budget & Appropriations

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** 1/13/2020

SENATE: 1/13/2020

DATE OF APPROVAL: 1/16/2020

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL
(Assembly Committee Substitute (First Reprint) enacted) Yes

A5248

SPONSOR'S STATEMENT: (Begins on page of introduced bill) xx

COMMITTEE STATEMENT: **ASSEMBLY**: Yes Appropriations

SENATE: Yes Budget & Appropriations

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

S562

SPONSOR'S STATEMENT: (Begins on page 3 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes Commerce

Budget &

Appropriations

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext.103 or mailto:refdesk@njstatelib.org

REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: Yes

"Gov. signs bills protecting Obamacare benefits," The Times, January 21, 2020

"Murphy signs legislation protecting ACA in NJ." NJBIZ (New Brunswick, NJ), January 16, 2020.

RWH/JA

§1 –
C.17B:27A-7.26
§2 –
C.17B:27A-19.30
§3 –
C.17B:27A-60
§§4,5 -
C.26:2S-35 &
26:2S-36

P.L. 2019, CHAPTER 354, ***approved January 16, 2020***
Assembly Committee Substitute ***(First Reprint)*** for Assembly, No. 5248

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

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

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

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

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

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

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.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SBA committee amendments adopted January 6, 2020.

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

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

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

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

2. a. A small employer health benefits plan subject to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall provide coverage under every plan delivered, issued, executed or renewed in this State, on or after the effective date of this act, that meets the essential health benefits requirements provided by this section.

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

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

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

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

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

d. The level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection b. of this section are provided to a standard population, and without

regard to the actual population to which the plan may provide benefits.

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

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

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

b. ensure that the essential health benefits reflect an appropriate balance among the categories described in [1]**[**this act**]** P.L. , c. (C.) (pending before the Legislature as this bill)[1], so that benefits shall not be unduly weighted toward any category;

c. not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

d. take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

e. ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

f. [1]**[**provide that a contract, plan or policy shall not be considered to provide coverage for the essential health benefits pursuant to P.L. , c. (C.)(pending before the Legislature as this bill) unless it provides that:

(1) coverage for emergency department services shall be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have a contractual relationship with the plan; and

(2) if those services are provided out-of-network, the cost-sharing requirement, expressed as a copayment amount or coinsurance rate, is the same requirement that would apply if those services were provided in-network;

g.]¹ provide that if a stand-alone dental plan is offered through the exchange, another health plan offered through the exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required; and

¹[h.] g.¹ periodically review the essential health benefits under P.L. , c. (C.)(pending before the Legislature as this bill), and provide a report to the Governor and the Legislature that provides:

(1) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(2) an assessment of whether the essential health benefits ¹[needs] need¹ to be modified or updated to account for changes in medical evidence or scientific advancement;

(3) information on how the essential health benefits will be modified to address any gaps in access or changes in the evidence base; and

(4) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in ¹[this act] P.L. , c. (C.) (pending before the Legislature as this bill)¹; ¹[and

i.] h.¹ periodically update the essential health benefits to address any gaps in access to coverage or changes in the evidence base the commissioner identifies in the review conducted pursuant to this section¹; and

i. establish limits on the dollar amounts of cost-sharing that may be imposed pursuant to a plan with respect to self-only coverage or coverage other than self-only coverage for a plan year. The limits initially established pursuant to this subsection shall not exceed the dollar amounts in effect under section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (42 U.S.C. s.18022), as those limits were in effect on June 1, 2020¹.

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

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

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

¹5. A carrier that offers a health benefits plan in this State shall provide that coverage for medically necessary services on an emergency or urgent basis shall be provided without imposing any requirement under the plan for prior authorization of the services or, if the services are provided by an out-of-network provider, any limitation

on coverage that is more restrictive than if the services were provided by an in-network provider.[1]

[1]**[**5.**]** 6.[1] This act shall take effect on [1]**[**January**]** June[1] 1, 2020, except the commissioner may take any anticipatory administrative action in advance of that date as shall be necessary for the implementation of this act.

