SENATE, No. 1567

STATE OF NEW JERSEY

220th LEGISLATURE

INTRODUCED FEBRUARY 14, 2022

Sponsored by:
Senator EDWARD DURR
District 3 (Cumberland, Gloucester and Salem)

SYNOPSIS

Prohibits use of State funds for termination of pregnancy under certain circumstances.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning abortion, supplementing Title 30 of the New Jersey Statutes, amending P.L.1961, c.49 and P.L.2007, c.103, and repealing sections 1 and 2 of P.L.2021, c.375.

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

1. (New section) a. Notwithstanding the provisions of any other law to the contrary, no Medicaid funds or other State funds for medical assistance shall be used for the termination of a woman's pregnancy for any reason except where it is medically indicated to be necessary to preserve the woman's life. In any case where a pregnancy is so terminated, the act shall be performed in a hospital and the physician performing the act shall submit in writing a report to the Division of Medical Assistance and Health Services in the Department of Human Services stating in detail the physician's reasons for finding it necessary to terminate the pregnancy.

b. No funds shall be appropriated in the annual Appropriations Act to fund abortion procedures.

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

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

(1) Basic benefits which shall include:

(a) Hospital benefits, including outpatient;

(b) Surgical benefits;

(c) Inpatient medical benefits;

(d) Obstetrical benefits; and

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

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

(i) Additional days of inpatient medical service;

(ii) Surgery elsewhere than in a hospital;

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.

1 (iii) X-ray, radioactive isotope therapy and pathology services;
2 (iv) Physical therapy services;
3 (v) Radium or radon therapy services;
4 and the extended basic benefits shall be subject to the same
5 conditions and limitations, applicable to such benefits, as are set
6 forth in "Extended Outpatient Hospital Benefits Rider," Form 1500,
7 71(9-66), and in "Extended Benefit Rider" (as amended), Form MS
8 7050J(9-66) issued by the New Jersey "Blue Cross" and "Blue
9 Shield" Plans, respectively, and as the same may be amended or
10 superseded, subject to filing by the Commissioner of Banking and
11 Insurance; and
12 (2) Major medical expense benefits which shall provide benefit
13 payments for reasonable and necessary eligible medical expenses
14 for hospitalization, surgery, medical treatment and other related
15 services and supplies to the extent they are not covered by basic
16 benefits. The commission may, by regulation, determine what types
17 of services and supplies shall be included as "eligible medical
18 services" under the major medical expense benefits coverage as
19 well as those which shall be excluded from or limited under such
20 coverage. Benefit payments for major medical expense benefits
21 shall be equal to a percentage of the reasonable charges for eligible
22 medical services incurred by a covered employee or an employee's
23 covered dependent, during a calendar year as exceed a deductible
24 for such calendar year of $100.00 subject to the maximums
25 hereinafter provided and to the other terms and conditions
26 authorized by this act. The percentage shall be 80% of the first
27 $2,000.00 of charges for eligible medical services incurred
28 subsequent to satisfaction of the deductible and 100% thereafter.
29 There shall be a separate deductible for each calendar year for (a)
30 each enrolled employee and (b) all enrolled dependents of such
31 employee. Not more than $1,000,000.00 shall be paid for major
32 medical expense benefits with respect to any one person for the
33 entire period of such person's coverage under the plan, whether
34 continuous or interrupted except that this maximum may be
35 reapplied to a covered person in amounts not to exceed $2,000.00 a
36 year. Maximums of $10,000.00 per calendar year and $20,000.00
37 for the entire period of the person's coverage under the plan shall
38 apply to eligible expenses incurred because of mental illness or
39 functional nervous disorders, and such may be reapplied to a
40 covered person, except as provided in P.L.1999, c.441 (C.52:14-
41 17.29d et al.). The same provisions shall apply for retired
42 employees and their dependents. Under the conditions agreed upon
43 by the commission and the carriers as set forth in the contract, the
44 deductible for a calendar year may be satisfied in whole or in part
45 by eligible charges incurred during the last three months of the prior
46 calendar year.
47 Any service determined by regulation of the commission to be an
48 "eligible medical service" under the major medical expense benefits

