

(d) The average cost for NJ PLUS and participating HMOs for each category of coverage for a rate time period shall be determined as follows:

1. Multiply the number of retirees who elected the category of coverage at the beginning of the rate time period immediately preceding the current rate time period by the premium or periodic charge rate for the category of coverage for the current rate time period for NJ PLUS and each participating HMO.

2. Determine the total premium and periodic charges for all retirees who elected the category of coverage by adding the amounts determined under (d)1 above for NJ PLUS and the participating HMOs.

3. Divide the total premium and periodic charges for all retirees who elected the category of coverage determined under (d)2 above by the total number of retirees who elected the category of coverage at the beginning of the immediately preceding rate time period for NJ PLUS and the participating HMOs.

(e) For retirees who accrue 25 years of service credit in a State-administered retirement system on or after July 1, 2000 or retire on a disability retirement after July 1, 2000, payroll deductions for Traditional Plan coverage shall be determined as follows:

1. Retirees electing the Traditional Plan shall pay 25 percent of the cost of that plan's premium as established by the State Health Benefits Commission pursuant to N.J.S.A. 52:14-17.32b; and

2. Retirees electing NJ PLUS, the State of New Jersey Managed Care/Point of Service Plan, or an HMO shall have no premium payment.

New Rule, R.1998 d.265, effective June 1, 1998.

See: 30 N.J.R. 803(a), 30 N.J.R. 2070(a).

Amended by R.2000 d.298, effective July 17, 2000.

See: 32 N.J.R. 1322(a), 32 N.J.R. 2601(b).

In (b), inserted "but before July 1, 2000," in the introductory paragraph; in (c), substituted "after July 1, 1997, but before July 1, 2000 or retire on a disability retirement after July 1, 1997 but before August 1, 2000" for "or retire on a disability retirement after July 1, 1997" following "system"; and added (e).

17:9-6.9 Eligibility for State payment of retiree coverage under P.L. 1997, c.330

(a) For the purposes of this section, "qualified retiree" means a person who:

1. Is a retiree from:

i. The Police and Firemen's Retirement System of New Jersey (N.J.S.A. 43:16A-1 et seq.), hereinafter referred to as PFRS;

ii. The Consolidated Police and Firemen's Pensions Fund (N.J.S.A. 43:16-1 et seq.), hereinafter referred to as CPFPPF; or

iii. The Public Employees' Retirement System of New Jersey (N.J.S.A. 43:15A-6 et seq.), hereinafter referred to as PERS, from a position included in the definition of "law enforcement officer" under section 1 of P.L. 1955, c.257 (N.J.S.A. 43:15A-97), from a PFRS covered position that would have made the member eligible for enrollment in the PFRS but for age, from a position that would have been eligible for enrollment in the PFRS had the employer joined the PFRS by referendum under the provisions of N.J.S.A. 43:16A-3(2) or from a position that is eligible for participation in PFRS as provided in section 9 of P.L. 1989, c.204 (N.J.S.A. 43:16A-1.2);

2. Retired on a benefit based on 25 or more years of service credit or on disability retirement under PFRS, CPFPPF, or PERS;

3. Was eligible to receive health benefits coverage at the expense of the employer immediately preceding retirement; and

4. Is not eligible for employer payment of health benefits coverage after retirement, regardless of whether the employer pays for health benefits coverage for other retirees.

(b) Pursuant to P.L. 1997, c.330 (N.J.S.A. 52:14-17.32i et seq.), a qualified retiree and his or her eligible dependents, as defined in section 2 of P.L. 1961, c.49 (N.J.S.A. 52:14-17.26), but not survivors, are eligible to participate in the State Health Benefits Program (SHBP) in accordance with the laws and rules governing the program, regardless of whether the retiree's employer participated in the program, and for State payment of an amount of the premium or periodic charges for the category of coverage elected by the qualified retiree equal to 80 percent of the premium or periodic charges for that category of coverage under the State managed care plan or health maintenance organization which provides services in the 21 counties of the State and the lower premium or periodic charges.

(c) The following persons are not eligible for benefits under N.J.S.A. 52:14-17.32i et seq.