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

ASSEMBLY, No. 5248

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED MAY 13, 2019

Sponsored by:
Assemblyman HERB CONAWAY, JR.
District 7 (Burlington)

SYNOPSIS

Preserves requirement that health insurance plans cover essential health benefits.

CURRENT VERSION OF TEXT

As introduced.

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

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

1. A hospital service corporation that provides hospital or medical expense benefits shall provide coverage under every such contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

2. A medical service corporation that provides hospital or medical expense benefits shall provide coverage under every such contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

3. A health service corporation that provides hospital or medical expense benefits shall provide coverage under every such contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section of 1302 the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

4. An individual health insurer that provides hospital or medical expense benefits shall provide coverage under every such policy delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

5. A group health insurer that provides hospital or medical expense benefits shall provide coverage under every such policy

delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

6. An individual health benefits plan that provides hospital or medical expense benefits shall provide coverage under every such 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, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

7. A small employer health benefits plan that provides hospital or medical expense benefits shall provide coverage under every such 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, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

8. A health maintenance organization that provides hospital or medical expense benefits shall provide coverage under every such contract delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

9. This act shall take effect immediately.

STATEMENT

This bill requires health insurers to continue providing coverage that at least meets the essential health benefits requirements contained in the Patient Protection and Affordable Care Act, Pub. L. 111–148, as those benefits were defined for New Jersey on January 1, 2017.

The Affordable Care Act requires certain health plans to cover EHBs, which include items and services in the following 10 benefit categories:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

The federal government defines EHB based on state-specific EHB benchmark plans, which in 2017 in New Jersey is a plan offered by Horizon Healthcare Services in the small group market, called the Advantage EPO Silver 100/50.

In light of federal efforts to repeal and replace the Affordable Care Act, including repeal of the essential health benefits requirements contained in that law, this bill is intended to ensure that New Jersey continues to require that certain plans sold in the State continue to contain coverage for essential health benefits.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 5248

STATE OF NEW JERSEY

DATED: JUNE 13, 2019

The Assembly Appropriations Committee reports favorably an Assembly Committee Substitute for Assembly Bill No. 5248.

This substitute requires certain health benefits plans to continue to offer essential health benefits.

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

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FISCAL NOTE:

This bill is not certified as requiring a fiscal note.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 5248

with committee amendments

STATE OF NEW JERSEY

DATED: JANUARY 6, 2020

The Senate Budget and Appropriations Committee reports favorably and with committee amendments Assembly Bill No. 5248 ACS.

This bill, as amended, requires certain health benefits plans to continue to offer essential health benefits.

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

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) periodically review and update the essential health benefits, and provide a report to the Governor and the Legislature that provides certain information; and

(8) establish limits on the dollar amounts of cost-sharing that may be imposed pursuant to a plan with respect to self-only coverage or coverage other than self-only coverage for a plan year. The limits initially established shall not exceed the dollar amounts in effect under section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (42 U.S.C. s.18022), as those limits were in effect on June 1, 2020.

The bill also supplements the “Health Care Quality Act,” which applies to the following health insurers: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; and health benefits plans issued

pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs.

The provisions of the bill supplementing the "Health Care Quality Act" provide that, notwithstanding any law to the contrary, a health benefits plan may not impose:

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

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

Those provisions also provide that a carrier that offers a health benefits plan in this State shall provide that coverage for medically necessary services on an emergency or urgent basis shall be provided without imposing any requirement under the plan for prior authorization of the services or, if the services are provided by an out-of-network provider, any limitation on coverage that is more restrictive than if the services were provided by an in-network provider.

As amended and reported by the committee, this bill is identical to the Senate Committee Substitute for S562(SCS) that was adopted and reported by the committee.

COMMITTEE AMENDMENTS:

The committee amendments:

(1) remove a requirement that the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs cover certain emergency services;

(2) supplement the "Health Care Quality Act" to provide that a carrier that offers a health benefits plan in this State shall provide that coverage for medically necessary services on an emergency or urgent basis shall be provided without imposing any requirement under the plan for prior authorization of the services or, if the services are provided by an out-of-network provider, any limitation on coverage that is more restrictive than if the services were provided by an in-network provider;

(3) provide that the Commissioner of Banking and Insurance shall establish limits on the dollar amounts of cost-sharing that may be imposed pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; and

(4) change the effective date from January 1, 2020, to June 1, 2020.