1 coverage which is performed by a duly licensed practicing
2 psychologist within the lawful scope of his practice shall be
3 recognized for reimbursement under the same conditions as would
4 apply were such service performed by a physician.
5 (B) The contract or contracts purchased by the commission
6 pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-
7 17.28) shall include coverage for services and benefits that are at a
8 level that is equal to or exceeds the level of services and benefits set
9 forth in this subsection, provided that such services and benefits
10 shall include only those that are eligible medical services and not
11 those deemed experimental, investigative or otherwise not eligible
12 medical services. The determination of whether services or benefits
13 are eligible medical services shall be made by the commission
14 consistent with the best interests of the State and participating
15 employers, employees, and dependents. The following list of
16 services is not intended to be exclusive or to require that any limits
17 or exclusions be exceeded.
18 Covered services shall include:
19 (1) Physician services, including:
20 (a) Inpatient services, including:
21 (i) medical care including consultations;
22 (ii) surgical services and services related thereto; and
23 (iii) obstetrical services including normal delivery**[**,**]** and
24 cesarean section, **[**and**]** but excluding abortion services.
25 (b) Outpatient/out-of-hospital services, including:
26 (i) office visits for covered services and care;
27 (ii) allergy testing and related diagnostic/therapy services;
28 (iii) dialysis center care;
29 (iv) maternity care;
30 (v) well child care;
31 (vi) child immunizations/lead screening;
32 (vii) routine adult physicals including pap, mammography, and
33 prostate examinations; and
34 (viii) annual routine obstetrical/gynecological exam.
35 (2) Hospital services, both inpatient and outpatient, including:
36 (a) room and board;
37 (b) intensive care and other required levels of care;
38 (c) semi-private room;
39 (d) therapy and diagnostic services;
40 (e) surgical services or facilities and treatment related thereto;
41 (f) nursing care;
42 (g) necessary supplies, medicines, and equipment for care; and
43 (h) maternity care and related services.
44 (3) Other facility and services, including:
45 (a) approved treatment centers for medical
46 emergency/accidental injury;
47 (b) approved surgical center;
48 (c) hospice;

1 (d) chemotherapy;
2 (e) diagnostic x-ray and lab tests;
3 (f) ambulance;
4 (g) durable medical equipment;
5 (h) prosthetic devices;
6 (i) foot orthotics;
7 (j) diabetic supplies and education; and
8 (k) oxygen and oxygen administration.
9 (4) All services for which coverage is required pursuant to
10 P.L.1961, c.49 (C.52:14-17.25 et seq.), as amended and
11 supplemented. Benefits under the contract or contracts purchased as
12 authorized by the State Health Benefits Program shall include those
13 for mental health services subject to limits and exclusions
14 consistent with the provisions of the New Jersey State Health
15 Benefits Program Act.
16 (C) The contract or contracts purchased by the commission
17 pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-
18 17.28) shall include the following provisions regarding
19 reimbursements and payments:
20 (1) In the successor plan, the co-payment for doctor's office
21 visits shall be $10 per visit with a maximum out-of-pocket of $400
22 per individual and $1,000 per family for in-network services for
23 each calendar year. The out-of-network deductible shall be $100 per
24 individual and $250 per family for each calendar year, and the
25 participant shall receive reimbursement for out-of-network charges
26 at the rate of 80% of reasonable and customary charges, provided
27 that the out-of-pocket maximum shall not exceed $2,000 per
28 individual and $5,000 per family for each calendar year.
29 (2) In the State managed care plan that is required to be included
30 in a contract entered into pursuant to subsection c. of section 4 of
31 P.L.1961, c.49 (C.52:14-17.28), the co-payment for doctor's office
32 visits shall be $15 per visit. The participant shall receive
33 reimbursement for out-of-network charges at the rate of 70% of
34 reasonable and customary charges. The in-network and out-of-
35 network limits, exclusions, maximums, and deductibles shall be
36 substantially equivalent to those in the NJ PLUS plan in effect on
37 June 30, 2007, with adjustments to that plan pursuant to a binding
38 collective negotiations agreement or pursuant to action by the
39 commission, in its sole discretion, to apply such adjustments to
40 State employees for whom there is no majority representative for
41 collective negotiations purposes.
42 (3) "Reasonable and customary charges" means charges based
43 upon the 90th percentile of the usual, customary, and reasonable
44 (UCR) fee schedule determined by the Health Insurance
45 Association of America or a similar nationally recognized database
46 of prevailing health care charges.
47 (D) Benefits under the contract or contracts purchased as
48 authorized by this act may be subject to such limitations,

