17:48-6uu; 17:48A-7rr; 17:48E-35.45 et al

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2019 **CHAPTER:** 472

NJSA: **17:48-6uu; 17:48A-7rr; 17:48E-35.45 et al** (Requires health insurers to provide plans that limit patient cost-sharing concerning certain prescription drug coverage)

BILL NO: A2431 (Substituted for S1865)

SPONSOR(S) Daniel R. Benson and others

DATE INTRODUCED: 2/1/2018

COMMITTEE: **ASSEMBLY:** AFI
Appropriations

SENATE: Commerce
Budget & Appropriations

AMENDED DURING PASSAGE: Yes

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

SENATE: 1/13/2020

DATE OF APPROVAL: 1/21/2020

FOLLOWING ARE ATTACHED IF AVAILABLE:

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

A2431

SPONSOR'S STATEMENT: (Begins on page 12 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes Financial Instit. & Insurance
Appropriations

SENATE: Yes Commerce
Budget & Approp.

(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: Yes 3/29/2019

S1865

SPONSOR'S STATEMENT: (Begins on page 12 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes Commerce
Budget & Approp.

(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: Yes 11/22/2019

VETO MESSAGE: Yes

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

[L]"aw limits out-of-pocket prescription drug," NJBIZ, January 21, 2020

RWH/JA

§1 - C.17:48-6uu
§2 - C.17:48A-7rr
§3 - C.17:48E-35.45
§4 - C.17B:26-2.1nn
§5 - C.17B:27-46.1uu
§6 - C.17B:27A-7.28
§7 - C.17B:27A-19.32
§8 - C.26:2J-4.46
§9 - Note

P.L. 2019, CHAPTER 472, ***approved January 21, 2020***
Assembly Committee Substitute ***(First Reprint)*** for
Assembly, No. 2431

AN ACT concerning health benefits coverage for prescription drugs 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. Notwithstanding any other provision of law to the contrary, a hospital service corporation that offers a contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, shall ensure that at least 25 percent of all plans, or at least one plan if the corporation offers less than four plans, offered by the corporation in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17), shall conform with the following:

(1) (a) a contract that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a contract that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

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

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]Assembly amendments adopted in accordance with Governor's recommendations January 13, 2020.

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

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

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

2. a. Notwithstanding any other provision of law to the contrary, a medical service corporation that offers a contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, shall ensure that at least 25 percent of all plans, or at least one plan if the corporation offers less than four plans, offered by the corporation in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17), shall conform with the following:

(1) (a) a contract that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person’s cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a contract that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person’s cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

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

(2) except as provided in paragraph (3) of this subsection, the limits described in paragraph (1) of this subsection shall apply at

any point in the benefit design, including before and after any applicable deductible is reached; and

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

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

3. a. Notwithstanding any other provision of law to the contrary, a health service corporation that offers a contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, shall ensure that at least 25 percent of all plans, or at least one plan if the corporation offers less than four plans, offered by the corporation in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17), shall conform with the following:

(1) (a) a contract that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person’s cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a contract that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person’s cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

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

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

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

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

4. a. Notwithstanding any other provision of law to the contrary, an insurer that offers an individual health insurance policy that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, shall ensure that at least 25 percent of all plans, or at least one plan if the carrier offers less than four plans, offered by the carrier in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall conform with the following:

(1) (a) a policy that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a policy that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

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

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

(3) for prescription drug benefits offered in conjunction with a high-deductible health plan, the policy shall not provide prescription drug benefits until the expenditures applicable to the

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

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

5. a. Notwithstanding any other provision of law to the contrary, an insurer that offers a group health insurance policy that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, shall ensure that the insurer offers at least two plans in the large group market pursuant to N.J.S.17B:27-26 et seq.

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

6. a. Notwithstanding any other provision of law to the contrary, a carrier that offers an individual health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall ensure that: at least 25 percent of all plans, or at least one plan if the carrier offers less than four plans, offered by the carrier in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall conform with the following:

(1) (a) a health benefits plan that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person’s cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a health benefits plan that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person’s cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

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

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

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

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

7. a. Notwithstanding any other provision of law to the contrary, a carrier that offers a small employer health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), shall ensure that at least 25 percent of all plans, or at least one plan if the carrier offers less than four plans, offered by the carrier in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), shall conform with the following:

(1) (a) a health benefits plan that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person’s cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) a health benefits plan that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person’s cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

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

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

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

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

8. a. Notwithstanding any other provision of law to the contrary, a health maintenance organization that offers a contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, shall ensure that at least 25 percent of all plans, or at least one plan if the organization offers less than four plans, offered by the organization in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, in the individual market pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), and in the small employer market pursuant to P.L.1992, c.162 (C.17B:27A-17), shall conform with the following:

(1) (a) an agreement that provides a silver, gold, or platinum level of coverage, as defined in 45 C.F.R. s.156.140, shall limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug;

(b) an agreement that provides a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug;

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

(2) except as provided in paragraph (3) of this subsection, the limits described in paragraph (1) of this subsection shall apply at

any point in the benefit design, including before and after any applicable deductible is reached; and

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

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

[1][9. Notwithstanding any other provision of law to the contrary, the State Health Benefits Commission shall ensure that every contract that provides benefits for expenses incurred in the purchase of prescription drugs, which is purchased by the commission shall conform with the following:

a. the contract shall limit a covered person's out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $200 per month for each prescription drug for up to a 30-day supply of any single drug;

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

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

[1][10. Notwithstanding any other provision of law to the contrary, the School Employees' Health Benefits Commission shall ensure that every contract that provides benefits for expenses

incurred in the purchase of prescription drugs, which is purchased by the commission shall conform with the following:

a. the contract shall limit a covered person's out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $200 per month for each prescription drug for up to a 30-day supply of any single drug;

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

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

[1]**[**11.**]** 9.[1] This act shall take effect as follows:

a. for large employer plans affected by section 5 of the act, the act shall take effect immediately and shall apply to plans issued or renewed on or after January 1 of the calendar year that begins 180 days after the date of enactment; [1]and[1]

b. for individual and small employer plans affected by sections 1 through 4 and sections 6 through 8 of the act, the act shall take effect immediately and apply to new plans or renewals issued on or after January 1 of the calendar year that begins 270 days after the date of enactment[1]**[**; and**]** .[1]

[1]**[**c. for contracts purchased by the State Health Benefits Program and the School Employees' Health Benefits Program affected by sections 9 and 10 of this act, the act shall take effect on the 90th day after the date of enactment and shall apply to contracts purchased on or after that date.**]**[1]

Requires health insurers to provide plans that limit patient cost-sharing concerning certain prescription drug coverage.

ASSEMBLY, No. 2431

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED FEBRUARY 1, 2018

Sponsored by:
Assemblyman DANIEL R. BENSON
District 14 (Mercer and Middlesex)
Assemblywoman ANGELICA M. JIMENEZ
District 32 (Bergen and Hudson)
Assemblywoman BETTYLOU DECROCE
District 26 (Essex, Morris and Passaic)
Assemblyman TIM EUSTACE
District 38 (Bergen and Passaic)

Co-Sponsored by:
Assemblywoman Vainieri Huttle, Assemblymen Mukherji, Bramnick, Assemblywoman Murphy, Assemblyman McKeon, Assemblywomen Jasey, Schepisi, Assemblymen Giblin, Dancer, Conaway and Johnson

SYNOPSIS

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

CURRENT VERSION OF TEXT

As introduced.

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

AN ACT concerning health benefits coverage for prescription drugs 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. Notwithstanding any other provision of law to the contrary, every hospital service corporation contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), 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, shall conform with the following:

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

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

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

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

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

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

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

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

2. a. Notwithstanding any other provision of law to the contrary, every medical service corporation contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), 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, shall conform with the following:

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

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

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

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

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

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

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

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

3. a. Notwithstanding any other provision of law to the contrary, every health service corporation contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), 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, shall conform with the following:

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

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

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

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

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

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

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

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

4. a. Notwithstanding any other provision of law to the contrary, every individual health insurance policy that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to chapter 26 of Title 17B of the New Jersey Statutes, 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, shall conform with the following:

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

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

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

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

applicable deductible is reached;

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

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

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

5. a. Notwithstanding any other provision of law to the contrary, every group health insurance policy that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes, 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, shall conform with the following:

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

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

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

paragraph;

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

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

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

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

6. a. Notwithstanding any other provision of law to the contrary, an individual health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, renewed, or approved for issuance or renewal in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), 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, shall conform with the following:

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

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

and

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

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

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

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

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

7. a. Notwithstanding any other provision of law to the contrary, a small employer health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, renewed, or approved for issuance or renewal in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), 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, shall conform with the following:

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

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

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

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

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

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

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

8. a. Notwithstanding any other provision of law to the contrary, a health maintenance organization enrollee agreement that provides coverage for the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), 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, shall conform with the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STATEMENT

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

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

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

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

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

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2431

STATE OF NEW JERSEY

DATED: JUNE 11, 2018

The Assembly Financial Institutions and Insurance Committee reports favorably Assembly Bill No. 2431.

