

AN ACT concerning employee health benefits, supplementing P.L.1961, c.49, revising various parts of the statutory law, and making an appropriation.

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

1. (New section) This act shall be known and may be cited as the “State Health Benefits Program Stabilization Act of 2025.”

2. (New section) a. (1) Notwithstanding the provisions of any other law, rule, or regulation to the contrary, an employer other than the State, except an independent State authority, that elects to participate in the State Health Benefits Program on or after August 1, 2026 shall be required to remain enrolled in the program for a minimum period of five consecutive plan years following the effective date of the employer’s initial enrollment. An employer other than the State, except an independent State authority, that voluntarily terminates its participation in the State Health Benefits Program prior to the expiration of the five-year commitment period required by this paragraph shall remain liable for the remittance of premium and periodic charges to the State treasury until the end of the five-year period in accordance with the rules prescribed by the State Health Benefits–Local Part Commission under which employers may participate in the program. An employer other than the State, except an independent State authority, that voluntarily terminates its participation in the State Health Benefits Program and fails to remit to the State treasury premiums and periodic charges as required by this paragraph shall be ineligible to receive any form or of State Aid or grant, including but not limited to Transitional Aid to Localities and Consolidated Municipal Property Tax Relief Aid until all contributions required under the provisions of this paragraph are made to the State treasury.

(2) Notwithstanding the provisions of any other law, rule, or regulation to the contrary, any employer other than the State, except an independent State authority, that voluntarily terminates its participation in the State Health Benefits Program on or after August 1, 2026 shall be ineligible to submit a resolution for re-entry in the program for a minimum period of five consecutive plan years following the effective date of the employer’s voluntary termination.

b. If an employer other than the State, except an independent State authority, does not remit payment of the contributions required to be remitted to the State treasury for premiums and periodic charges by the end of the month in which payment is due and owing, then the program shall notify the employer that the right to continue coverage shall be suspended if payment in full is not remitted within 30 days of such notice. If no payment is made, the program shall generate a notice of termination to the employer indicating the termination date and restating the amounts due to reinstate coverage. Termination shall be effective on the last day of the month for which premiums

were paid. The program shall not reinstate the employer unless the employer remits the entire balance due.

c. If any contributions required to be remitted to the State treasury for premiums and periodic charges for employee coverage of a participating employer or a former participating employer are in arrears for greater than 60 consecutive days, then such participating employer or former participating employer shall be ineligible to receive any form of State Aid or grant, including but not limited to Transitional Aid to Localities and Consolidated Municipal Property Tax Relief Aid, until all past-due contributions are made to the State treasury. This subsection shall not apply to independent State authorities participating in the program.

3. (New section) This section shall apply to employers other than the State that are participating in the State Health Benefits Program pursuant to section 3 of P.L.1964, c.125 (C.52:14-17.34), except independent State authorities.

a. Notwithstanding the provisions of any other law, rule, or regulation to the contrary, beginning with the plan year that commences January 1, 2027 and for each plan year thereafter, the State Health Benefits Program shall offer to employers other than the State that are participating in the State Health Benefits Program, except independent State authorities, only three plans in which the employees and retirees who are not Medicare-eligible of such employers may enroll. The three plans shall be designed and implemented in accordance with the provisions of this section. Beginning January 1, 2027 and thereafter, any changes in the provision of health care benefits through the program that are included in collective negotiations agreements between the State and its employees or designed by the committee established pursuant to subsection b. of section 3 of P.L.1961, c.49 (C.52:14-17.27) shall not be applicable to participating employers other than the State, except independent State authorities, and their employees and retirees. All other plans offered prior to January 1, 2027 to employers other than the State for employees and retirees who are not Medicare-eligible of such employers, and their dependents if any, shall no longer be offered to employers other than the State, their employees and retirees, and their dependents, if any.

b. Beginning with the plan year that commences January 1, 2027 and for each plan year thereafter, employers other than the State, except independent State authorities, shall offer coverage to its employees and retirees who are not Medicare eligible under only the following three plans:

(1) A qualifying high-deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) as developed by the State Health Benefits–Local Part Commission, established pursuant to section 4 of P.L. , c. (C.) (pending before the Legislature as this bill). The actuarial value of the qualifying high-deductible health plan shall at all times be at least 10 percentage points lower than the lower of the actuarial values of

the PPO Plan and Tiered Network Plan established under this subsection as calculated in accordance with the actuarial value calculations pursuant to the federal "Patient Protection and Affordable Care Act," Pub.L.111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, and as determined by the program's actuary;

