[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)

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

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

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

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

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

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

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

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

"Commissioner" means the Commissioner of Banking and Insurance.

"Community rating" means [4][:

(1) with respect to health benefits plans delivered, issued, executed or renewed prior to the effective date of P.L. , c. (C.) (now before the Legislature as this bill) and renewed on or after that effective date, [2]and with respect to health benefits plans delivered, issued or executed on or after the effective date of P.L. , c. (C.) (now before the Legislature as this bill) to an individual described in paragraph (3) of subsection a. of section 2 of P.L.1992, c.161 (C.17B:27A-3) and subsequently renewed,[2]][4] a rating system in which the premium for all persons covered [4][by] under[4] a contract [4]for a specific health benefits plan and a specific date of issue of that plan[4] is the same [4][, 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:
[1] Assembly AFI committee amendments adopted May 2, 2005.
[2] Assembly floor amendments adopted May 16, 2005.
[3] Assembly floor amendments adopted June 20, 2005.
[4] Senate SCM committee amendments adopted December 12, 2005.

contract,]4 without regard to 4[age,]4 sex, health status, occupation 4[and] ,4 geographical location 4[: and

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

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

There may be a reasonable differential among the premium rates charged for different family structure rating tiers within an individual health benefits plan or for different health benefits plans offered by the carrier4.

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

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

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

"Department" means the Department of Banking and Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the first of which shall begin January 1, 1997 and end December 31, 1998.
(cf: PL.2001, c.349, s.1.)

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

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

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

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

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

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

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

[2]The rate filed for any plan issued pursuant to this paragraph (3)

shall not exceed by more than 15% the rate filed for such a plan with an effective date one year earlier.[2]**]** this act.

For the purposes of this subsection, "renewed" means the earliest of the annual policy anniversary date, the date rates are changed or the date that a new individual health benefits plan becomes effective.[4]

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

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

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

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

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

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

P.L. , c.) [4](pending before the Legislature as this bill)[4].

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

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

(cf: P.L.1997, c.146, s.2)

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

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

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

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

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

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

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

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

if they are within the intent of this act or if the board changes the benefits included in the basic health benefits plan.[4]

(3) [A contract or policy for a basic health benefits plan provided for in this section may contain or provide for coinsurance or deductibles, or both, except that no deductible shall be payable in excess of a total of $250 by an individual or $500 by a family unit during any benefit year; and no coinsurance shall be payable in excess of a total of $500 by an individual or by a family unit during any benefit year.] [4][(Deleted by amendment, P.L. , c.).] A contract or policy for a basic health benefits plan provided for in this section may contain or provide for coinsurance or deductibles, or both, except that no deductible shall be payable in excess of a total of $250 by an individual or $500 by a family unit during any benefit year; and no coinsurance shall be payable in excess of a total of $500 by an individual or by a family unit during any benefit year.[4]

(4) [Notwithstanding the provisions of paragraph (3) of this subsection or any other law to the contrary, a carrier may provide for increased deductibles or coinsurance for a basic health benefits plan if approved by the board or if the board increases deductibles or coinsurance included in the basic health benefits plan.] [4][(Deleted by amendment, P.L. , c.).] Notwithstanding the provisions of paragraph (3) of this subsection or any other law to the contrary, a carrier may provide for increased deductibles or coinsurance for a basic health benefits plan if approved by the board or if the board increases deductibles or coinsurance included in the basic health benefits plan.[4]

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

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

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

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

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

f. Carriers may offer enhanced or additional benefits to the standard plans for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.[4]

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

[2]**[**[1]5. Section 2 of P.L.2001, c.368 (C.17B:27A-4.5) is amended to read as follows:

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

90 days hospital room and board - $500 copayment per hospital stay;
Outpatient and ambulatory surgery- $250 copayment per surgery;
Physicians' fees connected with hospital care, including general acute care and surgery;
Physicians' fees connected with outpatient and ambulatory surgery;
Anesthesia and the administration of anesthesia;
Coverage for newborns;
Treatment for complications of pregnancy;
Intravenous solutions, blood and blood plasma;
Oxygen and the administration of oxygen;
Radiation and x-ray therapy;
Inpatient physical therapy and hydrotherapy;
Outpatient physical therapy - 30 visits annually per covered person- $20 copayment per treatment;
Dialysis - inpatient or outpatient;
Inpatient diagnostic tests and $500 annual aggregate per covered person for out-of-hospital diagnostic tests;
Laboratory fees for treatment in hospital;
Delivery room fees;
Operating room fees;
Special care unit;
Treatment room fees;
Emergency room services for medically necessary treatment - $100 copayment per visit;

Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for biologically-based mental illness, as defined in subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% coinsurance;
Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;
Wellness benefit - $600 annual aggregate per covered person, $50 annual deductible, 20% coinsurance per service; and
Physicians visits for diagnosed illness or injury - to a $700 annual aggregate per covered person.

