

[Fourth Reprint]

## **ASSEMBLY, No. 3359**

# **STATE OF NEW JERSEY**

## **211th LEGISLATURE**

INTRODUCED OCTOBER 7, 2004

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**SYNOPSIS**

The "Health Insurance Affordability and Accessibility Reform Act."

**CURRENT VERSION OF TEXT**

As reported by the Senate Commerce Committee on December 12, 2005, with amendments.

(Sponsorship Updated As Of: 1/06/2006)

1 AN ACT concerning individual and small employer health benefits  
2 plans and revising parts of the statutory law.

3  
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*  
5 *of New Jersey:*

6  
7 1. (New section) This act shall be known and may be cited as the  
8 "Health Insurance Affordability and Accessibility Reform Act."

9  
10 2. Section 1 of P.L.1992, c.161 (C.17B:27A-2) is amended to read  
11 as follows:

12 1. As used in sections 1 through 15, inclusive, of this act:

13 "Board" means the board of directors of the program.

14 "Carrier" means any entity subject to the insurance laws and  
15 regulations of this State, or subject to the jurisdiction of the  
16 commissioner, that contracts or offers to contract to provide, deliver,  
17 arrange for, pay for, or reimburse any of the costs of health care  
18 services, including a sickness and accident insurance company, a health  
19 maintenance organization, a nonprofit hospital or health service  
20 corporation, or any other entity providing a plan of health insurance,  
21 health benefits or health services. For purposes of this act, carriers  
22 that are affiliated companies shall be treated as one carrier.

23 "Church plan" has the same meaning given that term under Title I,  
24 section 3 of Pub.L.93-406, the "Employee Retirement Income Security  
25 Act of 1974" (29 U.S.C. s.1002(33)).

26 "Commissioner" means the Commissioner of Banking and  
27 Insurance.

28 "Community rating" means <sup>4</sup>[:

29 (1) with respect to health benefits plans delivered, issued, executed  
30 or renewed prior to the effective date of P.L. , c. (C. ) (now  
31 before the Legislature as this bill) and renewed on or after that  
32 effective date, <sup>2</sup>and with respect to health benefits plans delivered,  
33 issued or executed on or after the effective date of P.L. , c. (C. )  
34 (now before the Legislature as this bill) to an individual described in  
35 paragraph (3) of subsection a. of section 2 of P.L.1992, c.161  
36 (C.17B:27A-3) and subsequently renewed, <sup>2</sup>]<sup>4</sup> a rating system in which  
37 the premium for all persons covered <sup>4</sup>[by] under<sup>4</sup> a contract <sup>4</sup>for a  
38 specific health benefits plan and a specific date of issue of that plan<sup>4</sup>  
39 is the same <sup>4</sup>[, based on the experience of all persons covered by that

**EXPLANATION** - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

<sup>1</sup> Assembly AFI committee amendments adopted May 2, 2005.

<sup>2</sup> Assembly floor amendments adopted May 16, 2005.

<sup>3</sup> Assembly floor amendments adopted June 20, 2005.

<sup>4</sup> Senate SCM committee amendments adopted December 12, 2005.

1 contract,]<sup>4</sup> without regard to <sup>4</sup>[age,]<sup>4</sup> sex, health status, occupation  
2 <sup>4</sup>[and] <sup>4</sup>geographical location <sup>4</sup>[; and

3 (2) with respect to health benefits plans delivered, issued, or  
4 executed on or after the effective date of P.L. , c. (C. )(now  
5 before the Legislature as this bill) and subsequently renewed on or  
6 after that effective date, a rating system in which the premium rate  
7 charged by a carrier to the highest rated plan shall not be greater than  
8 200% of the premium rate charged for the lowest rated plan; provided,  
9 however, that the only factors upon which the rate differential may be  
10 based are age, gender and geography; and provided further, that such  
11 factors are applied in a manner consistent with regulations  
12 promulgated and adopted by the commissioner. In developing the  
13 rating factor for geography, carriers may use counties as the smallest  
14 permissible rating territory. The commissioner shall prescribe through  
15 regulation age classifications which, at a minimum, shall be in five-year  
16 increments] or any other factor or characteristic of covered persons,  
17 other than age.

18 The rating system shall provide that the premium rate charged by  
19 the carrier for the highest rated individual or class of individuals shall  
20 not be greater than 200% of the premium rate charged for the lowest  
21 rated individual or class of individuals purchasing the same individual  
22 health benefits plan. The rate differential among the premium rate  
23 charged to individuals covered under the same individual health  
24 benefits plans shall be based on the actual or expected experience of  
25 persons covered under that plan; provided, however that the rate  
26 differential may also be based upon age. The factors upon which the  
27 rate differential is applied shall be consistent with regulations  
28 promulgated by the commissioner, which shall include age  
29 classifications established, at a minimum, in five year increments.

30 There may be a reasonable differential among the premium rates  
31 charged for different family structure rating tiers within an individual  
32 health benefits plan or for different health benefits plans offered by the  
33 carrier<sup>4</sup>.

34 "Creditable coverage" means, with respect to an individual,  
35 coverage of the individual under any of the following: a group health  
36 plan; a group or individual health benefits plan; Part A or Part B of  
37 Title XVIII of the federal Social Security Act (42 U.S.C. s.1395 et  
38 seq.); Title XIX of the federal Social Security Act (42 U.S.C. s.1396  
39 et seq.), other than coverage consisting solely of benefits under section  
40 1928 of Title XIX of the federal Social Security Act (42 U.S.C.  
41 s.1396s); Chapter 55 of Title 10, United States Code (10 U.S.C.  
42 s.1071 et seq.); a medical care program of the Indian Health Service  
43 or of a tribal organization; a State health plan offered under chapter 89  
44 of Title 5, United States Code (5 U.S.C. 8901 et seq.); a public health  
45 plan as defined by federal regulation; and a health benefits plan under  
46 section 5(e) of the "Peace Corps Act" (22 U.S.C. s.2504(e)); or

1 coverage under any other type of plan as set forth by the commissioner  
2 by regulation.

3 Creditable coverage shall not include coverage consisting solely of  
4 the following: coverage only for accident or disability income  
5 insurance, or any combination thereof; coverage issued as a  
6 supplement to liability insurance; liability insurance, including general  
7 liability insurance and automobile liability insurance; workers'  
8 compensation or similar insurance; automobile medical payment  
9 insurance; credit only insurance; coverage for on-site medical clinics;  
10 coverage, as specified in federal regulation, under which benefits for  
11 medical care are secondary or incidental to the insurance benefits; and  
12 other coverage expressly excluded from the definition of health  
13 benefits plan.

14 "Department" means the Department of Banking and Insurance.

15 "Dependent" means the spouse <sup>4</sup>, domestic partner as provided in  
16 P.L.2003, c.246 (C.26:8A-1 et seq.),<sup>4</sup> or child of an eligible person,  
17 subject to applicable terms of the individual health benefits plan.

18 "Eligible person" means a person who is a resident who is not  
19 eligible to be covered under a group health benefits plan, group health  
20 plan, governmental plan, church plan, or Part A or Part B of Title  
21 XVIII of the Social Security Act (42 U.S.C. s.1395 et seq.).

22 "Federally defined eligible individual" means an eligible person: (1)  
23 for whom, as of the date on which the individual seeks coverage under  
24 P.L.1992, c.161 (C.17B:27A-2 et seq.), the aggregate of the periods  
25 of creditable coverage is 18 or more months; (2) whose most recent  
26 prior creditable coverage was under a group health plan, governmental  
27 plan, church plan, or health insurance coverage offered in connection  
28 with any such plan; (3) who is not eligible for coverage under a group  
29 health plan, Part A or Part B of Title XVIII of the Social Security Act  
30 (42 U.S.C. s.1395 et seq.), or a State plan under Title XIX of the  
31 Social Security Act (42 U.S.C. s.1396 et seq.) or any successor  
32 program, and who does not have another health benefits plan, or  
33 hospital or medical service plan; (4) with respect to whom the most  
34 recent coverage within the period of aggregate creditable coverage  
35 was not terminated based on a factor relating to nonpayment of  
36 premiums or fraud; (5) who, if offered the option of continuation  
37 coverage under the COBRA continuation provision or a similar State  
38 program, elected that coverage; and (6) who has elected continuation  
39 coverage described in (5) above and has exhausted that continuation  
40 coverage.

41 "Financially impaired" means a carrier which, after the effective  
42 date of this act, is not insolvent, but is deemed by the commissioner to  
43 be potentially unable to fulfill its contractual obligations, or a carrier  
44 which is placed under an order of rehabilitation or conservation by a  
45 court of competent jurisdiction.

46 "Governmental plan" has the meaning given that term under Title

1 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
2 Security Act of 1974" (29 U.S.C. s.1002(32)) and any governmental  
3 plan established or maintained for its employees by the Government of  
4 the United States or by any agency or instrumentality of that  
5 government.

6 "Group health benefits plan" means a health benefits plan for groups  
7 of two or more persons.

8 "Group health plan" means an employee welfare benefit plan, as  
9 defined in Title I, section 3 of Pub.L.93-406, the "Employee  
10 Retirement Income Security Act of 1974" (29 U.S.C. s.1002(1)), to  
11 the extent that the plan provides medical care, and including items and  
12 services paid for as medical care to employees or their dependents  
13 directly or through insurance, reimbursement, or otherwise.

14 "Health benefits plan" means a hospital and medical expense  
15 insurance policy; health service corporation contract; hospital service  
16 corporation contract; medical service corporation contract; health  
17 maintenance organization subscriber contract; or other plan for  
18 medical care delivered or issued for delivery in this State. For  
19 purposes of this act, health benefits plan shall not include one or more,  
20 or any combination of, the following: coverage only for accident, or  
21 disability income insurance, or any combination thereof; coverage  
22 issued as a supplement to liability insurance; liability insurance,  
23 including general liability insurance and automobile liability insurance;  
24 stop loss or excess risk insurance; workers' compensation or similar  
25 insurance; automobile medical payment insurance; credit-only  
26 insurance; coverage for on-site medical clinics; and other similar  
27 insurance coverage, as specified in federal regulations, under which  
28 benefits for medical care are secondary or incidental to other insurance  
29 benefits. Health benefits plans shall not include the following benefits  
30 if they are provided under a separate policy, certificate or contract of  
31 insurance or are otherwise not an integral part of the plan: limited  
32 scope dental or vision benefits; benefits for long-term care, nursing  
33 home care, home health care, community-based care, or any  
34 combination thereof; and such other similar, limited benefits as are  
35 specified in federal regulations. Health benefits plan shall not include  
36 hospital confinement indemnity coverage if the benefits are provided  
37 under a separate policy, certificate or contract of insurance, there is no  
38 coordination between the provision of the benefits and any exclusion  
39 of benefits under any group health benefits plan maintained by the  
40 same plan sponsor, and those benefits are paid with respect to an event  
41 without regard to whether benefits are provided with respect to such  
42 an event under any group health plan maintained by the same plan  
43 sponsor. Health benefits plan shall not include the following if it is  
44 offered as a separate policy, certificate or contract of insurance:  
45 Medicare supplemental health insurance as defined under section  
46 1882(g)(1) of the federal Social Security Act (42 U.S.C.

1 s.1395ss(g)(1)); and coverage supplemental to the coverage provided  
2 under chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et  
3 seq.); and similar supplemental coverage provided to coverage under  
4 a group health plan.

5 "Health status-related factor" means any of the following factors:  
6 health status; medical condition, including both physical and mental  
7 illness; claims experience; receipt of health care; medical history;  
8 genetic information; evidence of insurability, including conditions  
9 arising out of acts of domestic violence; and disability.

10 "Individual health benefits plan" means: a. a health benefits plan for  
11 eligible persons and their dependents; and b. a certificate issued to an  
12 eligible person which evidences coverage under a policy or contract  
13 issued to a trust or association, regardless of the situs of delivery of  
14 the policy or contract, if the eligible person pays the premium and is  
15 not being covered under the policy or contract pursuant to  
16 continuation of benefits provisions applicable under federal or State  
17 law.

18 Individual health benefits plan shall not include a certificate issued  
19 under a policy or contract issued to a trust, or to the trustees of a  
20 fund, which trust or fund is an employee welfare benefit plan, to the  
21 extent the "Employee Retirement Income Security Act of 1974" (29  
22 U.S.C. s.1001 et seq.) preempts the application of P.L.1992, c.161  
23 (C.17B:27A-2 et seq.) to that plan.

24 "Medicaid" means the Medicaid program established pursuant to  
25 P.L.1968, c.413 (C.30:4D-1 et seq.).

26 "Medical care" means amounts paid: (1) for the diagnosis, care,  
27 mitigation, treatment, or prevention of disease, or for the purpose of  
28 affecting any structure or function of the body; and (2) transportation  
29 primarily for and essential to medical care referred to in (1) above.

30 "Member" means a carrier that issues or has in force health benefits  
31 plans in New Jersey. Member shall not include a carrier whose  
32 combined average Medicare, Medicaid, NJ FamilyCare and NJ  
33 KidCare enrollment represents more than 75% of its average total  
34 enrollment for all health benefits plans or whose combined Medicare,  
35 Medicaid, NJ FamilyCare and NJ KidCare net earned premium for the  
36 two-year calculation period represents more than 75% of its total net  
37 earned premium for the two-year calculation period.

38 ["Modified community rating" means a rating system in which the  
39 premium for all persons covered by a contract is formulated based on  
40 the experience of all persons covered by that contract, without regard  
41 to age, sex, occupation and geographical location, but which may  
42 differ by health status. The term modified community rating shall  
43 apply to contracts and policies issued prior to the effective date of this  
44 act which are subject to the provisions of subsection e. of section 2 of  
45 this act.]

46 "Net earned premium" means the premiums earned in this State on

1 health benefits plans, less return premiums thereon and dividends paid  
2 or credited to policy or contract holders on the health benefits plan  
3 business. Net earned premium shall include the aggregate premiums  
4 earned on the carrier's insured group and individual business and  
5 health maintenance organization business, including premiums from  
6 any Medicare, Medicaid, NJ FamilyCare or NJ KidCare contracts with  
7 the State or federal government, but shall not include premiums earned  
8 from contracts funded pursuant to the "Federal Employee Health  
9 Benefits Act of 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop  
10 loss insurance coverage issued by a carrier in connection with any self  
11 insured health benefits plan, or Medicare supplement policies or  
12 contracts.

13 "NJ FamilyCare" means the FamilyCare Health Coverage Program  
14 established pursuant to P.L.2000, c.71 (C.30:4J-1 et seq.).

15 "NJ KidCare" means the Children's Health Care Coverage Program  
16 established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.).

17 "Non-group person life year" means coverage of a person for 12  
18 months by an individual health benefits plan or conversion policy or  
19 contract subject to P.L.1992, c.161 (C.17B:27A-2 et seq.), Medicare  
20 cost or risk contract or Medicaid contract.

21 "Open enrollment" means the offering of an individual health  
22 benefits plan to any eligible person on a guaranteed issue basis,  
23 pursuant to procedures established by the board.

24 "Plan of operation" means the plan of operation of the program  
25 adopted by the board pursuant to this act.

26 "Plan sponsor" shall have the meaning given that term under Title  
27 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
28 Security Act of 1974" (29 U.S.C. s.1002(16)(B)).

29 "Preexisting condition" means a condition that, during a specified  
30 period of not more than six months immediately preceding the  
31 effective date of coverage, had manifested itself in such a manner as  
32 would cause an ordinarily prudent person to seek medical advice,  
33 diagnosis, care or treatment, or for which medical advice, diagnosis,  
34 care or treatment was recommended or received as to that condition  
35 or as to a pregnancy existing on the effective date of coverage.

36 "Program" means the New Jersey Individual Health Coverage  
37 Program established pursuant to this act.

38 "Resident" means a person whose primary residence is in New  
39 Jersey and who is present in New Jersey for at least six months of the  
40 calendar year, or, in the case of a person who has moved to New  
41 Jersey less than six months before applying for individual health  
42 coverage, who intends to be present in New Jersey for at least six  
43 months of the calendar year.

44 "Two-year calculation period" means a two calendar year period,

1 the first of which shall begin January 1, 1997 and end December 31,  
2 1998.

3 (cf: PL.2001, c.349, s.1.)

4

5 3. Section 2 of P.L.1992, c.161 (C.17B:27A-3) is amended to read  
6 as follows:

7 2. a. An individual health benefits plan issued <sup>4</sup>or renewed<sup>4</sup> on or  
8 after <sup>4</sup>[August 1, 1993] the effective date of P.L. , c. (C. ) (now  
9 before the Legislature as this bill)<sup>4</sup> shall be subject to the provisions of  
10 [this act] <sup>4</sup>[P.L.1992, c.161 (C.17B:27A-2 et seq.) or P.L. , c.  
11 (C. ) (now before the Legislature as this bill) as provided in this  
12 subsection.

13 (1) An individual health benefits plan issued prior to the effective  
14 date of P.L. , c. (C. ) (now before the Legislature as this bill)  
15 shall be subject to the rating provisions of P.L.1992, c.161  
16 (C.17B:27A-2 et seq.). <sup>2</sup>The rate filed for any plan issued pursuant to  
17 this paragraph (1) shall not exceed by more than 15% the rate filed for  
18 such a plan with an effective date one year earlier.<sup>2</sup>

19 (2) An individual health benefits plan issued on or after the effective  
20 date of P.L. , c. (C. ) (now before the Legislature as this bill)  
21 shall be subject to the rating provisions of P.L.1992, c.161  
22 (C.17B:27A-2 et seq.), as amended by P.L. , c. (C. ) (now  
23 before the Legislature as this bill).

24 <sup>1</sup>(3) Notwithstanding the provisions of paragraphs (1) and (2) of  
25 this subsection, an individual health benefits plan issued on or after the  
26 effective date of P.L. , c. (C. ) (now before the Legislature as  
27 this bill) shall be subject to the rating provisions of P.L.1992, c.161  
28 (C.17B:27A-2 et seq.) if that individual health benefits plan is issued:

29 (a) to an eligible person who was the policy or contract holder  
30 under an individual health benefits plan issued prior to the effective  
31 date of P.L. , c. (C. ) (now before the Legislature as this bill), (i)  
32 if that plan was terminated by the carrier for failure to pay premiums  
33 as provided in paragraph (1) of subsection b. of section 5 of P.L.1992,  
34 c. 161 (C. 17B:27A-6), if that failure to pay premiums was directly  
35 attributable to the loss of employment of the eligible person,<sup>3</sup> [ or]<sup>3</sup>  
36 (ii) if that plan was not renewed by the carrier as provided in  
37 subsection c. of section 5 of P.L. 1992, c. 161 (C. 17B:27A-6) <sup>3</sup>,or  
38 (iii) if the insurer is no longer providing coverage under that plan in  
39 this State due to removal of the insurer from the State <sup>3</sup>; or

40 (b) to an eligible person who was a dependent of a policy or  
41 contract holder and covered under an individual health benefits plan  
42 issued prior to the effective date of P.L. , c. (C. ) (now before  
43 the Legislature as this bill), who is no longer entitled to coverage  
44 under that plan by reason of the death of the policy or contract holder  
45 or the divorce of the policy or contract holder from the spouse.<sup>1</sup>

46 <sup>2</sup>The rate filed for any plan issued pursuant to this paragraph (3)



1 shall not exceed by more than 15% the rate filed for such a plan with  
2 an effective date one year earlier.<sup>2</sup>] this act.

3 For the purposes of this subsection, "renewed" means the earliest  
4 of the annual policy anniversary date, the date rates are changed or the  
5 date that a new individual health benefits plan becomes effective.<sup>4</sup>

6 b. [(1) An individual health benefits plan issued on an open  
7 enrollment, modified community rated basis or community rated basis  
8 prior to August 1, 1993 shall not be subject to sections 3 through 8,  
9 inclusive, of this act, unless otherwise specified therein.