(2) A PPO Plan in accordance with subsections e. of this section, which sets forth the plan design for such plan, which may be modified by the State Health Benefits–Local Part Commission, established pursuant to section 4 of P.L. , c. (C.) (pending before the Legislature as this bill), in accordance with the provisions of subsection g of this section; and

(3) A Tiered Network Plan in accordance with subsections f. of this section, which sets forth the plan design for such plan, which may be modified by the State Health Benefits–Local Part Commission, established pursuant to section 4 of P.L. , c. (C.) (pending before the Legislature as this bill), in accordance with the provisions of subsection g. of this section.

c. (1) Prior to January 1, 2027, the program, through the Division of Pensions and Benefits in the Department of the Treasury, shall provide for an enrollment period during which all employees of a participating employer other than the State, except independent State authorities, shall have the option to select affirmatively one of the three plans specified in subsection b. of this section or waive coverage. If such employee or retiree fails to select affirmatively a plan or waive coverage during this enrollment period, the program shall enroll the retiree or employee, and the retiree's and employee's dependents if any, in the Tiered Network Plan. In the event the commission is under contract with more than one third-party administrator to administer the Tiered Network Plan, the commission shall have the authority to determine which plan to enroll the retiree or employee in based on regulations adopted by the commission in order to achieve the lowest possible cost to the participating employer.

(2) Prior to January 1, 2027, the program, through the Division of Pensions and Benefits in the Department of the Treasury, shall provide for an enrollment period during which a retiree of a participating employer other than the State, except an independent State authority, who is not Medicare-eligible and who does not waive coverage, and any of the retiree's dependents who are not Medicare-eligible, if any, shall be required to select affirmatively one of the three plans specified in subsection b. of this section or waive coverage. If such retiree fails to select affirmatively a plan during this enrollment period, the program shall enroll the retiree, and the retiree's dependents, if any, in the Tiered Network Plan. In the event the commission is under contract with more than one third-party administrator to administer the Tiered Network Plan, the commission shall have the authority to determine which plan to enroll the retiree or employee in based on regulations adopted by the commission in order to achieve the lowest possible cost to the participating employer. Notwithstanding the provisions of section 40 of P.L.2011,

c.78 (C.52:14-17.28d) or any other law, rule, or regulation to the contrary, nothing in the “New Jersey State Health Benefits Program Act,” P.L.1961, c.49 (C.52:14-17.25 et seq.), shall be construed to entitle an employee or retiree of an employer other than the State access to a particular plan design offered through the program in retirement.

d. An employee of a participating employer other than the State, except an independent State authority, who commences employment on or after January 1, 2027, and who does not waive coverage, shall be required to select affirmatively one of the plans specified in subsection b. of this section or waive coverage. If such employee fails to select affirmatively a plan or waive coverage during this enrollment period, the program shall enroll the employee, and the employee’s dependents if any, in the Tiered Network Plan. In the event the commission is under contract with more than one third-party administrator to administer the Tiered Network Plan, the commission shall have the authority to determine which plan to enroll the retiree or employee in based on regulations adopted by the commission in order to achieve the lowest possible cost to the participating employer.

e. The plan design of the PPO Plan for the plan year that commences January 1, 2027 through December 31, 2028 shall be as follows, subject to any adjustments required to comply with federal law:

In-Network Benefits	Coverage
Member Coinsurance:	25%. Applies only to ambulance, durable medical equipment, diagnostic tests and imaging, advanced radiology facility charges, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, and hospice if paid on a fee for service basis.
Deductible:	\$1,000 Single / \$2,500 Family
Coinsurance Maximum:	\$3,000 Single / \$7,500 Family
Out-of-Pocket Maximum:	\$8,480 Single / \$16,960 Family (covers all in network copayments, coinsurance, and deductible)
Emergency Room Copayment:	\$300 (To be Waived if Admitted)
PCP Office Visit Copayment:	\$30
Specialist Office Visit Copayment:	\$50
Urgent Care Copayment	\$100
Outpatient Physical Therapy and Chiropractic Copayment:	\$50 (Subject to 30-visit annual limitation)