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

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than **[**350%**]**<u>200%</u> of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

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

loss ratio.

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

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

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

[4]5. Section 2 of P.L.2001, c.368 (C.17B:27A-4.5) is amended to read as follows:

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

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

Outpatient and ambulatory surgery- $250 copayment per surgery;

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

Physicians' fees connected with outpatient and ambulatory surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

Intravenous solutions, blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

Inpatient physical therapy and hydrotherapy;

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

Dialysis - inpatient or outpatient;

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

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;

Special care unit;

Treatment room fees;

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

Pharmaceuticals dispensed in hospital;

Dressings;

Splints;

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

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

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

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

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

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

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

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

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

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

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

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

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

[4]6. Section 4 of P.L.2001, c.368 (C.17B:27A-4.7) is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

(3) **[**board approval of a request by the individual**]** **4[**A**]** board approval of a request by the individual**4** carrier **4[**may choose**]4** to not renew a **[**particular type of health benefits plan, in accordance with rules adopted by the board. After receiving board approval, a carrier may not renew a**]** **4**particular type of health benefits plan, in accordance with rules adopted by the board. After receiving board approval, a carrier may not renew a**4** type of health benefits plan only if the carrier: (a) provides notice to each covered individual provided coverage of this type of the nonrenewal at least 90 days prior to the date of the nonrenewal of the coverage; (b) offers to each individual provided coverage of this type the option to purchase any other individual health benefits plan currently being offered by the carrier; and (c) in exercising the option to not renew coverage of this type and in offering coverage as required under (b) above, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for coverage; and

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

benefits plan not so renewed; and] Deleted by amendment, P.L. , c.) [4](pending before the Legislature as this bill)[4].

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

(cf: P.L.1997, c.146, s.3)

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

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

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

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

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

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

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

c. **[**In addition to the five standard individual health benefits plans provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board may develop up to five rider packages. Premium rates for the rider packages shall be determined in accordance with section 8 of P.L.1992, c.161 (C.17B:27A-9).**]** **[4]** **[**(Deleted by amendment, P.L. , c.).**]** In addition to the standard individual health benefits plans provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board may develop rider packages. Premium rates for the rider packages shall be determined in accordance with section 8 of P.L.1992, c.161 (C.17B:27A-9).[4]

d. **[**After the board's establishment of the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier shall file the policy or contract forms with the board and certify to the board that the health benefits plans to be used by the carrier are in substantial compliance with the provisions in the corresponding board approved plans. The certification shall be signed by the chief executive officer of the carrier. Upon receipt by the board of the certification, the certified plans may be used until the board, after notice and hearing, disapproves their continued use.**]** **[4]** **[**(Deleted by amendment, P.L. , c.).**]** After the board's establishment of the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier shall file the policy or contract forms with the board and certify to the board that the health benefits plans to be used by the carrier are in substantial compliance with the provisions in the corresponding board approved plans. The certification shall be signed by the chief executive officer of the carrier. Upon receipt by the board of the certification, the certified plans may be used until the board, after notice and hearing, disapproves their continued use.[4]

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

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

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

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

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

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

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

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

prescribed items under the health benefits plan.

This subsection shall apply to all individual health benefits plans [4][in which the carrier has reserved the right to change the premium.

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

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

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

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

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

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

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

[4]**[**No insurance contract or policy subject to the provisions of P.L.l992, c.161 (C.17B:27A-2 et seq.), as amended by P.L. , c. (C.) (now before the Legislature as this bill), may be entered into unless and until the carrier has made an informational filing with the commissioner of a schedule of premiums, not to exceed 12 months in duration, to be paid pursuant to that contract or policy, of the carrier's rating plan and classification system in connection with that contract or policy, and of the actuarial assumptions and methods used by the carrier in establishing premium rates for that contract or policy.**]** A carrier shall not issue individual health benefits plans on a new contract or policy form pursuant to this act until an informational filing of a full schedule of rates which applies to the contract or policy form has been filed with the commissioner.[4]

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

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

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

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

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

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

cancellation or termination by a policyholder.