10 (2) An individual health benefits plan issued other than on an open  
11 enrollment basis prior to August 1, 1993 shall not be subject to the  
12 provisions of this act, except that the plan shall be liable for  
13 assessments made pursuant to section 11 of this act.

14 (3) A group conversion contract or policy issued prior to August  
15 1, 1993 that is not issued on a modified community rated basis or  
16 community rated basis, shall not be subject to the provisions of this  
17 act, except that the contract or policy shall be liable for assessments  
18 made pursuant to section 11 of this act.

19 (4) Notwithstanding any other provision of law to the contrary, an  
20 individual health benefits plan issued by a hospital service corporation  
21 or medical service corporation prior to the effective date of P.L.1997,  
22 c.146 (C.17B:27-54 et al.) shall not be subject to the provisions of  
23 P.L.1992, c.161 (C.17B:27A-2 et seq.), except that the plan shall  
24 guarantee renewal pursuant to subsection b. of section 5 of P.L.1992,  
25 c.161 (C.17B:27A-6).

26 (5) Notwithstanding any other provision of law to the contrary, an  
27 individual health benefits plan issued by a hospital service corporation  
28 or medical service corporation to an eligible person or federally  
29 defined eligible individual after the effective date of P.L.1997, c.146  
30 (C.17B:27-54 et al.) shall comply with the provisions of subsections  
31 c. and d. of section 2, subsection b. of section 3, section 5, subsection  
32 b. of section 6, and subsections c., d., and e. of section 8 of P.L.1992,  
33 c.161 (C.17B:27A-3, C.17B:27A-4, 17B:27A-6, 17B:27A-7, and  
34 17B:27A-9), but shall not be subject to the remaining provisions of  
35 P.L.1992, c. 161.] (Deleted by amendment, P.L. \_\_, c. \_\_) <sup>4</sup>(pending  
36 before the Legislature as this bill)<sup>4</sup>.

37 c. [After August 1, 1993, an individual who is eligible to  
38 participate in a group health benefits plan that provides coverage for  
39 hospital or medical expenses shall not be covered by an individual  
40 health benefits plan which provides benefits for hospital and medical  
41 expenses that are the same or similar to coverage provided in the  
42 group health benefits plan, except that an individual who is eligible to  
43 participate in a group health benefits plan but is currently covered by  
44 an individual health benefits plan may continue to be covered by that  
45 plan until the first anniversary date of the group health benefits plan  
46 occurring on or after January 1, 1994.] (Deleted by amendment,

1 P.L. , c. ) <sup>4</sup>(pending before the Legislature as this bill)<sup>4</sup>.

2 d. [Except as otherwise provided in subsection c. of this section,  
3 after August 1, 1993, a person who is covered by an individual health  
4 benefits plan who is a participant in, or is eligible to participate in, a  
5 group health benefits plan that provides the same or similar coverages  
6 as the individual health benefits plan, and a person, including an  
7 employer or insurance producer, who causes another person to be  
8 covered by an individual health benefits plan which person is a  
9 participant in, or who is eligible to participate in a group health  
10 benefits plan that provides the same or similar coverages as the  
11 individual health benefits plan, shall be subject to a fine by the  
12 commissioner in an amount not less than twice the annual premium  
13 paid for the individual health benefits plan, together with any other  
14 penalties permitted by law.] (Deleted by amendment, P.L. , c. )  
15 <sup>4</sup>(pending before this Legislature as this bill)<sup>4</sup>.

16 e. (Deleted by amendment, P.L.1997, c.146).  
17 (cf: P.L.1997, c.146, s.2)

18

19 4. Section 3 of P.L.1992, c.161 (C.17B:27A-4) is amended to read  
20 as follows:

21 3. a. No later than 180 days after the effective date of [this act]  
22 P.L. , c. (C. ) <sup>4</sup>[now] pending<sup>4</sup> before the Legislature as this  
23 bill), a carrier shall, as a condition of issuing <sup>2</sup>[individual] small  
24 employer<sup>2</sup> health benefits plans in this State, also offer [individual]  
25 <sup>2</sup>[small employer] individual<sup>2</sup> health benefits plans. The plans shall be  
26 offered on an open enrollment, community rated basis, pursuant to the  
27 provisions of this act [; except that a carrier shall be deemed to have  
28 satisfied its obligation to provide the individual health benefits plans  
29 by paying an assessment or receiving an exemption pursuant to section  
30 11 of this act].

31 b. A carrier shall offer to an eligible person [a choice of five  
32 individual health benefits plans, any of which may contain provisions  
33 for managed care. One plan shall be a basic health benefits plan, one  
34 plan shall be a managed care plan and three plans shall include  
35 enhanced benefits of proportionally increasing actuarial value] <sup>4</sup>[all  
36 individual health benefits plans that it chooses to actively market in  
37 this State and those plans shall include at least one standard plan  
38 consistent with the type of health benefits plans that it offers. The  
39 board shall develop three standard plans <sup>3</sup>[.] :<sup>3</sup> a health maintenance  
40 organization plan <sup>3</sup>[.] :<sup>3</sup> a point of service plan <sup>3</sup>:<sup>3</sup> and an indemnity  
41 plan. The board shall have the sole authority to make changes to these  
42 standard plans on an annual basis, subject to the approval of those  
43 changes by the commissioner. [A] Except for an individual health  
44 benefits plan issued prior to the effective date of P.L. , c. (C. )  
45 (now before the Legislature as this bill) a carrier may elect to convert

1 any individual contract or policy forms [in force on the effective date  
 2 of this act to any of the five benefit plans, except that the carrier may  
 3 not convert more than 25% of existing contracts or policies each year,  
 4 and] to any of its other marketed plans as long as the replacement plan  
 5 [shall be] is of no less actuarial value than the policy or contract being  
 6 replaced, consistent with the requirements of the federal "Health  
 7 Insurance Portability and Accountability Act of 1996," Pub. L.104-  
 8 191, 110 Stat. 1936, (1996) (HIPAA), subject to the commissioner's  
 9 approval] a choice of individual health benefits plans, as established  
 10 by the board pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7).  
 11 One plan shall be an indemnity health benefits plan. One plan shall be  
 12 a basic health benefits plan, as described in subsection c. of this  
 13 section<sup>4</sup>.

14 [Notwithstanding the provisions of this subsection to the contrary,  
 15 at any time after three years after the effective date of this act, the  
 16 board, by regulation, may reduce the number of plans required to be  
 17 offered by a carrier.

18 Notwithstanding the provisions of this subsection to the contrary,  
 19 a health maintenance organization which is a qualified health  
 20 maintenance organization pursuant to the "Health Maintenance  
 21 Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.)  
 22 shall be permitted to offer a basic health benefits plan in accordance  
 23 with the provisions of that law in lieu of the five plans required  
 24 pursuant to this subsection.]

25 c. (1) [A basic health benefits plan shall provide the benefits set  
 26 forth in section 55 of P.L.1991, c.187 (C:17:48E-22.2), section 57 of  
 27 P.L.1991, c.187 (C.17B:26B-2) or section 59 of P.L.1991, c.187  
 28 (C.26:2J-4.3), as the case may be.] <sup>4</sup>[(Deleted by amendment, P.L. ,  
 29 c. ).] A basic health benefits plan shall provide the benefits set forth  
 30 in section 55 of P.L.1991, c.187 (C:17:48E-22.2), section 57 of  
 31 P.L.1991, c.187 (C.17B:26B-2) or section 59 of P.L.1991, c.187  
 32 (C.26:2J-4.3), as the case may be.<sup>4</sup>

33 (2) [Notwithstanding the provisions of this subsection or any other  
 34 law to the contrary, a carrier may, with the approval of the board,  
 35 modify the coverage provided for in sections 55, 57, and 59 of  
 36 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3,  
 37 respectively) or provide alternative benefits or services from those  
 38 required by this subsection if they are within the intent of this act or  
 39 if the board changes the benefits included in the basic health benefits  
 40 plan.] <sup>4</sup>[(Deleted by amendment, P.L. , c. ).] Notwithstanding  
 41 the provisions of this subsection or any other law to the contrary, a  
 42 carrier may, with the approval of the board, modify the coverage  
 43 provided for in sections 55, 57, and 59 of P.L.1991, c.187  
 44 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3, respectively) or provide  
 45 alternative benefits or services from those required by this subsection

1 if they are within the intent of this act or if the board changes the  
2 benefits included in the basic health benefits plan.<sup>4</sup>

3 (3) [A contract or policy for a basic health benefits plan provided  
4 for in this section may contain or provide for coinsurance or  
5 deductibles, or both, except that no deductible shall be payable in  
6 excess of a total of \$250 by an individual or \$500 by a family unit  
7 during any benefit year; and no coinsurance shall be payable in excess  
8 of a total of \$500 by an individual or by a family unit during any  
9 benefit year.] <sup>4</sup>[(Deleted by amendment, P.L. , c. ).] A contract  
10 or policy for a basic health benefits plan provided for in this section  
11 may contain or provide for coinsurance or deductibles, or both, except  
12 that no deductible shall be payable in excess of a total of \$250 by an  
13 individual or \$500 by a family unit during any benefit year; and no  
14 coinsurance shall be payable in excess of a total of \$500 by an  
15 individual or by a family unit during any benefit year.<sup>4</sup>

16 (4) [Notwithstanding the provisions of paragraph (3) of this  
17 subsection or any other law to the contrary, a carrier may provide for  
18 increased deductibles or coinsurance for a basic health benefits plan if  
19 approved by the board or if the board increases deductibles or  
20 coinsurance included in the basic health benefits plan.] <sup>4</sup>[(Deleted by  
21 amendment, P.L. , c. ).] Notwithstanding the provisions of  
22 paragraph (3) of this subsection or any other law to the contrary, a  
23 carrier may provide for increased deductibles or coinsurance for a  
24 basic health benefits plan if approved by the board or if the board  
25 increases deductibles or coinsurance included in the basic health  
26 benefits plan.<sup>4</sup>

27 (5) [The provisions of section 13 of P.L.1985, c.236  
28 (C.17:48E-13), N.J.S.17B:26-1, and section 8 of P.L.1973, c.337  
29 (C.26:2J-8) with respect to the filing of policy forms shall not apply to  
30 health plans issued on or after the effective date of this act.]  
31 <sup>4</sup>[(Deleted by amendment, P.L. , c. ).] The provisions of section  
32 13 of P.L.1985, c.236 (C.17:48E-13), N.J.S.17B:26-1, and section 8  
33 of P.L.1973, c.337 (C.26:2J-8) with respect to the filing of policy  
34 forms shall not apply to health plans issued on or after the effective  
35 date of this act.<sup>4</sup>

36 (6) The provisions of section 27 of P.L.1985, c.236 (C.17:48E-27)  
37 and section 7 of P.L.1988, c.71 (C.17:48E-27.1) with respect to rate  
38 filings shall not apply to individual health plans issued on or after the  
39 effective date of this act.

40 d. Every group conversion contract or policy issued after the  
41 effective date of this act shall be issued pursuant to this section; except  
42 that this requirement shall not apply to any group conversion contract  
43 or policy in which a portion of the premium is chargeable to, or  
44 subsidized by, the group policy from which the conversion is made.

45 e. [If all five of the individual health benefits plans are not

1 established by the board by the effective date of P.L.1993, c.164  
2 (C.17B:27A-16.1 et al.), a carrier may phase-in the offering of the five  
3 health benefits plans by offering each health benefits plan as it is  
4 established by the board; however, once the board establishes all five  
5 plans, the carrier shall be required to offer the five plans in accordance  
6 with the provisions of P.L.1992, c.161 (C.17B:27A-2 et al.).]  
7 (Deleted by amendment, P.L. , c. ) <sup>4</sup>(pending before the  
8 Legislature as this bill).

9 f. Carriers may offer enhanced or additional benefits to the  
10 standard plans for an additional premium amount in the form of a rider  
11 or riders, each of which shall be comprised of a combination of  
12 enhanced or additional benefits, in a manner which will avoid adverse  
13 selection to the extent possible.<sup>4</sup>

14 (cf: P.L.1994, c.102, s.1)

15  
16 <sup>2</sup>[<sup>15</sup>. Section 2 of P.L.2001, c.368 (C.17B:27A-4.5) is amended to  
17 read as follows:

18 2. a. Notwithstanding the provisions of P.L.1992, c.161  
19 (C.17B:27A-2 et seq.), every carrier that writes individual health  
20 benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits  
21 plan in the individual health insurance market that includes only the  
22 coverages enumerated in this section, as follows:

23 90 days hospital room and board - \$500 copayment per hospital stay;  
24 Outpatient and ambulatory surgery- \$250 copayment per surgery;  
25 Physicians' fees connected with hospital care, including general acute  
26 care and surgery;

27 Physicians' fees connected with outpatient and ambulatory surgery;  
28 Anesthesia and the administration of anesthesia;

29 Coverage for newborns;

30 Treatment for complications of pregnancy;

31 Intravenous solutions, blood and blood plasma;

32 Oxygen and the administration of oxygen;

33 Radiation and x-ray therapy;

34 Inpatient physical therapy and hydrotherapy;

35 Outpatient physical therapy - 30 visits annually per covered person-  
36 \$20 copayment per treatment;

37 Dialysis - inpatient or outpatient;

38 Inpatient diagnostic tests and \$500 annual aggregate per covered  
39 person for out-of-hospital diagnostic tests;

40 Laboratory fees for treatment in hospital;

41 Delivery room fees;

42 Operating room fees;

43 Special care unit;

44 Treatment room fees;

45 Emergency room services for medically necessary treatment - \$100  
46 copayment per visit;

- 1   Pharmaceuticals dispensed in hospital;  
2   Dressings;  
3   Splints;  
4   Treatment for biologically-based mental illness, as defined in  
5   subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90  
6   days inpatient with no coinsurance - \$500 copayment per inpatient  
7   stay, 30 days outpatient with 30% coinsurance;  
8   Alcohol and Substance Abuse Treatment - 30 days inpatient or  
9   outpatient - 30% coinsurance;  
10   Childhood immunizations in accordance with the provisions of  
11   subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult  
12   immunizations;  
13   Wellness benefit - \$600 annual aggregate per covered person, \$50  
14   annual deductible, 20% coinsurance per service; and  
15   Physicians visits for diagnosed illness or injury - to a \$700 annual  
16   aggregate per covered person.
- 17   b.   A carrier shall offer the benefits on an indemnity basis, with the  
18   option that: (1) coverage is restricted to health care providers in the  
19   carrier's network, including an exclusive provider organization, or the  
20   carrier's preferred provider organization; or (2) coverage is provided  
21   through health care providers in the carrier's network or preferred  
22   provider organization with an out-of-network option with 30%  
23   coinsurance in addition to whatever other coinsurance may be  
24   applicable under the policy.
- 25   c.   With respect to all policies or contracts issued pursuant to this  
26   section, the premium rate charged by a carrier to the highest rated  
27   individual or class of individuals shall not be greater than  
28   ~~[350%]~~200% of the premium rate charged for the lowest rated  
29   individual or class of individuals purchasing this health benefits plan,  
30   provided, however, that the only factors upon which the rate  
31   differential may be based are age, gender, and geography. Rates  
32   applicable to policies or contracts issued pursuant to this section shall  
33   reflect past and prospective loss experience for benefits included in  
34   such policies or contracts, and shall be formulated in a manner that  
35   does not result in an unfair subsidization of rates applicable to policies  
36   issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et  
37   seq.) as the result of differences in levels of benefits offered.
- 38   d.   Carriers may offer enhanced or additional benefits for an  
39   additional premium amount in the form of a rider or riders, each of  
40   which shall be comprised of a combination of enhanced or additional  
41   benefits, in a manner which will avoid adverse selection to the extent  
42   possible.
- 43   e.   The provisions of P.L.1992, c. 161 (C.17B:27A-2 et seq.) shall  
44   apply to this section to the extent that they are not contrary to the  
45   provisions of this section, including but not limited to, provisions  
46   relating to preexisting conditions, guaranteed issue, and calculation of

1 loss ratio.

2 f. No later than one year following enactment of this act, every  
3 carrier shall make an informational filing with the board, which shall  
4 include the policy form, the premiums to be charged for the coverage,  
5 and the anticipated loss ratio. If the board has not disapproved the  
6 form within 30 days, the form shall be deemed approved.

7 g. Every carrier that writes individual health benefits plans  
8 pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make  
9 available and shall make a good faith effort to market the contract or  
10 policy established pursuant to this section. A carrier who is in  
11 violation of this section shall be subject to the provisions of  
12 N.J.S.17B:30-1.<sup>1</sup>

13 (cf: P.L.2001, c.368, s.2)]<sup>2</sup>

14

15 <sup>4</sup>5. Section 2 of P.L.2001, c.368 (C.17B:27A-4.5) is amended to  
16 read as follows:

17 2. a. Notwithstanding the provisions of P.L.1992, c.161  
18 (C.17B:27A-2 et seq.), every carrier that writes individual health  
19 benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits  
20 plan in the individual health insurance market that includes only the  
21 coverages enumerated in this section, as follows:

22 90 days hospital room and board - \$500 copayment per hospital  
23 stay;

24 Outpatient and ambulatory surgery- \$250 copayment per surgery;

25 Physicians' fees connected with hospital care, including general  
26 acute care and surgery;

27 Physicians' fees connected with outpatient and ambulatory surgery;

28 Anesthesia and the administration of anesthesia;

29 Coverage for newborns;

30 Treatment for complications of pregnancy;

31 Intravenous solutions, blood and blood plasma;

32 Oxygen and the administration of oxygen;

33 Radiation and x-ray therapy;

34 Inpatient physical therapy and hydrotherapy;

35 Outpatient physical therapy - 30 visits annually per covered person-

36 \$20 copayment per treatment;

37 Dialysis - inpatient or outpatient;

38 Inpatient diagnostic tests and \$500 annual aggregate per covered  
39 person for out-of-hospital diagnostic tests;

40 Laboratory fees for treatment in hospital;

41 Delivery room fees;

42 Operating room fees;

43 Special care unit;

44 Treatment room fees;

45 Emergency room services for medically necessary treatment - \$100

46 copayment per visit;

1       Pharmaceuticals dispensed in hospital;

2       Dressings;

3       Splints;

4       Treatment for biologically-based mental illness, as defined in  
5 subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90  
6 days inpatient with no coinsurance - \$500 copayment per inpatient  
7 stay, 30 days outpatient with 30% coinsurance;

8       Alcohol and Substance Abuse Treatment - 30 days inpatient or  
9 outpatient - 30% coinsurance;

10       Childhood immunizations in accordance with the provisions of  
11 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult  
12 immunizations;

13       Wellness benefit - \$600 annual aggregate per covered person, \$50  
14 annual deductible, 20% coinsurance per service; and

15       Physicians visits for diagnosed illness or injury - to a \$700 annual  
16 aggregate per covered person.

17       b. A carrier shall offer the benefits on an indemnity basis, with the  
18 option that: (1) coverage is restricted to health care providers in the  
19 carrier's network, including an exclusive provider organization, or the  
20 carrier's preferred provider organization; or (2) coverage is provided  
21 through health care providers in the carrier's network or preferred  
22 provider organization with an out-of-network option with 30%  
23 coinsurance in addition to whatever other coinsurance may be  
24 applicable under the policy.

25       c. With respect to all policies or contracts issued pursuant to this  
26 section, the premium rate charged by a carrier to the highest rated  
27 individual or class of individuals shall not be greater than 350% of the  
28 premium rate charged for the lowest rated individual or class of  
29 individuals purchasing this health benefits plan, provided, however,  
30 that the only factors upon which the rate differential may be based are  
31 age, gender, and geography. Rates applicable to policies or contracts  
32 issued pursuant to this section shall reflect past and prospective loss  
33 experience for benefits included in such policies or contracts, and shall  
34 be formulated in a manner that does not result in an unfair  
35 subsidization of rates applicable to policies issued pursuant to the  
36 provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of  
37 differences in levels of benefits offered.