Out of Network Benefits	Coverage
Member Coinsurance:	50% of the Out-of-Network Fee Schedule
Deductible:	\$2,000 Single / \$5,000 Family
Out-of-Pocket Maximum:	\$6,500 Single / \$13,000 Family
Out-of-Network Fee Schedule:	175% of CMS – Medicare

Pharmacy	Coverage
Out-of-Pocket Maximum:	\$2,120 Single / \$4,240 Family (Indexed Annually Pursuant to Federal Law)
Generic Copayment:	\$10 Retail 30 Day Supply / \$20 Mail 90 Day Supply / \$50 Specialty 30 Day Supply
Preferred Brand Copayment	\$20 Retail 30 Day Supply / \$40 Mail 90 Day Supply / \$100 Specialty 30 Day Supply
Non-Preferred Brand Copayment:	\$50 Retail 30 Day Supply / \$100 Mail 90 Day Supply / \$250 Specialty 30 Day Supply
Mandatory Generic:	Member Pays Difference in Cost Between Generic and Brand, Plus Brand Copayment
Mandatory Mail:	Maintenance drugs
Formulary:	Closed Formulary as contracted with the Pharmacy Benefit Manager and the State Health Benefits Commission
Non-diabetic GLP-1 Prescribed for Weight Loss Copayment	\$45 for a 30-Day Supply

f. The plan design of the Tiered Network Plan for the plan year that commences January 1, 2027 through December 31, 2028 shall be as follows, subject to any adjustments required to comply with federal law:

In-Network Benefits	Coverage
Member Coinsurance:	5% in Tier 1 / 20% in Tier 2. Applies only to ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, and hospice if paid on a fee for service basis.

Deductible:	\$250 Single / \$625 Family in Tier 1 / \$2,000 Single / \$5,000 Family in Tier 2
Out-of-Pocket Maximum:	\$2,000 Single / \$5,000 Family in Tier 1 / \$4,000 Single / \$10,000 Family in Tier 2 (covers all in network copayments, coinsurance, and deductible)
Emergency Room Copayment:	\$200 in Tier 1 and Tier 2
PCP Office Visit Copayment:	\$0 in Tier 1 / \$30 in Tier 2
Specialist Office Visit Copayment:	\$35 in Tier 1 / \$60 in Tier 2
Urgent Care Copayment	\$75 in Tier 1 / \$125 in Tier 2
Outpatient Physical Therapy and Chiropractic Copayment:	\$35 in Tier 1 / \$60 in Tier 2 (Subject to 30-visit annual limitation)
Inpatient Stay Coinsurance	\$150 in Tier 1 / 20% in Tier 2

Pharmacy	Coverage
Out-of-Pocket Maximum:	\$2,120 Single / \$4,240 Family (Indexed Annually Pursuant to Federal Law)
Generic Copayment:	\$10 Retail 30 Day Supply / \$20 Mail 90 Day Supply / \$50 Specialty 30 Day Supply
Preferred Brand Copayment	\$20 Retail 30 Day Supply / \$40 Mail 90 Day Supply / \$100 Specialty 30 Day Supply
Non-Preferred Brand Copayment:	\$50 Retail 30 Day Supply / \$100 Mail 90 Day Supply / \$250 Specialty 30 Day Supply
Mandatory Generic:	Member Pays Difference in Cost Between Generic and Brand, Plus Brand Copayment
Mandatory Mail:	Maintenance drugs
Formulary:	Closed Formulary as contracted with the Pharmacy Benefit Manager and the State Health Benefits Commission
Non-diabetic GLP-1 Prescribed for Weight Loss Copayment	\$45 for a 30-Day Supply

The Tiered Network Plan shall not provide payment for any charges incurred out-of-network. Enrollees of the Tiered Network Plan shall not be offered the option to participate in a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) through which qualified medical expenses are paid.

g. Beginning with the plan year commencing January 1, 2029 and for each plan year thereafter, the plan design of the PPO Plan and

Tiered Network Plan as those plans are specified in subsections e. and f. of this section may be modified by the State Health Benefits–Local Part Commission, established pursuant to section 4 of P.L. , c. (C.) (pending before the Legislature as this bill). Notwithstanding the provisions of any other law, rule, or regulation to the contrary, any modifications to the plan designs of such plans made by the commission shall at all times result in the plans having an actuarial value not in excess of 88 percent under the actuarial value calculations pursuant to the federal "Patient Protection and Affordable Care Act," Pub.L.111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, as determined by the program's actuary.