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

(cf: P.L.1994, c.102, s.2)

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

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

The board shall have the specific authority to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[4]10. Section 9 of P.L.1992, c.161 (C.17B:27A-10) is amended to read as follows:

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

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

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

(2) a health maintenance organization;

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

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

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

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

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

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

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

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

f. The plan of operation shall establish procedures for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[2]f. **[4]**[Notwithstanding the provisions of subsections a., b., c. and d. of this section:

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

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

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

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

(4) There shall be no assessments, pursuant to this section for any purpose for any time period following the effective date of P.L. , c. (C.) (now before the Legislature as this bill).[2]] The loss assessment for the two-year calculation period in which P.L. , c. (C.) (pending before the Legislature as this bill) takes effect shall be the last loss assessment authorized under this section and no further loss assessments shall be calculated or collected; provided, however, that nothing in this act shall relieve a carrier of its obligations for loss assessments authorized under this section prior to the effective date of P.L. , c. (C.) (pending before the Legislature as this bill).[4]

(cf: P.L.1997, c.146, s.6)

[4]12. Section 5 of P.L.1995, c.196 (C.17B:27A-16.5) is amended to read as follows:

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

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

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

1. As used in this act:

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

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

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

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

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

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

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

"Department" means the Department of Banking and Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity non-expense incurred basis.[1]

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

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

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

(1) Basic inpatient and outpatient hospital care;

(2) Basic and extended medical-surgical benefits;

(3) Diagnostic tests, including X-rays;

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

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

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

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

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

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

(1) Basic inpatient and outpatient hospital care;

(2) Basic and extended medical-surgical benefits;

(3) Diagnostic tests, including X-rays;

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

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

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

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

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

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

d. **[**In addition to the five standard policies described in subsection a. of this section, the board may develop up to five rider packages. Any such package which a carrier chooses to offer shall be issued to a small employer who pays the premium therefor, and shall be subject to the rating methodology set forth in section 9 of P.L.1992, c.162 (C.17B:27A-25).**]** [4]**[**(Deleted by amendment, P.L. , c.).**]** In addition to the standard policies described in subsection a. of this section, the board may develop rider packages. Any such package which a carrier chooses to offer shall be issued to a small employer who pays the premium therefor, and shall be subject to the rating methodology set forth in section 9 of P.L.1992, c.162 (C.17B:27A-25).[4]

e. [Notwithstanding the provisions of subsection a. of this section to the contrary, the board may approve a health benefits plan containing only medical-surgical benefits or major medical expense benefits, or a combination thereof, which is issued as a separate policy in conjunction with a contract of insurance for hospital expense benefits issued by a hospital service corporation, if the health benefits plan and hospital service corporation contract combined otherwise comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the contract combined may be allocated between the separate contracts at the discretion of the carrier and the hospital service corporation.] [4] [(Deleted by amendment, P.L. , c.).] Notwithstanding the provisions of subsection a. of this section to the contrary, the board may approve a health benefits plan containing only medical-surgical benefits or major medical expense benefits, or a combination thereof, which is issued as a separate policy in conjunction with a contract of insurance for hospital expense benefits issued by a hospital service corporation, if the health benefits plan and hospital service corporation contract combined otherwise comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the contract combined may be allocated between the separate contracts at the discretion of the carrier and the hospital service corporation.[4]

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

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

required pursuant to this section.

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

g. **[**A carrier shall not be required to own or control a health maintenance organization or otherwise affiliate with a health maintenance organization in order to comply with the provisions of this section, but the carrier shall be required to offer the five health benefits plans which are formulated by the board and approved by the commissioner, including one plan which contains benefits and cost sharing levels that are equivalent to those required for health maintenance organizations.**]** [4]**[**(Deleted by amendment, P.L. , c.).**]** A carrier shall not be required to own or control a health maintenance organization or otherwise affiliate with a health maintenance organization in order to comply with the provisions of this section, but the carrier shall be required to offer the health benefits plans which are formulated by the board and approved by the commissioner, including one plan which contains benefits and cost sharing levels that are equivalent to those required for health maintenance organizations.[4]