38       d. Carriers may offer enhanced or additional benefits for an  
39 additional premium amount in the form of a rider or riders, each of  
40 which shall be comprised of a combination of enhanced or additional  
41 benefits, in a manner which will avoid adverse selection to the extent  
42 possible. A rider issued pursuant to this subsection shall be subject to  
43 review and approval by the commissioner. The commissioner shall  
44 consider as part of the review whether the health benefits plan  
45 modified by the rider offers only benefits and services that are  
46 considered basic and essential and is not substantially equivalent to



1 coverage for benefits and services under the standard plans developed  
 2 by the board pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4).

3 e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall  
 4 apply to this section to the extent that they are not contrary to the  
 5 provisions of this section, including but not limited to, provisions  
 6 relating to preexisting conditions, guaranteed issue, and calculation of  
 7 loss ratio.

8 f. [No later than one year following enactment of this act, every]  
 9 Every carrier offering a policy or contract in accordance with this  
 10 section shall make an informational filing with the [board]  
 11 commissioner, which shall include the policy form, the premiums to be  
 12 charged for the coverage, and the anticipated loss ratio. If the [board]  
 13 commissioner has not disapproved the form within 30 days, the form  
 14 shall be deemed approved.

15 g. Every carrier that writes individual health benefits plans  
 16 pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make  
 17 available and shall make a good faith effort to market the contract or  
 18 policy established pursuant to this section. A carrier who is in  
 19 violation of this section shall be subject to the provisions of  
 20 N.J.S.17B:30-1.<sup>4</sup>

21 (cf: P.L.2001, c.368, s.2)

22  
 23 <sup>4</sup>6. Section 4 of P.L.2001, c.368 (C.17B:27A-4.7) is amended to  
 24 read as follows:

25 4. In addition to the [five] health benefits plans offered by a carrier  
 26 on the effective date of this act, a carrier that writes individual health  
 27 benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may  
 28 also offer one or more of the plans through the carrier's network of  
 29 providers, with no reimbursement for any out-of-network benefits  
 30 other than emergency care, urgent care, and continuity of care. A  
 31 carrier's network of providers shall be subject to review and approval  
 32 or disapproval by the Commissioner of Banking and Insurance, in  
 33 consultation with the Commissioner of Health and Senior Services,  
 34 pursuant to regulations promulgated by the Department of Banking  
 35 and Insurance, including review and approval or disapproval before  
 36 plans with benefits provided through a carrier's network of providers  
 37 pursuant to this section may be offered by the carrier. Policies or  
 38 contracts written on this basis shall be rated in a separate rating pool  
 39 for the purposes of establishing a premium, but for the purpose of  
 40 determining a carrier's losses, these policies or contracts shall be  
 41 aggregated with the losses on the carrier's other business written  
 42 pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).<sup>4</sup>

43 (cf: P.L.2001, c.368, s.4)

44  
 45 <sup>1</sup>[5.] <sup>2</sup>[6.<sup>1</sup>] <sup>4</sup>[5.<sup>2</sup>] <sup>7</sup>.<sup>4</sup> Section 5 of P.L.1992, c.161  
 46 (C.17B:27A-6) is amended to read as follows:

1       5. An individual health benefits plan issued pursuant to section 3  
2 of this act is subject to the following provisions:

3       a. The health benefits plan shall guarantee coverage for an eligible  
4 person and his dependents on a community rated basis.

5       b. A health benefits plan shall be renewable with respect to an  
6 eligible person and his dependents at the option of the policy or  
7 contract holder. A carrier may terminate a health benefits plan under  
8 the following circumstances:

9       (1) the policy or contract holder has failed to pay premiums in  
10 accordance with the terms of the policy or contract or the carrier has  
11 not received timely premium payments;

12       (2) the policy or contract holder has performed an act or practice  
13 that constitutes fraud or made an intentional misrepresentation of  
14 material fact under the terms of the coverage;

15       c. A carrier may not renew a health benefits plan only under the  
16 following circumstances:

17       (1) termination of eligibility of the policy or contract holder if the  
18 person is no longer a resident or becomes eligible for a group health  
19 benefits plan, group health plan, governmental plan or church plan;

20       (2) cancellation or amendment by the board of the specific  
21 individual health benefits plan;

22       (3) ~~board approval of a request by the individual~~ <sup>4</sup>~~[A] board~~  
23 ~~approval of a request by the individual~~<sup>4</sup> carrier <sup>4</sup>~~[may choose]~~<sup>4</sup> to not  
24 renew a ~~[particular type of health benefits plan, in accordance with~~  
25 ~~rules adopted by the board. After receiving board approval, a carrier~~  
26 ~~may not renew a]~~ <sup>4</sup>~~particular type of health benefits plan, in~~  
27 ~~accordance with rules adopted by the board. After receiving board~~  
28 ~~approval, a carrier may not renew a~~<sup>4</sup> type of health benefits plan only  
29 if the carrier: (a) provides notice to each covered individual provided  
30 coverage of this type of the nonrenewal at least 90 days prior to the  
31 date of the nonrenewal of the coverage; (b) offers to each individual  
32 provided coverage of this type the option to purchase any other  
33 individual health benefits plan currently being offered by the carrier;  
34 and (c) in exercising the option to not renew coverage of this type and  
35 in offering coverage as required under (b) above, the carrier acts  
36 uniformly without regard to any health status-related factor of enrolled  
37 individuals or individuals who may become eligible for coverage; ~~and~~

38       (4) ~~board approval of a request by the individual carrier to cease~~  
39 ~~doing business in the individual health benefits market. A carrier may~~  
40 ~~not renew all individual health benefits plans only if the carrier: (a)~~  
41 ~~first receives approval from the board; and (b) provides notice to each~~  
42 ~~individual of the nonrenewal at least 180 days prior to the date of the~~  
43 ~~expiration of such coverage. A carrier ceasing to do business in the~~  
44 ~~individual health benefits market may not provide for the issuance of~~  
45 ~~any health benefits plan in the individual market during the five-year~~  
46 ~~period beginning on the date of the termination of the last health~~

1 benefits plan not so renewed; and] Deleted by amendment, P.L. \_\_, c. \_\_) <sup>4</sup>(pending before the Legislature as this bill)<sup>4</sup>.

3 (5) In the case of a health benefits plan made available by a health  
4 maintenance organization carrier, the carrier shall not be required to  
5 renew coverage to an eligible individual who no longer resides, lives,  
6 or works in the service area, or in an area for which the carrier is  
7 authorized to do business, but only if coverage is terminated under this  
8 paragraph uniformly without regard to any health status-related factor  
9 of covered individuals.  
10 (cf: P.L.1997, c.146, s.3)

11

12 <sup>1</sup>[6.] <sup>2</sup>[7.<sup>1</sup>] <sup>4</sup>[6.<sup>2</sup>] <sup>8</sup>.<sup>4</sup> Section 6 of P.L.1992, c.161  
13 (C.17B:27A-7) is amended to read as follows:

14 6. The [board] <sup>4</sup>[commissioner] board<sup>4</sup> shall [establish]  
15 <sup>4</sup>[approve] establish<sup>4</sup> the policy and contract forms and benefit levels  
16 to be made available by all carriers for the health benefits plans  
17 [required to be] <sup>4</sup>required to be<sup>4</sup> issued pursuant to section 3 of  
18 P.L.1992, c.161 (C.17B:27A-4) [, and shall adopt such modifications  
19 to one or more plans as the board determines are necessary to make  
20 available a "high deductible health plan" or plans consistent with  
21 section 301 of Title III of the "Health Insurance Portability and  
22 Accountability Act of 1996," Pub.L.104-191, regarding tax-deductible  
23 medical savings accounts, within 60 days after the enactment of  
24 P.L.1997, c.414 (C.54A:3-4 et al.). The board shall provide the  
25 commissioner with an informational filing of the policy and contract  
26 forms and benefit levels it establishes] <sup>4</sup>, and shall adopt such  
27 modifications to one or more plans as the board determines are  
28 necessary to make available a "high deductible health plan" or plans  
29 consistent with section 301 of Title III of the "Health Insurance  
30 Portability and Accountability Act of 1996," Pub.L.104-191, regarding  
31 tax-deductible medical savings accounts, within 60 days after the  
32 enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The board shall  
33 provide the commissioner with an informational filing of the policy and  
34 contract forms and benefit levels it establishes<sup>4</sup>.

35 a. The individual health benefits plans [established by the board]  
36 <sup>4</sup>[marketed by carriers] established by the board<sup>4</sup> may include cost  
37 containment measures such as, but not limited to: utilization review of  
38 health care services, including review of medical necessity of hospital  
39 and physician services; case management benefit alternatives; selective  
40 contracting with hospitals, physicians, and other health care providers;  
41 and reasonable benefit differentials applicable to participating and  
42 nonparticipating providers; and other managed care provisions.

43 b. An individual health benefits plan offered pursuant to section 3  
44 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no  
45 more than 12 months on coverage for preexisting conditions. An

1 individual health benefits plan offered pursuant to section 3 of  
2 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting  
3 condition limitation of any period under the following circumstances:

4 (1) to an individual who has, under creditable coverage, with no  
5 intervening lapse in coverage of more than 31 days, been treated or  
6 diagnosed by a physician for a condition under that plan or satisfied a  
7 12-month preexisting condition limitation; or

8 (2) to a federally defined eligible individual who applies for an  
9 individual health benefits plan within 63 days of termination of the  
10 prior coverage.

11 c. [In addition to the five standard individual health benefits plans  
12 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board  
13 may develop up to five rider packages. Premium rates for the rider  
14 packages shall be determined in accordance with section 8 of  
15 P.L.1992, c.161 (C.17B:27A-9).] <sup>4</sup>[(Deleted by amendment,  
16 P.L. , c. ).] In addition to the standard individual health benefits  
17 plans provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the  
18 board may develop rider packages. Premium rates for the rider  
19 packages shall be determined in accordance with section 8 of  
20 P.L.1992, c.161 (C.17B:27A-9).<sup>4</sup>

21 d. [After the board's establishment of the individual health benefits  
22 plans required pursuant to section 3 of P.L.1992, c.161  
23 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier  
24 shall file the policy or contract forms with the board and certify to the  
25 board that the health benefits plans to be used by the carrier are in  
26 substantial compliance with the provisions in the corresponding board  
27 approved plans. The certification shall be signed by the chief  
28 executive officer of the carrier. Upon receipt by the board of the  
29 certification, the certified plans may be used until the board, after  
30 notice and hearing, disapproves their continued use.] <sup>4</sup>[(Deleted by  
31 amendment, P.L. , c. ).] After the board's establishment of the  
32 individual health benefits plans required pursuant to section 3 of  
33 P.L.1992, c.161 (C.17B:27A-4), and notwithstanding any law to the  
34 contrary, a carrier shall file the policy or contract forms with the board  
35 and certify to the board that the health benefits plans to be used by the  
36 carrier are in substantial compliance with the provisions in the  
37 corresponding board approved plans. The certification shall be signed  
38 by the chief executive officer of the carrier. Upon receipt by the board  
39 of the certification, the certified plans may be used until the board,  
40 after notice and hearing, disapproves their continued use.<sup>4</sup>

41 e. Effective immediately for an individual health benefits plan  
42 issued on or after the effective date of P.L.1995, c.316  
43 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary  
44 date of an individual health benefits plan in effect on the effective date  
45 of P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health  
46 benefits plans required pursuant to section 3 of P.L.1992, c.161

1 (C.17B:27A-4), including any plan offered by a federally qualified  
2 health maintenance organization, shall contain benefits for expenses  
3 incurred in the following:

4 (1) Screening by blood lead measurement for lead poisoning for  
5 children, including confirmatory blood lead testing as specified by the  
6 Department of Health and Senior Services pursuant to section 7 of  
7 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any  
8 necessary medical follow-up and treatment for lead poisoned children.

9 (2) All childhood immunizations as recommended by the Advisory  
10 Committee on Immunization Practices of the United States Public  
11 Health Service and the Department of Health and Senior Services  
12 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier  
13 shall notify its insureds, in writing, of any change in the health care  
14 services provided with respect to childhood immunizations and any  
15 related changes in premium. Such notification shall be in a form and  
16 manner to be determined by the Commissioner of Banking and  
17 Insurance.

18 (3) Screening for newborn hearing loss by appropriate  
19 electrophysiologic screening measures and periodic monitoring of  
20 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
21 (C.26:2-103.1 et al.). Payment for this screening service shall be  
22 separate and distinct from payment for routine new baby care in the  
23 form of a newborn hearing screening fee as negotiated with the  
24 provider and facility.

25 The benefits shall be provided to the same extent as for any other  
26 medical condition under the health benefits plan, except that no  
27 deductible shall be applied for benefits provided pursuant to this  
28 subsection. This subsection shall apply to all individual health benefits  
29 plans in which the carrier has reserved the right to change the  
30 premium.

31 f. Effective immediately for a health benefits plan issued on or after  
32 the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective  
33 on the first 12-month anniversary date of a health benefits plan in  
34 effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the  
35 health benefits plans required pursuant to section 3 of P.L.1992, c.161  
36 (C.17B:27A-4) that provide benefits for expenses incurred in the  
37 purchase of prescription drugs shall provide benefits for expenses  
38 incurred in the purchase of specialized non-standard infant formulas,  
39 when the covered infant's physician has diagnosed the infant as having  
40 multiple food protein intolerance and has determined such formula to  
41 be medically necessary, and when the covered infant has not been  
42 responsive to trials of standard non-cow milk-based formulas,  
43 including soybean and goat milk. The coverage may be subject to  
44 utilization review, including periodic review, of the continued medical  
45 necessity of the specialized infant formula.

46 The benefits shall be provided to the same extent as for any other

1 prescribed items under the health benefits plan.

2 This subsection shall apply to all individual health benefits plans

3 <sup>4</sup>[in which the carrier has reserved the right to change the premium.

4 <sup>2</sup>g. Every carrier may offer, in connection with the individual health  
 5 benefits plans issued pursuant to section 3 of P.L.1992, c.161  
 6 (C.17B:27A-4), any number of riders which may revise the coverage  
 7 offered by the health benefits plans in any way, provided, however,  
 8 that any form of a rider or amendment thereof which decreases  
 9 benefits or decreases the actuarial value of a standard plan shall be  
 10 filed for informational purposes with the board and for approval by the  
 11 commissioner before the rider may be sold. Any rider or amendment  
 12 thereof which only adds benefits or increases the actuarial value of a  
 13 health benefits plan shall be filed with the board for informational  
 14 purposes before the rider may be sold.

15 The commissioner shall disapprove any rider filed pursuant to this  
 16 subsection that is unjust, unfair, inequitable, unreasonably  
 17 discriminatory, misleading or contrary to the law or public policy of  
 18 this State. The commissioner shall not approve any rider which  
 19 reduces benefits below those required by sections 55, 57 and 59 of  
 20 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). The  
 21 commissioner's determination shall be in writing and shall be  
 22 appealable.]<sup>4 2</sup>

23 (cf: P.L.2001, c.373, s.14)

24

25 <sup>1</sup>[7] <sup>2</sup>[8.1]<sup>4</sup>[ 7.2] 9.<sup>4</sup> Section 8 of P.L.1992, c.161  
 26 (C.17B:27A-9) is amended to read as follows:

27 8. a. [The board shall make application to the Hospital Rate  
 28 Setting Commission on behalf of all carriers for approval of discounted  
 29 or reduced rates of payment to hospitals for health care services  
 30 provided under an individual health benefits plan provided pursuant to  
 31 this act.] (Deleted by amendment, P.L. , c. ) <sup>4</sup>(pending before the  
 32 Legislature as this bill)<sup>4</sup>.

33 b. [In addition to discounted or reduced rates of hospital payment,  
 34 the board shall make application on behalf of all carriers for any other  
 35 subsidies, discounts, or funds that may be provided for under State or  
 36 federal law or regulation. A carrier may include discounted or reduced  
 37 rates of hospital payment and other subsidies or funds granted to the  
 38 board to reduce its premium rates for individual health benefits plans  
 39 subject to this act.] (Deleted by amendment, P.L. , c. ) <sup>4</sup>(pending  
 40 before the Legislature as this bill)<sup>4</sup>.

41 c. [A carrier shall not issue individual health benefits plans on a  
 42 new contract or policy form pursuant to this act until an informational  
 43 filing of a full schedule of rates which applies to the contract or policy  
 44 form has been filed with the board. The board shall forward the  
 45 informational filing to the commissioner and the Attorney General.]

1 <sup>4</sup>[No insurance contract or policy subject to the provisions of  
2 P.L.1992, c.161 (C.17B:27A-2 et seq.), as amended by P.L. , c.   
3 (C. ) (now before the Legislature as this bill), may be entered into  
4 unless and until the carrier has made an informational filing with the  
5 commissioner of a schedule of premiums, not to exceed 12 months in  
6 duration, to be paid pursuant to that contract or policy, of the carrier's  
7 rating plan and classification system in connection with that contract  
8 or policy, and of the actuarial assumptions and methods used by the  
9 carrier in establishing premium rates for that contract or policy.] A  
10 carrier shall not issue individual health benefits plans on a new  
11 contract or policy form pursuant to this act until an informational filing  
12 of a full schedule of rates which applies to the contract or policy form  
13 has been filed with the commissioner.<sup>4</sup>

14 d. [A carrier shall make an informational filing with the board of  
15 any change in its rates for individual health benefits plans pursuant to  
16 section 3 of this act prior to the date the rates become effective. The  
17 board shall file the informational filing with the commissioner and the  
18 Attorney General. If the carrier has filed all information required by  
19 the board, the filing shall be deemed to be complete.]

20 <sup>4</sup>[A carrier desiring to increase or decrease premiums for any  
21 contract or policy form may implement that increase or decrease upon  
22 making an informational filing with the commissioner of that increase  
23 or decrease, along with the actuarial assumptions and methods used by  
24 the carrier in establishing that increase or decrease<sup>2</sup>[<sup>1</sup>; provided,  
25 however, that the carrier shall not implement an increase in premiums  
26 in excess of 15% for any contract or policy form unless the increase  
27 has been reviewed and approved by the commissioner, through  
28 procedures to be prescribed by the commissioner by regulation<sup>1</sup>]. The  
29 commissioner may disapprove any informational filing on a finding that  
30 it is incomplete and not in substantial compliance with P.L.1992, c.161  
31 (C.17B:27A-2 et seq.), or that the rates are<sup>3</sup>[excessive,]<sup>3</sup> inadequate  
32 or unfairly discriminatory. Any increase in excess of 15% per year for  
33 any policy shall require review and approval by the commissioner  
34 through procedures set forth by regulation.<sup>3</sup>[Any increase in excess  
35 of 15% per year shall be presumed to result in rates that are excessive,  
36 with the burden on the carrier to show] If an increase is in excess of  
37 15% per year, the carrier shall demonstrate<sup>3</sup> that the rate increase is  
38 justified. Compliance with the minimum loss ratio requirement, while  
39 necessary, shall not in itself be considered justification.<sup>2</sup>] A carrier  
40 shall make an informational filing with the commissioner of any change  
41 in its rates for individual health benefits plans pursuant to section 3 of  
42 this act prior to the date the rates become effective. If the carrier has  
43 filed all information required by the commissioner, the filing shall be  
44 deemed to be complete.<sup>4</sup>

45 e. (1) Rates shall be formulated on contracts or policies required

1 pursuant to section 3 of this act so that the anticipated minimum loss  
 2 ratio for a contract or policy form <sup>4</sup>issued or renewed on or after the  
 3 effective date of P.L. , c. (C. ) (now before the Legislature as  
 4 this bill)<sup>4</sup> shall not be less than <sup>1</sup>[75%] <sup>2</sup>[80%<sup>1</sup>] <sup>3</sup>[78%<sup>2</sup>] <sup>4</sup>[75%<sup>3</sup>]  
 5 80%<sup>4</sup> of the premium therefor as provided in paragraph (2) of this  
 6 subsection. The carrier shall submit with its rate filing supporting  
 7 data, as determined by the [board] commissioner, and a certification  
 8 by a member of the American Academy of Actuaries, or other  
 9 individuals <sup>4</sup>in a format<sup>4</sup> acceptable to the [board and to the]  
 10 commissioner, that the carrier is in compliance with the provisions of  
 11 this subsection.