h. The obligations of employees of any participating employer other than the State to pay a share of the premium or periodic charges for health benefits coverage provided under the plans specified in subsection b. of this section may be determined by means of a binding collective negotiations agreement subject to the provisions of section 77 and 79 of P.L.2011, c.78 (C.52:14-17.28e and C.40A:10-21.2). For employers other than the State without a collective negotiations agreement binding on such employer, the obligations of the employees of such employer to pay a share of the premium or periodic charges for health benefits coverage provided under the plans specified in subsection b. of this section shall be determined by the employer.

i. Notwithstanding the provisions of any law to the contrary, former employees permitted to participate in the program pursuant to P.L.1997, c.330 (C.52:14-17.32i et al) shall be eligible to enroll only in the plans set forth in subsection b. of this section in accordance with the provisions of paragraph (2) of subsection c. of this section.

4. (New section) a. There is hereby created a State Health Benefits–Local Part Commission, consisting of seven members, each of whom shall be a covered employee under the program: the State Treasurer; the Commissioner of Banking and Insurance; the Chairperson of the Civil Service Commission; the Commissioner of Community Affairs, or their designees, who shall serve ex officio; a member appointed by the Governor upon recommendation of the New Jersey State League of Municipalities; a local employees' representative appointed by the Governor upon recommendation of the Public Employee Committee of the AFL-CIO; and a seventh member of the commission appointed by the Governor upon a joint recommendation of the head of the union, that is not affiliated with the AFL-CIO, that represents the greatest number of police officers in this State and the head of the union, that is not affiliated with the AFL-CIO, that represents the greatest number of firefighters in this State.

The Treasurer shall be chair of the commission and the local part of the health benefits program authorized by P.L.1961, c.49 shall be administered in the Department of the Treasury. The Director of the Division of Pensions and Benefits shall be the secretary of the commission. The commission shall oversee the health benefits

program for the employees of participating employers other than the State, except independent State authorities, the cost of which shall be paid as specified in sections 10 and 11 of P.L.1964, c.125 (C.52:14-17.41 and 52:14-17.42). The commission shall establish rules and regulations as may be deemed reasonable and necessary for the administration of the health benefits program for the employees of participating employers other than the State, except independent State authorities.

The Attorney General shall be the legal advisor of the commission.

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

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

b. The commission shall have the responsibility for and authority over the plan design of the three plans set forth in subsection b. of section 3 of P.L. , c. (C.) (pending before the Legislature as this bill). The commission shall have the authority to modify such plans, or components thereof, subject to the requirements of subsection g. of section 3 of P.L. , c. (C.) (pending before the Legislature as this bill), but shall not have the authority to create a plan or to terminate any of the plans set forth in subsection b. of section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

c. The members of the commission shall have a fiduciary duty to the program, the State, and those members and retirees who participate in the program.

d. Any reference in law to the State Health Benefits Commission or the State Health Benefits Plan Design Committee in the context of a plan or plan component offered to employees of employers other than the State, except independent State authorities, shall be deemed to apply to the commission established by this section.

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

3. a. There is hereby created a State Health Benefits Commission, consisting of five members, each of whom shall be a covered employee under the program: the State Treasurer; the Commissioner of Banking and Insurance; the Chairperson of the Civil Service Commission, or their designees, who shall serve ex officio; [a] and two State employees' [representative chosen by] representatives appointed by the Governor upon recommendation of the Public Employee Committee of the AFL-CIO; and the fifth member of the commission shall be a local employees' representative chosen by the Public Employee Committee of the AFL-CIO].

