

Computerized claims data regarding health benefits paid under state plan constituted "public records". Board of Educ. of Newark v. New Jersey Dept. of Treasury, Div. of Pensions, 279 N.J.Super. 489, 653 A.2d 589 (A.D.1995), leave to appeal granted 142 N.J. 440, 663 A.2d 1351, affirmed 145 N.J. 269, 678 A.2d 660.

17:9-1.3 Appeals from Commission decisions

(a) Any member of the traditional plan or NJ PLUS plan who disagrees with the decision of one of the claims administrators may request that the matter be considered by the State Health Benefits Commission. Requests for consideration must be directed to the Secretary, State Health Benefits Commission, and must contain the reason for the disagreement. Appeals shall be considered at the regular monthly meetings of the Commission. It shall be the responsibility of the member to provide the Commission with any medical or other information that the Commission may require in order to make a decision.

(b) Any member of an HMO who disagrees with a determination of medical necessity made by an HMO or any member of an HMO who feels that the HMO has violated the terms and conditions of its contract may request that the matter be considered by the State Health Benefits Commission. Such an appeal can only be considered after the member has exhausted the HMO's grievance process. Appeals shall be considered at the regular monthly meetings of the Commission.

(c) Notification of all Commission decisions will be made in writing to the member and the following statement shall be incorporated in every written notice setting forth the Commission's determination in a matter where such determination is contrary to the claim made by the claimant or his or her legal representative:

"If you disagree with the determination of the Commission in this matter, you may appeal by sending a written statement to the Commission within 45 days from the date of this letter informing the Commission of your disagreement and all of the reasons therefor. If no such written statement is received within the 45-day period, this determination shall be considered final."

(d) Any member who disagrees with the Commission's decision and submits the written statement as set forth in (c) above within 45 calendar days shall be notified of the disposition of the appeal in one of two ways:

1. The Commission shall determine whether to grant an administrative hearing on the basis of whether the matter involves contested facts or is solely a question of law. If the appeal involves solely a question of law, the Commission shall likely deny an administrative hearing request. If the request for an administrative hearing is denied, the Commission shall issue detailed findings of fact and conclusions of law. These findings and conclusions shall become the Commission's final administrative determination that may then be appealed to the Superior Court, Appellate Division.

2. If the appeal involves disputed facts, the Commission shall approve an administrative hearing request and transmit the matter to the Office of Administrative Law. Upon completion of this hearing, the Administrative Law Judge will submit to the Commission an initial decision that the Commission may adopt, reject or modify. If the Commission rejects or modifies the initial decision, it shall issue detailed findings of fact and conclusions of law that will become the Commission's final administrative determination that may then be appealed to the Superior Court, Appellate Division.

As amended, R.1970 d.147, effective December 10, 1970.

See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).

Amended by R.1996 d.551, effective December 2, 1996.

See: 28 N.J.R. 4083(b), 28 N.J.R. 5078(c).

Case Notes

Where the Commission has not exercised authority to regulate mental illness coverage, the Appellate Division would not defer to the Health Benefits' Commission's interpretation. Heaton v. State Health Benefits Com'n, 264 N.J.Super. 141, 624 A.2d 69 (A.D.1993).

Administrative remedies must be exhausted by appealing health insurance administrators' adverse determination before commencing suit against the administrator. Burley v. Prudential Ins. Co. of America, 251 N.J.Super. 493, 598 A.2d 936 (A.D.1991).

17:9-1.4 (Reserved)

As amended, R.1971 d.21, effective February 17, 1971.

See: 3 N.J.R. 10(a), 3 N.J.R. 52(c).

As amended, R.1979 d.159, effective April 23, 1979.

See: 11 N.J.R. 94(d), 11 N.J.R. 304(c).

As amended, R.1983 d.44, effective March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

This section formerly contained rules on local employer premium and interest.

17:9-1.5 Voluntary termination of employer; notice

(a) A resolution furnished by the Division of Pensions must be completed by employers who wish to voluntarily terminate their participation in the program.