1 exclusions, or waiting periods as the commission finds to be
2 necessary or desirable to avoid inequity, unnecessary utilization,
3 duplication of services or benefits otherwise available, including
4 coverage afforded under the laws of the United States, such as the
5 federal Medicare program, or for other reasons.
6 Benefits under the contract or contracts purchased as authorized
7 by this act shall include those for the treatment of alcoholism where
8 such treatment is prescribed by a physician and shall also include
9 treatment while confined in or as an outpatient of a licensed
10 hospital or residential treatment program which meets minimum
11 standards of care equivalent to those prescribed by the Joint
12 Commission on Hospital Accreditation. No benefits shall be
13 provided beyond those stipulated in the contracts held by the State
14 Health Benefits Commission.
15 (E) The rates charged for any contract purchased under the
16 authority of this act shall reasonably and equitably reflect the cost
17 of the benefits provided based on principles which in the judgment
18 of the commission are actuarially sound. The rates charged shall be
19 determined by the carrier on accepted group rating principles with
20 due regard to the experience, both past and contemplated, under the
21 contract. The commission shall have the right to particularize
22 subgroups for experience purposes and rates. No increase in rates
23 shall be retroactive.
24 (F) The initial term of any contract purchased by the
25 commission under the authority of this act shall be for such period
26 to which the commission and the carrier may agree, but permission
27 may be made for automatic renewal in the absence of notice of
28 termination by the commission. Subsequent terms for which any
29 contract may be renewed as herein provided shall each be limited to
30 a period not to exceed one year.
31 (G) A contract purchased by the commission pursuant to
32 subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall
33 contain a provision that if basic benefits or major medical expense
34 benefits of an employee or of an eligible dependent under the
35 contract, after having been in effect for at least one month in the
36 case of basic benefits or at least three months in the case of major
37 medical expense benefits, is terminated, other than by voluntary
38 cancellation of enrollment, there shall be a 31-day period following
39 the effective date of termination during which such employee or
40 dependent may exercise the option to convert, without evidence of
41 good health, to converted coverage issued by the carriers on a direct
42 payment basis. Such converted coverage shall include benefits of
43 the type classified as "basic benefits" or "major medical expense
44 benefits" in subsection (A) hereof and shall be equivalent to the
45 benefits which had been provided when the person was covered as
46 an employee. The provision shall further stipulate that the employee
47 or dependent exercising the option to convert shall pay the full
48 periodic charges for the converted coverage which shall be subject