The treasurer shall be [chairman] chair of the commission and the health benefits program authorized by P.L.1961, c.49 shall be

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

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

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

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

b. There is established a State Health Benefits Plan Design Committee, composed of [12] eight members, each of whom shall be a covered employee under the program, as follows:

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

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

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

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

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

[The members of the committee shall serve for a term of three years and until a successor is appointed and qualified. Of the initial appointments by the Governor, three members shall serve for two years and until a successor is appointed and qualified, and two shall serve for one year and until a successor is appointed and qualified. Of the initial appointment by the head of the union representing the greatest number of police officers in the State, the member shall serve for two years and until a successor is appointed and qualified. Of the initial appointment by the head of the union representing the greatest number of firefighters in the State, the member shall serve for one year and until a successor is appointed and qualified.] The members of the committee reconstituted pursuant to P.L. , c. (C.) (pending before the Legislature as this bill) shall serve for a term of three years and until a successor is appointed and qualified, except that of the

four members first appointed to the reconstituted committee by the Governor as representatives of public employers, two shall serve for two years and until a successor is appointed and qualified, and two shall serve for one year and until a successor is appointed and qualified. Of the three initial appointments by the Governor upon recommendation of the Public Employee Committee of the AFL-CIO, two shall serve for two years and until a successor is appointed and qualified, and one shall serve for one year and until a successor is appointed and qualified.

The four members of the committee representing public employers and the four members of the committee appointed by the Governor upon the recommendation of the Public Employee Committee of the AFL-CIO and the State Troopers Fraternal Association shall each select a [chairperson] co-chair from among the members, who shall serve for a term of one year, with no member serving more than one term as [chairperson until] co-chair unless all the members of the committee have served a term [in a manner alternating among the employer representatives and employee representatives, unless the committee determines otherwise with regard to this process] as co-chair. The co-chairs shall alternate presiding over meetings of the committee.

The committee shall have the responsibility for and authority over the plan design of the various plans and components of those plans, including for medical benefits, prescription benefits, dental, vision, and any other health care benefits, offered and administered by the program and offered to employees of the State and independent State authorities. The committee shall have the authority to create, modify, or terminate any plan or component offered to employees of the State and independent State authorities, at its sole discretion, but the committee shall not have the authority to direct the commission or State to enter into or amend any contract or agreement. Any reference in law to the State Health Benefits Commission in the context of the creation, modification, or termination of a plan or plan component offered to employees of the State and independent State authorities shall be deemed to apply to the committee.

The members of the committee shall have [the same duty and responsibility] a fiduciary duty to the program [as do the members of the commission], the State, and those members and retirees who participate in the program.

If any matter before the committee receives at least [seven] five votes in the affirmative, the commission shall approve and implement the committee's decision.

If any matter before the committee receives [six] four votes in the affirmative and [six] four votes in the negative or the committee otherwise reaches an impasse on a decision, [the provisions of section 55 of P.L.2011, c.78 (C.52:14-17.27b) shall be followed] the State Treasurer shall be authorized to vote on the matter.

(cf: P.L.2011, c.78, s.45)

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

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

(1) Basic benefits which shall include:

(a) Hospital benefits, including outpatient;

(b) Surgical benefits;

(c) Inpatient medical benefits;

(d) Obstetrical benefits; and

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

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

(i) Additional days of inpatient medical service;

(ii) Surgery elsewhere than in a hospital;

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

(iv) Physical therapy services;

(v) Radium or radon therapy services;

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

(2) Major medical expense benefits which shall provide benefit payments for reasonable and necessary eligible medical expenses for hospitalization, surgery, medical treatment and other related services and supplies to the extent they are not covered by basic benefits. The commission may, by regulation, determine what types of services and supplies shall be included as "eligible medical services" under the major medical expense benefits coverage as well as those which shall be excluded from or limited under such coverage. Benefit payments for major medical expense benefits shall be equal to a percentage of the reasonable charges for eligible medical services incurred by a covered employee or an employee's covered dependent, during a calendar year as exceed a deductible for such calendar year of \$100.00 subject to the maximums hereinafter provided and to the other terms and conditions authorized by this act. The percentage shall be 80 percent of the first \$2,000.00 of charges for eligible medical services incurred subsequent to satisfaction of the deductible and 100 percent thereafter. There shall be a separate deductible for each calendar year for (a) each enrolled employee and (b) all enrolled dependents of such employee. Not more than \$1,000,000.00 shall be

paid for major medical expense benefits with respect to any one person for the entire period of such person's coverage under the plan, whether continuous or interrupted except that this maximum may be reapplied to a covered person in amounts not to exceed \$2,000.00 a year. Maximums of \$10,000.00 per calendar year and \$20,000.00 for the entire period of the person's coverage under the plan shall apply to eligible expenses incurred because of mental illness or functional nervous disorders, and such may be reapplied to a covered person, except as provided in P.L.1999, c.441 (C.52:14-17.29d et al.). The same provisions shall apply for retired employees and their dependents. Under the conditions agreed upon by the commission and the carriers as set forth in the contract, the deductible for a calendar year may be satisfied in whole or in part by eligible charges incurred during the last three months of the prior calendar year.