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

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

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

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

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

(2) **[**The benefit riders provided for in paragraph (1) of this subsection shall be subject to the provisions of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).**]** [4]**[**(Deleted by amendment, P.L. , c.).**]** The benefit riders provided for in paragraph (1) of this subsection shall be subject to the provisions of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).[4]

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) **[**A health benefits plan filed with the commissioner pursuant to subparagraph (a) of this paragraph may be amended as to its benefit structure if the amendment does not reduce the actuarial value and benefits coverage of the health benefits plan below that of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. The amendment shall be filed with the commissioner for approval pursuant to the terms of sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and shall comply with the provisions of sections 2 and 9 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).**]** **4[**(Deleted by amendment, P.L. , c.).**]** A health benefits plan filed with the commissioner pursuant to subparagraph (a) of this paragraph may be amended as to its benefit structure if the amendment does not reduce the actuarial value and benefits coverage of the health benefits plan below that of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. The amendment shall be filed with the commissioner for approval pursuant to the terms of sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and shall comply with the provisions of sections 2 and 9 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).**4**

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

pursuant to paragraph (1) of this subsection upon approval by the commissioner and only if the benefits offered under the plan are at least equal to the actuarial value and benefits coverage of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. For the purposes of meeting the requirements of this subparagraph, carriers shall be required to file with the commissioner the health benefits plans issued through an out-of-State trust no later than 180 days after the date of enactment of P.L.1995, c.340. A health benefits plan issued by a carrier through an out-of-State trust that is not filed with the commissioner pursuant to this subparagraph, shall not be permitted to be continued or renewed after the 180-day period.**]** [4]**[**(Deleted by amendment, P.L. , c.).**]** A health benefits plan issued by a carrier through an out-of-State trust shall be permitted to be renewed or continued pursuant to paragraph (1) of this subsection upon approval by the commissioner and only if the benefits offered under the plan are at least equal to the actuarial value and benefits coverage of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. For the purposes of meeting the requirements of this subparagraph, carriers shall be required to file with the commissioner the health benefits plans issued through an out-of-State trust no later than 180 days after the date of enactment of P.L.1995, c.340. A health benefits plan issued by a carrier through an out-of-State trust that is not filed with the commissioner pursuant to this subparagraph, shall not be permitted to be continued or renewed after the 180-day period.[4]

(7) **[**Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, an association, multiple employer arrangement or out-of-State trust may offer a health benefits plan authorized to be renewed, continued or reinstated pursuant to this subsection to small employer groups that are otherwise eligible pursuant to paragraph (1) of subsection j. of this section during the period for which such health benefits plan is otherwise authorized to be renewed, continued or reinstated.**]** [4]**[** (Deleted by amendment, P.L. , c.).**]** Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, an association, multiple employer arrangement or out-of-State trust may offer a health benefits plan authorized to be renewed, continued or reinstated pursuant to this subsection to small employer groups that are otherwise eligible pursuant to paragraph (1) of subsection j. of this section during the period for which such health benefits plan is otherwise authorized to be renewed, continued or reinstated.[4]

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

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

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

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

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

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

[Notwithstanding the provisions of subparagraph (b) of paragraph (6) of this subsection to the contrary, a**]** [4]**[**A**]** Notwithstanding the provisions of subparagraph (b) of paragraph (6) of this subsection to

the contrary, a[4] small employer who changes its health benefits plan's issuing carrier pursuant to the provisions of this paragraph, shall not, upon changing carriers, modify the benefit structure of that health benefits plan within six months of the date the issuing carrier was changed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Pregnancy as a preexisting condition.[4]

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

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

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

a. A carrier may discontinue such coverage only if:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) **[**up to six geographic territories, none of which is smaller than a county; and**]** [4]**[**(Deleted by amendment, P.L. , c.).**]** geographic territories, none of which is smaller than a county; and[4]