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

Unless the plan or contract is required to provide bronze level coverage or is a catastrophic plan under the federal Affordable Care Act, the bill requires insurers to ensure that plans limit a covered person's out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $100 per month for each prescription drug for up to a 30-day supply of any single drug. If the plan or contract is required to provide bronze level coverage, as defined in 45 C.F.R. s.156.140, the plan shall ensure that any required enrollee cost-sharing, including any copayment or coinsurance, does not exceed $200 per month for each prescription drug for up to a 30-day supply of any single drug. In the case of a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, it is exempt from these requirements.

In the case of high-deductible plans, these cost sharing limits apply at any point in the benefit design, including before and after any applicable deductible is reached. For prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage,

respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits would be as specified in the bill.

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

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 2431

STATE OF NEW JERSEY

DATED: MARCH 18, 2019

The Assembly Appropriations Committee reports favorably an Assembly Committee Substitute for Assembly Bill No. 2431.

This Assembly Committee Substitute for Assembly Bill No.2431 requires certain health insurers, under certain policies or contracts that provide coverage for prescription drugs, to place limitations on covered persons' cost sharing for prescription drugs.

The substitute's provisions apply to the following insurers and programs that provide coverage for prescription drugs under a policy or contract: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP).

Unless the plan or contract is a catastrophic plan under the federal Affordable Care Act, the substitute requires insurers that offer plans in the individual and small employer markets to ensure that at least 25 percent of all plans, or at least one plan if the insurer offers less than four plans, offered by the insurer in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, shall conform with the following:

- a contract that provides a silver, gold, or platinum level of coverage shall limit a covered person's cost-sharing financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug; and
- a contract that provides a bronze level of coverage shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug.

In the case of high-deductible plans, these cost sharing limits apply at any point in the benefit design, including before and after any applicable deductible is reached. For prescription drug benefits

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

In the case of a carrier that offers a large employer group health insurance policy, the carrier is required to offer at least two plans in the large group market.

In the case of the SHBP and the SEHBP, the respective commissions for these programs shall ensure that every contract that provides benefits for expenses incurred in the purchase of prescription drugs, which is purchased by the commission shall:

- limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $200 per month for each prescription drug for up to a 30-day supply of any single drug, and the limits shall apply at any point in the benefit design, including before and after any applicable deductible is reached; and
- for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in the bill.

Finally, the substitute provides for various effective dates for the substitute, depending on the type of plan offered. The substitute provides:

- for large employer plans, the substitute shall take effect immediately and apply to plans issued or renewed on or after January 1 of the calendar year that begins 180 days after the date of enactment;
- for individual and small employer plans, the substitute shall take effect immediately and apply to new plans or renewals issued on or after January 1 of the calendar year that begins 270 days after the date of enactment; and
- for contracts purchased by the SHBP and the SEHBP, the substitute shall take effect on the 90th day after the date of

enactment and shall apply to contracts purchased on or after that date.

FISCAL IMPACT:

The Office of Legislative Services (OLS) estimates that this substitute bill will result in an indeterminate increase in State and local health benefit costs. Member copays for brand name drugs with generic equivalents in most SHBP and SEHBP plans require the member to pay the generic copay amount and the difference between the cost of a generic prescription drug and the cost of the brand name drug with a generic equivalent. This substitute will increase State and local costs by an indeterminate amount in cases where the cost to a member to pay the difference between generic and brand name drug with a generic equivalent is greater than $200. It is also likely that some local governments' plans that are external to the State-administered plans will be affected by the substitute in a manner that increases costs. The OLS has no basis for determining the number of prescriptions that may be filled for brand name drugs with a generic equivalent.

SENATE COMMERCE COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 2431

STATE OF NEW JERSEY

DATED: JUNE 17, 2019

The Senate Commerce Committee reports favorably Assembly Bill No. 2431 (ACS).

This bill requires certain health insurers, under certain policies or contracts that provide coverage for prescription drugs, to place limitations on covered persons' cost sharing for prescription drugs.

The substitute's provisions apply to the following insurers and programs that provide coverage for prescription drugs under a policy or contract: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP).

Unless the plan or contract is a catastrophic plan under the federal Affordable Care Act, the substitute requires insurers that offer plans in the individual and small employer markets to ensure that at least 25 percent of all plans, or at least one plan if the insurer offers less than four plans, offered by the insurer in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, shall conform with the following:

- a contract that provides a silver, gold, or platinum level of coverage shall limit a covered person's cost-sharing financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug; and
- a contract that provides a bronze level of coverage shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug.

In the case of high-deductible plans, these cost sharing limits apply at any point in the benefit design, including before and after any applicable deductible is reached. For prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the

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

In the case of a carrier that offers a large employer group health insurance policy, the carrier is required to offer at least two plans in the large group market.

In the case of the SHBP and the SEHBP, the respective commissions for these programs shall ensure that every contract that provides benefits for expenses incurred in the purchase of prescription drugs, which is purchased by the commission shall:

- limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $200 per month for each prescription drug for up to a 30-day supply of any single drug, and the limits shall apply at any point in the benefit design, including before and after any applicable deductible is reached; and
- for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in the bill.

Finally, the substitute provides for various effective dates for the substitute, depending on the type of plan offered. The substitute provides:

- for large employer plans, the substitute shall take effect immediately and apply to plans issued or renewed on or after January 1 of the calendar year that begins 180 days after the date of enactment;
- for individual and small employer plans, the substitute shall take effect immediately and apply to new plans or renewals issued on or after January 1 of the calendar year that begins 270 days after the date of enactment; and
- for contracts purchased by the SHBP and the SEHBP, the substitute shall take effect on the 90th day after the date of enactment and shall apply to contracts purchased on or after that date.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 2431

STATE OF NEW JERSEY

DATED: DECEMBER 5, 2019

The Senate Budget and Appropriations Committee reports favorably Assembly Bill No. 2431 ACS.

This bill requires certain health insurers, under certain policies or contracts that provide coverage for prescription drugs, to place limitations on covered persons' cost sharing for prescription drugs.

The bill's provisions apply to the following insurers and programs that provide coverage for prescription drugs under a policy or contract: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP).

Unless the plan or contract is a catastrophic plan under the federal Affordable Care Act, the bill requires insurers that offer plans in the individual and small employer markets to ensure that at least 25 percent of all plans, or at least one plan if the insurer offers less than four plans, offered by the insurer in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, shall conform with the following:

- a contract that provides a silver, gold, or platinum level of coverage shall limit a covered person's cost-sharing financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug; and
- a contract that provides a bronze level of coverage shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug.

In the case of high-deductible plans, these cost sharing limits apply at any point in the benefit design, including before and after any applicable deductible is reached. For prescription drug benefits offered in conjunction with a high-deductible health plan, the plan

shall not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in the bill.

In the case of a carrier that offers a large employer group health insurance policy, the carrier is required to offer at least two plans in the large group market.

In the case of the SHBP and the SEHBP, the respective commissions for these programs shall ensure that every contract that provides benefits for expenses incurred in the purchase of prescription drugs, which is purchased by the commission shall:

- limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $200 per month for each prescription drug for up to a 30-day supply of any single drug, and the limits shall apply at any point in the benefit design, including before and after any applicable deductible is reached; and
- for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in the bill.

Finally, the bill provides for various effective dates for the bill, depending on the type of plan offered. The bill provides:

- for large employer plans, the bill shall take effect immediately and apply to plans issued or renewed on or after January 1 of the calendar year that begins 180 days after the date of enactment;
- for individual and small employer plans, the bill shall take effect immediately and apply to new plans or renewals issued on or after January 1 of the calendar year that begins 270 days after the date of enactment; and
- for contracts purchased by the SHBP and the SEHBP, the bill shall take effect on the 90th day after the date of enactment and shall apply to contracts purchased on or after that date.

As reported, this bill is identical to Senate Bill No. 1865 (SCS), as also reported by the committee.

FISCAL IMPACT:

The Office of Legislative Services estimates that this bill will have an indeterminate fiscal impact on State and local employer costs, including from provisions that limit a member's cost-sharing for up to a 30-day supply for each prescription drug prescribed. The limits will apply at any point in the benefit design, including before and after any applicable deductible is reached, except for high deductible plans.

Brand name prescription drugs with generic equivalents could increase prescription drug costs to the State and local employers if those prescription drug costs exceed the limits specified in the bill. In 2018, copays for brand name prescription drugs with generic equivalents were changed in some health insurance plans from specific dollar amounts to requiring the member to pay the generic copay amount as well as the difference in cost between a generic prescription drug and the brand name drug with a generic equivalent.

LEGISLATIVE FISCAL ESTIMATE

ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, No. 2431

STATE OF NEW JERSEY
218th LEGISLATURE

DATED: MARCH 29, 2019

SUMMARY

Synopsis:	Requires health insurers to provide plans that limit cost-sharing concerning certain prescription drug coverage.
Type of Impact:	Multiyear expenditure increase to the State General Fund, local boards of education, and local governments.
Agencies Affected:	Division of Pensions and Benefits, Department of the Treasury; local government entities; local boards of education.

Office of Legislative Services Estimate

Fiscal Impact	Year 1	Year 2	Year 3
State Cost Increase		Indeterminate	
Local Cost Increase		Indeterminate	

- The Office of Legislative Services (OLS) estimates that this bill will have an indeterminate fiscal impact on State and local employer costs, including from provisions that limit a member's cost-sharing for up to a 30-day supply for each prescription drug prescribed. The limits will apply at any point in the benefit design, including before and after any applicable deductible is reached, except for high deductible plans.