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

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

Covered services shall include:

- (1) Physician services, including:
 - (a) Inpatient services, including:
 - (i) medical care including consultations;
 - (ii) surgical services and services related thereto; and
 - (iii) obstetrical services including normal delivery, cesarean section, and abortion.
 - (b) Outpatient/out-of-hospital services, including:
 - (i) office visits for covered services and care;
 - (ii) allergy testing and related diagnostic/therapy services;
 - (iii) dialysis center care;
 - (iv) maternity care;
 - (v) well child care;
 - (vi) child immunizations/lead screening;
 - (vii) routine adult physicals including pap, mammography, and prostate examinations; and
 - (viii) annual routine obstetrical/gynecological exam.
- (2) Hospital services, both inpatient and outpatient, including:

- (a) room and board;
- (b) intensive care and other required levels of care;
- (c) semi-private room;
- (d) therapy and diagnostic services;
- (e) surgical services or facilities and treatment related thereto;
- (f) nursing care;
- (g) necessary supplies, medicines, and equipment for care; and
- (h) maternity care and related services.
- (3) Other facility and services, including:
 - (a) approved treatment centers for medical emergency/accidental injury;
 - (b) approved surgical center;
 - (c) hospice;
 - (d) chemotherapy;
 - (e) diagnostic x-ray and lab tests;
 - (f) ambulance;
 - (g) durable medical equipment;
 - (h) prosthetic devices;
 - (i) foot orthotics;
 - (j) diabetic supplies and education; and
 - (k) oxygen and oxygen administration.

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

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

(1) In the successor plan, the co-payment for doctor's office visits shall be \$10 per visit with a maximum out-of-pocket of \$400 per individual and \$1,000 per family for in-network services for each calendar year. The out-of-network deductible shall be \$100 per individual and \$250 per family for each calendar year, and the participant shall receive reimbursement for out-of-network charges at the rate of 80 percent of reasonable and customary charges, provided that the out-of-pocket maximum shall not exceed \$2,000 per individual and \$5,000 per family for each calendar year.

(2) In the State managed care plan that is required to be included in a contract entered into pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28), the co-payment for doctor's office visits shall be \$15 per visit. The participant shall receive reimbursement for out-of-network charges at the rate of 70% of reasonable and customary charges. The in-network and out-of-network limits, exclusions, maximums, and deductibles shall be substantially equivalent to those in the NJ PLUS plan in effect on June 30, 2007, with adjustments to that plan pursuant to a binding collective negotiations agreement or pursuant to action by the

commission, in its sole discretion, to apply such adjustments to State employees for whom there is no majority representative for collective negotiations purposes.

(3) "Reasonable and customary charges" means charges based upon the 90th percentile of the usual, customary, and reasonable (UCR) fee schedule determined by the Health Insurance Association of America or a similar nationally recognized database of prevailing health care charges.

(D) Benefits under the contract or contracts purchased as authorized by this act may be subject to such limitations, exclusions, or waiting periods as the commission finds to be necessary or desirable to avoid inequity, unnecessary utilization, duplication of services or benefits otherwise available, including coverage afforded under the laws of the United States, such as the federal Medicare program, or for other reasons.

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

(E) (1) The rates charged for any contract purchased under the authority of this act shall reasonably and equitably reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound. The rates charged shall be determined by the carrier on accepted group rating principles with due regard to the experience, both past and contemplated, under the contract. The commission shall have the right to particularize subgroups for experience purposes and rates. No increase in rates shall be retroactive.

(2) The State Health Benefits-Local Part Commission shall establish and maintain a claims stabilization reserve fund or equivalent fund for participating employers other than the State, except independent State authorities. When adopting premium rates for a plan year, the commission shall ensure that the reserve fund balance at the end of a plan year shall be not less than five percent of the total claims paid in the year prior to the year in which the premium rates are adopted by the commission for a plan year. The balance may be attained by a surcharge on premium rates or as a result of lower than anticipated incurred claims during a plan year, or both. The balance in each fund shall be included by the program's actuary and the commission in the calculation for projected, recommended, and final premium increases for a plan year.