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

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

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

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

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

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

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

duration, to be paid pursuant to such contract or policy, of the carrier's rating plan and classification system in connection with such contract or policy, and of the actuarial assumptions and methods used by the carrier in establishing premium rates for such contract or policy. [4]Premiums that will be effective on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill) shall provide an anticipated minimum loss ratio of not less than 77%.[4]

g. (1) Beginning [4][January 1, 1995] on the effective date of P.L. , c. (C.) (pending before the Legislature as this bill)[4], a carrier desiring to increase or decrease premiums for any policy form [or benefit rider offered pursuant to subsection i. of section 3 of P.L.1992, c.162 (C.17B:27A-19)] [4]or benefit rider offered pursuant to subsection i. of section 3 of P.L.1992, c.162 (C.17B:27A-19)[4] subject to this act may implement such increase or decrease upon making an informational filing with the commissioner of such increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing such increase or decrease, provided that the anticipated minimum loss ratio for all policy forms shall not be less than [1][75%] [2][80%[1]] [3][78%[2]] [4][75%[3]]77%[4] of the premium therefor as provided in paragraph (2) of this subsection [2][1]; and provided further, however, that the carrier shall not implement an increase in premiums in excess of 15% for any contract or policy form unless the increase has been reviewed and approved by the commissioner, through procedures to be prescribed by the commissioner by regulation[1]][2]. [4][2]The commissioner may disapprove any informational filing on a finding that it is incomplete and not in substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are [3][excessive,][3] inadequate or unfairly discriminatory. Any increase in excess of 15% per year for any policy shall require review and approval by the commissioner through procedures set forth by regulation. [3][Any increase in excess of 15% per year shall be presumed to result in rates that are excessive, with the burden on the carrier to show] If an increase is in excess of 15% per year, the carrier shall demonstrate[3] that the rate increase is justified. Compliance with the minimum loss ratio requirement, while necessary, shall not in itself be considered justification.[2] Until December 31, 1996, the informational filing shall also include the carrier's rating plan and classification system in connection with such increase or decrease.][4]

(2) Each calendar year, a carrier shall return, in the form of aggregate benefits for all [of the five standard] [4]of the standard[4] policy forms offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19), at least [1][75%] [2][80%[1]] [3][78%[2]] [4][75%[3]]77%[4] of the aggregate premiums collected for all of the [standard] [4]standard[4] policy forms, other than alliance policy

forms [, and at least 75% of the aggregate premiums collected for all of the non-standard policy forms] , and at least 77% of the aggregate premiums collected for all of the non-standard policy forms during that calendar year. A carrier shall return at least [75%] [80%] [78%] [75%] 77% of the premiums collected for all of the alliances during that calendar year, which loss ratio may be calculated in the aggregate for all of the alliances or separately for each alliance. Carriers shall annually report, no later than August 1st of each year, the loss ratio calculated pursuant to this section for all of the [standard, other than alliance policy forms, non-standard] standard, other than alliance policy forms, non-standard policy forms and alliance policy forms for the previous calendar year, provided that a carrier may annually report the loss ratio calculated pursuant to this section for all of the alliances in the aggregate or separately for each alliance. In each case where the loss ratio fails to [substantially] substantially comply with the [75%] [80%] [78%] [75%] 77% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policyholders with the [standard, other than alliance policy forms, nonstandard] standard, other than alliance policy forms, nonstandard policy forms or alliance policy forms, as applicable, in an amount [sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal [75%] 80% of the aggregate premiums collected for the respective policy forms in the previous calendar year] equal to the difference between the net earned premium received in that year and the amount of net earned premium that would have been necessary to achieve the [78%] [75%] 77% loss ratio. All dividends and credits must be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include a carrier's calculation of the dividends and credits applicable to [standard, other than alliance policy forms, non-standard] standard, other than alliance policy forms, non-standard policy forms and alliance policy forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder. For purposes of this paragraph, "alliance policy forms" means policies purchased by small employers who are members of Small Employer Purchasing Alliances.

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

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

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

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

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

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

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

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

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

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

the taxable year for which the credit was allowed.

d. As used in this section:

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

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

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

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

[4]20. Section 13 of P.L.1992, c.162 (C.17B:27A-29) is amended to read as follows:

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

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

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

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

(4) Two health maintenance organizations; and

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

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

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

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

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

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

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

One representative of organized labor;

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

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

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

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

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

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

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

e. At least two copies of the minutes of every meeting of the board shall be delivered forthwith to the commissioner.[4]

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

[4]21. Section 17 of P.L.1992, c.162 (C.17B:27A-33) is amended to read as follows:

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

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

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

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

b. Managed care systems, including large case management;

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

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

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

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

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

h. The board or department shall provide the appropriate staff to respond to the public's inquiries regarding the Small Employer Health Benefits Program and the small employer health benefits plans developed by the board.[4]

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

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