1 to such terms and conditions as are normally prescribed by the
2 carrier for this type of coverage.
3 (H) The commission may purchase a contract or contracts to
4 provide drug prescription and other health care benefits or authorize
5 the purchase of a contract or contracts to provide drug prescription
6 and other health care benefits as may be required to implement a
7 duly executed collective negotiations agreement or as may be
8 required to implement a determination by a public employer to
9 provide such benefit or benefits to employees not included in
10 collective negotiations units.
11 (I) The commission shall take action as necessary, in
12 cooperation with the School Employees' Health Benefits
13 Commission established pursuant to section 33 of P.L.2007, c.103
14 (C.52:14-17.46.3), to effectuate the purposes of the School
15 Employees' Health Benefits Program Act as provided in sections 31
16 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-
17 17.46.11) and to enable the School Employees' Health Benefits
18 Commission to begin providing coverage to participants pursuant to
19 the School Employees' Health Benefits Program Act as of July 1,
20 2008.
21 (J) Beginning January 1, 2012, the State Health Benefits Plan
22 Design Committee shall provide to employees the option to select
23 one of at least three levels of coverage each for family, individual,
24 individual and spouse, and individual and dependent, or equivalent
25 categories, for each plan offered by the program differentiated by
26 out of pocket costs to employees including co-payments and
27 deductibles. Notwithstanding any other provision of law to the
28 contrary, the committee shall have the sole discretion to set the
29 amounts for maximums, co-pays, deductibles, and other such
30 participant costs for all plans in the program. The committee shall
31 also provide for a high deductible health plan that conforms with
32 Internal Revenue Code Section 223.
33 There shall be appropriated annually for each State fiscal year,
34 through the annual appropriations act, such amounts as shall be
35 necessary as funding by the State as an employer, or as otherwise
36 required, with regard to employees or retirees who have enrolled in
37 a high deductible health plan that conforms with Internal Revenue
38 Code Section 223.
39 (cf: P.L.2011, c.78, s.47)
40
41 3. Section 36 of P.L.2007, c.103 (C.52:14-17.46.6) is amended
42 to read as follows:
43 36. a. Notwithstanding the provisions of any other law to the
44 contrary, the commission shall not enter into a contract under the
45 School Employees' Health Benefits Program Act, sections 31
46 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-
47 17.46.11), for the benefits provided pursuant to the act, unless the
48 level of benefits provided under the contract entered into is equal to

or exceeds the level of benefits provided in this section, or as modified pursuant to section 40 of that act (C.52:14-17.46.10). Only benefits for medically necessary services that are not deemed experimental, investigative or otherwise not eligible medical services shall be provided. The determination that services are not "eligible medical services" shall be made by the commission consistent with the best interests of the State, participating employers and those persons covered hereunder. Benefits for services provided pursuant to the School Employees' Health Benefits Act shall be subject to limits or exclusions consistent with those that apply to benefits provided pursuant to the New Jersey State Health Benefits Program Act. The services provided pursuant to this section shall include all services, subject to applicable limits and exclusions, provided through the State Health Benefits Program as of July 1, 2007. The list of services in subsection b. of this section is not intended to be exclusive or to require that any limits or exclusions be exceeded.

b. The services covered hereunder by the School Employees' Health Benefits Program shall include:

(1) Physician services, including:

(a) Inpatient services, including:

(i) medical care including consultations;

(ii) surgical services and services related thereto; and

(iii) obstetrical services including normal delivery[,] and cesarean section, [and] but excluding abortion services.

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

(i) office visits for covered services and care;

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

(iii) dialysis center care;

(iv) maternity care;

(v) well child care;

(vi) child immunizations/lead screening;

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

(viii) annual routine obstetrical/gynecological exam.

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

(a) room and board;

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

(c) semi-private room;

(d) therapy and diagnostic services;

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

(f) nursing care;

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

(h) maternity care and related services.

(3) Other facility and services, including:

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

(b) approved surgical center;