12 (2) [Following the close of each calendar year, if the board  
 13 determines that a carrier's loss ratio was less than 75% for that  
 14 calendar year, the carrier shall be required to refund to policy or  
 15 contract holders the difference between the amount of net earned  
 16 premium it received that year and the amount that would have been  
 17 necessary to achieve the 75% loss ratio.]

18 Each calendar year, a carrier shall return, in the form of aggregate  
 19 benefits for all of the policy forms offered by the carrier pursuant to  
 20 subsection a. of section 3 of P.L.1992, c.161 <sup>1</sup>[(C.17B:27A-3)]  
 21 <sup>4</sup>[(C.17.B:27A-4)<sup>1</sup>](C.17B:27A-4)<sup>4</sup>, at least <sup>1</sup>[75%] <sup>2</sup>[80%<sup>1</sup>]  
 22 <sup>3</sup>[78%<sup>2</sup>] <sup>4</sup>[75%<sup>3</sup>] 80%<sup>4</sup> of the aggregate premiums collected for all  
 23 of the policy <sup>4</sup>or contract<sup>4</sup> forms during that calendar year. Carriers  
 24 shall annually report, no later than August 1 of each year, the loss ratio  
 25 calculated pursuant to this section for all of the policy <sup>4</sup>or contract<sup>4</sup>  
 26 forms for the previous calendar year. In each case in which the loss  
 27 ratio fails to <sup>2</sup>[substantially]<sup>2</sup> comply with the <sup>1</sup>[75%] <sup>2</sup>[80%<sup>1</sup>]  
 28 <sup>3</sup>[78%<sup>2</sup>] <sup>4</sup>[75%<sup>3</sup>] 80%<sup>4</sup> loss ratio requirement, the carrier shall issue  
 29 a dividend or credit against future premiums <sup>4</sup>[for] of <sup>4</sup>all  
 30 policyholders, as applicable, in an amount <sup>4</sup>[sufficient to assure that  
 31 the aggregate benefits paid in the previous calendar year plus the  
 32 amount of the dividends and credits equal <sup>1</sup>[75%] <sup>2</sup>[80%<sup>1</sup>] <sup>3</sup>[78%<sup>2</sup>]  
 33 75%<sup>3</sup> of the aggregate premiums collected for the policy forms in the  
 34 previous calendar year] equal to the difference between the amount of  
 35 net earned premium received in that year and the amount that would  
 36 have been necessary to achieve the 80% loss ratio<sup>4</sup>. All dividends and  
 37 credits shall be distributed by December 31 of the year following the  
 38 calendar year in which the loss ratio requirements were not satisfied.  
 39 The annual report required by this paragraph shall include a carrier's  
 40 calculation of the dividends and credits applicable to all policy forms,  
 41 as well as an explanation of the carrier's plan to issue dividends or  
 42 credits. The instructions and format for calculating and reporting loss  
 43 ratios and issuing dividends or credits shall be specified by the  
 44 commissioner by regulation. Those regulations shall include  
 45 provisions for the distribution of a dividend or credit in the event of



1 cancellation or termination by a policyholder.

2 f. [Notwithstanding the provisions of P.L.1992, c.161  
3 (C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed  
4 pursuant to this section by a carrier which insured at least 50% of the  
5 community-rated individually insured persons on the effective date of  
6 P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required to  
7 produce a loss ratio which when combined with the carrier's  
8 administrative costs and investment income results in self-sustaining  
9 rates prior to January 1, 1996, for individual policies or contracts  
10 issued prior to August 1, 1993. The carrier shall, not later than 30  
11 days after the effective date of P.L.1994, c.102 (C.17B:27A-4 et al.),  
12 file with the board for approval, a plan to achieve this objective.]  
13 (Deleted by amendment, P.L. , c. ) <sup>4</sup>(pending before the Legislature  
14 as this bill)<sup>4</sup>.  
15 (cf: P.L.1994, c.102, s.2)

16  
17 <sup>1</sup>[8.] <sup>2</sup>[9.<sup>1</sup>] <sup>4</sup>[8.<sup>2</sup> Section 10 of P.L.1992, c.161 (C.17B:27A-11)  
18 is amended to read as follows:

19 10. The program shall have the general powers and authority  
20 granted under the laws of New Jersey to insurance companies, health  
21 service corporations and health maintenance organizations licensed or  
22 approved to transact business in this State, except that the program  
23 shall not have the power to issue health benefits plans directly to either  
24 groups or individuals.

25 The board shall have the specific authority to:

26 a. assess members their proportionate share of program losses and  
27 administrative expenses in accordance with the provisions of section  
28 11 of this act, and make advance interim assessments, as may be  
29 reasonable and necessary for organizational and reasonable operating  
30 expenses and estimated losses. An interim assessment shall be credited  
31 as an offset against any regular assessment due following the close of  
32 the fiscal year;

33 b. establish rules, conditions, and procedures pertaining to the  
34 sharing of program losses and administrative expenses among the  
35 members of the program;

36 c. [review rate applications and form filings submitted by carriers  
37 in accordance with this act;] (Deleted by amendment, P.L. , c. ).

38 d. define the provisions of [individual] the three standard health  
39 benefits plans in accordance with the requirements of [this act]  
40 section 3 of P.L.1992, c.161 (C.17B:27A-4);

41 e. enter into contracts which are necessary or proper to carry out  
42 the provisions and purposes of this act;

43 f. [establish a procedure for the joint distribution of information on  
44 individual health benefits plans issued pursuant to section 3 of this  
45 act;] (Deleted by amendment, P.L. , c. ).

1 g. [establish, at the board's discretion, standards for the application  
2 of a means test for individual health benefits plans issued pursuant to  
3 section 3 of this act;] (Deleted by amendment, P.L. \_\_\_\_, c. \_\_.)

4 h. [establish, at the board's discretion, reasonable guidelines for the  
5 purchase of new individual health benefits plans by persons who  
6 already are enrolled in or insured by another individual health benefits  
7 plan;] (Deleted by amendment, P.L. \_\_\_\_, c. \_\_.)

8 i. [establish minimum requirements for performance standards for  
9 carriers that are reimbursed for losses submitted to the program and  
10 provide for performance audits from time to time;] (Deleted by  
11 amendment, P.L. \_\_\_\_, c. \_\_.)

12 j. sue or be sued, including taking any legal actions necessary or  
13 proper for recovery of an assessment for, on behalf of, or against the  
14 program or a member;

15 k. appoint from among its members appropriate legal, actuarial,  
16 and other committees as necessary to provide technical and other  
17 assistance in the operation of the program [, in policy and other  
18 contract design, and any other function within the authority of the  
19 program];

20 l. borrow money to effect the purposes of the program. Any notes  
21 or other evidence of indebtedness of the program not in default shall  
22 be legal investments for carriers and may be carried as admitted assets;  
23 [and]

24 m. contract for an independent actuary and any other professional  
25 services the board deems necessary to carry out its duties under  
26 P.L.1992, c.161 (C.17B:27A-2 et al.); and

27 n. in conjunction with the commissioner, develop a basic and  
28 essential health benefits plan designed to be a lower cost product than  
29 is currently available in the market to meet the health benefits  
30 purchasing needs of consumers, which plan may be offered by all  
31 carriers, subject to the prior approval of the commissioner. <sup>2</sup>With  
32 respect to a plan issued pursuant to this subsection, the premium rate  
33 charged by a carrier to the highest rated individual or class of  
34 individuals shall not be greater than 200% of the premium rate charged  
35 for the lowest rated individual or class of individuals purchasing this  
36 health benefits plan, provided, however, that the only factors upon  
37 which the rate differential may be based are age, gender and  
38 geography. Rates applicable to plans issued pursuant to this  
39 subsection shall reflect past and prospective loss experience for  
40 benefits included in those plans, and shall be formulated in a manner  
41 that does not result in an unfair subsidization of rates applicable to  
42 policies issued pursuant to the provisions of P.L.1992, c.161  
43 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits  
44 offered. <sup>2</sup><sup>4</sup>

45 (cf: P.L.1993, c.164, s.6)

1       <sup>4</sup>10. Section 9 of P.L.1992, c.161 (C.17B:27A-10) is amended to  
2 read as follows:

3       9. a. There is created the New Jersey Individual Health Coverage  
4 Program. All carriers subject to the provisions of this act shall be  
5 members of the program.

6       b. Within 30 days of the effective date of this act, the commissioner  
7 shall give notice to all members of the time and place for the initial  
8 organizational meeting, which shall take place within 60 days of the  
9 effective date. The board shall consist of nine representatives. The  
10 commissioner or his designee shall serve as an ex officio member on  
11 the board. Four members of the board shall be appointed by the  
12 Governor, with the advice and consent of the Senate: one of whom  
13 shall be a representative of an employer, appointed upon the  
14 recommendation of a business trade association, who is a person with  
15 experience in the management or administration of an employee health  
16 benefit plan; one of whom shall be a representative of organized labor,  
17 appointed upon the recommendation of the A.F.L.-C.I.O., who is a  
18 person with experience in the management or administration of an  
19 employee health benefit plan; [and two] one of whom shall be  
20 [consumers] a consumer of a health benefits plan who [are] is  
21 reflective of the population in the State; and one of whom shall  
22 presently or formerly be a consumer of an individual health benefits  
23 plan issued pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.). Four  
24 board members who represent carriers shall be elected by the  
25 members, subject to the approval of the commissioner, as follows: to  
26 the extent there is one licensed in this State that is willing to have a  
27 representative serve on the board, a representative from each of the  
28 following entities shall be elected:

29       (1) a health service corporation or a domestic stock insurer which  
30 converted from a health service corporation pursuant to the provisions  
31 of P.L.2001, c.131 (C.17:48E-49 et al.) and is primarily engaged in the  
32 business of issuing health benefit plans in this State;

33       (2) a health maintenance organization;

34       (3) an insurer authorized to write health insurance in this State  
35 subject to Subtitle 3 of Title 17B of the New Jersey Statutes; and

36       (4) a foreign health insurance company authorized to do business  
37 in this State.

38       In approving the selection of the carrier representatives of the  
39 board, the commissioner shall assure that all members of the program  
40 are fairly represented.

41       Initially, two of the Governor's appointees and two of the carrier  
42 representatives shall serve for a term of three years; one of the  
43 Governor's appointees and one of the carrier representatives shall  
44 serve for a term of two years; and one of the Governor's appointees  
45 and one of the carrier representatives shall serve for a term of one  
46 year. Thereafter, all board members shall serve for a term of three

1 years. Vacancies shall be filled in the same manner as the original  
2 appointments.

3 c. If the initial carrier representatives to the board are not elected  
4 at the organizational meeting, the commissioner shall appoint those  
5 members to the initial board within 15 days of the organizational  
6 meeting.

7 d. Within 90 days after the appointment of the initial board, the  
8 board shall submit to the commissioner a plan of operation and  
9 thereafter, any amendments to the plan necessary or suitable to assure  
10 the fair, reasonable, and equitable administration of the program. The  
11 commissioner may disapprove the plan of operation, if the  
12 commissioner determines that it is not suitable to assure the fair,  
13 reasonable, and equitable administration of the program, and that it  
14 does not provide for the sharing of program losses on an equitable and  
15 proportionate basis in accordance with the provisions of section 11 of  
16 this act. The plan of operation or amendments thereto shall become  
17 effective unless disapproved in writing by the commissioner within 45  
18 days of receipt by the commissioner.

19 e. If the board fails to submit a suitable plan of operation within 90  
20 days after its appointment, the commissioner shall adopt a temporary  
21 plan of operation pursuant to section 9 of P.L.1993, c.164  
22 (C.17B:27A-16.2). The commissioner shall amend or rescind a  
23 temporary plan adopted under this subsection, at the time a plan of  
24 operation is submitted by the board.

25 f. The plan of operation shall establish procedures for:

26 (1) the handling and accounting of assets and moneys of the  
27 program, and an annual fiscal reporting to the commissioner;

28 (2) collecting assessments from members to provide for sharing  
29 program losses in accordance with the provisions of section 11 of this  
30 act and administrative expenses incurred or estimated to be incurred  
31 during the period for which the assessment is made;

32 (3) approving the coverage, benefit levels, and contract forms for  
33 individual health benefits plans in accordance with the provisions of  
34 section 3 of this act;

35 (4) the imposition of an interest penalty for late payment of an  
36 assessment pursuant to section 11 of this act; and

37 (5) any additional matters at the discretion of the board.

38 g. The board shall appoint an insurance producer licensed to sell  
39 health insurance pursuant to P.L.1987, c.293 (C.17:22A-1 et seq.) to  
40 advise the board on issues related to sales of individual health benefits  
41 plans issued pursuant to this act.

42 h. The board or commissioner shall provide the appropriate staff  
43 to respond to the public's inquiries regarding the New Jersey  
44 Individual Health Coverage Program and the individual health benefits  
45 plans developed by the board.<sup>4</sup>

46 (cf: P.L.2001, c.131, s.21)

1       <sup>1</sup>[9.] <sup>2</sup>[10.] <sup>1</sup> [9.] <sup>2</sup> 11. <sup>4</sup>Section 11 of P.L.1992, c.161  
2 (C.17B:27A-12) is amended to read as follows:

3       11. The board shall establish procedures for the equitable sharing  
4 of program losses among all members in accordance with their total  
5 market share as follows:

6       a. (1) By March 1, 1999, and following the close of each two-year  
7 calculation period thereafter, or on a different date established by the  
8 board:

9       (a) every carrier issuing health benefits plans in this State shall file  
10 with the board its net earned premium for the preceding two-year  
11 calculation period; and

12       (b) every carrier issuing individual health benefits plans in the State  
13 shall file with the board the net earned premium on health benefits  
14 plans issued pursuant to paragraph (1) of subsection b. of section 2  
15 and section 3 of this act and the claims paid. If the claims paid for all  
16 health benefits plans during the two-year calculation period exceed  
17 [115%] <sup>2</sup>[120%] 115%<sup>2</sup> of the net earned premium [and any  
18 investment income thereon for the two-year calculation period] <sup>2</sup>and  
19 any investment income thereon for the two-year calculation period<sup>2</sup>,  
20 the amount of the excess shall be the net paid loss for the carrier that  
21 shall be reimbursable under this act.

22       (2) Every member shall be liable for an assessment to reimburse  
23 carriers issuing individual health benefits plans in this State which  
24 sustain net paid losses during the two-year calculation period, unless  
25 the member has received an exemption from the board pursuant to  
26 subsection d. of this section and has written a minimum number of  
27 non-group person life years as provided for in that subsection. The  
28 assessment of each member shall be in the proportion that the net  
29 earned premium of the member for the two-year calculation period  
30 preceding the assessment bears to the net earned premium of all  
31 members for the two-year calculation period preceding the assessment.  
32 Notwithstanding the provisions of this subsection to the contrary, a  
33 medical service corporation or a hospital service corporation shall not  
34 be liable for an assessment to reimburse carriers which sustain net paid  
35 losses.

36       (3) A member that is financially impaired may seek from the  
37 commissioner a deferment in whole or in part from any assessment  
38 issued by the board. The commissioner may defer, in whole or in part,  
39 the assessment of the member if, in the opinion of the commissioner,  
40 the payment of the assessment would endanger the ability of the  
41 member to fulfill its contractual obligations. If an assessment against  
42 a member is deferred in whole or in part, the amount by which the  
43 assessment is deferred may be assessed against the other members in  
44 a manner consistent with the basis for assessment set forth in this  
45 section. The member receiving the deferment shall remain liable to the  
46 program for the amount deferred.

1       b. The participation in the program as a member, the establishment  
2 of rates, forms or procedures, or any other joint or collective action  
3 required by this act shall not be the basis of any legal action, criminal  
4 or civil liability, or penalty against the program, a member of the board  
5 or a member of the program either jointly or separately except as  
6 otherwise provided in this act.

7       c. Payment of an assessment made under this section shall be a  
8 condition of issuing health benefits plans in the State for a carrier.  
9 Failure to pay the assessment shall be grounds for forfeiture of a  
10 carrier's authorization to issue health benefits plans of any kind in the  
11 State, as well as any other penalties permitted by law.

12       d. (1) Notwithstanding the provisions of this act to the contrary,  
13 a carrier may apply to the board, by a date established by the board,  
14 for an exemption from the assessment and reimbursement for losses  
15 provided for in this section. A carrier which applies for an exemption  
16 shall agree to cover a minimum number of non-group person life years  
17 on an open enrollment community rated basis, under a managed care  
18 or indemnity plan, as specified in this subsection, provided that any  
19 indemnity plan so issued conforms with sections 2 through 7,  
20 inclusive, of P.L.1992, c.161 (C.17B:27A-3 through 17B:27A-8). For  
21 the purposes of this subsection, non-group persons include individually  
22 enrolled persons, conversion policies issued pursuant to this act,  
23 Medicare cost and risk lives and Medicaid recipients; except that in  
24 determining whether the carrier meets the minimum number of  
25 non-group person life years required to be covered pursuant to this  
26 subsection, the number of Medicaid recipients and Medicare cost and  
27 risk lives shall not exceed 50% of the total. Pursuant to regulations  
28 adopted by the board, the carrier shall determine the number of  
29 non-group person life years it has covered by adding the number of  
30 non-group persons covered on the last day of each calendar quarter of  
31 the two-year calculation period, taking into account the limitations on  
32 counting Medicaid recipients and Medicare cost and risk lives, and  
33 dividing the total by eight.

34       (2) Notwithstanding the provisions of paragraph (1) of this  
35 subsection to the contrary, a health maintenance organization qualified  
36 pursuant to the "Health Maintenance Organization Act of 1973,"  
37 Pub.L.93-222 (42 U.S.C. s.300e et seq.) and tax exempt pursuant to  
38 paragraph (3) of subsection (c) of section 501 of the federal Internal  
39 Revenue Code of 1986, 26 U.S.C. s.501, may include up to one third  
40 Medicaid recipients and up to one third Medicare recipients in  
41 determining whether it meets its minimum number of non-group  
42 person life years.

43       (3) The minimum number of non-group person life years required  
44 to be covered, as determined by the board, shall equal the total number  
45 of non-group person life years of community rated, individually  
46 enrolled or insured persons, including Medicare cost and risk lives and

1 enrolled Medicaid lives, of all carriers subject to this act for the  
2 two-year calculation period, multiplied by the proportion that carrier's  
3 net earned premium bears to the net earned premium of all carriers for  
4 that two-year calculation period, including those carriers that are  
5 exempt from the assessment.

6 (4) On or before March 1 of the first year of each two-year  
7 calculation period, every carrier seeking an exemption pursuant to this  
8 subsection shall file with the board a statement of its net earned  
9 premium for the two-year calculation period. The board shall  
10 determine each carrier's minimum number of non-group person life  
11 years in accordance with this subsection.

12 (5) On or before March 1 of each year immediately following the  
13 close of a two-year calculation period, every carrier that was granted  
14 an exemption for the preceding two-year calculation period shall file  
15 with the board the number of non-group person life years, by category,  
16 covered for the two-year calculation period.

17 To the extent that the carrier has failed to cover the minimum  
18 number of non-group person life years established by the board, the  
19 carrier shall be assessed by the board on a pro rata basis for any  
20 differential between the minimum number established by the board and  
21 the actual number covered by the carrier.