FISCAL IMPACT:

This bill is not certified as requiring a fiscal note.

SENATE, No. 562

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:
Senator NIA H. GILL
District 34 (Essex and Passaic)
Senator TROY SINGLETON
District 7 (Burlington)

SYNOPSIS

Preserves requirement that health insurance plans cover essential health benefits.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

(Sponsorship Updated As Of: 1/17/2018)

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

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

1. A hospital service corporation that provides hospital or medical expense benefits shall provide coverage under every such contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

2. A medical service corporation that provides hospital or medical expense benefits shall provide coverage under every such contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

3. A health service corporation that provides hospital or medical expense benefits shall provide coverage under every such contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section of 1302 the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

4. An individual health insurer that provides hospital or medical expense benefits shall provide coverage under every such policy delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

5. A group health insurer that provides hospital or medical expense benefits shall provide coverage under every such policy

delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

6. An individual health benefits plan that provides hospital or medical expense benefits shall provide coverage under every such 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, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

7. A small employer health benefits plan that provides hospital or medical expense benefits shall provide coverage under every such 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, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

8. A health maintenance organization that provides hospital or medical expense benefits shall provide coverage under every such contract delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, that at least meets the essential health benefits requirements contained in section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those benefits were defined for New Jersey on January 1, 2017.

9. This act shall take effect immediately.

STATEMENT

This bill requires health insurers to continue providing coverage that at least meets the essential health benefits requirements contained in the Patient Protection and Affordable Care Act, Pub. L. 111–148, as those benefits were defined for New Jersey on January 1, 2017.

The Affordable Care Act requires certain health plans to cover EHBs, which include items and services in the following 10 benefit categories:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

The federal government defines EHB based on state-specific EHB benchmark plans, which in 2017 in New Jersey is a plan offered by Horizon Healthcare Services in the small group market, called the Advantage EPO Silver 100/50.

In light of federal efforts to repeal and replace the Affordable Care Act, including repeal of the essential health benefits requirements contained in that law, this bill is intended to ensure that New Jersey continues to require that certain plans sold in the State continue to contain coverage for essential health benefits.

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 562

STATE OF NEW JERSEY

DATED: JUNE 3, 2019

The Senate Commerce Committee reports favorably a Senate Committee Substitute for Senate Bill No. 562.

This substitute bill requires health insurers (health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs) to continue providing coverage that meets certain essential health benefits requirements.

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

Under the bill, the cost-sharing incurred under a contract, plan or policy with respect to self-only coverage or coverage other than self-only coverage for a contract, plan or policy year beginning in 2020 may not exceed the dollar amounts in effect under section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111–148 (42 U.S.C. s.18022), as those limits were in effect on January 1, 2020.

The cost-sharing incurred for a contract, plan or policy year beginning in 2021, and in each subsequent year, would be limited to:

(1) with respect to self-only coverage, an amount equal to the product of the amount for self-only coverage determined for contract, plan or policy year 2020 and a premium adjustment percentage; and

(2) with respect to coverage other than self-only coverage, twice the amount in effect for self-only coverage.

The bill provides that the premium adjustment percentage for any calendar year is to be the percentage by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2020.

The bill provides that, notwithstanding any law to the contrary, a contract, plan, or policy may not impose:

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

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

Under the bill, individual health benefits plans and small employer health benefits plans are required to provide for a level of coverage that is designed to provide benefits that are actuarially equivalent to:

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

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

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

The bill provides that the level of coverage of a plan is to be determined on the basis that the essential health benefits described in the bill are provided to a standard population, and without regard to the actual population to which the plan may provide benefits.