- Brand name prescription drugs with generic equivalents could increase prescription drug costs to the State and local employers if those prescription drug costs exceed the limits specified in the bill. In 2018, copays for brand name prescription drugs with generic equivalents were changed in some health insurance plans from specific dollar amounts to requiring the member to pay the generic copay amount as well as the difference in cost between a generic prescription drug and the brand name drug with a generic equivalent.

BILL DESCRIPTION

This bill includes provisions that, for example, require the State Health Benefits Program and the State Employees' Health Benefits Program to limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no

more than $200 per month for each prescription drug for up to a 30-day supply of any single drug, and the limits must apply at any point in the benefit design, including before and after any applicable deductible is reached. For prescription drug benefits offered in conjunction with a high-deductible health plan, the programs will not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under sections of the federal Internal Revenue Code. Once the expenditure amount has been met under the plan, coverage for prescription drug benefits will begin, and the limit on out-of-pocket expenditures for prescription drug benefits will be as specified in the bill.

The bill also requires insurers and other programs that provide coverage for prescription drugs to have at least 25 percent of all plans, or at least one plan if the insurer offers less than four plans, in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, that limit a covered person's cost-sharing financial responsibility under a silver, gold, or platinum level of coverage, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug, and that limit a covered person's cost-sharing under a bronze level of coverage, including any copayment or coinsurance, to $250 per month for each prescription drug for up to a 30-day supply of any single drug.

In the case of high-deductible plans, these cost sharing limits apply after any applicable deductible is reached.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS estimates that this bill will have an indeterminate fiscal impact on State and local employer costs, including from provisions that limit a member's cost-sharing for up to a 30-day supply for each prescription drug prescribed. Those limits will apply at any point in the benefit design, including before and after any applicable deductible is reached, except for high deductible plans. Brand name prescription drugs with generic equivalents could increase prescription drug costs to the State and local employers if those prescription drug costs exceed the limits specified in the bill. In 2018, copays for brand name prescription drugs with generic equivalents were changed in some health insurance plans from specific dollar amounts to requiring the member to pay the generic copay amount as well as the difference in cost between a generic prescription drug and the brand name drug with a generic equivalent. The OLS has no basis for determining the number of prescriptions that may be filled for brand name drugs with a generic equivalent.

Section:	*State Government*
Analyst:	*Kimberly M. Clemmensen* *Lead Fiscal Analyst*
Approved:	*Frank W. Haines III* *Legislative Budget and Finance Officer*

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

SENATE, No. 1865

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED FEBRUARY 15, 2018

Sponsored by:
Senator LORETTA WEINBERG
District 37 (Bergen)
Senator THOMAS H. KEAN, JR.
District 21 (Morris, Somerset and Union)

SYNOPSIS

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

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 4/6/2018)

AN ACT concerning health benefits coverage for prescription drugs 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. Notwithstanding any other provision of law to the contrary, every hospital service corporation contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), 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, shall conform with the following:

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

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

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

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

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

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

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

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

2. a. Notwithstanding any other provision of law to the contrary, every medical service corporation contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), 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, shall conform with the following:

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

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

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

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

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

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

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

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

3. a. Notwithstanding any other provision of law to the contrary, every health service corporation contract that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), 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, shall conform with the following:

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

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

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

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

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

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

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

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

4. a. Notwithstanding any other provision of law to the contrary, every individual health insurance policy that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to chapter 26 of Title 17B of the New Jersey Statutes, 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, shall conform with the following:

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

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

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

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

applicable deductible is reached;

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

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

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

5. a. Notwithstanding any other provision of law to the contrary, every group health insurance policy that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes, 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, shall conform with the following:

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

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

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

paragraph;

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

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

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

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

6. a. Notwithstanding any other provision of law to the contrary, an individual health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, renewed, or approved for issuance or renewal in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), 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, shall conform with the following:

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

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

and

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

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

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

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

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

7. a. Notwithstanding any other provision of law to the contrary, a small employer health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, renewed, or approved for issuance or renewal in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), 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, shall conform with the following:

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

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

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

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

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

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

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

8. a. Notwithstanding any other provision of law to the contrary, a health maintenance organization enrollee agreement that provides coverage for the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), 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, shall conform with the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits

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

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

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

STATEMENT

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

Unless the plan or contract is required to provide bronze level of coverage or is a catastrophic plan under the federal Affordable Care Act, the bill requires insurers to ensure that plans limit a covered person's out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $100 per month for each prescription drug for up to a 30-day supply of any single drug. If the plan or contract is required to provide a bronze level of coverage, as defined in 45 C.F.R. s.156.140, the plan shall ensure that any required enrollee cost-sharing, including any copayment or

coinsurance, does not exceed $200 per month for each prescription drug for up to a 30-day supply of any single drug. In the case of a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, it is exempt from these requirements.

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

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

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 1865

STATE OF NEW JERSEY

DATED: JUNE 17, 2019

The Senate Commerce Committee reports favorably a Senate Committee Substitute for Senate Bill No. 1865.

This bill requires certain health insurers, under certain policies or contracts that provide coverage for prescription drugs, to place limitations on covered persons' cost sharing for prescription drugs.

The substitute's provisions apply to the following insurers and programs that provide coverage for prescription drugs under a policy or contract: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP).

Unless the plan or contract is a catastrophic plan under the federal Affordable Care Act, the substitute requires insurers that offer plans in the individual and small employer markets to ensure that at least 25 percent of all plans, or at least one plan if the insurer offers less than four plans, offered by the insurer in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, shall conform with the following:

- a contract that provides a silver, gold, or platinum level of coverage shall limit a covered person's cost-sharing financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug; and
- a contract that provides a bronze level of coverage shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug.

In the case of high-deductible plans, these cost sharing limits apply at any point in the benefit design, including before and after any applicable deductible is reached. For prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the

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

In the case of a carrier that offers a large employer group health insurance policy, the carrier is required to offer at least two plans in the large group market.

In the case of the SHBP and the SEHBP, the respective commissions for these programs shall ensure that every contract that provides benefits for expenses incurred in the purchase of prescription drugs, which is purchased by the commission shall:

- limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $200 per month for each prescription drug for up to a 30-day supply of any single drug, and the limits shall apply at any point in the benefit design, including before and after any applicable deductible is reached; and
- for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in the bill.

Finally, the substitute provides for various effective dates for the substitute, depending on the type of plan offered. The substitute provides:

- for large employer plans, the substitute shall take effect immediately and apply to plans issued or renewed on or after January 1 of the calendar year that begins 180 days after the date of enactment;
- for individual and small employer plans, the substitute shall take effect immediately and apply to new plans or renewals issued on or after January 1 of the calendar year that begins 270 days after the date of enactment; and
- for contracts purchased by the SHBP and the SEHBP, the substitute shall take effect on the 90th day after the date of enactment and shall apply to contracts purchased on or after that date.

Finally, this substitute is identical to A2431 (ACS).

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 1865

STATE OF NEW JERSEY

DATED: DECEMBER 5, 2019

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 1865 SCS.

This bill requires certain health insurers, under certain policies or contracts that provide coverage for prescription drugs, to place limitations on covered persons' cost sharing for prescription drugs.

The bill's provisions apply to the following insurers and programs that provide coverage for prescription drugs under a policy or contract: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP).

Unless the plan or contract is a catastrophic plan under the federal Affordable Care Act, the bill requires insurers that offer plans in the individual and small employer markets to ensure that at least 25 percent of all plans, or at least one plan if the insurer offers less than four plans, offered by the insurer in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, shall conform with the following:

- a contract that provides a silver, gold, or platinum level of coverage shall limit a covered person's cost-sharing financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug; and
- a contract that provides a bronze level of coverage shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug.

In the case of high-deductible plans, these cost sharing limits apply at any point in the benefit design, including before and after any applicable deductible is reached. For prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall not provide prescription drug benefits until the expenditures

applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in the bill.

In the case of a carrier that offers a large employer group health insurance policy, the carrier is required to offer at least two plans in the large group market.

In the case of the SHBP and the SEHBP, the respective commissions for these programs shall ensure that every contract that provides benefits for expenses incurred in the purchase of prescription drugs, which is purchased by the commission shall:

- limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $200 per month for each prescription drug for up to a 30-day supply of any single drug, and the limits shall apply at any point in the benefit design, including before and after any applicable deductible is reached; and
- for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in the bill.

Finally, the bill provides for various effective dates for the bill, depending on the type of plan offered. The bill provides:

- for large employer plans, the bill shall take effect immediately and apply to plans issued or renewed on or after January 1 of the calendar year that begins 180 days after the date of enactment;
- for individual and small employer plans, the bill shall take effect immediately and apply to new plans or renewals issued on or after January 1 of the calendar year that begins 270 days after the date of enactment; and
- for contracts purchased by the SHBP and the SEHBP, the bill shall take effect on the 90th day after the date of enactment and shall apply to contracts purchased on or after that date.

As reported by the committee, this bill is identical to Assembly Bill No. 2431, as also reported by the committee.