22 (6) A carrier that applies for the exemption shall be deemed to be  
23 in compliance with the requirements of this subsection if it has covered  
24 100% of the minimum number of non-group person life years required.

25 (7) Any carrier that writes both managed care and indemnity  
26 business that is granted an exemption pursuant to this subsection may  
27 satisfy its obligation to cover a minimum number of non-group person  
28 life years by issuing either managed care or indemnity business, or  
29 both.

30 e. (Deleted by amendment, P.L.1997, c.146).

31 <sup>2</sup>f. <sup>4</sup>[Notwithstanding the provisions of subsections a., b., c. and  
32 d. of this section:

33 (1) For the years 1993 through 2000, all preliminary assessments  
34 made and reimbursements paid shall be deemed to have been adequate  
35 and complete to fulfill the purposes of this section and are not subject  
36 to review by the board.

37 (2) For the years 1993 through 2000, where there are any amounts  
38 timely disputed, put into escrow and subsequently ordered released by  
39 the board, the amounts for those years already reimbursed shall be  
40 deemed adequate and complete and the return shall fully discharge the  
41 board's responsibility for those years.

42 (3) For the years beginning in 2001 and ending in the year in which  
43 P.L. , c. (C. ) (now before the Legislature as this bill) takes  
44 effect, in which assessments have not been made, the board shall make  
45 assessments not exceeding market share multiplied by total losses, less  
46 exemptions as defined in and required by this section. These

1 assessments shall constitute adequate and complete reimbursement of  
 2 losses in those years, and no assessment shall be made or reimbursed  
 3 attributable to exempt market share.

4 (4) There shall be no assessments, pursuant to this section for any  
 5 purpose for any time period following the effective date of P.L. ,  
 6 c. (C. ) (now before the Legislature as this bill).<sup>2</sup>] The loss  
 7 assessment for the two-year calculation period in which P.L. , c.  
 8 (C. ) (pending before the Legislature as this bill) takes effect shall be  
 9 the last loss assessment authorized under this section and no further  
 10 loss assessments shall be calculated or collected; provided, however,  
 11 that nothing in this act shall relieve a carrier of its obligations for loss  
 12 assessments authorized under this section prior to the effective date of  
 13 P.L. , c. (C. ) (pending before the Legislature as this bill).<sup>4</sup>  
 14 (cf: P.L.1997, c.146, s.6)

15  
 16 <sup>4</sup>12. Section 5 of P.L.1995, c.196 (C.17B:27A-16.5) is amended  
 17 to read as follows:

18 5. A domestic mutual insurer which has converted from a health  
 19 service corporation pursuant to the provisions of sections 2 through  
 20 4 of P.L.1995, c.196 (C.17:48E-46 through C.17:48E-48) shall not  
 21 renew individual hospital or medical insurance policies or health  
 22 service contracts originally issued prior to November 30, 1992, until  
 23 it has made an informational filing with [the New Jersey Individual  
 24 Health Coverage Program Board, of a full schedule of rates which are  
 25 to apply to those contracts. The New Jersey Individual Health  
 26 Coverage Program Board shall forward a copy of such filing to] the  
 27 commissioner. The rates shall be formulated so that the anticipated  
 28 minimum loss ratio for such policy or contract form shall not be less  
 29 than [75%] 80% of the premium. Such domestic mutual insurer shall  
 30 submit with its rate filing supporting data and a certification that the  
 31 insurer is in compliance with the anticipated loss ratio requirement.  
 32 The content and form of the supporting data and certification required  
 33 pursuant to subsection e. of section 8 of P.L.1992, c.161  
 34 (C.17B:27A-9) shall satisfy the requirements of this section. Any  
 35 other insurer may irrevocably elect to become subject to the provisions  
 36 of this section by written notice to the commissioner [, except that  
 37 such informational filing by any other insurer shall be in a format  
 38 specified by the commissioner and shall be made directly to the  
 39 commissioner and not to the New Jersey Individual Health Coverage  
 40 Program Board].<sup>4</sup>

41 (cf: P.L.1995, c.196, s.5)

42  
 43 <sup>2</sup>[<sup>11</sup>.] <sup>4</sup>[<sup>10</sup>.<sup>2</sup>] <sup>13</sup>.<sup>4</sup> Section 1 of P.L.1992, c.162 (C.17B:27A-17)  
 44 is amended to read as follows:

45 1. As used in this act:

46 "Actuarial certification" means a written statement by a member of



1 the American Academy of Actuaries or other individual acceptable to  
2 the commissioner that a small employer carrier is in compliance with  
3 the provisions of section 9 of P.L.1992, c.162 (C.17B:27A-25), based  
4 upon examination, including a review of the appropriate records and  
5 actuarial assumptions and methods used by the small employer carrier  
6 in establishing premium rates for applicable health benefits plans.

7 "Anticipated loss ratio" means the ratio of the present value of the  
8 expected benefits, not including dividends, to the present value of the  
9 expected premiums, not reduced by dividends, over the entire period  
10 for which rates are computed to provide coverage. For purposes of  
11 this ratio, the present values must incorporate realistic rates of interest  
12 which are determined before federal taxes but after investment  
13 expenses.

14 "Board" means the board of directors of the program.

15 "Carrier" means any entity subject to the insurance laws and  
16 regulations of this State, or subject to the jurisdiction of the  
17 commissioner, that contracts or offers to contract to provide, deliver,  
18 arrange for, pay for, or reimburse any of the costs of health care  
19 services, including an insurance company authorized to issue health  
20 insurance, a health maintenance organization, a hospital service  
21 corporation, medical service corporation and health service  
22 corporation, or any other entity providing a plan of health insurance,  
23 health benefits or health services. The term "carrier" shall not include  
24 a joint insurance fund established pursuant to State law. For purposes  
25 of this act, carriers that are affiliated companies shall be treated as one  
26 carrier, except that any insurance company, health service corporation,  
27 hospital service corporation, or medical service corporation that is an  
28 affiliate of a health maintenance organization located in New Jersey or  
29 any health maintenance organization located in New Jersey that is  
30 affiliated with an insurance company, health service corporation,  
31 hospital service corporation, or medical service corporation shall treat  
32 the health maintenance organization as a separate carrier.

33 "Church plan" has the same meaning given that term under Title I,  
34 section 3 of Pub.L.93-406, the "Employee Retirement Income Security  
35 Act of 1974" (29 U.S.C. s.1002(33)).

36 "Commissioner" means the Commissioner of Banking and  
37 Insurance.

38 "Community rating" or "community rated" means a rating  
39 methodology in which the premium charged by a carrier for all persons  
40 covered by a policy or contract form is the same based upon the  
41 experience of the entire pool of risks covered by that policy or  
42 contract form without regard to age, gender, health status, residence  
43 or occupation.

44 "Creditable coverage" means, with respect to an individual,  
45 coverage of the individual under any of the following: a group health  
46 plan; a group or individual health benefits plan; Part A or part B of

1 Title XVIII of the federal Social Security Act (42 U.S.C. s.1395 et  
2 seq.); Title XIX of the federal Social Security Act (42 U.S.C. s.1396  
3 et seq.), other than coverage consisting solely of benefits under section  
4 1928 of Title XIX of the federal Social Security Act (42 U.S.C.  
5 s.1396S); chapter 55 of Title 10, United States Code (10 U.S.C.  
6 s.1071 et seq.); a medical care program of the Indian Health Service  
7 or of a tribal organization; a state health plan offered under chapter 89  
8 of Title 5, United States Code (5 U.S.C. s.8901 et seq.); a public  
9 health plan as defined by federal regulation; a health benefits plan  
10 under section 5(e) of the "Peace Corps Act" (22 U.S.C. s.2504(e)); or  
11 coverage under any other type of plan as set forth by the commissioner  
12 by regulation.

13 Creditable coverage shall not include coverage consisting solely of  
14 the following: coverage only for accident or disability income  
15 insurance, or any combination thereof; coverage issued as a  
16 supplement to liability insurance; liability insurance, including general  
17 liability insurance and automobile liability insurance; workers'  
18 compensation or similar insurance; automobile medical payment  
19 insurance; credit only insurance; coverage for on-site medical clinics;  
20 coverage, as specified in federal regulation, under which benefits for  
21 medical care are secondary or incidental to the insurance benefits; and  
22 other coverage expressly excluded from the definition of health  
23 benefits plan.

24 "Department" means the Department of Banking and Insurance.

25 "Dependent" means the spouse <sup>4</sup>, domestic partner as provided in  
26 P.L.2003, c.246 (C.26:8A-1 et seq.)<sup>4</sup> or child of an eligible employee,  
27 subject to applicable terms of the health benefits plan covering the  
28 employee.

29 "Eligible employee" means [a full-time] <sup>4</sup>[an] a full time <sup>4</sup>  
30 employee who works [a normal work week of 25] <sup>2</sup>[one] <sup>4</sup>[20]<sup>2</sup> a  
31 normal work week of 25<sup>4</sup> or more hours <sup>4</sup>[per week]<sup>4</sup>. The term  
32 includes a sole proprietor, a partner of a partnership, or an  
33 independent contractor, if the sole proprietor, partner, or independent  
34 contractor is included as an employee under a health benefits plan of  
35 a small employer, but does not include employees who [work less than  
36 25 hours a week,] <sup>4</sup>work less than 25 hours a week, <sup>4</sup>work on a  
37 temporary or substitute basis or are participating in an employee  
38 welfare arrangement established pursuant to a collective bargaining  
39 agreement.

40 "Enrollment date" means, with respect to a person covered under  
41 a health benefits plan, the date of enrollment of the person in the  
42 health benefits plan or, if earlier, the first day of the waiting period for  
43 such enrollment.

44 "Financially impaired" means a carrier which, after the effective  
45 date of this act, is not insolvent, but is deemed by the commissioner to  
46 be potentially unable to fulfill its contractual obligations or a carrier

1 which is placed under an order of rehabilitation or conservation by a  
2 court of competent jurisdiction.

3 "Governmental plan" has the meaning given that term under Title  
4 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
5 Security Act of 1974" (29 U.S.C. s.1002(32)) and any governmental  
6 plan established or maintained for its employees by the Government of  
7 the United States or by any agency or instrumentality of that  
8 government.

9 "Group health plan" means an employee welfare benefit plan, as  
10 defined in Title I of section 3 of Pub.L.93-406, the "Employee  
11 Retirement Income Security Act of 1974" (29 U.S.C. s.1002(1)), to  
12 the extent that the plan provides medical care and including items and  
13 services paid for as medical care to employees or their dependents  
14 directly or through insurance, reimbursement or otherwise.

15 "Health benefits plan" means any hospital and medical expense  
16 insurance policy or certificate; health, hospital, or medical service  
17 corporation contract or certificate; or health maintenance organization  
18 subscriber contract or certificate delivered or issued for delivery in this  
19 State by any carrier to a small employer group pursuant to section 3  
20 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health  
21 benefits plan" shall not include one or more, or any combination of,  
22 the following: coverage only for accident or disability income  
23 insurance, or any combination thereof; coverage issued as a  
24 supplement to liability insurance; liability insurance, including general  
25 liability insurance and automobile liability insurance; workers'  
26 compensation or similar insurance; automobile medical payment  
27 insurance; credit-only insurance; coverage for on-site medical clinics;  
28 and other similar insurance coverage, as specified in federal  
29 regulations, under which benefits for medical care are secondary or  
30 incidental to other insurance benefits. Health benefits plans shall not  
31 include the following benefits if they are provided under a separate  
32 policy, certificate or contract of insurance or are otherwise not an  
33 integral part of the plan: limited scope dental or vision benefits;  
34 benefits for long-term care, nursing home care, home health care,  
35 community-based care, or any combination thereof; and such other  
36 similar, limited benefits as are specified in federal regulations. Health  
37 benefits plan shall not include hospital confinement indemnity coverage  
38 if the benefits are provided under a separate policy, certificate or  
39 contract of insurance, there is no coordination between the provision  
40 of the benefits and any exclusion of benefits under any group health  
41 benefits plan maintained by the same plan sponsor, and those benefits  
42 are paid with respect to an event without regard to whether benefits  
43 are provided with respect to such an event under any group health plan  
44 maintained by the same plan sponsor. Health benefits plan shall not  
45 include the following if it is offered as a separate policy, certificate or  
46 contract of insurance: Medicare supplemental health insurance as

1 defined under section 1882(g)(1) of the federal Social Security Act (42  
2 U.S.C. s.1395ss(g)(1)); and coverage supplemental to the coverage  
3 provided under chapter 55 of Title 10, United States Code (10 U.S.C.  
4 s.1071 et seq.); and similar supplemental coverage provided to  
5 coverage under a group health plan.

6 "Health status-related factor" means any of the following factors:  
7 health status; medical condition, including both physical and mental  
8 illness; claims experience; receipt of health care; medical history;  
9 genetic information; evidence of insurability, including conditions  
10 arising out of acts of domestic violence; and disability.

11 "Late enrollee" means an eligible employee or dependent who  
12 requests enrollment in a health benefits plan of a small employer  
13 following the initial minimum 30-day enrollment period provided under  
14 the terms of the health benefits plan. An eligible employee or  
15 dependent shall not be considered a late enrollee if the individual: a.  
16 was covered under another employer's health benefits plan at the time  
17 he was eligible to enroll and stated at the time of the initial enrollment  
18 that coverage under that other employer's health benefits plan was the  
19 reason for declining enrollment, but only if the plan sponsor or carrier  
20 required such a statement at that time and provided the employee with  
21 notice of that requirement and the consequences of that requirement  
22 at that time; b. has lost coverage under that other employer's health  
23 benefits plan as a result of termination of employment or eligibility,  
24 reduction in the number of hours of employment, involuntary  
25 termination, the termination of the other plan's coverage, death of a  
26 spouse, or divorce or legal separation; and c. requests enrollment  
27 within 90 days after termination of coverage provided under another  
28 employer's health benefits plan. An eligible employee or dependent  
29 also shall not be considered a late enrollee if the individual is employed  
30 by an employer which offers multiple health benefits plans and the  
31 individual elects a different plan during an open enrollment period; the  
32 individual had coverage under a COBRA continuation provision and  
33 the coverage under that provision was exhausted and the employee  
34 requests enrollment not later than 30 days after the date of exhaustion  
35 of COBRA coverage; or if a court of competent jurisdiction has  
36 ordered coverage to be provided for a spouse or minor child under a  
37 covered employee's health benefits plan and request for enrollment is  
38 made within 30 days after issuance of that court order.

39 "Medical care" means amounts paid: (1) for the diagnosis, care,  
40 mitigation, treatment, or prevention of disease, or for the purpose of  
41 affecting any structure or function of the body; and (2) transportation  
42 primarily for and essential to medical care referred to in (1) above.

43 "Member" means all carriers issuing health benefits plans in this  
44 State on or after the effective date of this act.

45 "Multiple employer arrangement" means an arrangement established  
46 or maintained to provide health benefits to employees and their

1 dependents of two or more employers, under an insured plan  
2 purchased from a carrier in which the carrier assumes all or a  
3 substantial portion of the risk, as determined by the commissioner, and  
4 shall include, but is not limited to, a multiple employer welfare  
5 arrangement, or MEWA, multiple employer trust or other form of  
6 benefit trust.

7 "Plan of operation" means the plan of operation of the program  
8 including articles, bylaws and operating rules approved pursuant to  
9 section 14 of P.L.1992, c.162 (C.17B:27A-30).

10 "Plan sponsor" has the meaning given that term under Title I of  
11 section 3 of Pub.L.93-406, the "Employee Retirement Income Security  
12 Act of 1974" (29 U.S.C. s.1002(16)(B)).

13 "Preexisting condition exclusion" means, with respect to coverage,  
14 a limitation or exclusion of benefits relating to a condition based on  
15 the fact that the condition was present before the date of enrollment  
16 for that coverage, whether or not any medical advice, diagnosis, care,  
17 or treatment was recommended or received before that date. Genetic  
18 information shall not be treated as a preexisting condition in the  
19 absence of a diagnosis of the condition related to that information.

20 "Program" means the New Jersey Small Employer Health Benefits  
21 Program established pursuant to section 12 of P.L.1992, c.162  
22 (C.17B:27A-28).

23 "Small employer" means, in connection with a group health plan  
24 with respect to a calendar year and a plan year, any person, firm,  
25 corporation, partnership, or political subdivision that is actively  
26 engaged in business that employed an average of at least two but not  
27 more than 50 eligible employees on business days during the preceding  
28 calendar year and who employs at least two employees on the first day  
29 of the plan year, and the majority of the employees are employed in  
30 New Jersey. All persons treated as a single employer under subsection  
31 (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of  
32 1986 (26 U.S.C. s.414) shall be treated as one employer. Subsequent  
33 to the issuance of a health benefits plan to a small employer and for the  
34 purpose of determining continued eligibility, the size of a small  
35 employer shall be determined annually. Except as otherwise  
36 specifically provided, provisions of P.L.1992, c.162 (C.17B:27A-17  
37 et seq.) that apply to a small employer shall continue to apply at least  
38 until the plan anniversary following the date the small employer no  
39 longer meets the requirements of this definition. In the case of an  
40 employer that was not in existence during the preceding calendar year,  
41 the determination of whether the employer is a small or large employer  
42 shall be based on the average number of employees that it is  
43 reasonably expected that the employer will employ on business days  
44 in the current calendar year. Any reference in P.L.1992, c.162  
45 (C.17B:27A-17 et seq.) to an employer shall include a reference to any  
46 predecessor of such employer.

1 "Small employer carrier" means any carrier that offers health  
2 benefits plans covering eligible employees of one or more small  
3 employers.

4 "Small employer health benefits plan" means a health benefits plan  
5 for small employers approved by the commissioner pursuant to section  
6 17 of P.L.1992, c.162 (C.17B:27A-33).

7 "Stop loss" or "excess risk insurance" means an insurance policy  
8 designed to reimburse a self-funded arrangement of one or more small  
9 employers for catastrophic, excess or unexpected expenses, wherein  
10 neither the employees nor other individuals are third party beneficiaries  
11 under the insurance policy. In order to be considered stop loss or  
12 excess risk insurance for the purposes of P.L.1992, c.162  
13 (C.17B:27A-17 et seq.), the policy shall establish a per person  
14 attachment point or retention or aggregate attachment point or  
15 retention, or both, which meet the following requirements:

16 a. If the policy establishes a per person attachment point or  
17 retention, that specific attachment point or retention shall not be less  
18 than \$20,000 per covered person per plan year; and

19 b. If the policy establishes an aggregate attachment point or  
20 retention, that aggregate attachment point or retention shall not be less  
21 than 125% of expected claims per plan year.

22 "Supplemental limited benefit insurance" means insurance that is  
23 provided in addition to a health benefits plan on an indemnity  
24 non-expense incurred basis.<sup>1</sup>

25 (cf: P.L.1997, c.146, s.7)

26

27 <sup>1</sup>[10.] <sup>2</sup>[12.] <sup>1</sup>[11.] <sup>2</sup>14. <sup>4</sup>Section 3 of P.L.1992, c.162  
28 (C.17B:27A-19) is amended to read as follows:

29 3. a. [Except as provided in subsection f. of this section, every]  
30 <sup>4</sup>[Every] Except as provided in subsection f. of this section, every<sup>4</sup>  
31 small employer carrier shall, as a condition of transacting business in  
32 this State, offer to every small employer [the five] <sup>4</sup>the<sup>4</sup> health benefit  
33 plans [as provided in this section. The board shall establish a standard  
34 policy form for each of the five plans, which except as otherwise  
35 provided in subsection j. of this section, shall be the only plans offered  
36 to small groups on or after January 1, 1994. One policy form shall  
37 contain the benefits provided for in sections 55, 57, and 59 of  
38 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the  
39 case of indemnity carriers, one policy form shall be established which  
40 contains benefits and cost sharing levels which are equivalent to the  
41 health benefits plans of health maintenance organizations pursuant to  
42 the "Health Maintenance Organization Act of 1973," Pub.L.93-222  
43 (42 U.S.C. s.300e et seq.). The remaining policy forms shall contain  
44 basic hospital and medical-surgical benefits, including, but not limited  
45 to:

46 (1) Basic inpatient and outpatient hospital care;

- 1 (2) Basic and extended medical-surgical benefits;
- 2 (3) Diagnostic tests, including X-rays;
- 3 (4) Maternity benefits, including prenatal and postnatal care; and
- 4 (5) Preventive medicine, including periodic physical examinations
- 5 and inoculations.