1. A retired State employee whose premium or periodic charges for health benefits under the State Health Benefits Program are paid by the State pursuant to section 8 of P.L. 1961, c.49 (N.J.S.A. 52:14-17.32) or section 6 of P.L. 1996, c.8 (N.J.S.A. 52:14-17.28b);

2. A retiree of an employer other than the State for whom the employer pays premium or periodic charges for health benefits under the SHBP as authorized by section 7 of P.L. 1964, c.125 (N.J.S.A. 52:14-17.38) and pursuant to a collective negotiations agreement, ordinance, or resolution on July 1, 1998;

3. A retiree of an employer other than the State for whom the employer pays premium or periodic charges for health benefits as authorized by N.J.S.A. 40A:10-23 and

pursuant to a collective negotiations agreement, ordinance, or resolution, for the life of the retiree, on July 1, 1998;

4. A retiree of an employer other than the State for whom the employer pays premium or periodic charges for health benefits as authorized by N.J.S.A. 40A:10-23, and pursuant to a collective negotiations agreement, ordinance, or resolution, for a period of time less than the life of the retiree while the employer is paying the amount of the premium or periodic charges, on July 1, 1998;

5. A retiree otherwise eligible for State payment of health benefits under the SHBP pursuant to N.J.S.A. 52:14-17.32i et seq. who is receiving health benefits coverage from an employer in connection with employment after retirement while the retiree is receiving the coverage; and

6. A retiree of an employer other than the State who would have been ineligible for State payment for health benefits under the SHBP pursuant to N.J.S.A. 52:14-17.32i et seq. because of employer payment for health benefits coverage after retirement for the collective negotiations unit, the employment classification or the category, of which the retiree was a member, under a negotiated agreement, ordinance, or resolution on July 1, 1998, and who otherwise meets the eligibility requirements for the benefit as a result of a change in the negotiated agreement, ordinance, or resolution after July 1, 1998.

(d) A qualified retiree who is ineligible for benefits under N.J.S.A. 52:14-17.32i et seq. because of employer payment for retiree coverage under (c)4 above or receipt of health benefits coverage in connection with employment after retirement under (c)5 above shall be eligible for the benefits after termination of employer payment for retiree coverage or employer coverage if the retiree applies to the SHBP for the benefits within 60 days after the effective date of termination of employer payment or coverage.

New Rule, R.1999 d.373, effective November 1, 1999.
See: 31 N.J.R. 2300(b), 31 N.J.R. 3524(b).
Amended by R.2000 d.495, effective December 18, 2000.
See: 32 N.J.R. 3387(a), 32 N.J.R. 4451(a).
In (a)1, rewrote iii.

17:9-6.10 Retiree prescription drug card plan

(a) The following terms, as used in this section, shall have the following meanings:

“Brand name” means the proprietary or trade name assigned to a drug product by the manufacturer or distributor of the drug product.

“Generic drug products” means prescription drug products and insulin approved and designated by the U.S. Food and Drug Administration as therapeutic equivalents for reference listed drug products. It includes drug products listed in the New Jersey Generic Formulary by the Drug Utilization Review Council pursuant to N.J.S.A. 24:6E-1 et seq.

“Mail-order pharmacy” means the mail order program available through the provider.

“Preferred brands” means brand name prescription drug products and insulin determined by the provider, to be more cost effective alternatives for prescription drug products and insulin with comparable therapeutic efficacy within a therapeutic class, as defined or recognized in the United States Pharmacopeia or the American Hospital Formulary Service Drug Information, or by the American Society of Health Systems Pharmacists. A drug product for which there is no other therapeutically equivalent drug product shall be a preferred brand. Determinations of preferred brands by the provider shall be subject to review and modification by the Commission.

“Prescription drug card plan” or “card plan” means the plan for providing payment for eligible prescription drug expenses of retired members of the State Health Benefits Program and their eligible dependents who participate in the Traditional Plan or the State managed care plan (NJ PLUS) as prescribed by this section.

“Provider” means an insurance company, hospital, medical, or health service corporation, or health maintenance organization under agreement or contract with the Commission to administer the card plan.

“Retail pharmacy” means a pharmacy, drug store or other retail establishment in this State at which prescription drug products are dispensed by a registered pharmacist under the laws of this State, or a pharmacy, drug store or other retail establishment in another state at which prescription drug products are dispensed by a registered pharmacist under the laws of that state if expenses for prescription drug products dispensed at the pharmacy, drug store or other retail establishment are eligible for payment under the card plan.

