

**SENATE, No. 2773**

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**STATE OF NEW JERSEY**  
**211th LEGISLATURE**

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INTRODUCED NOVEMBER 10, 2005

**Sponsored by:**

**Senator NIA H. GILL**

**District 34 (Essex and Passaic)**

**Senator JOHN H. ADLER**

**District 6 (Camden)**

**SYNOPSIS**

The "Health Insurance Affordability and Accessibility Reform Act."

**CURRENT VERSION OF TEXT**

As introduced.



**(Sponsorship Updated As Of: 11/14/2005)**

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

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

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

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

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

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

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

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

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

28 "Community rating" means:

29 (1) with respect to health benefits plans delivered, issued, executed  
30 or renewed prior to the effective date of P.L. , c. (C. ) (now  
31 before the Legislature as this bill) and renewed on or after that  
32 effective date, and with respect to health benefits plans delivered,  
33 issued or executed on or after the effective date of P.L. , c. (C. )  
34 (now before the Legislature as this bill) to an individual described in  
35 paragraph (3) of subsection a. of section 2 of P.L.1992, c.161  
36 (C.17B:27A-3) and subsequently renewed, a rating system in which  
37 the premium for all persons covered by a contract is the same, based  
38 on the experience of all persons covered by that contract, without  
39 regard to age, sex, health status, occupation and geographical  
40 location; and

41 (2) with respect to health benefits plans delivered, issued, or  
42 executed on or after the effective date of P.L. , c. (C. )(now  
43 before the Legislature as this bill) and subsequently renewed on or

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

Matter underlined thus is new matter.

1 after that effective date, a rating system in which the premium rate  
2 charged by a carrier to the highest rated plan shall not be greater than  
3 200% of the premium rate charged for the lowest rated plan; provided,  
4 however, that the only factors upon which the rate differential may be  
5 based are age, gender and geography; and provided further, that such  
6 factors are applied in a manner consistent with regulations  
7 promulgated and adopted by the commissioner. In developing the  
8 rating factor for geography, carriers may use counties as the smallest  
9 permissible rating territory. The commissioner shall prescribe through  
10 regulation age classifications which, at a minimum, shall be in five-year  
11 increments.

12 "Creditable coverage" means, with respect to an individual,  
13 coverage of the individual under any of the following: a group health  
14 plan; a group or individual health benefits plan; Part A or Part B of  
15 Title XVIII of the federal Social Security Act (42 U.S.C. s.1395 et  
16 seq.); Title XIX of the federal Social Security Act (42 U.S.C. s.1396  
17 et seq.), other than coverage consisting solely of benefits under section  
18 1928 of Title XIX of the federal Social Security Act (42  
19 U.S.C.s.1396s); Chapter 55 of Title 10, United States Code (10  
20 U.S.C. s.1071 et seq.); a medical care program of the Indian Health  
21 Service or of a tribal organization; a State health plan offered under  
22 chapter 89 of Title 5, United States Code (5 U.S.C. 8901 et seq.); a  
23 public health plan as defined by federal regulation; and a health  
24 benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C.  
25 s.2504(e)); or coverage under any other type of plan as set forth by the  
26 commissioner by regulation.

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

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

39 "Dependent" means the spouse or child of an eligible person,  
40 subject to applicable terms of the individual health benefits plan.

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

45 "Federally defined eligible individual" means an eligible person: (1)  
46 for whom, as of the date on which the individual seeks coverage under

1 P.L.1992, c.161 (C.17B:27A-2 et seq.), the aggregate of the periods  
2 of creditable coverage is 18 or more months; (2) whose most recent  
3 prior creditable coverage was under a group health plan, governmental  
4 plan, church plan, or health insurance coverage offered in connection  
5 with any such plan; (3) who is not eligible for coverage under a group  
6 health plan, Part A or Part B of Title XVIII of the Social Security Act  
7 (42 U.S.C.s.1395 et seq.), or a State plan under Title XIX of the  
8 Social Security Act (42 U.S.C.s.1396 et seq.) or any successor  
9 program, and who does not have another health benefits plan, or  
10 hospital or medical service plan; (4) with respect to whom the most  
11 recent coverage within the period of aggregate creditable coverage  
12 was not terminated based on a factor relating to nonpayment of  
13 premiums or fraud; (5) who, if offered the option of continuation  
14 coverage under the COBRA continuation provision or a similar State  
15 program, elected that coverage; and (6) who has elected continuation  
16 coverage described in (5) above and has exhausted that continuation  
17 coverage.

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

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

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

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

37 "Health benefits plan" means a hospital and medical expense  
38 insurance policy; health service corporation contract; hospital service  
39 corporation contract; medical service corporation contract; health  
40 maintenance organization subscriber contract; or other plan for  
41 medical care delivered or issued for delivery in this State. For  
42 purposes of this act, health benefits plan shall not include one or more,  
43 or any combination of, the following: coverage only for accident, or  
44 disability income insurance, or any combination thereof; coverage  
45 issued as a supplement to liability insurance; liability insurance,  
46 including general liability insurance and automobile liability insurance;