6 At least three of the forms shall provide for major medical benefits  
7 in varying lifetime aggregates, one of which shall provide at least  
8 \$1,000,000 in lifetime aggregate benefits. The policy forms provided  
9 pursuant to this section shall contain benefits representing  
10 progressively greater actuarial values.

11 Notwithstanding the provisions of this subsection to the contrary,  
12 the board also may establish additional policy forms by which a small  
13 employer carrier, other than a health maintenance organization, may  
14 provide indemnity benefits for health maintenance organization  
15 enrollees by direct contract with the enrollees' small employer through  
16 a dual arrangement with the health maintenance organization. The  
17 dual arrangement shall be filed with the commissioner for approval.  
18 The additional policy forms shall be consistent with the general  
19 requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).] <sup>4</sup>[that it  
20 chooses to actively market in this State and those plans shall include  
21 at least one standard plan consistent with the type of health benefits  
22 plans that it offers, as developed by the board pursuant to the  
23 provisions of section 3 of P.L.1992, c.161 (C.17B:27A-4). A carrier  
24 <sup>2</sup>[wishing to offer individual health benefits plans in this State]<sup>2</sup> shall  
25 offer to every small employer at least one standard plan consistent  
26 with the type of health benefits plans that it offers to fulfill its  
27 requirements to offer small employer health benefits plans in this State.

28 A carrier may elect to convert any contract or policy form in force  
29 on the effective date of P.L. , c. (C. ) (now before the Legislature  
30 as this bill) to any of its currently marketed plans as long as the  
31 replacement plan is of no less actuarial value than the policy or  
32 contract being replaced, consistent with the requirements of the federal  
33 "Health Insurance Portability and Accountability Act of 1996," Pub.  
34 L.104-191, 110 Stat. 1936, (1996) (HIPAA), and may elect to convert  
35 any contract or policy form after that effective date to any of its  
36 currently marketed plans subject to the prior approval of the  
37 commissioner.] as provided in this section. The board shall establish  
38 a standard policy form for each of the plans, which except as otherwise  
39 provided in subsection j. of this section, shall be the only plans offered  
40 to small groups on or after January 1, 1994. One policy form shall  
41 contain the benefits provided for in sections 55, 57, and 59 of  
42 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the  
43 case of indemnity carriers, one policy form shall be established which  
44 contains benefits and cost sharing levels which are equivalent to the  
45 health benefits plans of health maintenance organizations pursuant to  
46 the "Health Maintenance Organization Act of 1973," Pub.L.93-222

1 (42 U.S.C. s.300e et seq.). The remaining policy forms shall contain  
2 basic hospital and medical-surgical benefits, including, but not limited  
3 to:

4 (1) Basic inpatient and outpatient hospital care;

5 (2) Basic and extended medical-surgical benefits;

6 (3) Diagnostic tests, including X-rays;

7 (4) Maternity benefits, including prenatal and postnatal care; and

8 (5) Preventive medicine, including periodic physical examinations  
9 and inoculations.

10 The policy forms shall provide for major medical benefits in varying  
11 lifetime aggregates, one of which shall provide at least \$1,000,000 in  
12 lifetime aggregate benefits. The policy forms provided pursuant to this  
13 section shall contain benefits representing progressively greater  
14 actuarial values.

15 Notwithstanding the provisions of this subsection to the contrary,  
16 the board also may establish additional policy forms by which a small  
17 employer carrier, other than a health maintenance organization, may  
18 provide indemnity benefits for health maintenance organization  
19 enrollees by direct contract with the enrollees' small employer through  
20 a dual arrangement with the health maintenance organization. The  
21 dual arrangement shall be filed with the commissioner for approval.  
22 The additional policy forms shall be consistent with the general  
23 requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).<sup>4</sup>

24 b. Initially, a carrier shall offer a plan within 90 days of the  
25 approval of such plan by the commissioner. Thereafter, the plans shall  
26 be available to all small employers on a continuing basis. Every small  
27 employer which elects to be covered under any health benefits plan  
28 who pays the premium therefor and who satisfies the participation  
29 requirements of the plan shall be issued a policy or contract by the  
30 carrier.

31 c. The carrier may establish a premium payment plan which  
32 provides installment payments and which may contain reasonable  
33 provisions to ensure payment security, provided that provisions to  
34 ensure payment security are uniformly applied.

35 d. [In addition to the five standard policies described in subsection  
36 a. of this section, the board may develop up to five rider packages.  
37 Any such package which a carrier chooses to offer shall be issued to  
38 a small employer who pays the premium therefor, and shall be subject  
39 to the rating methodology set forth in section 9 of P.L.1992, c.162  
40 (C.17B:27A-25).] <sup>4</sup>[(Deleted by amendment, P.L. \_\_\_\_, c. \_\_).] In  
41 addition to the standard policies described in subsection a. of this  
42 section, the board may develop rider packages. Any such package  
43 which a carrier chooses to offer shall be issued to a small employer  
44 who pays the premium therefor, and shall be subject to the rating  
45 methodology set forth in section 9 of P.L.1992, c.162  
46 (C.17B:27A-25).<sup>4</sup>



1 e. [Notwithstanding the provisions of subsection a. of this section  
2 to the contrary, the board may approve a health benefits plan  
3 containing only medical-surgical benefits or major medical expense  
4 benefits, or a combination thereof, which is issued as a separate policy  
5 in conjunction with a contract of insurance for hospital expense  
6 benefits issued by a hospital service corporation, if the health benefits  
7 plan and hospital service corporation contract combined otherwise  
8 comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et  
9 seq.). Deductibles and coinsurance limits for the contract combined  
10 may be allocated between the separate contracts at the discretion of  
11 the carrier and the hospital service corporation.] <sup>4</sup>[(Deleted by  
12 amendment, P.L. \_\_\_, c. \_\_\_.)] Notwithstanding the provisions of  
13 subsection a. of this section to the contrary, the board may approve a  
14 health benefits plan containing only medical-surgical benefits or major  
15 medical expense benefits, or a combination thereof, which is issued as  
16 a separate policy in conjunction with a contract of insurance for  
17 hospital expense benefits issued by a hospital service corporation, if  
18 the health benefits plan and hospital service corporation contract  
19 combined otherwise comply with the provisions of P.L.1992, c.162  
20 (C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the  
21 contract combined may be allocated between the separate contracts at  
22 the discretion of the carrier and the hospital service corporation.<sup>4</sup>

23 f. [Notwithstanding the provisions of this section to the contrary,  
24 a health maintenance organization which is a qualified health  
25 maintenance organization pursuant to the "Health Maintenance  
26 Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.)  
27 shall be permitted to offer health benefits plans formulated by the  
28 board and approved by the commissioner which are in accordance with  
29 the provisions of that law in lieu of the five plans required pursuant to  
30 this section.

31 Notwithstanding the provisions of this section to the contrary, a  
32 health maintenance organization which is approved pursuant to  
33 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health  
34 benefits plans formulated by the board and approved by the  
35 commissioner which are in accordance with the provisions of that law  
36 in lieu of the five plans required pursuant to this section, except that  
37 the plans shall provide the same level of benefits as required for a  
38 federally qualified health maintenance organization, including any  
39 requirements concerning copayments by enrollees.] <sup>4</sup>[(Deleted by  
40 amendment, P.L. \_\_\_, c. \_\_\_.)] Notwithstanding the provisions of this  
41 section to the contrary, a health maintenance organization which is a  
42 qualified health maintenance organization pursuant to the "Health  
43 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.  
44 s.300e et seq.) shall be permitted to offer health benefits plans  
45 formulated by the board and approved by the commissioner which are  
46 in accordance with the provisions of that law in lieu of the plans

1 required pursuant to this section.

2 Notwithstanding the provisions of this section to the contrary, a  
3 health maintenance organization which is approved pursuant to  
4 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health  
5 benefits plans formulated by the board and approved by the  
6 commissioner which are in accordance with the provisions of that law  
7 in lieu of the plans required pursuant to this section, except that the  
8 plans shall provide the same level of benefits as required for a federally  
9 qualified health maintenance organization, including any requirements  
10 concerning copayments by enrollees.<sup>4</sup>

11 g. [A carrier shall not be required to own or control a health  
12 maintenance organization or otherwise affiliate with a health  
13 maintenance organization in order to comply with the provisions of  
14 this section, but the carrier shall be required to offer the five health  
15 benefits plans which are formulated by the board and approved by the  
16 commissioner, including one plan which contains benefits and cost  
17 sharing levels that are equivalent to those required for health  
18 maintenance organizations.] <sup>4</sup>[(Deleted by amendment, P.L. , c. ).]  
19 A carrier shall not be required to own or control a health maintenance  
20 organization or otherwise affiliate with a health maintenance  
21 organization in order to comply with the provisions of this section, but  
22 the carrier shall be required to offer the health benefits plans which are  
23 formulated by the board and approved by the commissioner, including  
24 one plan which contains benefits and cost sharing levels that are  
25 equivalent to those required for health maintenance organizations.<sup>4</sup>

26 h. [Notwithstanding the provisions of subsection a. of this section  
27 to the contrary, the board may modify the benefits provided for in  
28 sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2  
29 and 26:2J-4.3).] <sup>4</sup>[(Deleted by amendment, P.L. , c. ).]  
30 Notwithstanding the provisions of subsection a. of this section to the  
31 contrary, the board may modify the benefits provided for in sections  
32 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and  
33 26:2J-4.3).<sup>4</sup>

34 i. (1) [ In addition to the rider packages provided for in subsection  
35 d. of this section, every carrier may offer, in connection with the five  
36 health benefits plans required to be offered by this section, any number  
37 of riders which may revise the coverage offered by the five plans in  
38 any way, provided, however, that any form of such rider or  
39 amendment thereof which decreases benefits or decreases the actuarial  
40 value of one of the five plans shall be filed for informational purposes  
41 with the board and for approval by the commissioner before such rider  
42 may be sold. Any rider or amendment thereof which adds benefits or  
43 increases the actuarial value of one of the five plans shall be filed with  
44 the board for informational purposes before such rider may be sold.

45 The commissioner shall disapprove any rider filed pursuant to this  
46 subsection that is unjust, unfair, inequitable, unreasonably

1 discriminatory, misleading, contrary to law or the public policy of this  
2 State. The commissioner shall not approve any rider which reduces  
3 benefits below those required by sections 55, 57 and 59 of P.L.1991,  
4 c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and required to be  
5 sold pursuant to this section. The commissioner's determination shall  
6 be in writing and shall be appealable.] <sup>4</sup>~~[(Deleted by amendment,~~  
7 ~~P.L. \_\_\_\_\_, c. \_\_\_\_).] In addition to the rider packages provided for in~~  
8 ~~subsection d. of this section, every carrier may offer, in connection~~  
9 ~~with the health benefits plans required to be offered by this section,~~  
10 ~~any number of riders which may revise the coverage offered by the~~  
11 ~~plans in any way, provided, however, that any form of such rider or~~  
12 ~~amendment thereof which decreases benefits or decreases the actuarial~~  
13 ~~value of one of the plans shall be filed for informational purposes with~~  
14 ~~the board and for approval by the commissioner before such rider may~~  
15 ~~be sold. Any rider or amendment thereof which adds benefits or~~  
16 ~~increases the actuarial value of one of the plans shall be filed with the~~  
17 ~~board for informational purposes before such rider may be sold.~~

18 The commissioner shall disapprove any rider filed pursuant to this  
19 subsection that is unjust, unfair, inequitable, unreasonably  
20 discriminatory, misleading, contrary to law or the public policy of this  
21 State. The commissioner shall not approve any rider which reduces  
22 benefits below those required by sections 55, 57 and 59 of P.L.1991,  
23 c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and required to be  
24 sold pursuant to this section. The commissioner's determination shall  
25 be in writing and shall be appealable.<sup>4</sup>

26 (2) [(The benefit riders provided for in paragraph (1) of this  
27 subsection shall be subject to the provisions of section 2, subsection  
28 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162  
29 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23,  
30 17B:27A-24, 17B:27A-25, and 17B:27A-27).] <sup>4</sup>~~[(Deleted by~~  
31 ~~amendment, P.L. \_\_\_\_\_, c. \_\_\_\_).] The benefit riders provided for in~~  
32 ~~paragraph (1) of this subsection shall be subject to the provisions of~~  
33 ~~section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of~~  
34 ~~P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,~~  
35 ~~17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).]~~<sup>4</sup>

36 j. (1) Notwithstanding the provisions of P.L.1992, c.162  
37 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued  
38 by or through a carrier, association, or multiple employer arrangement  
39 prior to January 1, 1994 or, if the requirements of subparagraph (c) of  
40 paragraph (6) of this subsection are met, issued by or through an  
41 out-of-State trust prior to January 1, 1994, at the option of a small  
42 employer policy or contract holder, may be renewed or continued after  
43 February 28, 1994, or in the case of such a health benefits plan whose  
44 anniversary date occurred between March 1, 1994 and the effective  
45 date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated  
46 within 60 days of that anniversary date and renewed or continued if,

1 beginning on the first 12-month anniversary date occurring on or after  
2 the sixtieth day after the board adopts regulations concerning the  
3 implementation of the rating factors permitted by section 9 of  
4 P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of  
5 delivery of the health benefits plan, the health benefits plan renewed,  
6 continued or reinstated pursuant to this subsection complies with the  
7 provisions of section 2, subsection b. of section 3, and sections 6, 7,  
8 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19,  
9 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and  
10 17B:27A-27) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

11 Nothing in this subsection shall be construed to require an  
12 association, multiple employer arrangement or out-of-State trust to  
13 provide health benefits coverage to small employers that are not  
14 contemplated by the organizational documents, bylaws, or other  
15 regulations governing the purpose and operation of the association,  
16 multiple employer arrangement or out-of-State trust. Notwithstanding  
17 the foregoing provision to the contrary, an association, multiple  
18 employer arrangement or out-of-State trust that offers health benefits  
19 coverage to its members' employees and dependents:

20 (a) shall offer coverage to all eligible employees and their  
21 dependents within the membership of the association, multiple  
22 employer arrangement or out-of-State trust;

23 (b) shall not use actual or expected health status in determining its  
24 membership; and

25 (c) shall make available to its small employer members at least one  
26 of the standard benefits plans, as determined by the commissioner, in  
27 addition to any health benefits plan permitted to be renewed or  
28 continued pursuant to this subsection.

29 (2) Notwithstanding the provisions of this subsection to the  
30 contrary, a carrier or out-of-State trust which writes the health  
31 benefits plans required pursuant to subsection a. of this section shall  
32 be required to offer those plans to any small employer, association or  
33 multiple employer arrangement.

34 (3) (a) A carrier, association, multiple employer arrangement or  
35 out-of-State trust may withdraw a health benefits plan marketed to  
36 small employers that was in effect on December 31, 1993 with the  
37 approval of the commissioner. The commissioner shall approve a  
38 request to withdraw a plan, consistent with regulations adopted by the  
39 commissioner, only on the grounds that retention of the plan would  
40 cause an unreasonable financial burden to the issuing carrier, taking  
41 into account the rating provisions of section 9 of P.L.1992, c.162  
42 (C.17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

43 (b) A carrier which has renewed, continued or reinstated a health  
44 benefits plan pursuant to this subsection that has not been newly issued  
45 to a new small employer group since January 1, 1994, may, upon  
46 approval of the commissioner, continue to establish its rates for that

1 plan based on the loss experience of that plan if the carrier does not  
2 issue that health benefits plan to any new small employer groups.

3 (4) (Deleted by amendment, P.L.1995, c.340).

4 (5) A health benefits plan that otherwise conforms to the  
5 requirements of this subsection shall be deemed to be in compliance  
6 with this subsection, notwithstanding any change in the plan's  
7 deductible or copayment.

8 (6) [(a) Except as otherwise provided in subparagraphs (b) and (c)  
9 of this paragraph, a] <sup>4</sup>[A] (a) Except as otherwise provided in  
10 subparagraphs (b) and (c) of this paragraph, a<sup>4</sup> health benefits plan  
11 renewed, continued or reinstated pursuant to this subsection shall be  
12 filed with the commissioner for informational purposes within 30 days  
13 after its renewal date. No later than 60 days after the board adopts  
14 regulations concerning the implementation of the rating factors  
15 permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing  
16 shall be amended to show any modifications in the plan that are  
17 necessary to comply with the provisions of this subsection. The  
18 commissioner shall monitor compliance of any such plan with the  
19 requirements of this subsection, except that the board shall enforce the  
20 loss ratio requirements.

21 (b) [A health benefits plan filed with the commissioner pursuant to  
22 subparagraph (a) of this paragraph may be amended as to its benefit  
23 structure if the amendment does not reduce the actuarial value and  
24 benefits coverage of the health benefits plan below that of the lowest  
25 standard health benefits plan established by the board pursuant to  
26 subsection a. of this section. The amendment shall be filed with the  
27 commissioner for approval pursuant to the terms of sections 4, 8, 12  
28 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and  
29 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and  
30 shall comply with the provisions of sections 2 and 9 of P.L.1992,  
31 c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995,  
32 c.340 (C.17B:27A-19.3).] <sup>4</sup>[(Deleted by amendment, P.L. , c. ).]  
33 A health benefits plan filed with the commissioner pursuant to  
34 subparagraph (a) of this paragraph may be amended as to its benefit  
35 structure if the amendment does not reduce the actuarial value and  
36 benefits coverage of the health benefits plan below that of the lowest  
37 standard health benefits plan established by the board pursuant to  
38 subsection a. of this section. The amendment shall be filed with the  
39 commissioner for approval pursuant to the terms of sections 4, 8, 12  
40 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and  
41 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and  
42 shall comply with the provisions of sections 2 and 9 of P.L.1992,  
43 c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995,  
44 c.340 (C.17B:27A-19.3).<sup>4</sup>

45 (c) [A health benefits plan issued by a carrier through an  
46 out-of-State trust shall be permitted to be renewed or continued

1 pursuant to paragraph (1) of this subsection upon approval by the  
2 commissioner and only if the benefits offered under the plan are at  
3 least equal to the actuarial value and benefits coverage of the lowest  
4 standard health benefits plan established by the board pursuant to  
5 subsection a. of this section. For the purposes of meeting the  
6 requirements of this subparagraph, carriers shall be required to file  
7 with the commissioner the health benefits plans issued through an  
8 out-of-State trust no later than 180 days after the date of enactment  
9 of P.L.1995, c.340. A health benefits plan issued by a carrier through  
10 an out-of-State trust that is not filed with the commissioner pursuant  
11 to this subparagraph, shall not be permitted to be continued or  
12 renewed after the 180-day period.] <sup>4</sup>[(Deleted by amendment,  
13 P.L. \_\_, c. \_\_).] A health benefits plan issued by a carrier through an  
14 out-of-State trust shall be permitted to be renewed or continued  
15 pursuant to paragraph (1) of this subsection upon approval by the  
16 commissioner and only if the benefits offered under the plan are at  
17 least equal to the actuarial value and benefits coverage of the lowest  
18 standard health benefits plan established by the board pursuant to  
19 subsection a. of this section. For the purposes of meeting the  
20 requirements of this subparagraph, carriers shall be required to file  
21 with the commissioner the health benefits plans issued through an  
22 out-of-State trust no later than 180 days after the date of enactment  
23 of P.L.1995, c.340. A health benefits plan issued by a carrier through  
24 an out-of-State trust that is not filed with the commissioner pursuant  
25 to this subparagraph, shall not be permitted to be continued or  
26 renewed after the 180-day period.<sup>4</sup>

27 (7) [Notwithstanding the provisions of P.L.1992, c.162  
28 (C.17B:27A-17 et seq.) to the contrary, an association, multiple  
29 employer arrangement or out-of-State trust may offer a health benefits  
30 plan authorized to be renewed, continued or reinstated pursuant to this  
31 subsection to small employer groups that are otherwise eligible  
32 pursuant to paragraph (1) of subsection j. of this section during the  
33 period for which such health benefits plan is otherwise authorized to  
34 be renewed, continued or reinstated.] <sup>4</sup>[(Deleted by amendment,  
35 P.L. \_\_, c. \_\_).] Notwithstanding the provisions of P.L.1992, c.162  
36 (C.17B:27A-17 et seq.) to the contrary, an association, multiple  
37 employer arrangement or out-of-State trust may offer a health benefits  
38 plan authorized to be renewed, continued or reinstated pursuant to this  
39 subsection to small employer groups that are otherwise eligible  
40 pursuant to paragraph (1) of subsection j. of this section during the  
41 period for which such health benefits plan is otherwise authorized to  
42 be renewed, continued or reinstated.<sup>4</sup>

43 (8) [Notwithstanding the provisions of P.L.1992, c.162  
44 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple  
45 employer arrangement or out-of-State trust may offer coverage under  
46 a health benefits plan authorized to be renewed, continued or

1 reinstated pursuant to this subsection to new employees of small  
2 employer groups covered by the health benefits plan in accordance  
3 with the provisions of paragraph (1) of this subsection.] <sup>4</sup>[(Deleted by  
4 amendment, P.L. \_\_\_\_\_, c. \_\_\_\_).] Notwithstanding the provisions of  
5 P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, a carrier,  
6 association, multiple employer arrangement or out-of-State trust may  
7 offer coverage under a health benefits plan authorized to be renewed,  
8 continued or reinstated pursuant to this subsection to new employees  
9 of small employer groups covered by the health benefits plan in  
10 accordance with the provisions of paragraph (1) of this subsection.<sup>4</sup>

11 (9) Notwithstanding the provisions of P.L.1992, c.162  
12 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to  
13 the contrary, any individual, who is eligible for small employer  
14 coverage under a policy issued, renewed, continued or reinstated  
15 pursuant to this subsection, but who would be subject to a preexisting  
16 condition exclusion under the small employer health benefits plan, or  
17 who is a member of a small employer group who has been denied  
18 coverage under the small employer group health benefits plan for  
19 health reasons, may elect to purchase or continue coverage under an  
20 individual health benefits plan until such time as the group health  
21 benefits plan covering the small employer group of which the  
22 individual is a member complies with the provisions of P.L.1992, c.162  
23 (C.17B:27A-17 et seq.).