(b) For purposes of local coverage, when a participating employer voluntarily terminates coverage, the coverage for the employer's active and retired employees shall terminate as of the first of the month following a 60-day period beginning with the receipt of the resolution by the Health Benefits Commission. The Commission may, from time to time, establish a re-entry application period not to exceed 30 days for those employers who have terminated coverage. During this period, an employer who has terminated coverage only once may submit a resolution for automatic re-entry. The re-entry shall be effective upon a date set by the Commission which date shall be not less than 60 days nor more than 365 days following the receipt of the resolution for re-entry. Automatic re-entry into the program will be permitted only once.

1. An employer who has terminated coverage more than once may submit a resolution for re-entry during the re-entry application period. The Commission shall con-

sider the relevant facts accompanying the resolution, including any hardship or emergency, the impact of re-entry on the program and individual members, and whether re-entry is consistent with statutory law or judicial determinations. The Commission shall approve or disapprove the resolution for re-entry and shall so notify the employer within 30 days following receipt of the resolution. If the Commission approves the re-entry, the re-entry shall be effective upon a date determined by the Commission, which date shall be not less than 60 days nor more than 365 days following the Commission's approval. The re-entry shall be contingent upon the employer's reimbursement to the Commission of administrative expenses reasonably based upon the approximate cost to the Commission of re-enrolling the employer.

(c) The employer shall notify all active employees of the date their coverage in the program has terminated.

(d) The Division of Pensions shall act to notify all retired employees or survivors of the termination of coverage and to send a list of the names and addresses to the terminating employer for his or her information, upon his or her request.

Amended by R.1970 d.147, effective December 10, 1970.

See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).

Amended by R.1976 d.124, effective April 22, 1976.

See: 8 N.J.R. 85(c), 8 N.J.R. 263(a).

Amended by R.1983 d.332, effective August 15, 1983.

See: 15 N.J.R. 793(a), 15 N.J.R. 1383(d).

List of names and addresses to be sent to terminating employer upon request.

Amended by R.1985 d.587, effective November 18, 1985.

See: 17 N.J.R. 1399(a), 17 N.J.R. 2784(b).

(b): Added text "for a period . . . permitted only once."

Amended by R.1993 d.269, effective June 7, 1993.

See: 25 N.J.R. 460(a), 25 N.J.R. 2505(d).

Case Notes

State Health Benefits Commission cannot compel participants to remain in the State Health Benefits Program by depriving them of information necessary to make an informed decision. Board of Education of Newark v. New Jersey Department of Treasury, Division of Pensions, 145 N.J. 269, 678 A.2d 660 (1996).

17:9-1.6 Default of employer; notice

(a) For purposes of local coverage, a participating employer will be considered in default 31 days after the beginning of the coverage period for which charges were due. At that point, coverage will terminate for all employers and their dependents covered by the employer.

(b) The secretary of the commission will notify the Attorney General's office, the Division of Local Finance, the Department of Education and the carriers. The Division of Pensions will notify every participating employee, active and retired, or survivors, of the termination of coverage.

As amended, R.1970 d.147, effective December 10, 1970.

See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).

As amended, R.1983 d.44, effective March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premiums" was changed to "charges" and the phrase "his" to "his or her".

17:9-1.7 Guidelines; local employers; purchase of contracts

Pursuant to the provisions of N.J.S.A. 52:14-17.25 et seq., it is the policy of the State Health Benefits Commission that when local governments purchase insurance contracts of health benefits, such as prescription drug, dental expense and vision care coverages, such contracts and coverage therein must adhere to the guidelines approved by the State Health Benefits Commission for such contracts or coverages, as such guidelines were transmitted to all public employers by the Division of Pensions. Local governments cannot deviate from such guidelines in purchasing such contracts or coverages without the approval of the State Health Benefits Commission.

As amended, R.1983 d.331, effective August 15, 1983.

See: 15 N.J.R. 884(a), 15 N.J.R. 1383(e).

17:9-1.8 Employer incentives for non-enrollment prohibited

An employer shall not offer a financial enticement of cash or anything else of value to an employee who elects not to enroll or to terminate enrollment in the State Health Benefits Program.