“Other brands” means prescription drug products which are not preferred brands or generic drug products. A new drug product approved by the U.S. Food and Drug Administration which is not a generic drug product shall be included in this category until the provider makes a determination concerning inclusion of the drug product in the list of preferred brands.

(b) As a pilot program for five years (from March 20, 2000 to March 20, 2005), payment for eligible prescription drug expenses of retired members of the State Health Benefits Program and their eligible dependents who participate in the Traditional Plan or NJ PLUS shall be provided under the prescription drug card plan. Payment for prescription drug expenses or the co-payments required under the card plan shall not be made under the major medical portion of the Traditional Plan or NJ PLUS. There shall be no annual deductible amount that retired members or their eligible dependents shall satisfy before eligibility for payment of prescription drug expenses under the card plan.

(c) Eligibility of prescription drug expenses for coverage under the card plan shall be determined on the same basis as reasonable and necessary medical expenses under the major medical portion of the Traditional Plan and NJ PLUS.

(d) A co-payment shall be required for each prescription drug expense until a retired member or eligible dependent satisfied the maximum annual out-of-pocket expense for a calendar year prescribed in (g) and (h) below. The initial amounts of the co-payments for calendar years 2000 and 2001 shall be as follows:

Type of Drug Product	Retail Pharmacy	Mail-Order Pharmacy
Generic	\$ 5.00	\$ 5.00
Preferred Brands	\$10.00	\$15.00
Other Brands	\$20.00	\$25.00

(e) The supply of a drug product eligible for coverage under the card plan for each prescription drug expense shall be limited to 30 days if the prescription is filled at a retail pharmacy, and 90 days if the prescription is filled through the mail-order pharmacy.

(f) The co-payment amounts under (d) above shall be reviewed annually and shall be increased by the rate of increase of the average wholesale price for a one-day supply of prescription drug products covered under the card plan for the immediately preceding fiscal year over the second preceding fiscal year rounded to the nearest whole dollar. The basis for determining an increase in the amounts of co-payments from year to year from the initial amounts shall be the actual results of the calculations to determine the increased amounts, and not the rounded amounts of co-payments applicable for any year or years. The co-payments shall be reviewed initially for calendar year 2002. Since there will not be a full fiscal year of experience for fiscal year 2000 under the card plan, the experience for fiscal year 2000 shall be annualized on an actuarial basis. The rate of increase in the co-payment amounts for calendar years 2002 and 2003 shall not exceed seven percent.

(g) The amount of out-of-pocket expense that a retired member or eligible dependent shall pay for a calendar year for eligible prescription drug expenses under the card plan

shall be limited initially for calendar years 2000 and 2001 to \$300.00.

(h) The maximum amount of annual out-of-pocket expense under (g) above shall be reviewed annually and shall be increased by the rate of increase in the amount of prescription drug expenses paid per member under the card plan for the immediately preceding fiscal year over the second preceding fiscal year rounded to the nearest whole dollar. The maximum amount of annual out-of-pocket expense shall be reviewed initially for calendar year 2002. Since there will not be a full fiscal year of experience for fiscal year 2000 under the card plan, the experience for fiscal year 2000 shall be annualized on an actuarial basis. The rate of increase in the maximum amount of annual out-of-pocket expense for calendar years 2002 and 2003 shall not exceed 15 percent.

(i) Notice of increases in the amounts of the co-payments and the maximum out-of-pocket expense shall be published in the New Jersey Register and shall be sent to all retirees affected by the increases.

(j) The provider administering the card plan shall comply with N.J.A.C. 11:4-37.3(c)1 through 4, 6 and 7 in administration of the card plan.

(k) The Commission may limit the annual increases in the co-payments and the maximum out-of-pocket expense for the following reasons:

1. To limit excessive annual increases which are significantly higher than the trends for the increases over the preceding five years;
2. To maintain an appropriate spread between the categories of co-payment amounts; or
3. To prevent undue hardship to retirees if general economic circumstances in the State or economic circumstances relative to health care for retirees are such that strict application of the formulas for the annual increases in the co-payments or the maximum out-of-pocket expense would produce such hardship.

New Rule R.2000 d.116, effective March 20, 2000.
See: 31 N.J.R. 4235(a), 32 N.J.R. 1048(a).