The commissioner is required develop guidelines to provide for a de minimis variation in the actuarial calculations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

In light of federal efforts to repeal and replace the Affordable Care Act, including repeal of the essential health benefits requirements contained in that law, this bill is intended to ensure that New Jersey continues to require that certain plans sold in the State continue to contain coverage for essential health benefits.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 562

STATE OF NEW JERSEY

DATED: JANUARY 6, 2020

The Senate Budget and Appropriations Committee reports favorably a Senate Committee Substitute for Senate Bill No. 562 SCS.

This substitute bill requires certain health benefits plans to continue to offer essential health benefits.

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

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

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

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

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

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

Under the bill, the level of coverage of a plan is to be determined on the basis that the essential health benefits are provided to a standard

population, and without regard to the actual population to which the plan may provide benefits. The bill directs the commissioner to develop guidelines to provide for a de minimis variation in the actuarial calculations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

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

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

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

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

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

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

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

(7) periodically review and update the essential health benefits, and provide a report to the Governor and the Legislature that provides certain information; and

(8) establish limits on the dollar amounts of cost-sharing that may be imposed pursuant to a plan with respect to self-only coverage or coverage other than self-only coverage for a plan year. The limits initially established shall not exceed the dollar amounts in effect under section 1302 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (42 U.S.C. s.18022), as those limits were in effect on June 1, 2020.

The bill also supplements the “Health Care Quality Act,” which applies to the following health insurers: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs.

The provisions of the bill supplementing the "Health Care Quality Act" provide that, notwithstanding any law to the contrary, a health benefits plan may not impose:

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

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

Those provisions also provide that a carrier that offers a health benefits plan in this State shall provide that coverage for medically necessary services on an emergency or urgent basis shall be provided without imposing any requirement under the plan for prior authorization of the services or, if the services are provided by an out-of-network provider, any limitation on coverage that is more restrictive than if the services were provided by an in-network provider.

This Senate Committee Substitute is identical to the Assembly Committee Substitute for Assembly Bill No. 5248, as amended and reported by the committee.

FISCAL IMPACT:

This bill is not certified as requiring a fiscal note.

Governor Murphy Signs Legislative Package Protecting the Affordable Care Act in New Jersey

01/16/2020

TRENTON – Governor Phil Murphy today signed a package of bills to safeguard the provisions of the Affordable Care Act (ACA) in New Jersey. The bills, which will codify into state law the basic protections for health care consumers that are part of the Affordable Care Act, include protections for no-cost preventative care and contraception, prohibit exclusions for pre-existing conditions, allow children to stay on their parents' plan until age 26, and incorporate mental health and maternity care as part of essential benefits, among others. The Governor highlighted the importance of these bills during an armchair discussion with Hackensack Meridian Health Chief Executive Officer Bob Garret.

"At a time when the Affordable Care Act is under siege by the Trump Administration and being challenged in the courts, New Jersey has a responsibility to protect and provide access to high-quality, affordable health care for all of our residents," **said Governor Murphy.** "I applaud my colleagues in the Legislature for taking the critical steps necessary to ensure that the provisions of the Affordable Health Care Act are codified into state law and for working to make the health of our residents a top priority."

The Governor signed the following bills into law:

A5500 (Greenwald, Lopez, Lampitt/Pou, Lagana) - Expands rate review process in DOBI for certain individual and small employer health benefits plans.

A5501 (McKeon, Vainieri Huttle, Speight/Pou, Weinberg) - Requires continuation of health benefits dependent coverage until child turns 26 years of age.

A5503 (Reynolds-Jackson, Swain/Vitale, Cryan) - Establishes open enrollment period under Individual Health Coverage Program.

A5504 (Benson, Schaer/Cryan, Diegnan) - Applies 85 percent loss ratio requirement to certain large group health benefits carriers.

A5506 (Tully, Danielsen/Singleton, Diegnan) - Repeals statute authorizing offering of "Basic and Essential" health benefits plans under individual health benefits plans and other statutes concerning basic health plans; makes conforming amendments.

A5507 (McKeon, Conaway, Mukherji/Pou, Ruiz) - Requires health benefits coverage for certain preventive services.

A5508 (Zwicker, Murphy, Sumter/Ruiz, Pou) - Revises law requiring health benefits coverage for certain contraceptives.