1 stop loss or excess risk insurance; workers' compensation or similar  
2 insurance; automobile medical payment insurance; credit-only  
3 insurance; coverage for on-site medical clinics; and other similar  
4 insurance coverage, as specified in federal regulations, under which  
5 benefits for medical care are secondary or incidental to other insurance  
6 benefits. Health benefits plans shall not include the following benefits  
7 if they are provided under a separate policy, certificate or contract of  
8 insurance or are otherwise not an integral part of the plan: limited  
9 scope dental or vision benefits; benefits for long-term care, nursing  
10 home care, home health care, community-based care, or any  
11 combination thereof; and such other similar, limited benefits as are  
12 specified in federal regulations. Health benefits plan shall not include  
13 hospital confinement indemnity coverage if the benefits are provided  
14 under a separate policy, certificate or contract of insurance, there is no  
15 coordination between the provision of the benefits and any exclusion  
16 of benefits under any group health benefits plan maintained by the  
17 same plan sponsor, and those benefits are paid with respect to an event  
18 without regard to whether benefits are provided with respect to such  
19 an event under any group health plan maintained by the same plan  
20 sponsor. Health benefits plan shall not include the following if it is  
21 offered as a separate policy, certificate or contract of insurance:  
22 Medicare supplemental health insurance as defined under section  
23 1882(g)(1) of the federal Social Security Act (42  
24 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage  
25 provided under chapter 55 of Title 10, United States Code (10 U.S.C.  
26 s.1071 et seq.); and similar supplemental coverage provided to  
27 coverage under a group health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 "Two-year calculation period" means a two calendar year period,  
22 the first of which shall begin January 1, 1997 and end December 31,  
23 1998.

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

25

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

28 2. a. An individual health benefits plan issued on or after August  
29 1, 1993 shall be subject to the provisions of [this act] P.L.1992, c.161  
30 (C.17B:27A-2 et seq.) or P.L. , c. (C. )(now before the  
31 Legislature as this bill) as provided in this subsection.

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

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

43 (3) Notwithstanding the provisions of paragraphs (1) and (2) of  
44 this subsection, an individual health benefits plan issued on or after the  
45 effective date of P.L. , c. (C. )(now before the Legislature as this  
46 bill) shall be subject to the rating provisions of P.L.1992, c.161

1 (C.17B:27A-2 et seq.) if that individual health benefits plan is issued:  
2 (a) to an eligible person who was the policy or contract holder  
3 under an individual health benefits plan issued prior to the effective  
4 date of P.L. , c. (C. )(now before the Legislature as this bill), (i)  
5 if that plan was terminated by the carrier for failure to pay premiums  
6 as provided in paragraph (1) of subsection b. of section 5 of P.L.1992,  
7 c.161 (C.17B:27A-6), if that failure to pay premiums was directly  
8 attributable to the loss of employment of the eligible person, (ii) if that  
9 plan was not renewed by the carrier as provided in subsection c. of  
10 section 5 of P.L.1992, c.161 (C.17B:27A-6), or (iii) if the insurer is no  
11 longer providing coverage under that plan in this State due to removal  
12 of the insurer from the State; or

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

19 The rate filed for any plan issued pursuant to this paragraph (3)  
20 shall not exceed by more than 15% the rate filed for such a plan with  
21 an effective date one year earlier.

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

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

30 (3) A group conversion contract or policy issued prior to August  
31 1, 1993 that is not issued on a modified community rated basis or  
32 community rated basis, shall not be subject to the provisions of this  
33 act, except that the contract or policy shall be liable for assessments  
34 made pursuant to section 11 of this act.

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

42 (5) Notwithstanding any other provision of law to the contrary, an  
43 individual health benefits plan issued by a hospital service corporation  
44 or medical service corporation to an eligible person or federally  
45 defined eligible individual after the effective date of P.L.1997, c.146  
46 (C.17B:27-54 et al.) shall comply with the provisions of subsections



1 c. and d. of section 2, subsection b. of section 3, section 5, subsection  
2 b. of section 6, and subsections c., d., and e. of section 8 of P.L.1992,  
3 c.161 (C.17B:27A-3, C.17B:27A-4, 17B:27A-6, 17B:27A-7, and  
4 17B:27A-9), but shall not be subject to the remaining provisions of  
5 P.L.1992, c. 161.] (Deleted by amendment, P.L. , c. ).

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

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

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

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

32

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

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

44 b. A carrier shall offer to an eligible person [a choice of five  
45 individual health benefits plans, any of which may contain provisions

1 for managed care. One plan shall be a basic health benefits plan, one  
2 plan shall be a managed care plan and three plans shall include  
3 enhanced benefits of proportionally increasing actuarial value] all  
4 individual health benefits plans that it chooses to actively market in  
5 this State and those plans shall include at least one standard plan  
6 consistent with the type of health benefits plans that it offers. The  
7 board shall develop three standard plans: a health maintenance  
8 organization plan; a point of service plan; and an indemnity plan. The  
9 board shall have the sole authority to make changes to these standard  
10 plans on an annual basis, subject to the approval of those changes by  
11 the commissioner. [A] Except for an individual health benefits plan  
12 issued prior to the effective date of P.L. , c. (C. )(now before the  
13 Legislature as this bill) a carrier may elect to convert any individual  
14 contract or policy forms [in force on the effective date of this act to  
15 any of the five benefit plans, except that the carrier may not convert  
16 more than 25% of existing contracts or policies each year, and] to any  
17 of its other marketed plans as long as the replacement plan [shall be]  
18 is of no less actuarial value than the policy or contract being replaced,  
19 consistent with the requirements of the federal "Health Insurance  
20 Portability and Accountability Act of 1996," Pub. L.104-191, 110 Stat.  
21 1936, (1996) (HIPAA), subject to the commissioner's approval.

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

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

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

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

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

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

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

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

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

28 e. [If all five of the individual health benefits plans are not  
29 established by the board by the effective date of P.L.1993, c.164  
30 (C.17B:27A-16.1 et al.), a carrier may phase-in the offering of the five  
31 health benefits plans by offering each health benefits plan as it is  
32 established by the board; however, once the board establishes all five  
33 plans, the carrier shall be required to offer the five plans in accordance  
34 with the provisions of P.L.1992, c.161 (C.17B:27A-2 et al.).] (Deleted by amendment, P.L. , c. ).