17:9-1.9 Definitions

The following words and terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Act" means the New Jersey State Health Benefits Program Act, P.L. 1961, c.49 (N.J.S.A. 52:14-17.25 et seq.), as amended and supplemented.

"Base salary" means an employee's annual base salary as of the first pay period of the calendar year for Federal and State income taxes.

"Category of coverage" means one of the options used for determining the rates for the premium or periodic charges for different levels of coverage under the program which include single, husband and wife, parent and child, and family coverage, with and without Medicare.

"Commission" means the State Health Benefits Commission created by Section 3 (N.J.S.A. 52:14-17.27) of the Act.

"NJ PLUS" is the name of the State managed care plan as defined in Section 2 (N.J.S.A. 52:14-17.26) of the Act.

"Participating HMO" means a health maintenance organization duly authorized to operate in the State which is under contract with the Commission to participate in the program.

As amended, R.1983 d.44, eff. March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premiums" was changed to "charges".

Case Notes

Statute calls for uniformity in coverage to all eligible employees with respect to contracts made on prospective basis. *Weiner v. County of Essex*, 262 N.J.Super. 270, 620 A.2d 1071 (L.1992).

County, which was successor to county welfare board, was collaterally estopped from asserting defenses that it did not specifically assume obligation to pay postretirement medical benefits. *Weiner v. County of Essex*, 262 N.J.Super. 270, 620 A.2d 1071 (L.1992).

Requirement of paragraph (a)1 held valid as reasonable and necessary for the administration of the Health Benefits Program Act; denial of implementation of negotiated health benefits plan by Commission upheld due to discrimination between eligible employees. *New Jersey Policemen's Benevolent Ass'n Local # 42 v. New Jersey State Health Benefits Commission*, 153 N.J.Super. 152, 379 A.2d 285 (App.Div. 1977).

17:9-5.6 Health maintenance organization charges

For purposes of State and local coverage, the employer who pays any portion of the cost for the employee and for dependent coverage cannot pay any more for the same type of coverage if the employee enrolls himself or herself and his or her dependents in a health maintenance organization as an alternative program. If the cost of the coverage in the alternative plan exceeds the cost of the State program, the additional charge would be collected by payroll deductions from the employee.

Amended by R.1974 d.228, eff. August 19, 1974.

See: 6 N.J.R. 156(a), 6 N.J.R. 360(c).

Amended by R.1983 d.44, eff. March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premiums" was changed to "charges" and "his" to "his or her".

Administrative Correction.

See: 24 N.J.R. 4068(b).

17:9-5.7 State and local; multiple coverage refunds

In the case of State and local coverage, when a husband and wife have secured coverage in the health benefits program as a result of one of them being employed by the State and the other by a local employer who has adopted the program, a refund is possible in the case of an employee of a local employer who is paying the full cost of dependent coverage for a spouse, who is an employee of the State and eligible for coverage but who has rejected such coverage.

Amended by R.1973 d.8, eff. January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).

17:9-5.8 Medicare refunds

(a) Each active employee, as well as the employee's spouse, who is covered under Part B of the Federal Medicare program, shall receive a refund of the amount paid for Part B semiannually.

(b) All refunds for subgroups of the State are accomplished with the preparation and submission to the Health Benefits Bureau of a claim for refund form duly signed by the employee claiming the refund as verified from the records of the program.

(c) The State centralized payroll unit will process similar claims for refund by State employees paid by that agency.

(d) The local employer is responsible for refunds to any of his or her active employees, as well as the employee's spouse, who are covered under Part B of the Federal Medicare Program.

(e) All refunds will be made payable to the active or retired employee constituting the most timely charge payment for Part B coverage.

(f) Similar reimbursement will be made by the State and local employers, who have adopted the necessary resolution, to eligible retired employees for himself or herself and the retired employee's spouse, but in no event shall duplicate refunds be made to any employee for himself or herself or his or her spouse.