A5248 (Conaway, Mukherji, McKeon/Gill, Singleton) - Preserves certain requirements that health insurance plans cover essential health benefits.

S626 (Vitale, Diegnan/Vainieri Huttle, Chiaravalloti, Downey, Danielsen) - Clarifies prohibition on preexisting condition exclusions in health insurance policies.

"It is more than health insurance, it is security. It is the safety you feel in knowing that if something goes wrong you have somewhere to go," **said Senator Pou.** "While not every New Jerseyan has health insurance coverage, there are a lot more people covered now because of the Affordable Care Act than there were before the landmark legislation led by the Obama administration. This life-saving federal program, however, is currently being attacked by Trump and the Republicans in Congress and I am proud of the Governor and Legislature for

standing up for residents and making the ACA the law of our state, regardless of who is in the White House."

"With the President trying to do everything he can to destroy the Affordable Care Act, I'm glad the legislature and the administration worked together to ensure that the people who benefitted from the ACA will be protected in New Jersey," **said Senator Vitale**. "We cannot leave the health and safety of New Jerseyans up to the whims of the oval office. These laws, along with the state health care exchange signed earlier, will go a long way to make sure our state can offer affordable health care to all of our residents."

"The Affordable Care Act gave millions of people across the country access to health care and protected those with pre-existing conditions from being discriminated against by health insurance companies," **said Senator Singleton.**"Taking away a person's health insurance, regardless of whether or not they will be able to find an alternative, is disgraceful. New Jersey is a state that protects its residents, and by strengthening the ACA in this state, we will continue to protect working and middle class families."

"Contraception was named as one of the top ten public health achievements of the 20th century by the Centers for Disease Control and Prevention. That was twenty years ago, whether or not insurance plans cover contraceptives shouldn't be a question today," **said Senator Ruiz.** "It's a matter of public health and it's a matter of gender equity. People should have access to birth control and this law will help ensure that they do."

A5500

"The affordable care act has helped tens of thousands of New Jersey residents gain access to healthcare for themselves and their families," **said Assemblyman Greenwald.** "With this law, we are keeping healthcare affordable for working families by preventing unreasonable rate hikes for the insured, preserving the substantial progress we've made on increasing access to quality healthcare in New Jersey."

"The Affordable Care Act has changed the lives of many New Jersey families," **said Assemblywoman Lopez.** "Protecting families against unjustified rate changes is critical to maintaining and expanding access to healthcare in the state for many more residents."

"This is the next practical step in protecting thousands of New Jerseyans who have been afforded healthcare benefits under the Affordable Care Act," **said Assemblywoman Lampitt.** "The key is to ensure health insurance remains affordable for all residents by keeping an eye on and preventing unnecessary rate increases."

A5501

Assemblymembers McKeon, Vainieri Huttle, and Speight issued a joint statement:

"With many college graduates returning home while they look for jobs, there was a steep rise in residents ages 19 -26 without access to healthcare. For those who did have insurance through their parents, the cost became an additional, unexpected burden on families. The Affordable Care Act has significantly helped to reduce the uninsured rate for young adults under the age of 26 by allowing parents to cover them in their own plans without the requirement of a separate premium. Codifying this into New Jersey State law will help families ensure their children, whether they are continuing their education or at home temporarily, are provided for in terms of healthcare."

A5503

Assemblymembers Reynolds-Jackson and Swain issued the following statement:

"Changes on the federal level of ACA have deliberately shortened the open enrollment period by 50 percent placing consumers at a great disadvantage. There's less time to research their coverage options and enroll. As New Jersey embarks on the creation of a State-based healthcare exchange, it is critical to ensure open enrollment periods which provide enough time, promotion and access for residents."

A5504

"The Affordable Care Act was groundbreaking in expanding health insurance coverage for millions of Americans. It is important for our state that we maintain the essential protections of Obamacare for all our families," **said Assemblyman Benson.** "This new state law will help guarantee the money residents spend on their health insurance overwhelmingly goes to the medical care and services they need."