FISCAL IMPACT:

The Office of Legislative Services estimates that this bill will have an indeterminate fiscal impact on State and local employer costs, including from provisions that limit a member's cost-sharing for up to a 30-day supply for each prescription drug prescribed. The limits will apply at any point in the benefit design, including before and after any applicable deductible is reached, except for high deductible plans.

Brand name prescription drugs with generic equivalents could increase prescription drug costs to the State and local employers if those prescription drug costs exceed the limits specified in the bill. In 2018, copays for brand name prescription drugs with generic equivalents were changed in some health insurance plans from specific dollar amounts to requiring the member to pay the generic copay amount as well as the difference in cost between a generic prescription drug and the brand name drug with a generic equivalent.

LEGISLATIVE FISCAL ESTIMATE

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 1865

STATE OF NEW JERSEY
218th LEGISLATURE

DATED: NOVEMBER 22, 2019

SUMMARY

Synopsis:	Requires health insurers to provide plans that limit cost-sharing concerning certain prescription drug coverage.
Type of Impact:	Multiyear expenditure increase to the State General Fund, local boards of education, and local governments.
Agencies Affected:	Division of Pensions and Benefits, Department of the Treasury; local government entities; local boards of education.

Office of Legislative Services Estimate

Fiscal Impact	Year 1	Year 2	Year 3
State Cost Increase		Indeterminate	
Local Cost Increase		Indeterminate	

- The Office of Legislative Services (OLS) estimates that this bill will have an indeterminate fiscal impact on State and local employer costs, including from provisions that limit a member's cost-sharing for up to a 30-day supply for each prescription drug prescribed. The limits will apply at any point in the benefit design, including before and after any applicable deductible is reached, except for high deductible plans.

- Brand name prescription drugs with generic equivalents could increase prescription drug costs to the State and local employers if those prescription drug costs exceed the limits specified in the bill. In 2018, copays for brand name prescription drugs with generic equivalents were changed in some health insurance plans from specific dollar amounts to requiring the member to pay the generic copay amount as well as the difference in cost between a generic prescription drug and the brand name drug with a generic equivalent.

BILL DESCRIPTION

This bill includes provisions that, for example, require the State Health Benefits Program and the State Employees' Health Benefits Program to limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than

$200 per month for each prescription drug for up to a 30-day supply of any single drug, and the limits must apply at any point in the benefit design, including before and after any applicable deductible is reached. For prescription drug benefits offered in conjunction with a high-deductible health plan, the programs will not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under sections of the federal Internal Revenue Code. Once the expenditure amount has been met under the plan, coverage for prescription drug benefits will begin, and the limit on out-of-pocket expenditures for prescription drug benefits will be as specified in the bill.

The bill also requires insurers and other programs that provide coverage for prescription drugs to have at least 25 percent of all plans, or at least one plan if the insurer offers less than four plans, in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, that limit a covered person's cost-sharing financial responsibility under a silver, gold, or platinum level of coverage, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug, and that limit a covered person's cost-sharing under a bronze level of coverage, including any copayment or coinsurance, to $250 per month for each prescription drug for up to a 30-day supply of any single drug.

In the case of high-deductible plans, these cost sharing limits apply after any applicable deductible is reached.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS estimates that this bill will have an indeterminate fiscal impact on State and local employer costs, including from provisions that limit a member's cost-sharing for up to a 30-day supply for each prescription drug prescribed. Those limits will apply at any point in the benefit design, including before and after any applicable deductible is reached, except for high deductible plans. Brand name prescription drugs with generic equivalents could increase prescription drug costs to the State and local employers if those prescription drug costs exceed the limits specified in the bill. In 2018, copays for brand name prescription drugs with generic equivalents were changed in some health insurance plans from specific dollar amounts to requiring the member to pay the generic copay amount as well as the difference in cost between a generic prescription drug and the brand name drug with a generic equivalent. The OLS has no basis for determining the number of prescriptions that may be filled for brand name drugs with a generic equivalent.

Section:	*State Government*
Analyst:	*Kimberly M. Clemmensen* *Lead Fiscal Analyst*
Approved:	*Frank W. Haines III* *Legislative Budget and Finance Officer*

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

Governor Murphy Signs Prescription Drug Bill to Limit Out-of-Pocket Prescription Drug Expenses for New Jersey Families

01/21/2020

TRENTON – Governor Phil Murphy today signed legislation (A2431) to help limit out-of-pocket prescription drug expenses for New Jersey families. The bill, which requires health insurers to provide plans that limit patient cost-sharing concerning prescription drug coverage, will improve affordability and access for those who require necessary medication.

"Few issues have a greater financial impact on New Jersey families than the unpredictable and ever-increasing cost of prescription drugs," **said Governor Murphy.** "Cost-sharing too often presents a barrier to a patient's ability to access medically-necessary treatments. This legislation will improve the affordability of medical care for many residents who unfortunately must make sacrifices in order to pay for their required medications."
Primary sponsors of the legislation include Assemblymembers Daniel Benson, Angelica Jimenez, BettyLou DeCroce, and Tim Eustace, and Senators Loretta Weinberg and Thomas Kean, Jr.

"Now more than ever, the need for this law is critical," **said Assemblyman Benson.** "Increasingly, health plans are imposing a serious financial burden on patients whose diseases and conditions are treated by so-called 'specialty' medications. That burden usually comes in the form of coinsurance, which can leave enrollees of health care plans left to pay thousands of dollars for one month's supply of a specialty medication. It is absolutely unacceptable that nearly every health plan available on the Healthcare.gov marketplace features co-payments of between 40-50 percent for 'specialty' medications which are life-sustaining drugs for those who take them. We can and will do better for the people of New Jersey."

"Many of the individuals who face high copayments, coinsurance or deductibles are already suffering with difficult and expensive health issues," **said Assemblywoman Jimenez.** "Some of these individuals, although they have insurance, cannot afford the exorbitant out-of-pocket expenses them for their much-needed prescription medications. We can do more to help residents with prescription costs with this new law."

"The state of our current healthcare system is untenable. Health insurance loses its value if the doctor prescribed medication is unaffordable. For patients with chronic conditions in particular, out-of-pocket costs can range into the thousands of dollars each month, putting both their health and their livelihood in jeopardy," **said Senator Weinberg.** "This law, however, is going to improve affordability and therefore access to vital medication. I'm glad, with the Governor's signature, that New Jersey is taking a step to help keep costs down and keep people from having to choose between their basic needs like food or housing and their necessary medicine."

"Patients should never have to make the impossible choice between paying for medicine and paying for necessities like groceries or rent. New Jerseyans who depend on expensive drugs to manage chronic conditions now know there will be health plans that serve their unique needs," **said Jennifer McGarry, New Jersey Advocacy Director for The Leukemia & Lymphoma Society and Chair of a Coalition of 25 patient and health care provider organizations that advocates for affordable health care in New Jersey.** "We commend the leadership of Assemblyman Daniel Benson and Senator Loretta Weinberg for their commitment to protecting patients. We are grateful to Governor Phil Murphy for supporting this critical, bipartisan legislation, which will improve the lives of many New Jerseyans."

"I've seen firsthand the devastating financial toll chronic illness can take on families," **said Jana Boyer, Executive Director of the New Jersey chapter of The Leukemia & Lymphoma Society.** "This law will make it easier for New Jersey residents to afford the prescription drugs they require in order to stay healthy and live productive lives. On behalf of New Jersey families affected by blood cancer, we're grateful for Governor Phil Murphy's support of this critical, bipartisan legislation. Patients who've faced extraordinary costs for their medicine will now have access to health insurance plans that better suit their needs."

Governor Murphy Takes Action on Legislation

01/21/2020

TRENTON – Today, Governor Phil Murphy signed the following bills into law:

S-62/A-2478 (Singleton, Oroho/DeAngelo, Houghtaling, Space) – Requires certain contractors to register under "The Public Works Contractor Registration Act"

S-358/A-4587 (Rice/Sumter, Reynolds-Jackson) – Establishes database with certain information about individuals elected to public office in this State

S-376/A-3839 (Madden, Gopal/Moriarty, Lagana, Mukherji, Murphy) – Eliminates eligibility time limit on tuition benefits for spouses of certain public safety workers killed in performance of their duties

S-497/A-4626 (Vitale, Madden/Mosquera, McKnight, Vainieri Huttle) – Allows certain prior statements by children to be admitted into evidence in child abuse and termination of parental rights cases

S-498/ACS for A-3391 (Vitale, Oroho/DeCroce, Johnson, DiMaso) – Makes various changes to "Criminal Injuries Compensation Act of 1971"

S-521/A-4378 (T. Kean, C.A. Brown, Pou, Ruiz/Caputo, Mukherji, Vainieri Huttle) – Requires NJ State Council on Arts to establish "Artist District" designation and select certain municipalities or areas within municipalities for such designation

S-589/ACS for A-422 (Weinberg/Mosquera, Jones, Moriarty) – Requires Secretary of State to establish secure Internet website for online voter registration; authorizes use of digitized signatures from New Jersey Motor Vehicle Commission’s database

S-700/A-3836 (Ruiz, Cunningham/Schaer, Mukherji, Jasey) – "Higher Education Citizenship Equality Act"; defines domicile for dependent students for purpose of eligibility for State student grants and scholarships, and resident tuition rate

S-721/A-1751 (Greenstein, Cunningham, Diegnan/Quijano, Benson) – Authorizes use of certain electric school buses