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

37  
38 5. Section 5 of P.L.1992, c.161 (C.17B:27A-6) is amended to read  
39 as follows:

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

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

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

1 the following circumstances:

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

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

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

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

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

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

28 (4) ~~board approval of a request by the individual carrier to cease~~  
29 ~~doing business in the individual health benefits market. A carrier may~~  
30 ~~not renew all individual health benefits plans only if the carrier: (a)~~  
31 ~~first receives approval from the board; and (b) provides notice to each~~  
32 ~~individual of the nonrenewal at least 180 days prior to the date of the~~  
33 ~~expiration of such coverage. A carrier ceasing to do business in the~~  
34 ~~individual health benefits market may not provide for the issuance of~~  
35 ~~any health benefits plan in the individual market during the five-year~~  
36 ~~period beginning on the date of the termination of the last health~~  
37 ~~benefits plan not so renewed; and~~ Deleted by amendment, P.L. \_\_,  
38 c. \_\_).

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

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

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

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

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

23       b. An individual health benefits plan offered pursuant to section 3  
24 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no  
25 more than 12 months on coverage for preexisting conditions. An  
26 individual health benefits plan offered pursuant to section 3 of  
27 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting  
28 condition limitation of any period under the following circumstances:

29       (1) to an individual who has, under creditable coverage, with no  
30 intervening lapse in coverage of more than 31 days, been treated or  
31 diagnosed by a physician for a condition under that plan or satisfied a  
32 12-month preexisting condition limitation; or

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

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

42       d. ~~[After the board's establishment of the individual health benefits~~  
43 ~~plans required pursuant to section 3 of P.L.1992, c.161~~  
44 ~~(C.17B:27A-4), and notwithstanding any law to the contrary, a carrier~~  
45 ~~shall file the policy or contract forms with the board and certify to the~~  
46 ~~board that the health benefits plans to be used by the carrier are in~~

1 substantial compliance with the provisions in the corresponding board  
2 approved plans. The certification shall be signed by the chief  
3 executive officer of the carrier. Upon receipt by the board of the  
4 certification, the certified plans may be used until the board, after  
5 notice and hearing, disapproves their continued use.】 (Deleted by  
6 amendment, P.L. , c. ).

7 e. Effective immediately for an individual health benefits plan  
8 issued on or after the effective date of P.L.1995, c.316  
9 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary  
10 date of an individual health benefits plan in effect on the effective date  
11 of P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health  
12 benefits plans required pursuant to section 3 of P.L.1992, c.161  
13 (C.17B:27A-4), including any plan offered by a federally qualified  
14 health maintenance organization, shall contain benefits for expenses  
15 incurred in the following:

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

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

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

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

43 f. Effective immediately for a health benefits plan issued on or after  
44 the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective  
45 on the first 12-month anniversary date of a health benefits plan in  
46 effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the

1 health benefits plans required pursuant to section 3 of P.L.1992, c.161  
2 (C.17B:27A-4) that provide benefits for expenses incurred in the  
3 purchase of prescription drugs shall provide benefits for expenses  
4 incurred in the purchase of specialized non-standard infant formulas,  
5 when the covered infant's physician has diagnosed the infant as having  
6 multiple food protein intolerance and has determined such formula to  
7 be medically necessary, and when the covered infant has not been  
8 responsive to trials of standard non-cow milk-based formulas,  
9 including soybean and goat milk. The coverage may be subject to  
10 utilization review, including periodic review, of the continued medical  
11 necessity of the specialized infant formula.

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

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

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

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

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

36

37 7. Section 8 of P.L.1992, c.161 (C.17B:27A-9) is amended to read  
38 as follows:

39 8. a. [The board shall make application to the Hospital Rate  
40 Setting Commission on behalf of all carriers for approval of discounted  
41 or reduced rates of payment to hospitals for health care services  
42 provided under an individual health benefits plan provided pursuant to  
43 this act.] (Deleted by amendment, P.L. \_\_, c. \_\_).

44 b. [In addition to discounted or reduced rates of hospital payment,  
45 the board shall make application on behalf of all carriers for any other  
46 subsidies, discounts, or funds that may be provided for under State or

1 federal law or regulation. A carrier may include discounted or reduced  
2 rates of hospital payment and other subsidies or funds granted to the  
3 board to reduce its premium rates for individual health benefits plans  
4 subject to this act.] (Deleted by amendment, P.L. , c. ).

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

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

25 A carrier desiring to increase or decrease premiums for any contract  
26 or policy form may implement that increase or decrease upon making  
27 an informational filing with the commissioner of that increase or  
28 decrease, along with the actuarial assumptions and methods used by  
29 the carrier in establishing that increase or decrease. The commissioner  
30 may disapprove any informational filing on a finding that it is  
31 incomplete and not in substantial compliance with P.L.1992, c.161  
32 (C.17B:27A-2 et seq.), or that the rates are inadequate or unfairly  
33 discriminatory. Any increase in excess of 15% per year for any policy  
34 shall require review and approval by the commissioner through  
35 procedures set forth by regulation. If an increase is in excess of 15%  
36 per year, the carrier shall demonstrate that the rate increase is justified.  
37 Compliance with the minimum loss ratio requirement, while necessary,  
38 shall not in itself be considered justification.

39 e. (1) Rates shall be formulated on contracts or policies required  
40 pursuant to section 3 of this act so that the anticipated minimum loss  
41 ratio for a contract or policy form shall not be less than 75% of the  
42 premium therefor as provided in paragraph (2) of this subsection. The  
43 carrier shall submit with its rate filing supporting data, as determined  
44 by the [board] commissioner, and a certification by a member of the  
45 American Academy of Actuaries, or other individuals acceptable to the  
46 [board and to the] commissioner, that the carrier is in compliance



1 with the provisions of this subsection.