“This law allows for continued oversight of health insurance companies so that our state can make sure they are properly applying customers’ payments,” **said Assemblyman Schaer.** “There is no room for frivolous spending when it comes to health; the hard-earned money coming out of our residents’ paychecks for health insurance should go towards actually giving them the treatments, tests, procedures and medications they need.”

A5507

Assemblymembers McKeon, Conaway and Mukherji joint statement:

“Preventive healthcare is critical to helping individuals’ live longer, healthier lives. In the long run, preventive medicine and services helps families’ keep healthcare costs down and avoid potential health problems. These are services every resident relies on for themselves and their children. The Affordable Care Act ensured more residents’ access to preventive care than before. Setting these same standards under the State-based healthcare exchange will continue to protect New Jersey families’ and their access to these critical services.”

A5506

“It’s understandable that the government wanted to encourage Americans to purchase ACA health insurance by initially offering simple and inexpensive plans,” **said Assemblyman Tully.** “However, we now know these ‘Basic and Essential Plans’ simply do not cover the healthcare services many people require, which is why the ACA no longer allows them. In case the ACA is ever dismantled at the federal level, this law will make sure providers in our state do not begin offering these limited plans again.”

“Although some people were drawn to the lower-cost healthcare plans the ACA once provided, many didn’t realize just how limited their coverage would be,” **said Assemblyman Danielsen.** “When it comes to healthcare, the services provided can literally mean the difference between life and death. From high stakes procedures to daily medicine, no one should have to lose their life or experience crushing medical debt due to a lack of coverage. This will help make sure such restrictive plans can never be offered in the future.”

A5508

Assemblymembers Zwicker, Murphy, and Sumter joint statement:

“Federal changes to the Affordable Care Act aimed to jeopardize women’s access to safe, preventive care. This new law will remove those obstacles in New Jersey and preserve the benefits afforded to residents’ under the ACA. With this law, women will continue to have insurance that covers contraception without having to pay out of pocket.”

“Because of the Affordable Care Act, as many as 133 million people – or 51 percent of Americans – who have pre-existing conditions are guaranteed that condition will be covered by their health insurer,” **said Assemblywoman Vainieri Huttle.** “But the ACA has been threatened in the past few years. This new law will safeguard this crucial protection for patients should anything ever happen to the ACA.”

“When the ACA was passed, state law was never changed to include the mandate for coverage of pre-existing conditions,” **said Assemblyman Chiaravalloti.** “This important update sends a clear message that we in New Jersey believe health care is not a privilege, but a right.”

“People with pre-existing conditions had their lives changed when the Affordable Care Act became law in 2010,” **said Assemblywoman Downey.** “For the first time, they could not be denied coverage by an insurance company because of their conditions, from diabetes to allergies to cancer. We cannot go back to a world where people had less access to critical medications or treatments because of poor insurance coverage. With this law, we ensure that will never happen in New Jersey.”

“No one should ever be penalized for having a medical condition,” **said Assemblyman Danielsen.** “The ACA paved the way for Americans to begin seeing what was possible when they had access to coverage for pre-existing conditions. So many people now have far better quality of life as a result, and that’s something we will fight to protect and guarantee for all New Jersey residents.”

A5248

“As a physician, I firmly believe that access to health care is a right, not a privilege,” **said Assemblyman Conaway.** “We took a tremendous step forward toward securing that right for all Americans under the Affordable Care Act. The legislation signed today will enshrine the essential health benefits and guiding principles of the ACA into State law, so that New Jerseyans will continue receiving the same benefits if the ACA were ever struck down.”

“We hear stories far too often of patients facing discrimination because of their age or disability,” **said Assemblyman Mukherji.** “No one should be penalized or taken advantage for having a health condition. This is the law of the land nationwide, and we’ve now reaffirmed these values here in New Jersey.”

“Essential health benefits are exactly that: essential,” **said Assemblyman McKeon.** “Our children need vision and oral care; our new mothers need maternity care; and at any moment, anyone may need emergency services. I’m proud to live in a state that values the health and wellbeing of its residents, so much that it guarantees certain protections under the law.”