S-758/A-1987 (Cunningham, Cruz-Perez/Sumter, Mukherji, Quijano) – Requires incarcerated individual from State to be counted at residential address for legislative redistricting purposes

S-765/A-541 (Cunningham, T. Kean, Ruiz/Mazzeo, Jasey, Vainieri Huttle, Sumter, Benson) – Prohibits Higher Education Student Assistance Authority from referring defaulted loans under New Jersey College Loans to Assist State Students (NJCLASS) Loan Program for certain actions if authority and borrower have entered into settlement agreement

S-782/A-1110 (Sarlo, Scutari/Downey, Houghtaling, Dancer) – Increases workers’ compensation for loss of hand or foot

S-834 wGR/A-4186 (Scutari, Greenstein/Jones, Pintor Marin) – Prohibits resale of non-prescription diabetes test devices by pharmacists

S-939/A-3331 (Pou/Vainieri Huttle, Lopez, McKnight) – Requires forms and materials for individuals with developmental disabilities to be available in languages other than English

S-974/A-3040 (Singleton, T. Kean/Vainieri Huttle, Timberlake, Mosquera) – Requires newborn infants be screened for spinal muscular atrophy

S-1032/A-2389 (Vitale, Gopal/Schaer, Benson, Verrelli) – Concerns expansion of services provided by DHS mental health screening services

S-1146/A-2365 (Codey, Rice/Vainieri Huttle, Mukherji, Downey) – Requires hospital patient's medical record to include notation if patient is at increased risk of confusion, agitation, behavioral problems, and wandering due to dementia related disorder

S-1298/ACS for A-2972 (A.M. Bucco, Singleton/Mazzeo, Dunn, Space) – Permits municipalities to provide information on property tax bills concerning amount of local tax dollars saved through shared services

S-1318/A-3156 (Ruiz, Scutari/Lampitt, Mosquera) – Permits counties and non-governmental, community-based agencies to establish family justice centers which provide coordinated, multi-agency governmental and non-governmental assistance to victims of certain crimes and offenses, including domestic violence, and their family members

S-1505/A-1707 (Vitale/Vainieri Huttle, Lampitt, Benson, Mosquera) – Expands membership of NJ Task Force on Child Abuse and Neglect

S-1647/A-3181 (Diegnan, Codey/Conaway, Vainieri Huttle, Benson, Murphy) – Prohibits use of coupons, price rebates, and price reduction promotions in sales of tobacco and vapor products

S-1683/A-4267 (Smith, Greenstein/McKeon, Space, Wirths) – Concerns regulation of solid waste, hazardous waste, and soil and fill recycling industries

S-1703/A-715 (Connors, Holzapfel/Gove, Rumpf, DiMaso) – Exempts disabled veterans from beach buggy permit fees

S-1791/A-3414 (Weinberg/Johnson, Vainieri Huttle, Houghtaling) – Requires employers to disclose certain wage information to employees

S-1796/A-4693 (Addiego, Sweeney/Murphy) – Permits school district of residence to provide aid in-lieu-of transportation to pupil attending Marine Academy of Science and Technology provided certain conditions are met

S-1832/A-211 (Ruiz, Sarlo/Chiaravalloti, Zwicker, Pintor Marin) – Establishes loan redemption program and tuition reimbursement program for certain teachers of science, technology, engineering, and mathematics

S-2267/A-3616 (Sweeney, Corrado/Burzichelli, Holley, Calabrese) – Gives State lottery winners option of remaining anonymous indefinitely

S-2303/A-4843 (Sweeney, Ruiz, Cunningham/Wimberly, Karabinchak, Calabrese) – Requires establishment of Work and Learn Consortiums by certain educational institutions to establish certificate and degree programs identified in high labor-demand industries

S-2389 wGR/A-5449 (Singleton/Quijano, Downey, Houghtaling, Moriarty) – Requires New Jersey State Board of Pharmacy to establish prescription drug pricing disclosure website and certain pharmaceutical manufacturing companies to provide prescription drug price information

S-2428/A-4965 (Scutari/Quijano, Vainieri Huttle) – Requires that massage and bodywork therapists and employers carry professional liability insurance

S-2469/A-3745 (Singleton, Oroho/Wirths, Mazzeo, Space) – Prohibits person from contracting for public work if person is federally debarred from receiving federal contract

S-2511/A-4020 (Madden/Mazzeo, Murphy, Johnson) – Changes title of DEP "conservation officer" to "conservation police officer"

S-2521/A-4087 (Cryan, Greenstein/Vainieri Huttle, Lopez, Timberlake) – Requires reporting of inmate abuse by employees of State correctional facilities and establishes reporting and investigation program

S-2522/A-4090 (Cryan, Greenstein/Vainieri Huttle, Lopez, Timberlake) – Limits cross gender strip searches in

State correctional facilities

S-2532/A-4086 (Greenstein, Cruz-Perez/Vainieri Huttle, Lopez, Timberlake) – Requires correctional police officers receive 20 hours in-service training, including four hours in prevention of sexual misconduct, non-fraternization, and manipulation

S-2555/A-3990 (Gopal, Ruiz/Mukherji, Benson, Karabinchak) – Allows dependent students whose parents or guardians hold H-1B visas to qualify for in-State tuition at public institutions of higher education provided they meet certain criteria

S-2564/A-3519 (Turner, Singleton/Benson, McKnight, Jasey) – Establishes "Restorative Justice in Education Pilot Program" in Department of Education

SCS for S-2599/ACS for A-1268 (Bateman, Beach/Tucker, Conaway, Lampitt, Quijano) – Authorizes veterans' property tax exemption and veterans' property tax deduction for honorably discharged veterans of United States Armed Forces who did not serve in time of war or other emergency

S-2826/A-3274 (Greenstein/Vainieri Huttle, Dancer, Benson) – Requires institutions of higher education to offer cats and dogs no longer used for educational, research, or scientific purposes for adoption; designated the "Homes for Animal Heroes Act"

S-2849/A-4590 (A.M. Bucco/DiMaio, Caputo, Dunn) – Designates Seeing Eye® dog as State Dog

S-3036/A-1697 (Lagana, Scutari/Dancer, Downey) – Prohibits medical providers from reporting certain workers' compensation medical charges to collection and credit reporting agencies

S-3061/A-4603 (Ruiz, Greenstein/Lampitt, Mukherji, Benson) – Provides corporation business tax and gross income tax credits for businesses that participate in DOL registered apprenticeship programs; establishes grant program for tax-exempt organizations participating in DOL registered apprenticeship programs

S-3065/A-4657 (Ruiz, Singleton/Armato, Benson, Timberlake) – Establishes youth apprenticeship pilot program in Department of Education

S-3067/A-4602 (Ruiz, Singleton/Lampitt, Reynolds-Jackson, Sumter) – Establishes five year Apprentice Assistance and Support Services Pilot Program

S-3116/A-4683 (Ruiz/Speight, Munoz, Tucker) – Requires certain medical facilities to undertake end-of-life planning and training

S-3117/A-4685 (Ruiz/Speight, Pinkin, Munoz) – Requires emergency departments to take certain measures concerning palliative care for patients

S-3126/A-4107 (Gopal/Benson, DeCroce, Chiaravalloti) – Requires drivers to stop at railroad crossing when on-track equipment is approaching railroad crossing

S-3170/A-5145 (Cryan, Pou/Quijano, Milam, Land) – Increases prenotification time and requires severance pay in certain plant closings, transfers, and mass layoffs

S-3227/A-5261 (Gopal/Tully, Pinkin, Swain) – Requires restaurants to post signs advising customers to notify servers of food allergies; requires restaurant managers to complete food allergen training

S-3265/A-3178 (Turner, Codey, Vitale/Conaway, Murphy, Vainieri Huttle) – Prohibits sale or distribution of flavored vapor products

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S-3330 wGR/A-5066 (Addiego, Singleton/Jones, Vainieri Huttle, Lampitt, Murphy) – Establishes pilot program in DCF to study impact of child care services provided by community providers operating in public school facilities; requires community providers to meet certain criteria

S-3422/A-6056 (Singer, T. Kean/Houghtaling, Downey, Vainieri Huttle) – Requires declaration of Code Blue

alert when National Weather Service predicts temperatures of 32 degrees Fahrenheit or lower

S-3468/A-5105 (Sweeney, Singleton/Murphy, Karabinchak, Vainieri Huttle) – Establishes Task Force on Maximizing Employment for People with Disabilities

S-3511/A-5298 (Singer, T. Kean/Mukherji, Vainieri Huttle, Downey) – Authorizes certain health care and social service resources to be made available during Code Blue alert

S-3581/A-5963 (Singleton/Lopez, Quijano) – Prohibits certain business financing contracts that contain judgment by confession provisions

S-3685/A-5345 (Sarlo, Singleton/Mukherji, Conaway, McKnight) – Establishes program to increase participation of underrepresented students in New Jersey's science and engineering workforce

S-3756/A-6115 (Ruiz, Sarlo, O'Scanlon/Jasey, Jones, Wirths) – Requires limited purpose regional school districts to coordinate with constituent districts regarding school calendar and curriculum

S-3763/A-6116 (Addiego, Bateman, Sarlo/DeAngelo, Dancer, Space) – Renames joint meetings as regional service agencies; grandfathers existing joint meetings