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

8 Each calendar year, a carrier shall return, in the form of aggregate  
9 benefits for all of the policy forms offered by the carrier pursuant to  
10 subsection a. of section 3 of P.L.1992, c.161 (C.17.B:27A-4), at least  
11 75% of the aggregate premiums collected for all of the policy forms  
12 during that calendar year. Carriers shall annually report, no later than  
13 August 1 of each year, the loss ratio calculated pursuant to this section  
14 for all of the policy forms for the previous calendar year. In each case  
15 in which the loss ratio fails to comply with the 75% loss ratio  
16 requirement, the carrier shall issue a dividend or credit against future  
17 premiums for all policyholders, as applicable, in an amount sufficient  
18 to assure that the aggregate benefits paid in the previous calendar year  
19 plus the amount of the dividends and credits equal 75% of the  
20 aggregate premiums collected for the policy forms in the previous  
21 calendar year. All dividends and credits shall be distributed by  
22 December 31 of the year following the calendar year in which the loss  
23 ratio requirements were not satisfied. The annual report required by  
24 this paragraph shall include a carrier's calculation of the dividends and  
25 credits applicable to all policy forms, as well as an explanation of the  
26 carrier's plan to issue dividends or credits. The instructions and format  
27 for calculating and reporting loss ratios and issuing dividends or  
28 credits shall be specified by the commissioner by regulation. Those  
29 regulations shall include provisions for the distribution of a dividend  
30 or credit in the event of cancellation or termination by a policyholder.

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

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

44

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

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

7       The board shall have the specific authority to:

8       a. assess members their proportionate share of program losses and  
9 administrative expenses in accordance with the provisions of section  
10 11 of this act, and make advance interim assessments, as may be  
11 reasonable and necessary for organizational and reasonable operating  
12 expenses and estimated losses. An interim assessment shall be credited  
13 as an offset against any regular assessment due following the close of  
14 the fiscal year;

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

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

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

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

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

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

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

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

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

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

1 program];

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

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

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

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

28

29 9. Section 11 of P.L.1992, c.161 (C.17B:27A-12) is amended to  
30 read as follows:

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

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

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

40 (b) every carrier issuing individual health benefits plans in the State  
41 shall file with the board the net earned premium on health benefits  
42 plans issued pursuant to paragraph (1) of subsection b. of section 2  
43 and section 3 of this act and the claims paid. If the claims paid for all  
44 health benefits plans during the two-year calculation period exceed  
45 115% of the net earned premium and any investment income thereon  
46 for the two-year calculation period, the amount of the excess shall be

1 the net paid loss for the carrier that shall be reimbursable under this  
2 act.

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

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

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

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

39 d. (1) Notwithstanding the provisions of this act to the contrary,  
40 a carrier may apply to the board, by a date established by the board,  
41 for an exemption from the assessment and reimbursement for losses  
42 provided for in this section. A carrier which applies for an exemption  
43 shall agree to cover a minimum number of non-group person life years  
44 on an open enrollment community rated basis, under a managed care  
45 or indemnity plan, as specified in this subsection, provided that any  
46 indemnity plan so issued conforms with sections 2 through 7,

1 inclusive, of P.L.1992, c.161 (C.17B:27A-3 through 17B:27A-8). For  
2 the purposes of this subsection, non-group persons include individually  
3 enrolled persons, conversion policies issued pursuant to this act,  
4 Medicare cost and risk lives and Medicaid recipients; except that in  
5 determining whether the carrier meets the minimum number of  
6 non-group person life years required to be covered pursuant to this  
7 subsection, the number of Medicaid recipients and Medicare cost and  
8 risk lives shall not exceed 50% of the total. Pursuant to regulations  
9 adopted by the board, the carrier shall determine the number of  
10 non-group person life years it has covered by adding the number of  
11 non-group persons covered on the last day of each calendar quarter of  
12 the two-year calculation period, taking into account the limitations on  
13 counting Medicaid recipients and Medicare cost and risk lives, and  
14 dividing the total by eight.

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

24 (3) The minimum number of non-group person life years required  
25 to be covered, as determined by the board, shall equal the total number  
26 of non-group person life years of community rated, individually  
27 enrolled or insured persons, including Medicare cost and risk lives and  
28 enrolled Medicaid lives, of all carriers subject to this act for the  
29 two-year calculation period, multiplied by the proportion that carrier's  
30 net earned premium bears to the net earned premium of all carriers for  
31 that two-year calculation period, including those carriers that are  
32 exempt from the assessment.

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

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

44 To the extent that the carrier has failed to cover the minimum  
45 number of non-group person life years established by the board, the  
46 carrier shall be assessed by the board on a pro rata basis for any

1 differential between the minimum number established by the board and  
2 the actual number covered by the carrier.

3 (6) A carrier that applies for the exemption shall be deemed to be  
4 in compliance with the requirements of this subsection if it has covered  
5 100% of the minimum number of non-group person life years required.

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

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

12 f. Notwithstanding the provisions of subsections a., b., c. and d. of  
13 this section:

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

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

23 (3) For the years beginning in 2001 and ending in the year in which  
24 P.L. , c. (C. ) (now before the Legislature as this bill) takes  
25 effect, in which assessments have not been made, the board shall make  
26 assessments not exceeding market share multiplied by total losses, less  
27 exemptions as defined in and required by this section. These  
28 assessments shall constitute adequate and complete reimbursement of  
29 losses in those years, and no assessment shall be made or reimbursed  
30 attributable to exempt market share.

31 (4) There shall be no assessments, pursuant to this section for any  
32 purpose for any time period following the effective date of P.L. ,  
33 c. (C. ) (now before the Legislature as this bill).

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

35

36 10. Section 1 of P.L.1992, c.162 (C.17B:27A-17) is amended to  
37 read as follows:

38 1. As used in this act:

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

46 "Anticipated loss ratio" means the ratio of the present value of the

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

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

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

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

29 "Commissioner" means the Commissioner of Banking and  
30 Insurance.