(g) Since Medicare premiums reimbursements are dependent upon sufficient, annual appropriations from the legislature, eligible reimbursements regarding Medicare Part B premiums will include only those premiums that have been paid within the 12 months immediately preceding the date of submission for the appropriate claim for refund form by the employee. Medicare Part B premiums paid prior to the 12 months immediately preceding the date of submission of the appropriate claim for refund form are not eligible for reimbursement.

Amended by R.1973 d.285, eff. October 2, 1973.
See: 5 N.J.R. 243(a), 5 N.J.R. 393(a).
Amended by R.1978 d.442, eff. December 26, 1978.
See: 10 N.J.R. 456(a), 11 N.J.R. 105(b).
Amended by R.1981 d.139, eff. June 4, 1981.

See: 13 N.J.R. 110(c), 13 N.J.R. 376(c).
(g) added.

Amended by R.1983 d.44, eff. March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premium" was changed to "charges" and "his" to "his or her".

Case Notes

County, which was successor to county welfare board, was collaterally estopped from asserting defenses that it did not specifically assume obligation to pay postretirement medical benefits. *Weiner v. County of Essex*, 262 N.J.Super. 270, 620 A.2d 1071 (L.1992).

Statute calls for uniformity in coverage to all eligible employees with respect to contracts made on prospective basis. *Weiner v. County of Essex*, 262 N.J.Super. 270, 620 A.2d 1071 (L.1992).

17:9-5.9 Refunds rejected

Any request for refund not specified in N.J.A.C. 17:9-5.7 and 5.8 shall be denied. For example, a husband and wife may be employed in the same or in different locations, each location participating in the State Health Benefits Program and both having family coverage, or both having husband and wife coverage; in spite of the apparent duplication of coverage, neither of the covered employees would be eligible for a refund. Or, the wife carries only single employee coverage under the State program while her husband is covered by a plan in private industry where the employer pays for employee and dependent coverage; no refund would be payable since both would have to have been in public employment covered by the State program. Or, if one spouse applies for Medicare reimbursement for himself or herself and his or her spouse, the other shall not receive duplicate reimbursement.

Amended by R.1973 d.8, eff. January 4, 1973.

See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).

Amended by R.1976 d.313, eff. October 8, 1976.

See: 8 N.J.R. 443(c), 8 N.J.R. 539(a).

Case Notes

County was not entitled to a refund of health care benefit premiums erroneously paid on behalf of terminated employees or employees who were eligible for lower premiums. *Essex County v. State Health Benefits Commission*, 93 N.J.A.R.2d (TYP) 317.

17:9-5.10 Retroactive charges; payment due

Retroactive charges covering the entire period of retroactivity will be calculated on the basis of the charge in effect on the date the employee is actually enrolled.

R.1975 d.159, eff. June 9, 1975.

See: 7 N.J.R. 118(e), 7 N.J.R. 349(b).

As amended, R.1983 d.44, eff. March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

"premiums" was changed to "charges".

17:9-5.11 Charges and coverage; 10-month employees

(a) Employees hired as of September 1 under a 10-month contract shall have charges deducted from the wages they received in September to establish their coverage as of the beginning date of their employment. In order to

continue a 10-month employee's coverage during the months of July and August, sufficient charges will be deducted prior to the expiration of their 10-month contract to continue their coverage during the heretofore mentioned months, provided their employment resumes in September.

(b) Regarding 10-month contract State employees paid on a biweekly basis, the effective date of coverage for September enrollments will be the period which is the one nearest September 1.

(c) A 10-month employee whose employment resumes in September may enroll eligible dependents within 60 days of the qualifying event. Should any part of the 60-day period occur during July and August, that period will be extended day for day up to 60 days after the employee resumes work in September.

R.1978 d.131, eff. April 18, 1978.

See: 10 N.J.R. 80(b), 10 N.J.R. 265(b).

As amended, R.1982 d.341, eff. October 18, 1982.

See: 14 N.J.R. 36(a), 14 N.J.R. 1165(a).

Clarified coverage of biweekly cases of 10-month employees.

As amended, R.1983 d.330, eff. August 15, 1983.