S-3869/A-5561 (Sarlo/Burzichelli, Houghtaling) – Prohibits local governments from imposing fines on alarm companies in certain circumstances

S-3871/A-5427 (Bateman, Scutari/DePhillips, McKeon) – Adds member from Retired Judges Association of New Jersey to State Investment Council

SCS for S-3878/ACS for A-5394 (Ruiz, Weinberg, Cunningham/Moriarty, McKnight, Pinkin) – Reaffirms and clarifies that Attorney General and Division on Civil Rights may initiate actions in Superior Court to enforce "Law Against Discrimination"

S-3920 wGR/A-5552 (Pou/Wimberly, Sumter) – Concerns provision of energy to certain manufacturing facilities by providing exemptions to certain energy related taxes

S-3923/A-5680 (Madden, Singleton/Giblin, Timberlake, Murphy) – Concerns labor harmony agreements for hospitality projects

SCS for S-3939 and 3944/ACS for A-5681 and 5682 (Smith, Greenstein, Bateman, Codey/Pinkin, Lopez, McKeon) – Establishes Recycling Market Development Council

S-3985/A-5663 (Smith/McKeon, Pinkin, Vainieri Huttle) – Amends "Electric Discount and Energy Competition Act" to add definition of "open access offshore wind transmission facility" and revises law concerning "qualified offshore wind projects"

S-4025/A-5695 (Pou/Wimberly, Sumter) – Makes FY 2020 language allocation of $1,000,000 appropriated to Grants for Urban Parks to Hinchliffe Stadium in Paterson

S-4162/A-6014 (Smith, Greenstein/Vainieri Huttle, Pinkin, Houghtaling) – Establishes NJ Climate Change Resource Center at Rutgers University; appropriates up to $500,000

S-4165/A-4364 (Rice/Giblin, Caputo, Tucker) – Expands University Hospital board of directors membership from 11 to 13 members

S-4188/A-6075 (Beach/Murphy, Dancer, Lampitt) – "Lindsay's Law"; provides tax benefits to organ and bone marrow donors and their employers, and provides paid time off to donors who are State or local government employees

S-4200/A-5855 (Ruiz, Turner/Coughlin, Lampitt, Holley) – Requires State to pay difference between federal allocation and total cost of reduced price breakfast or lunch; appropriates $4.5 million

S-4247/A-6049 (Gopal, O'Scanlon/Conaway, Houghtaling, Downey) – Establishes criteria for distribution of Fiscal Year 2020 funding to Community Food Bank of New Jersey and partner organizations

S-4264/A-5962 (Pou/Wimberly, Sumter, Calabrese) – Designates State Highway Route 19 as "William J. Pascrell Jr. Highway"

S-4275/A-6088 (Smith, Greenstein/Burzichelli) – Allows BPU to increase cost to customers of Class I renewable energy requirement for energy years 2022 through 2024, under certain conditions

S-4276/A-6109 (Corrado, Bateman/Armato, Calabrese, Land) – Appropriates $32,153,936 to State Agriculture Development Committee, and amends 2017 appropriations for stewardship activities, for farmland preservation purposes

S-4277/A-6112 (Greenstein, Bateman/Freiman, Danielsen, Downey) – Appropriates $5,000,000 from constitutionally dedicated CBT revenues to State Agriculture Development Committee for municipal planning incentive grants for farmland preservation purposes

S-4278/A-6108 (Greenstein, Bateman/Taliaferro, Karabinchak, Kennedy) – Appropriates $21 million from constitutionally dedicated CBT revenues to State Agriculture Development Committee for county planning incentive grants for farmland preservation purposes

S-4279/A-6106 (Smith, Bateman/Houghtaling, Reynolds-Jackson, Pinkin) – Appropriates $1,350,000 from constitutionally dedicated CBT revenues to State Agriculture Development Committee for grants to certain nonprofit organizations for farmland preservation purposes

S-4286/A-5890 (Vitale/Swain, Jones) – Clarifies procedures concerning collection of child support on behalf of child over age 19 when court has ordered such support

S-4309/A-6107 (Turner, Cruz-Perez/Mejia, Vainieri Huttle, Zwicker) – Appropriates $13,902,723 from constitutionally dedicated CBT revenues to NJ Historic Trust for grants for certain historic preservation projects and associated administrative expenses

S-4310/A-6114 (Codey, Bateman/Carter, Murphy, Lopez) – Appropriates $8,872,682 to DEP from constitutionally dedicated CBT revenues for grants to certain nonprofit entities to acquire or develop lands for recreation and conservation purposes

S-4311/A-6113 (Greenstein, Bateman/Speight, Mukherji, Verrelli) – Appropriates $77,450,448 from constitutionally dedicated CBT revenues and various Green Acres funds to DEP for local government open space acquisition and park development projects

S-4312/A-6111 (Smith, Bateman/Giblin, Mazzeo, Land) – Appropriates $36.143 million from constitutionally dedicated CBT revenues for recreation and conservation purposes to DEP for State capital and park development projects

S-4313/A-6110 (Corrado, Bateman/Moriarty, McKeon, Swain) – Appropriates $33.915 million from constitutionally dedicated CBT revenues to DEP for State acquisition of lands for recreation and conservation purposes, including Blue Acres projects

SCS for S-4315/ACS for A-6063 (Beach, Turner/Jones, Zwicker) – Creates fund to reimburse local units of government for cost of certain mail-in ballot procedures; appropriates $3,000,000

SJR-51/AJR-189 (Rice, Turner/Verrelli, Reynolds-Jackson, Sumter) – Establishes the "New Jersey State Commission on Urban Violence"

SJR-65/AJR-90 (Weinberg, Addiego/DiMaso, Vainieri Huttle, Schepisi) – Designates March 19th "Women in Public Office Day" in New Jersey

SJR-80/AJR-121 (Lagana, Weinberg/Jones, Benson, Chiaravalloti, DeCroce) – Urges federal government to adhere to commitment to improve Northeast Corridor rail infrastructure by providing funding to complete Gateway Program

SJR-125/AJR-169 (Gopal, Codey/Wolfe, Pinkin) – Designates the second week of October of each year as "Obesity Care Week" in NJ

A-344/S-1575 (Murphy, McKeon, Timberlake/Cruz-Perez, Singleton) – Revises certain aspects of the New Jersey Individual Development Account Program

A-1040/S-3928 (Houghtaling, Taliaferro/Andrzejczak) – Establishes NJ "Landowner of the Year" award program

A-1146/S-4330 (Wimberly, Holley/Pou, Singleton) – Establishes "New Jersey Investing in You Promise Neighborhood Commission"

A-1277/S-2629 (Tucker, Holley, Lopez/Singleton, Gopal) – Requires hospitals and homeless shelters to provide information on services and resources to individuals who are homeless or military veterans

A-1449/S-3168 (Benson, DeAngelo/Greenstein, Turner) – Provides job security to certain organ and bone marrow donors

A-1477/S-3228 (Chaparro, Vainieri Huttle, Benson, Jimenez, Mukherji, Downey/Gopal, Scutari) – Establishes Statewide Hit and Run Advisory Program to facilitate apprehension of persons fleeing motor vehicle accident scene; designated as "Zackhary's Law"

A-1478/S-1648 (Chaparro, Vainieri Huttle/Diegnan, T. Kean) – Revises law governing theater liquor licenses

A-1604/S-2734 (Conaway, Murphy, Jimenez/Singleton) – "Recreational Therapists Licensing Act"

A-1796/S-2609 (McKeon, Downey/Lagana, Gopal) – Prevents criminal defendant from asserting "gay and transgender panic" defense to murder charge in order to reduce charge to manslaughter committed in heat of passion

A-1924/S-2930 (Mukherji, A.M. Bucco, DeAngelo, DeCroce/Beach) – Exempts certain honorably discharged United States military veterans from initial insurance producer licensing fee

A-1992/S-1780 (Sumter, Benson, Vainieri Huttle, Houghtaling, Wimberly/Diegnan, Turner) – "New Jersey Call Center Jobs Act"

A-2183/S-1687 (Land, Johnson/Cruz-Perez, Andrzejczak) – "Music Therapist Licensing Act"

ACS for A-2431 wGR/SCS for S-1865 (Benson, Jimenez, DeCroce/Weinberg, T. Kean) – Requires health insurers to provide plans that limit patient cost-sharing concerning certain prescription drug coverage

ACS for A-2444 and S-2656/S-2081 (Benson, Lampitt, Pinkin, Mukherji/Turner, Singleton) – Provides for coverage of comprehensive tobacco cessation benefits in Medicaid

A-2767/S-2924 (Greenwald, Mosquera, McKnight/Greenstein, Singleton) – Amends certain provisions of sexual assault statute to clarify elements necessary for conviction

A-3312/S-1972 (Murphy, Lagana, Downey, Sumter/Gopal, Corrado) – Requires Legislature to adopt and distribute policy prohibiting sexual harassment; requires members, officers, and employees of Legislature to complete online training on policy once every two years

A-3670/S-995 (Benson, Giblin, Murphy/Vitale, Weinberg) – Provides for designation of acute stroke ready hospitals, establishes Stroke Care Advisory Panel and Statewide stroke database, and requires development of emergency medical services stroke care protocols