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

37 "Creditable coverage" means, with respect to an individual,  
38 coverage of the individual under any of the following: a group health  
39 plan; a group or individual health benefits plan; Part A or part B of  
40 Title XVIII of the federal Social Security Act (42 U.S.C. s.1395 et  
41 seq.); Title XIX of the federal Social Security Act (42 U.S.C. 1396 et  
42 seq.), other than coverage consisting solely of benefits under section  
43 1928 of Title XIX of the federal Social Security Act (42  
44 U.S.C.s.1396s); chapter 55 of Title 10, United States Code (10 U.S.C.  
45 1071 et seq.); a medical care program of the Indian Health Service or  
46 of a tribal organization; a state health plan offered under chapter 89 of

1 Title 5, United States Code (5 U.S.C. s.8901 et seq.); a public health  
2 plan as defined by federal regulation; a health benefits plan under  
3 section 5(e) of the "Peace Corps Act" (22 U.S.C. s.2504(e)); or  
4 coverage under any other type of plan as set forth by the commissioner  
5 by regulation.

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

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

18 "Dependent" means the spouse or child of an eligible employee,  
19 subject to applicable terms of the health benefits plan covering the  
20 employee.

21 "Eligible employee" means [a full-time] an employee who works [a  
22 normal work week of 25] 20 or more hours per week. The term  
23 includes a sole proprietor, a partner of a partnership, or an  
24 independent contractor, if the sole proprietor, partner, or independent  
25 contractor is included as an employee under a health benefits plan of  
26 a small employer, but does not include employees who [work less than  
27 25 hours a week,] work on a temporary or substitute basis or are  
28 participating in an employee welfare arrangement established pursuant  
29 to a collective bargaining agreement.

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

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

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

45 "Group health plan" means an employee welfare benefit plan, as  
46 defined in Title I of section 3 of Pub.L.93-406, the "Employee



1 Retirement Income Security Act of 1974" (29 U.S.C.s.1002(1)), to the  
2 extent that the plan provides medical care and including items and  
3 services paid for as medical care to employees or their dependents  
4 directly or through insurance, reimbursement or otherwise.

5 "Health benefits plan" means any hospital and medical expense  
6 insurance policy or certificate; health, hospital, or medical service  
7 corporation contract or certificate; or health maintenance organization  
8 subscriber contract or certificate delivered or issued for delivery in this  
9 State by any carrier to a small employer group pursuant to section 3  
10 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health  
11 benefits plan" shall not include one or more, or any combination of,  
12 the following: coverage only for accident or disability income  
13 insurance, or any combination thereof; coverage issued as a  
14 supplement to liability insurance; liability insurance, including general  
15 liability insurance and automobile liability insurance; workers'  
16 compensation or similar insurance; automobile medical payment  
17 insurance; credit-only insurance; coverage for on-site medical clinics;  
18 and other similar insurance coverage, as specified in federal  
19 regulations, under which benefits for medical care are secondary or  
20 incidental to other insurance benefits. Health benefits plans shall not  
21 include the following benefits if they are provided under a separate  
22 policy, certificate or contract of insurance or are otherwise not an  
23 integral part of the plan: limited scope dental or vision benefits;  
24 benefits for long-term care, nursing home care, home health care,  
25 community-based care, or any combination thereof; and such other  
26 similar, limited benefits as are specified in federal regulations. Health  
27 benefits plan shall not include hospital confinement indemnity coverage  
28 if the benefits are provided under a separate policy, certificate or  
29 contract of insurance, there is no coordination between the provision  
30 of the benefits and any exclusion of benefits under any group health  
31 benefits plan maintained by the same plan sponsor, and those benefits  
32 are paid with respect to an event without regard to whether benefits  
33 are provided with respect to such an event under any group health plan  
34 maintained by the same plan sponsor. Health benefits plan shall not  
35 include the following if it is offered as a separate policy, certificate or  
36 contract of insurance: Medicare supplemental health insurance as  
37 defined under section 1882(g)(1) of the federal Social Security Act (42  
38 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage  
39 provided under chapter 55 of Title 10, United States Code (10 U.S.C.  
40 s.1071 et seq.); and similar supplemental coverage provided to  
41 coverage under a group health plan.

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

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

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

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

35 "Multiple employer arrangement" means an arrangement established  
36 or maintained to provide health benefits to employees and their  
37 dependents of two or more employers, under an insured plan  
38 purchased from a carrier in which the carrier assumes all or a  
39 substantial portion of the risk, as determined by the commissioner, and  
40 shall include, but is not limited to, a multiple employer welfare  
41 arrangement, or MEWA, multiple employer trust or other form of  
42 benefit trust.

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

46 "Plan sponsor" has the meaning given that term under Title I of

1 section 3 of Pub.L.93-406, the "Employee Retirement Income Security  
2 Act of 1974" (29 U.S.C.s.1002(16)(B)).

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

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

13 "Small employer" means, in connection with a group health plan  
14 with respect to a calendar year and a plan year, any person, firm,  
15 corporation, partnership, or political subdivision that is actively  
16 engaged in business that employed an average of at least two but not  
17 more than 50 eligible employees on business days during the preceding  
18 calendar year and who employs at least two employees on the first day  
19 of the plan year, and the majority of the employees are employed in  
20 New Jersey. All persons treated as a single employer under subsection  
21 (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of  
22 1986 (26 U.S.C.s.414) shall be treated as one employer. Subsequent  
23 to the issuance of a health benefits plan to a small employer and for the  
24 purpose of determining continued eligibility, the size of a small  
25 employer shall be determined annually. Except as otherwise  
26 specifically provided, provisions of P.L.1992, c.162 (C.17B:27A-17  
27 et seq.) that apply to a small employer shall continue to apply at least  
28 until the plan anniversary following the date the small employer no  
29 longer meets the requirements of this definition. In the case of an  
30 employer that was not in existence during the preceding calendar year,  
31 the determination of whether the employer is a small or large employer  
32 shall be based on the average number of employees that it is  
33 reasonably expected that the employer will employ on business days  
34 in the current calendar year. Any reference in P.L.1992, c.162  
35 (C.17B:27A-17 et seq.) to an employer shall include a reference to any  
36 predecessor of such employer.