24 (10) In a case in which an association made available a health  
25 benefits plan on or before March 1, 1994 and subsequently changed  
26 the issuing carrier between March 1, 1994 and the effective date of  
27 P.L.1995, c.340, the new issuing carrier shall be deemed to have been  
28 eligible to continue and renew the plan pursuant to paragraph (1) of  
29 this subsection.

30 (11) In a case in which an association, multiple employer  
31 arrangement or out-of-State trust made available a health benefits plan  
32 on or before March 1, 1994 and subsequently changes the issuing  
33 carrier for that plan after the effective date of P.L.1995, c.340, the  
34 new issuing carrier shall file the health benefits plan with the  
35 commissioner for approval in order to be deemed eligible to continue  
36 and renew that plan pursuant to paragraph (1) of this subsection.

37 (12) In a case in which a small employer purchased a health benefits  
38 plan directly from a carrier on or before March 1, 1994 and  
39 subsequently changes the issuing carrier for that plan after the  
40 effective date of P.L.1995, c.340, the new issuing carrier shall file the  
41 health benefits plan with the commissioner for approval in order to be  
42 deemed eligible to continue and renew that plan pursuant to paragraph  
43 (1) of this subsection.

44 [Notwithstanding the provisions of subparagraph (b) of paragraph  
45 (6) of this subsection to the contrary, a] <sup>4</sup>[A] Notwithstanding the  
46 provisions of subparagraph (b) of paragraph (6) of this subsection to

1 the contrary, a<sup>4</sup> small employer who changes its health benefits plan's  
2 issuing carrier pursuant to the provisions of this paragraph, shall not,  
3 upon changing carriers, modify the benefit structure of that health  
4 benefits plan within six months of the date the issuing carrier was  
5 changed.

6 k. Effective immediately for a health benefits plan issued on or  
7 after the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.) and  
8 effective on the first 12-month anniversary date of a health benefits  
9 plan in effect on the effective date of P.L.1995, c.316  
10 (C.17:48E-35.10 et al.), the health benefits plans required pursuant to  
11 this section, including any plans offered by a State approved or  
12 federally qualified health maintenance organization, shall contain  
13 benefits for expenses incurred in the following:

14 (1) Screening by blood lead measurement for lead poisoning for  
15 children, including confirmatory blood lead testing as specified by the  
16 Department of Health and Senior Services pursuant to section 7 of  
17 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any  
18 necessary medical follow-up and treatment for lead poisoned children.

19 (2) All childhood immunization as recommended by the Advisory  
20 Committee on Immunization Practices of the United <sup>4</sup>[State] States<sup>4</sup>  
21 Public Health Service and the Department of Health and Senior  
22 Services pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A  
23 carrier shall notify its insureds, in writing, of any change in the health  
24 care services provided with respect to childhood immunizations and  
25 any related changes in premium. Such notification shall be in a form  
26 and manner to be determined by the Commissioner of Banking and  
27 Insurance.

28 (3) Screening for newborn hearing loss by appropriate  
29 electrophysiologic screening measures and periodic monitoring of  
30 infants for delayed onset hearing loss, pursuant to 2001, c.373  
31 (C.26:2-103.1 et al.). Payment for this screening service shall be  
32 separate and distinct from payment for routine new baby care in the  
33 form of a newborn hearing screening fee as negotiated with the  
34 provider and facility.

35 The benefits shall be provided to the same extent as for any other  
36 medical condition under the health benefits plan, except that no  
37 deductible shall be applied for benefits provided pursuant to this  
38 subsection. This subsection shall apply to all small employer health  
39 benefits plans in which the carrier has reserved the right to change the  
40 premium.

41 l. The board shall consider including benefits for speech-language  
42 pathology and audiology services, as rendered by speech-language  
43 pathologists and audiologists within the scope of their practices, in at  
44 least one of the five standard policies and in at least one of the five  
45 riders to be developed under this section.

46 m. Effective immediately for a health benefits plan issued on or



1 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and  
 2 effective on the first 12-month anniversary date of a health benefits  
 3 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et  
 4 al.), the health benefits plans required pursuant to this section that  
 5 provide benefits for expenses incurred in the purchase of prescription  
 6 drugs shall provide benefits for expenses incurred in the purchase of  
 7 specialized non-standard infant formulas, when the covered infant's  
 8 physician has diagnosed the infant as having multiple food protein  
 9 intolerance and has determined such formula to be medically  
 10 necessary, and when the covered infant has not been responsive to  
 11 trials of standard non-cow milk-based formulas, including soybean and  
 12 goat milk. The coverage may be subject to utilization review,  
 13 including periodic review, of the continued medical necessity of the  
 14 specialized infant formula.

15 The benefits shall be provided to the same extent as for any other  
 16 prescribed items under the health benefits plan.

17 This subsection shall apply to all small employer health benefits  
 18 plans in which the carrier has reserved the right to change the  
 19 premium.

20 <sup>4</sup>[n. No restriction or limit on deductibles, coinsurance, co-  
 21 payments, or annual or lifetime maximum payments shall apply to any  
 22 health benefits plan policy or contract, including a standard plan,  
 23 offered to a small employer unless the restriction or limit is made  
 24 expressly applicable to that policy or contract.]<sup>4</sup>

25 (cf: P.L.2001, c.373, s.15)

26

27 <sup>1</sup>[11.] <sup>2</sup>[13.<sup>1</sup>] <sup>4</sup>[12. <sup>3</sup> 15. <sup>4</sup> Section 5 of P.L.2001, c.368  
 28 (C.17B:27A-19.11) is amended to read as follows:

29 5. In addition to the [five] health benefits plans offered by a carrier  
 30 on the effective date of this act, a carrier that writes small employer  
 31 health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et  
 32 seq.) may also offer one or more of the plans through the carrier's  
 33 network of providers, with no reimbursement for any out-of-network  
 34 benefits other than emergency care, urgent care, and continuity of  
 35 care. A carrier's network of providers shall be subject to review and  
 36 approval or disapproval by the Commissioner of Banking and  
 37 Insurance, in consultation with the Commissioner of Health and Senior  
 38 Services, pursuant to regulations promulgated by the Department of  
 39 Banking and Insurance, including review and approval or disapproval  
 40 before plans with benefits provided through a carrier's network of  
 41 providers pursuant to this section may be offered by the carrier.  
 42 Policies or contracts written on this basis shall be rated in a separate  
 43 rating pool for the purposes of establishing a premium, but for the  
 44 purpose of determining a carrier's losses, these policies or contracts  
 45 shall be aggregated with the losses on the carrier's other business  
 46 written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17

1 et seq.).

2 (cf: P.L.2001, c.368, s.5)

3

4 <sup>4</sup>16. Section 6 of P.L.1992, c.162 (C.17B:27A-22) is amended to  
5 read as follows:

6 6. a. No health benefits plan subject to this act shall include any  
7 provision excluding coverage for a preexisting condition regardless of  
8 the cause of the condition, provided that a preexisting condition  
9 provision may apply to a late enrollee or to any group [of two to five  
10 persons] if such provision excludes coverage for a period of no more  
11 than 180 days following the effective date of coverage of such  
12 enrollee, and relates only to conditions, whether physical or mental,  
13 manifesting themselves during the six months immediately preceding  
14 the enrollment date of such enrollee and for which medical advice,  
15 diagnosis, care, or treatment was recommended or received during the  
16 six months immediately preceding the effective date of coverage;  
17 provided that, if 10 or more late enrollees request enrollment during  
18 any 30-day enrollment period, then no preexisting condition provision  
19 shall apply to any such enrollee.

20 b. In determining whether a preexisting condition provision applies  
21 to an eligible employee or dependent, all health benefits plans shall  
22 credit the time that person was covered under creditable coverage if  
23 the creditable coverage was continuous to a date not more than 90  
24 days prior to the effective date of the new coverage, exclusive of any  
25 applicable waiting period under such plan. A carrier shall provide  
26 credit pursuant to this provision in one of the following methods:

27 (1) A carrier shall count a period of creditable coverage without  
28 regard to the specific benefits covered during the period; or

29 (2) A carrier shall count a period of creditable coverage based on  
30 coverage of benefits within each of several classes or categories of  
31 benefits specified in federal regulation rather than the method  
32 provided in paragraph (1) of this subsection. This election shall be  
33 made on a uniform basis for all covered persons. Under this election,  
34 a carrier shall count a period of creditable coverage with respect to  
35 any class or category of benefits if any level of benefits is covered  
36 within that class or category. A carrier which elects to provide credit  
37 pursuant to this provision shall comply with all federal notice  
38 requirements.

39 c. A health benefits plan shall not impose a preexisting condition  
40 exclusion for the following:

41 (1) A newborn child who, as of the last date of the 30-day period  
42 beginning with the date of birth, is covered under creditable coverage;

43 (2) A child who is adopted or placed for adoption before attaining  
44 18 years of age and who, as of the last day of the 30-day period  
45 beginning on the date of the adoption or placement for adoption, is  
46 covered under creditable coverage. This provision shall not apply to

1 coverage before the date of the adoption or placement for adoption;  
2 or

3 (3) Pregnancy as a preexisting condition.<sup>4</sup>

4 (cf: P.L.1997, c.146, s.9)

5

6 <sup>1</sup>[12.] <sup>2</sup>[14.<sup>1</sup>] <sup>4</sup>[13.<sup>2</sup>] 17.<sup>4</sup> Section 7 of P.L.1992, c.162  
7 (C.17B:27A-23) is amended to read as follows:

8 7. Every policy or contract issued to small employers in this State  
9 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be  
10 renewable with respect to all eligible employees or dependents at the  
11 option of the policy or contract holder, or small employer except that  
12 a carrier may discontinue or not renew a health benefits plan in  
13 accordance with the provisions of this section:

14 a. A carrier may discontinue such coverage only if:

15 (1) The policyholder, contract holder, or employer has failed to pay  
16 premiums or contributions in accordance with the terms of the health  
17 benefits plan or the carrier has not received timely premium payments;  
18 or

19 (2) The policyholder, contract holder, or employer has performed  
20 an act or practice that constitutes fraud or made an intentional  
21 misrepresentation of material fact under the terms of the coverage;

22 b. (Deleted by amendment, P.L.1997, c.146).

23 c. The number of employees covered under the health benefits plan  
24 is less than the number or percentage of employees required by  
25 participation requirements under the health benefits policy or contract;

26 d. Noncompliance with a carrier's employment contribution  
27 requirements;

28 e. Any carrier doing business pursuant to the provisions of this act  
29 ceases doing business in the small employer [market] and individual  
30 health benefits plan markets, if the following conditions are satisfied:

31 (1) The carrier gives notice to cease doing business in the small  
32 employer [market] and individual health benefits plan markets to the  
33 commissioner not later than eight months prior to the date of the  
34 planned withdrawal from the small [group market] employer and  
35 individual health benefits plan markets, during which time the carrier  
36 shall continue to be governed by this act with respect to business  
37 written pursuant to this act. For the purposes of this subsection, "date  
38 of withdrawal" means the date upon which the first notice to small  
39 employers and individual policyholders is sent by the carrier pursuant  
40 to paragraph (2) of this subsection;

41 (2) No later than two months following the date of the notification  
42 to the commissioner that the carrier intends to cease doing business in  
43 the small employer [market] and individual health benefits plan  
44 markets, the carrier shall mail a notice to every small business  
45 employer and individual policyholder insured by the carrier, and all  
46 covered persons, that the policy or contract of insurance will not be

1 renewed. This notice shall be sent by certified mail to the small  
2 business employer or individual policyholder not less than six months  
3 in advance of the effective date of the nonrenewal date of the policy  
4 or contract;

5 (3) Any carrier that ceases to do business pursuant to this act  
6 <sup>4</sup>~~[shall]~~ may<sup>4</sup> be prohibited from writing new business in the small  
7 employer ~~[market]~~ and individual health benefits plan markets for a  
8 period of five years from the date of termination of the last health  
9 insurance coverage not so renewed <sup>2</sup>~~[, unless the commissioner agrees~~  
10 to an earlier date on which the carrier may begin to write new small  
11 employer and individual health benefits plan business. In considering  
12 such requests, the commissioner shall take into account the availability  
13 of coverage in the market and the value of more competition or new  
14 products]<sup>2</sup>;

15 f. In the case of policies or contracts issued in connection with  
16 membership in an association or trust of employers, an employer  
17 ceases to maintain its membership in the association or trust, but only  
18 if such coverage is terminated under this provision uniformly without  
19 regard to any health status-related factor relating to any covered  
20 individual.

21 g. (Deleted by amendment, P.L.1995, c.50).

22 h. A decision by the small employer carrier to cease offering and  
23 not renew a particular type of group health benefits plan in the small  
24 employer market ~~[, if the board discontinues a standard health benefits~~  
25 plan or as permitted or required pursuant to subsection j. of section 3  
26 of P.L.1992, 162 (C.17B:27A-19), and pursuant to regulations  
27 adopted by the commissioner] <sup>4</sup>~~, if the board discontinues a standard~~  
28 health benefits plan or as permitted or required pursuant to subsection  
29 j. of section 3 of P.L.1992, c.162 (C.17B:27A-19), and pursuant to  
30 regulations adopted by the commissioner<sup>4</sup>;

31 i. In the case of a health maintenance organization plan issued to  
32 a small employer:

33 (1) an eligible person who no longer resides, lives, or works in the  
34 carrier's approved service area, but only if coverage is terminated  
35 under this paragraph uniformly without regard to any health  
36 status-related factor of covered individuals; or

37 (2) a small employer that no longer has any enrollee in connection  
38 with such plan who lives, resides, or works in the service area of the  
39 carrier and the carrier would deny enrollment with respect to such plan  
40 pursuant to subsection a. of section 10 of P.L.1992, c.162  
41 (C.17B:27A-26).

42 (cf: P.L.1997, c.146, s.10)

1       <sup>4</sup>[<sup>2</sup>14.] 18.<sup>4</sup> Section 8 of P.L.1992, c.162 (C.17B:27A-24) is  
 2 amended to read as follows:

3       8. <sup>4</sup>a.<sup>4</sup> Any small employer carrier may require a reasonable  
 4 specified minimum participation <sup>4</sup>[with the same carrier]<sup>4</sup> of eligible  
 5 employees <sup>4</sup>[or employees working a normal work week of 35 or  
 6 more hours, at the option of the employer]<sup>4</sup>, which shall not exceed  
 7 75%, <sup>4</sup>except as may otherwise be required by the board pursuant to  
 8 subsection b. of this section.<sup>4</sup> or reasonable minimum employer  
 9 contributions in determining whether to accept a small group pursuant  
 10 to this act. The standards so established by the carrier shall be first  
 11 approved by the board and shall be applied uniformly to all small  
 12 groups, except that in no event shall a carrier require an employer to  
 13 contribute more than 10% to the annual cost of the policy or contract,  
 14 or an amount as otherwise provided by the board, and any minimum  
 15 participation standards established by the carrier shall be reasonable.  
 16 In establishing the percentage of employee participation, a one-to-one  
 17 credit shall be given for each employee covered by a spouse's health  
 18 benefits coverage, Medicare, Medicaid, NJ FamilyCare or another  
 19 group health benefits plan. In calculating an employer's participation,  
 20 the carrier shall include all insured employees, regardless of whether  
 21 the employees chose an indemnity plan or a health maintenance  
 22 organization, or a combination thereof <sup>4</sup>, except as may otherwise be  
 23 required by the board pursuant to subsection b. of this section.

24       b. The board shall adopt rules and regulations pursuant to the  
 25 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.)  
 26 to require a specified minimum percentage of employee participation  
 27 with the same small employer carrier<sup>4</sup>.<sup>2</sup>

28 (cf: P.L.2005, c.166, s.1)

29  
 30       <sup>1</sup>[13] <sup>4</sup>[<sup>15</sup>.<sup>1</sup>] 19.<sup>4</sup> Section 9 of P.L.1992, c.162 (C.17B:27A-25)  
 31 is amended to read as follows:

32       9 . a. (1) (Deleted by amendment, P.L.1997, c.146).

33       (2) (Deleted by amendment, P.L.1997, c.146).

34       (3) For all policies or contracts providing health benefits plans for  
 35 small employers issued pursuant to section 3 of P.L.1992, c.162  
 36 (C.17B:27A-19), and including policies or contracts offered by a  
 37 carrier to a small employer who is a member of a Small Employer  
 38 Purchasing Alliance pursuant to the provisions of P.L.2001, c.225  
 39 (C.17B:27A-25.1 et al.) the premium rate charged by a carrier to the  
 40 highest rated small group purchasing a small employer health benefits  
 41 plan issued pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19)  
 42 shall not be greater than 200% of the premium rate charged for the  
 43 lowest rated small group purchasing that same health benefits plan;  
 44 provided, however, that the only factors upon which the rate  
 45 differential may be based are age, gender and geography, and provided  
 46 further, that such factors are applied in a manner consistent with

1 regulations adopted by the board. <sup>4</sup>[In developing the rating factor  
2 for geography, carriers may use counties as the smallest permissible  
3 rating territory.]<sup>4</sup> For the purposes of this paragraph (3), policies or  
4 contracts offered by a carrier to a small employer who is a member of  
5 a Small Employer Purchasing Alliance shall be rated separately from  
6 the carrier's other small employer health benefits policies or contracts.