1 (c) hospice;
2 (d) chemotherapy;
3 (e) diagnostic x-ray and lab tests;
4 (f) ambulance;
5 (g) durable medical equipment;
6 (h) prosthetic devices;
7 (i) foot orthotics;
8 (j) diabetic supplies and education; and
9 (k) oxygen and oxygen administration.
10 c. Benefits under the contract or contracts purchased as
11 authorized by the School Employees' Health Benefits Program Act
12 shall include those for the treatment of alcoholism where such
13 treatment is prescribed by a physician and shall also include
14 treatment while confined in or as an outpatient of a licensed
15 hospital or residential treatment program which meets minimum
16 standards of care equivalent to those prescribed by the Joint
17 Commission on Hospital Accreditation. No benefits shall be
18 provided beyond those stipulated in the contracts held by the School
19 Employees' Health Benefits Commission.
20 d. Benefits under the contract or contracts purchased as
21 authorized by the School Employees' Health Benefits Program Act
22 shall include those for mental health services subject to limits and
23 exclusions consistent with those that apply to benefits for such
24 services pursuant to the New Jersey State Health Benefits Program
25 Act. Coverage for biologically-based mental illness, as defined in
26 section 1 of P.L.1999, c.441 (C.52:14-17.29d), shall be provided in
27 accordance with section 2 of P.L.1999, c.441 (C.52:14-17.29e).
28 e. Coverage provided under the School Employees' Health
29 Benefits Program Act shall include coverage for all services for
30 which coverage is mandated in the State Health Benefits Program
31 pursuant to P.L.1961, c.49 (C.52:14-17.25 et seq.).
32 f. (1) As used in this subsection:
33 (a) "brand name" means the proprietary or trade name assigned
34 to a drug product by the manufacturer or distributor of the drug
35 product.
36 (b) "carrier" means an insurance company, hospital, medical, or
37 health service corporation, preferred provider organization, or
38 health maintenance organization under agreement or contract with
39 the commission to administer the School Employee Prescription
40 Drug Plan.
41 (c) "School Employee Prescription Drug Plan" means the plan
42 for providing payment for eligible prescription drug expenses of
43 members of the School Employees' Health Benefits Program and
44 their eligible dependents.
45 (d) "generic drug products" means prescription drug products
46 and insulin approved and designated by the United States Food and
47 Drug Administration as therapeutic equivalents for reference listed
48 drug products. The term includes drug products listed in the New

1 Jersey Generic Formulary by the Drug Utilization Review Council
2 pursuant to P.L.1977, c.240 (C.24:6E-1 et al.).
3 (e) "mail-order pharmacy" means the mail order program
4 available through the carrier.
5 (f) "preferred brands" means brand name prescription drug
6 products and insulin determined by the carrier to be a more cost
7 effective alternative for prescription drug products and insulin with
8 comparable therapeutic efficacy within a therapeutic class, as
9 defined or recognized in the United States Pharmacopeia or the
10 American Hospital Formulary Service Drug Information, or by the
11 American Society of Health Systems Pharmacists. A drug product
12 for which there is no other therapeutically equivalent drug product
13 shall be a preferred brand. Determinations of preferred brands by
14 the carrier shall be subject to review and modification by the
15 commission.
16 (g) "retail pharmacy" means a pharmacy, drug store or other
17 retail establishment in this State at which prescription drugs are
18 dispensed by a registered pharmacist under the laws of this State, or
19 a pharmacy, drug store or other retail establishment in another state
20 at which prescription drug products are dispensed by a registered
21 pharmacist under the laws of that state if expenses for prescription
22 drug products dispensed at the pharmacy, drug store, or other retail
23 establishment are eligible for payment under the School Employee
24 Prescription Drug Plan.
25 (h) "other brands" means prescription drug products which are
26 not preferred brands or generic drug products. A new drug product
27 approved by the United States Food and Drug Administration which
28 is not a generic drug product shall be included in this category until
29 the carrier makes a determination concerning inclusion of the drug
30 product in the list of preferred brands.
31 (2) (a) Employers that participate in the School Employees'
32 Health Benefits Program may offer to their employees and eligible
33 dependents:
34 (i) enrollment in the School Employee Prescription Drug Plan,
35 or
36 (ii) enrollment in another free-standing prescription drug plan,
37 or
38 (iii) election of prescription drug coverage under their health
39 care coverage through the School Employees' Health Benefits
40 Program plan or as otherwise determined by the commission.
41 (b) A co-payment shall be required for each prescription drug
42 expense if the employer chooses to participate in the School
43 Employee Prescription Drug Plan. The initial amounts of the co-
44 payments shall be the same as those in effect on July 1, 2007 for the
45 employee prescription drug plan offered through the State Health
46 Benefits Program.
47 (c) If the employer elects to offer a free-standing prescription
48 drug plan, the employee's share of the cost for this prescription drug