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

40 "Small employer health benefits plan" means a health benefits plan  
41 for small employers approved by the commissioner pursuant to section  
42 17 of P.L.1992, c.162 (C.17B:27A-33).

43 "Stop loss" or "excess risk insurance" means an insurance policy  
44 designed to reimburse a self-funded arrangement of one or more small  
45 employers for catastrophic, excess or unexpected expenses, wherein  
46 neither the employees nor other individuals are third party beneficiaries

1 under the insurance policy. In order to be considered stop loss or  
2 excess risk insurance for the purposes of P.L.1992, c.162  
3 (C.17B:27A-17 et seq.), the policy shall establish a per person  
4 attachment point or retention or aggregate attachment point or  
5 retention, or both, which meet the following requirements:

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

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

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

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

16  
17 11. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to  
18 read as follows:

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

35 (1) Basic inpatient and outpatient hospital care;

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

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

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

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

41 At least three of the forms shall provide for major medical benefits  
42 in varying lifetime aggregates, one of which shall provide at least  
43 \$1,000,000 in lifetime aggregate benefits. The policy forms provided  
44 pursuant to this section shall contain benefits representing  
45 progressively greater actuarial values.

46 Notwithstanding the provisions of this subsection to the contrary,

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

17 A carrier may elect to convert any contract or policy form in force  
18 on the effective date of P.L. , c. (C. ) (now before the Legislature  
19 as this bill) to any of its currently marketed plans as long as the  
20 replacement plan is of no less actuarial value than the policy or  
21 contract being replaced, consistent with the requirements of the federal  
22 "Health Insurance Portability and Accountability Act of 1996," Pub.  
23 L.104-191, 110 Stat. 1936, (1996) (HIPAA), and may elect to convert  
24 any contract or policy form after that effective date to any of its  
25 currently marketed plans subject to the prior approval of the  
26 commissioner.

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

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

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

44 e. [Notwithstanding the provisions of subsection a. of this section  
45 to the contrary, the board may approve a health benefits plan  
46 containing only medical-surgical benefits or major medical expense

1 benefits, or a combination thereof, which is issued as a separate policy  
2 in conjunction with a contract of insurance for hospital expense  
3 benefits issued by a hospital service corporation, if the health benefits  
4 plan and hospital service corporation contract combined otherwise  
5 comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et  
6 seq.). Deductibles and coinsurance limits for the contract combined  
7 may be allocated between the separate contracts at the discretion of  
8 the carrier and the hospital service corporation.] (Deleted by  
9 amendment, P.L. , c. ).

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

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

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

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

40 i. (1) [ In addition to the rider packages provided for in subsection  
41 d. of this section, every carrier may offer, in connection with the five  
42 health benefits plans required to be offered by this section, any number  
43 of riders which may revise the coverage offered by the five plans in  
44 any way, provided, however, that any form of such rider or  
45 amendment thereof which decreases benefits or decreases the actuarial  
46 value of one of the five plans shall be filed for informational purposes

1 with the board and for approval by the commissioner before such rider  
2 may be sold. Any rider or amendment thereof which adds benefits or  
3 increases the actuarial value of one of the five plans shall be filed with  
4 the board for informational purposes before such rider may be sold.

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

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

20 j. (1) Notwithstanding the provisions of P.L.1992, c.162  
21 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued  
22 by or through a carrier, association, or multiple employer arrangement  
23 prior to January 1, 1994 or, if the requirements of subparagraph (c) of  
24 paragraph (6) of this subsection are met, issued by or through an  
25 out-of-State trust prior to January 1, 1994, at the option of a small  
26 employer policy or contract holder, may be renewed or continued after  
27 February 28, 1994, or in the case of such a health benefits plan whose  
28 anniversary date occurred between March 1, 1994 and the effective  
29 date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated  
30 within 60 days of that anniversary date and renewed or continued if,  
31 beginning on the first 12-month anniversary date occurring on or after  
32 the sixtieth day after the board adopts regulations concerning the  
33 implementation of the rating factors permitted by section 9 of  
34 P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of  
35 delivery of the health benefits plan, the health benefits plan renewed,  
36 continued or reinstated pursuant to this subsection complies with the  
37 provisions of section 2, subsection b. of section 3, and sections 6, 7,  
38 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19,  
39 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and  
40 17B:27A-27) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

41 Nothing in this subsection shall be construed to require an  
42 association, multiple employer arrangement or out-of-State trust to  
43 provide health benefits coverage to small employers that are not  
44 contemplated by the organizational documents, bylaws, or other  
45 regulations governing the purpose and operation of the association,  
46 multiple employer arrangement or out-of-State trust. Notwithstanding

1 the foregoing provision to the contrary, an association, multiple  
2 employer arrangement or out-of-State trust that offers health benefits  
3 coverage to its members' employees and dependents:

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

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

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

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

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

27 (b) A carrier which has renewed, continued or reinstated a health  
28 benefits plan pursuant to this subsection that has not been newly issued  
29 to a new small employer group since January 1, 1994, may, upon  
30 approval of the commissioner, continue to establish its rates for that  
31 plan based on the loss experience of that plan if the carrier does not  
32 issue that health benefits plan to any new small employer groups.

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

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

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



1 monitor compliance of any such plan with the requirements of this  
2 subsection, except that the board shall enforce the loss ratio  
3 requirements.