See: 15 N.J.R. 792(b), 15 N.J.R. 1383(c).

The word "premiums" replaced by "charges".

Amended by R.1989 d.335, effective July 3, 1989.

See: 21 N.J.R. 886(a), 21 N.J.R. 1836(a).

Provisions governing coverages and charges for 10-month employees added at (c).

17:9-5.12 Premium-sharing for Traditional Plan coverage

(a) All State employees for whom there is no majority representative for collective negotiations purposes shall be subject to payroll deductions for Traditional Plan coverage in advance of the coverage period in accordance with standard payroll procedures as set forth in this section.

(b) For employees hired before December 11, 1995, payroll deductions for Traditional Plan coverage shall be determined as follows:

1. Effective with the coverage period commencing on July 1, 1996 for State monthly sub-groups, and July 6, 1996 for State bi-weekly sub-groups, employees with a base salary of \$50,000 or more shall pay the difference between the cost of the Traditional Plan and the average cost to the State for NJ PLUS and participating HMOs as determined hereinafter. Employees with a base salary of less than \$50,000 shall pay, on a monthly basis, one percent of base salary but not less than \$20.00 per month.

2. Effective with the coverage period commencing on July 1, 1997 for State monthly sub-groups, and the first day of the bi-weekly coverage period closest to July 1, 1997 for State bi-weekly sub-groups, employees with a base salary of \$40,000 or more shall pay the difference between the cost of the Traditional Plan and the average cost to the State for NJ PLUS and participating HMOs as determined hereinafter. Employees with a base salary of less than \$40,000 shall pay, on a monthly basis, one percent of base salary but not less than \$20.00 per month.

(c) Employees hired on or after December 11, 1995 shall pay the difference between the cost of the Traditional Plan and the average cost to the State for NJ PLUS and participating HMOs as determined hereinafter, effective with the coverage period commencing on July 1, 1996 for State monthly sub-groups, and July 6, 1996 for State bi-weekly sub-groups.

(d) The average cost to the State 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 employees 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 employees 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 employees who elected the category of coverage determined under (d)2 above by the total number of employees who elected the category of coverage at the beginning of the immediately preceding rate time period for NJ PLUS and the participating HMOs.

New Rule, R.1996 d.298, effective June 17, 1996.

See: 28 N.J.R. 1944(a), 28 N.J.R. 3171(a).

SUBCHAPTER 6. RETIREMENT

17:9-6.1 Retired employee defined

(a) "Retired employee" means a person who is eligible for coverage under the program, or under the health insurance plan of the person's employer where the employer is not participating in the program and the person is eligible to participate under P.L. 1987, c.384, immediately preceding retirement and receives a periodic retirement allowance from a State or locally administered retirement system or plan upon retirement. This "retired employee" status, once established, will continue in effect even though the employer is subsequently disbanded and no successor agency is created upon the dissolution of such employer. An employee who continued his or her coverage while on an official leave of absence for illness without pay but whose coverage terminated when his or her leave exceeded the period established by the statute for the continuation of coverage for such leave, will be permitted to elect to continue health benefits coverage into retirement provided such leave was in effect immediately preceding the date of his or her retirement.

As amended, R.1983 d.44, eff. March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premium" was changed to "charge" and "his" to "his or her".

17:9-6.6 Beneficiary, dependent or survivor

(a) An eligible beneficiary or survivor will have their coverage discontinued upon the death of the retirant but will be given the opportunity to continue coverage on a prospective basis only, once they have filed proper applications for pensions. Coverage may be made retroactive for as much as six months provided the necessary charges are paid. Any request for retroactive coverage in excess of six months shall be submitted to the secretary.

(b) An eligible dependent, who is not the recipient of any monthly retirement benefit from a State-administered retirement system upon the death of the retired member, will be offered the opportunity to continue participation in the State Health Benefits Program subsequent to the death of the retired member. The coverage will be no greater than the coverage that was in effect at the time of the retired member's death and will be limited to only those dependents covered at the time of the member's death. The Division of Pensions will bill the appropriate dependent at the group rate then in effect for such coverage on a quarterly calendar basis.