7 A health benefits plan issued pursuant to subsection j. of section 3  
8 of P.L.1992, c.162 (C.17B:27A-19) shall be rated in accordance with  
9 the provisions of section 7 of P.L.1995, c.340 (C.17B:27A-19.3), for  
10 the purposes of meeting the requirements of this paragraph.

11 (4) (Deleted by amendment, P.L.1994, c.11).

12 (5) Any policy or contract issued after January 1, 1994 to a small  
13 employer who was not previously covered by a health benefits plan  
14 issued by the issuing small employer carrier, shall be subject to the  
15 same premium rate restrictions as provided in paragraph (3) of this  
16 subsection, which rate restrictions shall be effective on the date the  
17 policy or contract is issued.

18 (6) The board shall establish, pursuant to section 17 of P.L.1993,  
19 c.162 (C.17B:27A-51):

20 (a) [up to six geographic territories, none of which is smaller than  
21 a county; and] <sup>4</sup>[(Deleted by amendment, P.L. , c. ).] geographic  
22 territories, none of which is smaller than a county; and<sup>4</sup>

23 (b) age classifications which, at a minimum, shall be in five-year  
24 increments.

25 b. (Deleted by amendment, P.L.1993, c.162).

26 c. (Deleted by amendment, P.L.1995, c.298).

27 d. Notwithstanding any other provision of law to the contrary, this  
28 act shall apply to a carrier which provides a health benefits plan to one  
29 or more small employers through a policy issued to an association or  
30 trust of employers.

31 A carrier which provides a health benefits plan to one or more small  
32 employers through a policy issued to an association or trust of  
33 employers after the effective date of P.L.1992, c.162 (C.17B:27A-17  
34 et seq.), shall be required to offer small employer health benefits plans  
35 to non-association or trust employers in the same manner as any other  
36 small employer carrier is required pursuant to P.L.1992, c.162  
37 (C.17B:27A-17 et seq.).

38 e. Nothing contained herein shall prohibit the use of premium rate  
39 structures to establish different premium rates for individuals and  
40 family units.

41 f. No insurance contract or policy subject to this act, including a  
42 contract or policy entered into with a small employer who is a member  
43 of a Small Employer Purchasing Alliance pursuant to the provisions of  
44 P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be entered into unless  
45 and until the carrier has made an informational filing with the  
46 commissioner of a schedule of premiums, not to exceed 12 months in

1 duration, to be paid pursuant to such contract or policy, of the carrier's  
 2 rating plan and classification system in connection with such contract  
 3 or policy, and of the actuarial assumptions and methods used by the  
 4 carrier in establishing premium rates for such contract or policy.  
 5 <sup>4</sup>Premiums that will be effective on or after the effective date of P.L.  
 6 , c. (C. ) (pending before the Legislature as this bill) shall provide  
 7 an anticipated minimum loss ratio of not less than 77%.<sup>4</sup>  
 8 g. (1) Beginning <sup>4</sup>[January 1, 1995] on the effective date of P.L.  
 9 , c. (C. ) (pending before the Legislature as this bill)<sup>4</sup>, a carrier  
 10 desiring to increase or decrease premiums for any policy form [or  
 11 benefit rider offered pursuant to subsection i. of section 3 of P.L.1992,  
 12 c.162 (C.17B:27A-19)] <sup>4</sup>or benefit rider offered pursuant to  
 13 subsection i. of section 3 of P.L.1992, c.162 (C.17B:27A-19)<sup>4</sup> subject  
 14 to this act may implement such increase or decrease upon making an  
 15 informational filing with the commissioner of such increase or  
 16 decrease, along with the actuarial assumptions and methods used by  
 17 the carrier in establishing such increase or decrease, provided that the  
 18 anticipated minimum loss ratio for all policy forms shall not be less  
 19 than <sup>1</sup>[75%] <sup>2</sup>[80%<sup>1</sup>] <sup>3</sup>[78% <sup>3</sup>] <sup>4</sup>[75% ]<sup>3</sup>77% <sup>4</sup> of the premium  
 20 therefor as provided in paragraph (2) of this subsection <sup>2</sup>[<sup>1</sup>; and  
 21 provided further, however, that the carrier shall not implement an  
 22 increase in premiums in excess of 15% for any contract or policy form  
 23 unless the increase has been reviewed and approved by the  
 24 commissioner, through procedures to be prescribed by the  
 25 commissioner by regulation<sup>1</sup>]<sup>2</sup>. <sup>4</sup>[<sup>2</sup>The commissioner may disapprove  
 26 any informational filing on a finding that it is incomplete and not in  
 27 substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et seq.),  
 28 or that the rates are <sup>3</sup>[excessive,]<sup>3</sup> inadequate or unfairly  
 29 discriminatory. Any increase in excess of 15% per year for any policy  
 30 shall require review and approval by the commissioner through  
 31 procedures set forth by regulation. <sup>3</sup>[Any increase in excess of 15%  
 32 per year shall be presumed to result in rates that are excessive, with  
 33 the burden on the carrier to show] If an increase is in excess of 15%  
 34 per year, the carrier shall demonstrate<sup>3</sup> that the rate increase is  
 35 justified. Compliance with the minimum loss ratio requirement, while  
 36 necessary, shall not in itself be considered justification.<sup>2</sup> Until  
 37 December 31, 1996, the informational filing shall also include the  
 38 carrier's rating plan and classification system in connection with such  
 39 increase or decrease.]<sup>4</sup>  
 40 (2) Each calendar year, a carrier shall return, in the form of  
 41 aggregate benefits for all [of the five standard] <sup>4</sup>of the standard<sup>4</sup>  
 42 policy forms offered by the carrier pursuant to subsection a. of section  
 43 3 of P.L.1992, c.162 (C.17B:27A-19), at least <sup>1</sup>[75%] ~~[80% ]~~  
 44 <sup>3</sup>[78%<sup>2</sup>] <sup>4</sup>[75%<sup>3</sup>] 77%<sup>4</sup> of the aggregate premiums collected for all  
 45 of the [standard] <sup>4</sup>standard<sup>4</sup> policy forms, other than alliance policy

1 forms [, and at least 75% of the aggregate premiums collected for all  
 2 of the non-standard policy forms] <sup>4</sup>, and at least 77% of the aggregate  
 3 premiums collected for all of the non-standard policy forms<sup>4</sup> during  
 4 that calendar year. A carrier shall return at least <sup>1</sup>[75%] <sup>2</sup>[80%<sup>1</sup>]  
 5 <sup>3</sup>[78%<sup>2</sup>] <sup>4</sup>[75%<sup>3</sup>] 77%<sup>4</sup> of the premiums collected for all of the  
 6 alliances during that calendar year, which loss ratio may be calculated  
 7 in the aggregate for all of the alliances or separately for each alliance.  
 8 Carriers shall annually report, no later than August 1st of each year,  
 9 the loss ratio calculated pursuant to this section for all of the  
 10 [standard, other than alliance policy forms, non-standard] <sup>4</sup>standard,  
 11 other than alliance policy forms, non-standard<sup>4</sup> policy forms and  
 12 alliance policy forms for the previous calendar year, provided that a  
 13 carrier may annually report the loss ratio calculated pursuant to this  
 14 section for all of the alliances in the aggregate or separately for each  
 15 alliance. In each case where the loss ratio fails to <sup>2</sup>[substantially]<sup>2</sup>  
 16 <sup>4</sup>substantially<sup>4</sup> comply with the <sup>1</sup>[75%] <sup>2</sup>[80%<sup>1</sup>] <sup>3</sup>[78%<sup>2</sup>] <sup>4</sup>[75%<sup>3</sup>]  
 17 77%<sup>4</sup> loss ratio requirement, the carrier shall issue a dividend or credit  
 18 against future premiums for all policyholders with the [standard, other  
 19 than alliance policy forms, nonstandard] <sup>4</sup>standard, other than alliance  
 20 policy forms, nonstandard<sup>4</sup> policy forms or alliance policy forms, as  
 21 applicable, in an amount <sup>2</sup>[sufficient to assure that the aggregate  
 22 benefits paid in the previous calendar year plus the amount of the  
 23 dividends and credits shall equal <sup>1</sup>[75%] 80%<sup>1</sup> of the aggregate  
 24 premiums collected for the respective policy forms in the previous  
 25 calendar year] equal to the difference between the net earned premium  
 26 received in that year and the amount of net earned premium that would  
 27 have been necessary to achieve the <sup>3</sup>[78%] <sup>4</sup>[75%<sup>3</sup>] 77%<sup>4</sup> loss ratio<sup>2</sup>.  
 28 All dividends and credits must be distributed by December 31 of the  
 29 year following the calendar year in which the loss ratio requirements  
 30 were not satisfied. The annual report required by this paragraph shall  
 31 include a carrier's calculation of the dividends and credits applicable  
 32 to [standard, other than alliance policy forms, non-standard]  
 33 <sup>4</sup>standard, other than alliance policy forms, non-standard<sup>4</sup> policy forms  
 34 and alliance policy forms, as well as an explanation of the carrier's plan  
 35 to issue dividends or credits. The instructions and format for  
 36 calculating and reporting loss ratios and issuing dividends or credits  
 37 shall be specified by the commissioner by regulation. Such regulations  
 38 shall include provisions for the distribution of a dividend or credit in  
 39 the event of cancellation or termination by a policyholder. For  
 40 purposes of this paragraph, "alliance policy forms" means policies  
 41 purchased by small employers who are members of Small Employer  
 42 Purchasing Alliances.

43 (3) The loss ratio of a health benefits plan issued pursuant to  
 44 subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be  
 45 calculated in accordance with the provisions of section 7 of P.L.1995,



1 c.340 (C.17B:27A-19.3), for the purposes of meeting the requirements  
2 of this subsection.

3 h. (Deleted by amendment, P.L.1993, c.162).

4 i. The provisions of this act shall apply to health benefits plans  
5 which are delivered, issued for delivery, renewed or continued on or  
6 after January 1, 1994.

7 j. (Deleted by amendment, P.L.1995, c.340).

8 k. A carrier who negotiates a reduced premium rate with a Small  
9 Employer Purchasing Alliance for members of that alliance shall  
10 provide a reduction in the premium rate filed in accordance with  
11 paragraph (3) of subsection a. of this section, expressed as a  
12 percentage, which reduction shall be based on volume or other  
13 efficiencies or economies of scale and shall not be based on health  
14 status-related factors.

15 (cf: P.L.2003, c.163, s.1)

16  
17 <sup>1</sup>[15. (New section) a. A taxpayer who meets the income  
18 standards of the NJ FamilyCare program, but who is not currently  
19 enrolled in that program, shall be allowed a credit against the tax  
20 otherwise due for the taxable year under the "New Jersey Gross  
21 Income Tax Act," N.J.S.54A:1-1 et seq., in an amount equal to 10%  
22 of the cost incurred for premium payments for health benefits coverage  
23 for the taxpayer and the taxpayer's dependent family members during  
24 the taxable year.

25 b. A taxpayer other than a taxpayer that meets the requirements of  
26 subsection a. of this subsection whose annual gross income does not  
27 exceed \$50,000 for the taxable year shall be allowed a credit against  
28 the tax otherwise due for the taxable year under the "New Jersey  
29 Gross Income Tax Act," N.J.S.54A:1-1 et seq., in an amount equal to  
30 10% of the cost incurred for premium payments for health benefits  
31 coverage for the taxpayer and the taxpayer's dependent family  
32 members during the taxable year.

33 c. The amount of the credits applied under this section for a  
34 taxable year shall not exceed 50% of the taxpayer's liability for tax for  
35 the taxable year that bears the same proportional relationship to the  
36 total amount of such liability as the amount of the taxpayer's gross  
37 income, derived from New Jersey sources and attributable to the  
38 business or professional activity for which the taxpayer incurred costs  
39 for premium payments for health benefits coverage for the taxpayer  
40 and the taxpayer's dependent family members, bears to the taxpayer's  
41 entire gross income for that year. Credits allowed pursuant to this  
42 section shall be taken only after the taxpayer has taken all credits  
43 allowed under section 2 of P.L.2000, c.80 (C.54A:407). The amount  
44 of the credit otherwise allowable under this section which cannot be  
45 applied for the taxable year due to the limitations of this subsection,  
46 may be carried over, if necessary to the seven taxable years following

1 the taxable year for which the credit was allowed.

2 d. As used in this section:

3 "Health benefits coverage" means an individual or group health  
4 benefits plan as that term is defined in section 2 of P.L.1992, c.161  
5 (C.17B:27A-2) and section 1 of P.L.1992, c.162 (C.17B:27A-17).

6 e. A partnership shall not be allowed a credit under this section  
7 directly, but the amount of credit of a taxpayer in respect of a  
8 distributive share of partnership income under the "New Jersey Gross  
9 Income Tax Act," N.J.S.54A:1-1 et seq., shall be determined by  
10 allocating to the taxpayer that proportion of the credit acquired by the  
11 partnership that is equal to the taxpayer's share, whether or not  
12 distributed, of the total distributive income or gain of the partnership  
13 for its taxable year ending within or with the taxpayer's taxable year.

14 f. The provisions of this section shall apply to the cost incurred for  
15 premium payments for health benefits coverage after the effective date  
16 of P.L. , c. (C. )(now before the Legislature as this bill).]<sup>1</sup>

17

18 <sup>4</sup>[16. Sections 1 through 4 of P.L.2001, c.368 (C.17B:27A-4.4  
19 through 17B:27A-4.7) are repealed.]<sup>4</sup>

20

21 <sup>4</sup>20. Section 13 of P.L.1992, c.162 (C.17B:27A-29) is amended to  
22 read as follows:

23 13. a. Within 60 days of the effective date of this act, the  
24 commissioner shall give notice to all members of the time and place for  
25 the initial organizational meeting, which shall take place within 90 days  
26 of the effective date. The members shall elect the initial board, subject  
27 to the approval of the commissioner. The board shall consist of 10  
28 elected public members and two ex officio members who include the  
29 Commissioner of Health and Senior Services and the commissioner or  
30 their designees. Initially, three of the public members of the board  
31 shall be elected for a three-year term, three shall be elected for a  
32 two-year term, and three shall be elected for a one-year term.  
33 Thereafter, all elected board members shall serve for a term of three  
34 years. The following categories shall be represented among the  
35 elected public members:

36 (1) Three carriers whose principal health insurance business is in  
37 the small employer market;

38 (2) One carrier whose principal health insurance business is in the  
39 large employer market;

40 (3) A health service corporation or a domestic stock insurer which  
41 converted from a health service corporation pursuant to the provisions  
42 of P.L.2001, c.131 (C.17:48E-49 et al.) and is primarily engaged in the  
43 business of issuing health benefit plans in this State;

44 (4) Two health maintenance organizations; and

45 (5) (Deleted by amendment, P.L.1995, c.298).

46 (6) (Deleted by amendment, P.L.1995, c.298).

1 (7) Three persons representing small employers, at least one of  
2 whom represents minority small employers, and at least one of whom  
3 is or was a consumer of a small employer health benefits plan.

4 No carrier shall have more than one representative on the board.

5 The board shall hold an election for the two members added  
6 pursuant to P.L.1995, c.298 within 90 days of the date of enactment  
7 of that act. Initially, one of the two new members shall serve for a  
8 term of one year and one of the two new members shall serve for a  
9 term of two years. Thereafter, the new members shall serve for a term  
10 of three years. The terms of the risk-assuming carrier and reinsuring  
11 carrier shall terminate upon the election of the two new members  
12 added pursuant to P.L.1995, c.298, notwithstanding the provisions of  
13 this section to the contrary.

14 In addition to the 10 elected public members, the board shall  
15 include six public members appointed by the Governor with the advice  
16 and consent of the Senate who shall include:

17 Two insurance producers licensed to sell health insurance pursuant  
18 to P.L.1987, c.293 (C.17:22A-1 et seq.);

19 One representative of organized labor;

20 One physician licensed to practice medicine and surgery in this  
21 State; and

22 Two persons who represent the general public and are not  
23 employees of a health benefits plan provider.

24 The public members shall be appointed for a term of three years,  
25 except that of the members first appointed, two shall be appointed for  
26 a term of one year, two for a term of two years and two for a term of  
27 three years.

28 A vacancy in the membership of the board shall be filled for an  
29 unexpired term in the manner provided for the original election or  
30 appointment, as appropriate.

31 b. If the initial board is not elected at the organizational meeting,  
32 the commissioner shall appoint the public members within 15 days of  
33 the organizational meeting, in accordance with the provisions of  
34 paragraphs (1) through (7) of subsection a. of this section.

35 c. (Deleted by amendment, P.L.1995, c.298).

36 d. All meetings of the board shall be subject to the requirements of  
37 the "Open Public Meetings Act," P.L.1975, c.231 (C.10:4-6 et seq.).

38 e. At least two copies of the minutes of every meeting of the board  
39 shall be delivered forthwith to the commissioner.<sup>4</sup>

40 (cf: P.L.2001, c.131, s.22)

41  
42 <sup>4</sup>21. Section 17 of P.L.1992, c.162 (C.17B:27A-33) is amended to  
43 read as follows:

44 17. Subject to the approval of the commissioner, the board shall  
45 formulate the [five] health benefits plans to be made available by small  
46 employer carriers in accordance with the provisions of this act, and

1 shall promulgate [five] the standard forms pursuant thereto. The  
2 board may establish benefit levels, deductibles and co-payments,  
3 exclusions, and limitations for such health benefits plans in accordance  
4 with the law. The board shall ensure that the means exist for a carrier  
5 to offer high deductible health benefits plan options that are consistent  
6 with section 301 of Title III of the "Health Insurance Portability and  
7 Accountability Act of 1996," Pub.L. 104-191, regarding tax-deductible  
8 medical savings accounts.

9 The board shall submit the forms so established to the commissioner  
10 for approval. The commissioner shall approve the forms if the  
11 commissioner finds them to be consistent with the provisions of  
12 section 3 of P.L.1992, c. 162 (C.17B:27A-19). Any form submitted  
13 to the commissioner by the board shall be deemed approved if not  
14 expressly disapproved in writing within 60 days of its receipt by the  
15 commissioner. Such forms may contain, but shall not be limited to, the  
16 following provisions:

17 a. Utilization review of health care services, including review of  
18 medical necessity of hospital and physician services;

19 b. Managed care systems, including large case management;

20 c. Provisions for selective contracting with hospitals, physicians,  
21 and other participating and nonparticipating providers;

22 d. Reasonable benefits differentials which are applicable to  
23 participating and nonparticipating providers;

24 e. Notwithstanding the provisions of section 4 of P.L.1992, c.162  
25 (C.17B:27A-20) to the contrary, the board may, from time to time,  
26 adjust coinsurance and deductibles;

27 f. Such other provisions which may be quantifiably established to  
28 be cost containment devices;

29 g. The department shall publish annually a list of the premiums  
30 charged for each of the [five] small employer health benefits plans and  
31 for any rider package by all carriers writing such plans. The  
32 department shall also publish the toll free telephone number of each  
33 such carrier.

34 h. The board or department shall provide the appropriate staff to  
35 respond to the public's inquiries regarding the Small Employer Health  
36 Benefits Program and the small employer health benefits plans  
37 developed by the board.<sup>4</sup>

38 (cf: P.L.1997, c.146, s.13)

39  
40 <sup>4</sup>[17.] 22.<sup>4</sup> This act shall take effect on the <sup>4</sup>[90th] 120th<sup>4</sup> day  
41 after enactment <sup>4</sup>and shall apply to all contracts and policies that are  
42 delivered, issued, executed or renewed or approved for issuance or  
43 renewal in this State on or after the effective date<sup>4</sup>.