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

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

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

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

1 amendment, P.L. , c. ).

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

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

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

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

35 [Notwithstanding the provisions of subparagraph (b) of paragraph  
36 (6) of this subsection to the contrary, a] A small employer who  
37 changes its health benefits plan's issuing carrier pursuant to the  
38 provisions of this paragraph, shall not, upon changing carriers, modify  
39 the benefit structure of that health benefits plan within six months of  
40 the date the issuing carrier was changed.

41 k. Effective immediately for a health benefits plan issued on or  
42 after the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.) and  
43 effective on the first 12-month anniversary date of a health benefits  
44 plan in effect on the effective date of P.L.1995, c.316  
45 (C.17:48E-35.10 et al.), the health benefits plans required pursuant to  
46 this section, including any plans offered by a State approved or

1 federally qualified health maintenance organization, shall contain  
2 benefits for expenses incurred in the following:

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

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

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

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

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

35 m. Effective immediately for a health benefits plan issued on or  
36 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and  
37 effective on the first 12-month anniversary date of a health benefits  
38 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et  
39 al.), the health benefits plans required pursuant to this section that  
40 provide benefits for expenses incurred in the purchase of prescription  
41 drugs shall provide benefits for expenses incurred in the purchase of  
42 specialized non-standard infant formulas, when the covered infant's  
43 physician has diagnosed the infant as having multiple food protein  
44 intolerance and has determined such formula to be medically  
45 necessary, and when the covered infant has not been responsive to  
46 trials of standard non-cow milk-based formulas, including soybean and

1 goat milk. The coverage may be subject to utilization review,  
2 including periodic review, of the continued medical necessity of the  
3 specialized infant formula.

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

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

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

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

15  
16 12. Section 5 of P.L.2001, c.368 (C.17B:27A-19.11) is amended  
17 to read as follows:

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

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

38  
39 13. Section 7 of P.L.1992, c.162 (C.17B:27A-23) is amended to  
40 read as follows:

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

- 1 a. A carrier may discontinue such coverage only if:
- 2 (1) The policyholder, contract holder, or employer has failed to pay
- 3 premiums or contributions in accordance with the terms of the health
- 4 benefits plan or the carrier has not received timely premium payments;
- 5 or
- 6 (2) The policyholder, contract holder, or employer has performed
- 7 an act or practice that constitutes fraud or made an intentional
- 8 misrepresentation of material fact under the terms of the coverage;
- 9 b. (Deleted by amendment, P.L.1997, c.146).
- 10 c. The number of employees covered under the health benefits plan
- 11 is less than the number or percentage of employees required by
- 12 participation requirements under the health benefits policy or contract;
- 13 d. Noncompliance with a carrier's employment contribution
- 14 requirements;
- 15 e. Any carrier doing business pursuant to the provisions of this act
- 16 ceases doing business in the small employer **[market]** and individual
- 17 health benefits plan markets, if the following conditions are satisfied:
- 18 (1) The carrier gives notice to cease doing business in the small
- 19 employer **[market]** and individual health benefits plan markets to the
- 20 commissioner not later than eight months prior to the date of the
- 21 planned withdrawal from the small **[group market]** employer and
- 22 individual health benefits plan markets, during which time the carrier
- 23 shall continue to be governed by this act with respect to business
- 24 written pursuant to this act. For the purposes of this subsection, "date
- 25 of withdrawal" means the date upon which the first notice to small
- 26 employers and individual policyholders is sent by the carrier pursuant
- 27 to paragraph (2) of this subsection;
- 28 (2) No later than two months following the date of the notification
- 29 to the commissioner that the carrier intends to cease doing business in
- 30 the small employer **[market]** and individual health benefits plan
- 31 markets, the carrier shall mail a notice to every small business
- 32 employer and individual policyholder insured by the carrier, and all
- 33 covered persons, that the policy or contract of insurance will not be
- 34 renewed. This notice shall be sent by certified mail to the small
- 35 business employer or individual policyholder not less than six months
- 36 in advance of the effective date of the nonrenewal date of the policy
- 37 or contract;
- 38 (3) Any carrier that ceases to do business pursuant to this act shall
- 39 be prohibited from writing new business in the small employer
- 40 **[market]** and individual health benefits plan markets for a period of
- 41 five years from the date of termination of the last health insurance
- 42 coverage not so renewed;
- 43 f. In the case of policies or contracts issued in connection with
- 44 membership in an association or trust of employers, an employer
- 45 ceases to maintain its membership in the association or trust, but only
- 46 if such coverage is terminated under this provision uniformly without

1 regard to any health status-related factor relating to any covered  
2 individual.

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

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

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

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

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

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

22

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

25 8. Any small employer carrier may require a reasonable specified  
26 minimum participation with the same carrier of eligible employees or  
27 employees working a normal work week of 35 or more hours, at the  
28 option of the employer, which shall not exceed 75%, or reasonable  
29 minimum employer contributions in determining whether to accept a  
30 small group pursuant to this act. The standards so established by the  
31 carrier shall be first approved by the board and shall be applied  
32 uniformly to all small groups, except that in no event shall a carrier  
33 require an employer to contribute more than 10% to the annual cost  
34 of the policy or contract, or an amount as otherwise provided by the  
35 board, and any minimum participation standards established by the  
36 carrier shall be reasonable. In establishing the percentage of employee  
37 participation, a one-to-one credit shall be given for each employee  
38 covered by a spouse's health benefits coverage, Medicare, Medicaid,  
39 NJ Family Care or another group health benefits plan. In calculating  
40 an employer's participation, the carrier shall include all insured  
41 employees, regardless of whether the employees chose an indemnity  
42 plan or a health maintenance organization, or a combination thereof.  
43 (cf: P.L.2001, c.346, s.1)