(3) If the premium rates adopted by the State Health Benefits-Local Part Commission are insufficient to cover the cost of services and benefits provided to employees and retirees, who are not Medicaid eligible, of employers other than the State, except independent State authorities, and to maintain a reserve fund balance

of not less than five percent for the plan year, the commission shall impose a surcharge on participating employers other than the State in an amount that the commission, in consultation with the program's actuary, determines is necessary to cover the cost of services and benefits for the plan year and to ensure that the reserve fund balance at the end of a plan year shall be not less than five percent in accordance with paragraph (2) of this subsection.

(4) The State Health Benefits-Local Part Commission shall not approve a temporarily suspension of a participating employer's responsibility to remit premium and periodic charges to the State treasury or otherwise attempt to institute a premium contribution "holiday."

(F) The initial term of any contract purchased by the commission under the authority of this act shall be for such period to which the commission and the carrier may agree, but permission may be made for automatic renewal in the absence of notice of termination by the commission. Subsequent terms for which any contract may be renewed as herein provided shall each be limited to a period not to exceed one year.

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

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

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

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

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

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

(cf: P.L.2023, c.177, s.139)

7. Section 1 of P.L.1997, c.330 (C.52:14-17.32i) is amended to read as follows:

1. a. A qualified retiree from the Police and Firemen's Retirement System of New Jersey (C.43:16A-1 et seq.), hereinafter referred to as PFRS, the Consolidated Police and Firemen's Pension Fund (C.43:16-1 et seq.), hereinafter referred to as CPFPPF, or the Public Employees' Retirement System of New Jersey (C.43:15A-1 et seq.), hereinafter referred to as PERS, and dependents, as defined in section 2 of P.L.1961, c.49 (C.52:14-17.26), of a qualified retiree, are eligible to participate in the program, in accordance with the law and rules governing the program, except as otherwise provided by this act, regardless of whether the retiree's employer participated in the program.

A qualified retiree is a retiree who:

(1) retired on a benefit based on 25 or more years of service credit in PFRS or CPFPPF, or in PERS as a law enforcement officer as defined in section 1 of P.L.1955, c.257 (C.43:15A-97) or in a position eligible for participation in PFRS as provided in section 9 of P.L.1989, c.204 (C.43:16A-1.2); or

(2) retired on a disability retirement under PFRS or CPFPPF, or under PERS as a law enforcement officer or in a position eligible for participation in PFRS, based on fewer years of service credit; and

(3) was eligible to receive health benefits coverage at the expense of the employer of the person immediately preceding retirement.

b. The State shall pay the amount of the premium or periodic charges for the coverage for the qualified retiree and dependents, but

not including survivors, equal to 80 percent of the premium or periodic charges for the category of coverage elected by the qualified retiree under the [State managed care plan or a health maintenance organization participating in the program which provides services in the 21 counties in the State, whichever provides the lower premium or periodic charge] Tiered Network Plan established pursuant to section 3 of P.L. , c. (C.) (pending before the Legislature as this bill). The qualified retiree shall pay the difference between the premium or periodic charge for the coverage and the amount paid by the State.

c. The State Health Benefits Commission shall annually certify to the State the cost for providing health benefits coverage to qualified retirees and their dependents under this section. The State shall annually remit to the commission the amount certified at a time specified by the State Treasurer.

d. The provisions of this section shall not apply to (1) a retired State employee whose premium or periodic charges for benefits under the program are paid by the State pursuant to section 8 of P.L.1961, c.49 (C.52:14-17.32) or section 6 of P.L.1996, c.8 (C.52:14-17.28b); and (2) a retiree of an employer other than the State which pays the premium or periodic charges for health care benefits for eligible retirees pursuant to section 7 of P.L.1964, c.125 (C.52:14-17.38) or N.J.S.40A:10-23 on the effective date of P.L.1997, c.330 (C.52:14-17.32i et al.).
(cf: P.L.1997,c.330,s.1)

8. Section 43 of P.L.2011, c.78 (C.52:14-17.34a) is amended to read as follows:

43. As used in this section, "independent State authority" means a public authority, board, commission, corporation, or other agency or instrumentality of the State allocated, in but not of, a principal department of State government pursuant to Article V, Section IV, paragraph 1 of the New Jersey Constitution, or which is not subject to supervision or control by the department in which it is allocated, and a regional authority, but shall not include a college or university.