1 plan may be determined by means of a binding collective
2 negotiations agreement, including any agreements in force at the
3 time the employer commences participation in the School
4 Employees' Health Benefits Program.
5 (d) If an employee declines the employer's offering of a free-
6 standing prescription drug plan, no reimbursement for prescription
7 drugs shall be provided under the health care coverage through the
8 School Employees' Health Benefits Program plan in which the
9 employee is enrolled.
10 (e) Prescription drug classifications that are not eligible for
11 coverage under the employer's prescription drug plan shall also not
12 be eligible for coverage under the health care coverage through the
13 School Employees' Health Benefits Program plan except as
14 federally or State mandated.
15 (f) If the employer elects to not offer a free-standing
16 prescription drug plan, then the employer shall offer prescription
17 drug coverage under the health care coverage through the School
18 Employees' Health Benefits Program plan or as determined by the
19 commission. Any plan that has in-network and out-of-network
20 coverage shall cover prescription drugs at 90% in-network and at
21 the out-of-network rate applicable to health care coverage in the
22 plan. The out-of-pocket amounts paid towards prescription drugs
23 shall be combined with out-of-pocket medical payments to reach all
24 out-of-pocket maximums.
25 (g) Health care coverages through the School Employees' Health
26 Benefits Program that only have in-network benefits shall include a
27 prescription card with co-payment amounts the same as those in
28 effect on July 1, 2007 for such coverages offered through the State
29 Health Benefits Program.
30 (h) In the fifth year following the initial appointment of all of its
31 members, the commission shall, as part of the fifth year audit and
32 review undertaken pursuant to section 40 of that act (C.52:14-
33 17.46.10), review the prescription drug program established in this
34 subsection and may make changes in the program pursuant to the
35 terms of section 40 by majority vote of the full authorized
36 membership of the commission.
37 g. Beginning January 1, 2012, the School Employees' Health
38 Benefits Plan Design Committee shall provide to employees the
39 option to select one of at least three levels of coverage each for
40 family, individual, individual and spouse, and individual and
41 dependent, or equivalent categories, for each plan offered by the
42 program differentiated by out of pocket costs to employees
43 including co-payments and deductibles. Notwithstanding any other
44 provision of law to the contrary, the committee shall have the sole
45 discretion to set the amounts for maximums, co-pays, deductibles,
46 and other such participant costs for all plans in the program. The
47 committee shall also provide for a high deductible health plan that
48 conforms with Internal Revenue Code Section 223.

1 There shall be appropriated annually for each State fiscal year,
2 through the annual appropriations act, such amounts as shall be
3 necessary as funding by the State with regard to retirees who have
4 enrolled in a high deductible health plan that conforms with Internal
5 Revenue Code Section 223.
6 (cf: P.L.2011, c.78, s.48)
7
8 4. Sections 1 and 2 of P.L.2021, c.375 (C.10:7-1 and C.10:7-2)
9 are repealed.
10
11 5. This act shall take effect immediately.
12
13
14 STATEMENT
15
16 This bill provides that no Medicaid funds or other State funds for
17 medical assistance will be used for the termination of a woman's
18 pregnancy for any reason except where it is medically indicated to
19 be necessary to preserve the woman's life. In any case where a
20 pregnancy is terminated, the act will be performed in a hospital and
21 the physician performing the act will submit a written report to the
22 Division of Medical Assistance and Health Services in the
23 Department of Human Services stating in detail the physician's
24 reasons for finding it necessary to terminate the pregnancy.
25 The bill also eliminates funding for abortion under both the State
26 Health Benefits Program and the School Employees' Health
27 Benefits Program, and provides that no funds may be appropriated
28 in the annual Appropriations Act that would fund abortion
29 procedures.
30 Finally, the bill repeals sections 1 and 2 of P.L.2021, c.375,
31 which set forth provisions of law that would contradict the
32 provisions of the bill.