R.1976 d.313, eff. October 8, 1976.

See: 8 N.J.R. 443(a), 8 N.J.R. 539(a).

As amended, R.1983 d.44, eff. March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premium" was changed to "charge".

Amended by R.1986 d.424, effective October 20, 1986.

See: 18 N.J.R. 1452(a), 18 N.J.R. 2135(d).

(b) added.

17:9-6.7 Coverage for PFRS and SPRS accidental death benefit recipients

(a) For the purposes of this section, "eligible person" means the widow or widower and child, as defined in N.J.S.A. 43:16A-1, of a member of the Police and Firemen's Retirement System, to or for whom an accidental death benefit is payable under N.J.S.A. 43:16A-10, and the surviving spouse and child, as defined in N.J.S.A. 53:5A-3, of a member of the State Police Retirement System, to or for whom an accidental death benefit is payable under N.J.S.A. 53:5A-14.

(b) An eligible person may participate in the State Health Benefits Program regardless of whether the member's employer is a participating employer. The premiums for the coverage shall be paid by the State of New Jersey, as provided in P.L. 1989, c.271.

(c) Persons eligible to participate in the program under this section shall participate in the retiree group. If there is a widow or widower, or surviving spouse, eligible children shall participate as dependents of the widow or widower, or surviving spouse. If there is no widow or widower, or surviving spouse, eligible children shall participate as mem-

bers of the program, and their eligibility to participate shall continue as long as they qualify as children under the laws governing the retirement system of the deceased member.

(d) An eligible person, as defined in (a) above, shall be eligible for coverage under the program as of February 1, 1990, or the effective date for an accidental death benefit under the retirement system of the deceased member, whichever is later. An eligible person shall receive a refund for premiums paid for health insurance coverage comparable to that provided under the program for the period from the date of eligibility for coverage under this section and the effective date of enrollment, but the refund shall not exceed the cost of the coverage under the program. An eligible person who is covered under Part B of the Federal Medicare program shall receive a refund for the amount paid for Part B. While an application for an accidental death benefit is pending, an eligible person enrolled in the program may continue coverage on a direct payment basis. If an accidental death benefit is granted, the eligible person shall receive a refund of the payments made.

New Rule, R.1990 d.481, effective October 1, 1990.

See: 22 N.J.R. 1903(b), 22 N.J.R. 3158(c).

17:9-6.8 Premium-sharing for Traditional Plan coverage

(a) All State employees who accrue 25 years of service credit in a State-administered retirement system or retire on disability retirement after July 1, 1997, for whom there is no majority representative for collective negotiations purposes, shall, upon retirement, receive Medicare Part B reimbursement after retirement up to a cap of \$46.10 per month per eligible employee and the employee's spouse and be subject to payroll deductions for Traditional Plan coverage in advance of the coverage period in accordance with standard payroll procedures as set forth below.

(b) For employees hired before December 11, 1995, who accrue 25 years of service credit in a State-administered retirement system or retire on disability retirement after July 1, 1997, payroll deductions upon retirement for Traditional Plan coverage shall be determined as follows:

1. Upon retirement, retirees with a base salary of \$40,000 or more in the year of retirement shall pay the difference between the cost of the Traditional Plan and the average cost for NJ PLUS and participating HMOs as determined hereinafter.

2. Upon retirement, retirees with a base salary of less than \$40,000 in the year of retirement shall pay, on a monthly basis, one percent of the base salary but not less than \$20.00 per month.

(c) Employees hired on or after December 11, 1995, who accrue 25 years of service credit in a State-administered retirement system or retire on disability retirement after July 1, 1997, shall upon retirement pay the difference between the cost of the Traditional Plan and the average cost

for NJ PLUS and participating HMOs as determined hereinafter.

(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.

New Rule, R.1998 d.265, effective June 1, 1998.
See: 30 N.J.R. 803(a), 30 N.J.R. 2070(a).

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 CPFPF; 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) or a position 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, CPFPF, 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).

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).