ACS for A-4136/SCS for S-2675 (Land, Milam/Andrzejczak, Van Drew) – Establishes Possession In Excess of Daily Limit Vessel License for black sea bass and summer flounder; dedicates fees therefrom to marine fisheries programs

A-4147/S-2744 (Lampitt, Houghtaling, Zwicker/Ruiz, Corrado) – Requires school districts and nonpublic schools to conduct audit of security features of buildings, grounds, and communication systems and to submit audit to NJ Office of Homeland Security and Preparedness and DOE

A-4150/S-2742 (Lampitt, Jones, Timberlake/Ruiz, Corrado) – Requires meeting between student and appropriate school personnel after multiple suspensions or proposed expulsion from public school to identify behavior or health difficulties

A-4151/S-2745 (Swain, Tully, Jasey/Ruiz, Corrado) – Requires school security training for persons employed by public and nonpublic schools in substitute capacity and for employees and volunteers of youth programs operated in school buildings

A-4260/S-4335 (Timberlake, Giblin, Tucker, Caputo/Pou, Scutari) – Prohibits sale of certain toy guns and imitation firearms

A-4370/S-2919 (Carroll/A.M. Bucco) – Increases membership of board of trustees of Washington Association of New Jersey

A-4377/S-2934 (Benson, Land, DeCroce/Greenstein) – Requires DOT and OIT to develop materials concerning capabilities of airports in NJ and establishes "Public Use Airports Task Force"

A-4517/S-4341 (Wimberly, Speight, Reynolds-Jackson/Singleton, Cunningham) – Establishes "New Jersey Eviction Crisis Task Force"

A-4529/S-3191 (Mazzeo, Armato/Gopal, Andrezejczak) – Concerns reimbursements to Superstorm Sandy-impacted homeowners subjected to contractor fraud

A-4563/S-3096 (Zwicker, Benson/Greenstein, Gill) – Prohibits use of bots to deceive person about origin and content of communication for certain commercial or election purposes

A-4564/S-3087 (Zwicker, Freiman/Greenstein) – Establishes "Voting Precinct Transparency Act;" requires filing of election district, county district, and municipal ward boundary data with Secretary of State for posting and download on official website with matching election results data

A-4699/S-2938 (Moriarty, Burzichelli, Bramnick/Turner) – Regulates annual report filing services

A-4803/S-4211 (Greenwald, Johnson, Pintor Marin/Cryan, Vitale) – Authorizes certain entities to directly bill Victims of Crime Compensation Office for counseling services provided to victims of firearm and stabbing crimes

A-4822/S-3408 (Wimberly, Tully, Swain/Singleton, Greenstein) – Permits municipalities to lease vacant municipal land for tiny home occupancy; directs DCA to enhance regulatory guidance on acceptable tiny home construction and use

A-4904 wGR/S-3347 (Mukherji, Quijano, Mazzeo/Cryan, Sweeney) – Concerns property taxes due and owing on real property owned by certain federal employees or contractors under certain circumstances

A-4954/S-3368 (Quijano, Murphy, Carter/Singleton, Greenstein) – Revises requirements for provision of counseling and support services to emergency services personnel

ACS for A-4972/SCS for S-1490 (Moriarty/Beach, Scutari) – Establishes certain consumer protections related to arbitration organizations

A-4978 wGR/S-3498 (Timberlake, Zwicker, Vainieri Huttle/Greenstein, Cryan) – Prohibits online education services from using and disclosing certain information, engaging in targeted advertising, and requires deletion of certain information in certain circumstances

A-5023/S-3467 (McKnight, Mukherji, Chaparro, Chiaravalloti/Cunningham) – Exempts from DOT permitting requirements certain signs not located in protected areas that have been approved by municipality

A-5028/S-3523 (Mukherji, Conaway, Pintor Marin/Vitale, Diegnan) – Establishes "James Nicholas Rentas's Law," revises "New Jersey SmokeFree Air Act"

A-5029/S-3522 (Sumter, Reynolds-Jackson, Johnson/Rice, T. Kean) – Requires New Jersey Office on Minority and Multicultural Health to study racial disparities on sexual and reproductive health of African-American women

A-5031/S-3455 (Speight, McKnight, Timberlake/Ruiz) – Requires hospital emergency departments to ask person of childbearing age about recent pregnancy history

A-5314/S-3692 (Zwicker, Milam, Mazzeo/Cryan, Ruiz) – Requires DHS to study social isolation occurring in certain population groups

A-5344/S-3833 (Mukherji, Vainieri Huttle, Milam/Gopal, Corrado) – Establishes uniform standard for acceptable proof of veteran status for veteran's ID cards and various State and local programs

A-5388/S-3895 (Speight, Pintor Marin, Greenwald/Greenstein, Ruiz) – Requires specialized in-service training regarding crime victims for police departments in certain high-crime areas

A-5389/S-3896 (Speight, Pintor Marin, Greenwald/Greenstein, Ruiz) – Requires training or experience in crime victims' rights for certain members of Victims of Crime Compensation Review Board

A-5432/S-3796 (Milam, Land/Andrzejczak) – Requires DEP Commissioner to establish individual transferable quota system for menhaden purse seine fishery

A-5445/S-3909 (Swain, Tully, Spearman/T. Kean, Corrado) – Requires AG to establish program to detect fentanyl in State's illegal drug supply and make information related to presence of fentanyl available in database accessible by law enforcement

A-5511/S-1852 (Spearman, Jones, Reynolds-Jackson/Turner, Cruz-Perez) – Revises certain penalties for illegal operation of snowmobile, all-terrain vehicle, or dirt bike

A-5580/S-3842 (Johnson, Moriarty, Greenwald/Weinberg, Sarlo) – Extends availability period for tax credits for certain expenses incurred for production of certain film and digital media content, raises annual cap related to film production, and provides for annual administration of film tax credits

A-5583/S-3919 (Pinkin, Lopez, Mukherji/Smith, Bateman) – Prohibits sale, lease, rent, or installation of certain equipment or products containing hydrofluorocarbons or other greenhouse gases

A-5630/S-3981 (Pintor Marin, Munoz, Reynolds-Jackson/Weinberg, Corrado) – Requires Civil Service Commission to establish and maintain hotline for State employees to submit reports of workplace discrimination and harassment

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A-5667/S-3933 (Mukherji, Vainieri Huttle, Armato, DeCroce, Karabinchak/Singer, Scutari) – "Charlie's Law"; requires pharmacy practice sites and hospice programs to furnish patients with information and means to safely dispose of unused prescription drugs and medications

A-5801/S-4064 (Coughlin, Houghtaling, Verrelli/Singleton, Sweeney) – Concerns responsibility of contractors for wage claims against subcontractors

A-5817/S-4263 (Mazzeo, Armato/Cunningham, Sweeney, C.A. Brown) – Allows certain persons to qualify for casino key employee license and casino employee registration

A-5916/S-4255 (Chiaravalloti, McKnight, Karabinchak/Cunningham, Weinberg) – Authorizes DOH to notify elected officials of financial distress of certain hospitals

A-5918/SCS for S-3741 and 4253 (Chiaravalloti, McKnight/Weinberg, Cunningham, Vitale) – Expands hospital reporting requirements

A-5970/S-4201 (Lopez, Speight, Chaparro/Codey) – Amends list of environmental infrastructure projects approved for long-term funding for FY2020 to include new projects, remove certain projects, and modify estimated loan amounts for certain projects

A-5971/S-4202 (Mukherji, Pintor Marin, Spearman/Bateman, Corrado) – Authorizes NJ Infrastructure Bank to expend additional sums to make loans for environmental infrastructure projects for FY2020

A-5972/S-4203 (Pinkin, Benson, Zwicker/Greenstein, Singleton) – Makes changes to New Jersey Infrastructure Bank's enabling act

A-5977/S-4282 (Greenwald, Downey, Vainieri Huttle/Vitale, Singleton) – Provides for establishment of Regional Health Hub Program as replacement to Accountable Care Organization Demonstration Project, and designates existing accountable care organizations and look-alike organizations as Regional Health Hubs

A-6119/S-4336 (Egan, Houghtaling/Madden) – Revises "The Public Works Contractor Registration Act" and amends definition of registered apprenticeship program

AJR-35/SJR-159 (McKnight, Chaparro, Chiaravalloti, DeCroce/Cunningham, Greenstein) – Designates third full week in March as "Domestic Violence Services Awareness Week" to bring awareness of services available to domestic violence victims

AJR-103/SJR-70 (Rooney, DePhillips, Murphy/Corrado) – Permanently designates January as "NUT Carcinoma Awareness Month" in New Jersey

AJR-118/SJR-157 (McKnight, Timberlake, McKeon/Pou, Madden) – Designates April of each year as "Financial Literacy Month" in New Jersey

AJR-180/SJR-112 (DeAngelo, McKnight, Murphy/Singleton, Corrado) –Designates February in each year as "Career and Technical Education Month" in New Jersey

Governor Murphy declined to sign the following bills, meaning they expire without becoming law:

S-691/A-657 (Ruiz, Pou/Jasey, Caputo, Pintor Marin, Sumter, Wimberly) – Requires that if a school district satisfies 80% or more of the required NJ Quality Single Accountability Continuum standards in an area of district effectiveness under State intervention, the State must return that area to local control