Notwithstanding the provisions of any other law to the contrary, public employees of an independent State authority who are not subject to the provisions of section 40 of P.L.2011, c.78 (C.52:14-17.28d) shall contribute, through the withholding of the contribution from the pay, salary, or other compensation or from the monthly retirement allowance, toward the cost of health care benefits coverage for the employee and any dependent provided by the authority during active service and in retirement in an amount that shall be determined as closely as possible in accordance with sections 39 and 40 of P.L.2011, c.78 (C.52:14-17.28c and C.52:14-17.28d).

Once those employees are subjected to the contribution requirements set forth in this section, the public employers and public employees shall be bound by this act, P.L.2011, c.78, to apply the contribution levels set forth in section 39 of this act until all affected employees are contributing the full amount of the contribution, as determined by the implementation schedule set forth in subsection a.

of section 40 of this act. Notwithstanding the expiration date set forth in section 83 of this act, P.L.2011, c.78, or the expiration date of any successor agreements, the parties shall be bound to apply the requirements of this paragraph until they have reached the full implementation of the schedule set forth in subsection a. of section 40 of this act.

Notwithstanding the provisions of any other law, rule, or regulation to the contrary, beginning with the plan year that commences January 1, 2027 and thereafter, an employee or retiree of an independent State authority shall be deemed to be an employee of the State with regard to plan availability and shall have access to the plan design offered to State employees by the State Health Benefits Commission; provided,, however, that the premium and period charges for employee and retiree health benefits coverage of an independent State authority shall be paid to the health benefits fund established pursuant to section 6 of P.L.1961, c.49 (C.52:14-17.30), or a subaccount thereof, by the independent State authority at a rate set by the commission based on a per member cost to the program determined by the commission pursuant to regulation adopted by the commission. The State shall not be liable for the premium or periodic charges, including administrative expenses, for the coverage for employees and retirees of independent State authorities, including their dependents, if any.

(cf: P.L.2011, c.78, s.43)

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

5. a. The commission established by section 3 of chapter 49 of the laws of 1961, is hereby authorized to prescribe rules and regulations satisfactory to the carrier or carriers under which employers may participate in the health benefits program provided by that act. [All provisions of that act will, except as expressly stated herein, be construed as to participating employers and to their employees and to dependents of such employees the same as for the State, employees of the State and dependents of such employees.] The commission established by section 4 of P.L. , c. (C.) (pending before the Legislature as this bill) is hereby authorized to prescribe rules and regulations satisfactory to the carrier or carriers under which employers other than the State, except independent State authorities, may participate in the health benefits program provided by P.L.1961, c.49 (C.52:14-17.25 et seq.), as supplemented and amended by P.L. , c. (C.) (pending before the Legislature as this bill).

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

P.L.2007, c.103 (C.52:14-17.46.1 et seq.].] (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill))
(cf: P.L.2010, c.2, s.8)

10. Notwithstanding the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary, the State Health Benefits-Local Part Commission shall adopt, immediately upon filing with the Office of Administrative Law, such rules and regulations as the commission deems necessary to implement the provisions of P.L. , c. (C.) (pending before the Legislature as this bill), which rules and regulations shall be effective for a period not to exceed 365 days after the date of the filing. Before the expiration of the rules and regulations, the commission shall amend, adopt, or readopt the rules and regulations in accordance with the requirements of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

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

12. Notwithstanding any law or regulation to the contrary, an amount not to exceed \$260,000,000 is appropriated to the health benefits funds established pursuant to sections 10 and 11 of P.L.1964, c.125 (C.52:14-17.41 and 52:14-17.42) in amounts determined by the Director of the Division of Pensions and Benefits, subject to the approval of the Director of the Division of Budget and Accounting. From the amount appropriated, an amount determined by the Director of the Division of Pensions and Benefits shall be to reimburse such health benefits funds for amounts transferred on or before January 1, 2026 from the health benefits fund established pursuant to section 6 of P.L.1961, c.49 (C.52:14-17.30) to such health benefits funds pursuant to section 2 of P.L.2024, c.86 (C.52:14-17.42a).

13. This act shall take effect immediately.