S-1083/A-544 (Cruz-Perez, Gopal/Mazzeo, Houghtaling, Holley, Dancer) – Establishes loan program and provides corporation business tax and gross income tax credits for establishment of new vineyards and wineries

S-2421/A-1030 (Smith, Bateman/Johnson, Kennedy, Benson, DeAngelo) – Concerns installation of electric vehicle charging stations in common interest communities

S-2425/A-3851 (Singleton, Andrzejczak/Conaway) – Revises law relating to common interest communities

S-2429/A-4028 (Scutari, Pou/Bramnick, Downey) – Requires automobile insurers to disclose policy limits upon request by an attorney under certain circumstances

S-2835/A-3926 (Singleton, Ruiz/Conaway, Lampitt, Murphy) – Requires public schools to administer written screenings for depression for students in certain grades

S-2897/A-1433 (Madden, Singer/Benson, Wimberly, Carter) – Requires DCA to establish procedures for inspection and abatement of mold hazards in residential buildings and school facilities, and certification programs for mold inspectors and mold hazard abatement workers

S-2957/A-4712 (Stack/Mukherji, Chaparro) – Establishes five-year moratorium on conversions of certain residential rental premises in qualified counties

S-2958/A-4535 (Sarlo, Oroho/Zwicker, DePhillips, DeCroce) – Establishes the "Energy Infrastructure Public-Private Partnership Act"

S-3062/A-2049 (Ruiz, Greenstein/Howarth, Benson, Murphy) – Provides corporation business tax and gross income tax credits for businesses that employ apprentices in DOL registered apprenticeships

S-3063/A-4655 (Ruiz/Armato, Vainieri Huttle, DeAngelo) – Provides tuition fee waiver apprenticeship courses

S-3137/A-1308 (Sweeney, Oroho, Singleton/Greenwald, Milam, Land) – The "Electronic Construction Procurement Act"

S-3252/A-4713 (Greenstein, Stack/DeAngelo, Quijano) – "New Townhouse Fire Safety Act"; requires automatic fire sprinkler systems in new townhomes

S-3263/A-4837 (T. Kean, Diegnan/Vainieri Huttle, Chiaravalloti, McKnight) – Revises and updates membership and purpose of Advisory Council on the Deaf and Hard of Hearing in DHS

S-3270/A-5095 (Pou/McKeon, Freiman, DeCroce) – Establishes certain requirements for stop loss insurance offered to small employers

S-3393/ACS for A-5384 and 5157 (Sarlo, Addiego/Mazzeo, Murphy, Houghtaling, Calabrese, Armato, Dancer) – Allows certain preserved farms to hold 14 special occasion events per year; imposes further event restrictions on residentially-exposed preserved farms

S-3770/A-6118 (Sarlo, Oroho, Sweeney/Greenwald, Jones) – Establishes "New Jersey Economic and Fiscal Policy Review Commission" to provide ongoing review of State and local tax structure, economic conditions, and related fiscal issues

S-3888/A-5585 (Ruiz/Dancer, Pintor Marin) – Extends document submission deadlines under Economic Redevelopment and Growth Grant program and Urban Transit Hub Tax Credit program

S-4035/A-5702 (Pou, Singleton/Wimberly, Reynolds-Jackson, Sumter) – Makes Fiscal Year 2020 supplemental appropriation of $1,700,000 for Thomas Edison State University

S-4281/A-6094 (Smith, Diegnan/Danielsen, Pinkin) – Requires State to sell and convey to Educational Services Commission of New Jersey certain land and improvements known as Piscataway Regional Day School

S-4331/A-4727 (Diegnan, Madden/Karabinchak, Holley, Jones) – Requires person taking written examination for permit to watch video of rights and responsibilities of driver stopped by law enforcement; requires testing on rights and responsibilities of driver stopped by law enforcement

A-491/S-4340 (Jimenez/Sacco, Stack) – Enhances PFRS accidental death pension for surviving spouse by providing for minimum of $50,000 annually

A-1044/S-1441 (Houghtaling, Downey, DiMaio, Space/Doherty, Madden) – Requires Director of Division of Taxation to examine feasibility of centralized property tax information system to verify property taxes paid by homestead property tax reimbursement claimants

A-1045/S-2856 (Houghtaling, Downey, Dancer/Gopal, Oroho) – Clarifies sales tax collection responsibilities of horse-boarding businesses in New Jersey

A-1526/S-1048 (Zwicker, Johnson/Vitale) – Concerns payment of independent contractors

A-2731/S-3407 (Taliaferro, Space/Sweeney, Oroho) – Removes statutory limitation on number of permits that may be issued by Division of Fish and Wildlife for the taking of beaver

A-4382/S-2815 (Pinkin, Lopez, Kennedy/Beach, Smith) – Requires paint producers to implement or participate in paint stewardship program

A-4463/S-3927 (Freiman, Egan, Karabinchak/Oroho, Andrzejczak) – Establishes "Electronic Permit Processing Review System"

A-4788/S-3880 (Karabinchak, Freiman, Calabrese/Diegnan) – Establishes expedited construction inspection program

A-5072/S-3496 (Karabinchak, Johnson, Mukherji/Greenstein, Cryan) – "Defense Against Porch Pirates Act"; creates new category of theft, with penalties including mandatory restitution and community service, for taking package delivered to residence by cargo carrier

A-5446/S-3907 (Land, Reynolds-Jackson, Verrelli/T. Kean, Lagana) – Requires reporting of opioid deaths

A-5629/S-3980 (Pintor Marin, Munoz/Weinberg, Corrado) – Clarifies provisions concerning disclosure of existence and content of discrimination or harassment complaints; requires certain disclosures to person against whom complaint is made

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ACS for A-5922 and 5923/SCS for S-4223 and 4224 (Conaway, Vainieri Huttle, Lopez, Pinkin/Vitale, Sweeney) – Revises requirements for sale of tobacco and vapor products; increases penalties for prohibited sales; increases fees for cigarette and vapor business licensure

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ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY BILL NO. 2431

To the General Assembly:

Pursuant to Article V, Section I, Paragraph 14 of the New Jersey Constitution, I am returning Assembly Committee Substitute for Assembly Bill No. 2431 with my recommendations for reconsideration.

This bill would require private health insurers, the State Health Benefits Plan ("SHBP"), and the School Employees' Health Benefits Plan ("SEHBP") to place limitations on covered persons' cost sharing for prescription drugs. Specifically, the bill would require a contract that provides a silver, gold, or platinum level of coverage to limit a covered person's cost sharing to no more than $150 per month for each prescription, and a contract that provides bronze-level coverage to no more than $250 per month for each prescription with limited exceptions for high-deductible plans.

Few issues have a greater financial impact on New Jersey families than the unpredictable and ever-increasing cost of prescription drugs. Cost-sharing too often presents a barrier to a patient's ability to access medically-necessary treatments. Although this legislation would not limit the actual cost of prescription drugs, it would be likely to improve the affordability of medical care for many residents who unfortunately must make difficult sacrifices in order to pay for their required medications.

While I am pleased with the prospect of this bill helping more people gain access to necessary medical care, I am concerned about this bill's potential impact on taxpayers due to the mandates it imposes on the SHBP and SEHBP. In an effort to achieve real and sustainable public employee health benefit cost savings, my

Administration has worked, and continues to work, with the SHBP and SEHBP plan design committees to institute numerous reforms. One such reform instituted by the plan design committees is a policy commonly referred to as Member Pays the Difference ("MPD").

Under the MPD policy, if a member elects to use brand name drugs that have generic equivalents, the member is required to pay the applicable generic copay plus the cost difference between the brand name drug and the generic drug. The MPD policy is meant to increase the rates of generic drug dispensation for the SHBP and SEHBP, which are consistently below both private and public sector benchmarks. The plans' current generic dispense rate is approximately 82.9 percent, whereas the public sector benchmark is over 89 percent and the private sector benchmark is over 94 percent. According to the Division of Pensions and Benefits in the Department of the Treasury, for every one percent increase in the rate of generic drug dispensation, there is a corresponding three percent decrease in the maximum amount the plans will pay for covered prescription drugs. Conversely, even a minor reduction of the plans' generic dispense rate could result in an increase of millions of dollars in the amount the plans pay for covered prescription drugs.

The limitation on out-of-pocket expenses contained in this bill would reduce the effectiveness of the MPD policy by removing the incentive for public employees to choose generic drugs over their brand name equivalents once the out-of-pocket limit established by the bill is reached. Given the potential impact on taxpayers, I am recommending changes to the bill that would exempt the plans from the bill's requirements.

Therefore, I herewith return Assembly Committee Substitute for Assembly Bill No. 2431 and recommend that it be amended as follows:

Page 8, Section 9, Lines 38-48:	Delete in their entirety
Page 9, Section 9, Lines 1-14:	Delete in their entirety
Page 9, Section 10, Lines 16-40:	Delete in their entirety
Page 9, Section 11, Line 42:	Delete “11.” and insert “9.”
Page 9, Section 11, Line 46:	After “enactment;” insert “and”
Page 10, Section 11, Line 3:	Delete “; and” and insert “.”
Page 10, Section 11, Lines 4-8:	Delete in their entirety

Respectfully,

[seal]

/s/ Philip D. Murphy

Governor

Attest:

/s/ Matthew J. Platkin

Chief Counsel to the Governor