44

45 15. Section 9 of P.L.1992, c.162 (C.17B:27A-25) is amended to  
46 read as follows:

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

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

3 (3) For all policies or contracts providing health benefits plans for  
4 small employers issued pursuant to section 3 of P.L.1992, c.162  
5 (C.17B:27A-19), and including policies or contracts offered by a  
6 carrier to a small employer who is a member of a Small Employer  
7 Purchasing Alliance pursuant to the provisions of P.L.2001, c.225  
8 (C.17B:27A-25.1 et al.) the premium rate charged by a carrier to the  
9 highest rated small group purchasing a small employer health benefits  
10 plan issued pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19)  
11 shall not be greater than 200% of the premium rate charged for the  
12 lowest rated small group purchasing that same health benefits plan;  
13 provided, however, that the only factors upon which the rate  
14 differential may be based are age, gender and geography, and provided  
15 further, that such factors are applied in a manner consistent with  
16 regulations adopted by the board. In developing the rating factor for  
17 geography, carriers may use counties as the smallest permissible rating  
18 territory. For the purposes of this paragraph (3), policies or contracts  
19 offered by a carrier to a small employer who is a member of a Small  
20 Employer Purchasing Alliance shall be rated separately from the  
21 carrier's other small employer health benefits policies or contracts.

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

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

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

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

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

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

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

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

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

45 A carrier which provides a health benefits plan to one or more small  
46 employers through a policy issued to an association or trust of

1 employers after the effective date of P.L.1992, c.162 (C.17B:27A-17  
2 et seq.), shall be required to offer small employer health benefits plans  
3 to non-association or trust employers in the same manner as any other  
4 small employer carrier is required pursuant to P.L.1992, c.162  
5 (C.17B:27A-17 et seq.).

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

9 f. No insurance contract or policy subject to this act, including a  
10 contract or policy entered into with a small employer who is a member  
11 of a Small Employer Purchasing Alliance pursuant to the provisions of  
12 P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be entered into unless  
13 and until the carrier has made an informational filing with the  
14 commissioner of a schedule of premiums, not to exceed 12 months in  
15 duration, to be paid pursuant to such contract or policy, of the carrier's  
16 rating plan and classification system in connection with such contract  
17 or policy, and of the actuarial assumptions and methods used by the  
18 carrier in establishing premium rates for such contract or policy.

19 g. (1) Beginning January 1, 1995, a carrier desiring to increase or  
20 decrease premiums for any policy form [or benefit rider offered  
21 pursuant to subsection i. of section 3 of P.L.1992, c.162  
22 (C.17B:27A-19)] subject to this act may implement such increase or  
23 decrease upon making an informational filing with the commissioner  
24 of such increase or decrease, along with the actuarial assumptions and  
25 methods used by the carrier in establishing such increase or decrease,  
26 provided that the anticipated minimum loss ratio for all policy forms  
27 shall not be less than 75% of the premium therefor as provided in  
28 paragraph (2) of this subsection. The commissioner may disapprove  
29 any informational filing on a finding that it is incomplete and not in  
30 substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et seq.),  
31 or that the rates are inadequate or unfairly discriminatory. Any  
32 increase in excess of 15% per year for any policy shall require review  
33 and approval by the commissioner through procedures set forth by  
34 regulation. If an increase is in excess of 15% per year, the carrier shall  
35 demonstrate that the rate increase is justified. Compliance with the  
36 minimum loss ratio requirement, while necessary, shall not in itself be  
37 considered justification. Until December 31, 1996, the informational  
38 filing shall also include the carrier's rating plan and classification  
39 system in connection with such increase or decrease.

40 (2) Each calendar year, a carrier shall return, in the form of  
41 aggregate benefits for all [of the five standard] policy forms offered  
42 by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162  
43 (C.17B:27A-19), at least 75% of the aggregate premiums collected for  
44 all of the [standard] policy forms, other than alliance policy forms [,  
45 and at least 75% of the aggregate premiums collected for all of the  
46 non-standard policy forms] during that calendar year. A carrier shall



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

31 (3) The loss ratio of a health benefits plan issued pursuant to  
32 subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be  
33 calculated in accordance with the provisions of section 7 of P.L.1995,  
34 c.340 (C.17B:27A-19.3), for the purposes of meeting the requirements  
35 of this subsection.

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

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

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

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

1 status-related factors.

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

3

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

6

7 17. This act shall take effect on the 90th day after enactment.

8

9

#### 10 STATEMENT

11

12 This bill, designated the "Health Insurance Affordability and  
13 Accessibility Reform Act," represents a major restructuring of the  
14 health insurance marketplace in this State in order to stabilize costs of,  
15 and enrollment in, individual and small employer health benefits plan.

16 The bill provides that individual health benefits plans will be  
17 community rated, but modifies that rating structure to provide that the  
18 premium rate charged by a carrier to the highest rated plan shall not  
19 be greater than 200% of the premium rate charged for the lowest rated  
20 plan. The bill also applies this premium rating structure to a lower  
21 cost basic and essential health benefits plan, to be developed by the  
22 commissioner to replace the current plans repealed by the bill.

23 In order to protect consumers, especially senior citizens currently  
24 purchasing individual health benefits plans in New Jersey, the bill  
25 "grandfathers" the community rating structure for current  
26 policyholders in the individual market by providing that the provisions  
27 of the bill shall apply to health benefits plans issued on or after the  
28 bill's effective date, and do not apply to health benefits plans currently  
29 in force and renewed on or after the bill's effective date. In addition  
30 the bill "grandfathers" the community rating structure for current  
31 policyholders in the individual market who lose coverage after the  
32 effective date of the bill, under certain circumstances as specified in  
33 the bill.

34 The bill establishes that the only factors upon which the rate  
35 differential in the individual market may be based are age, gender and  
36 geography, and requires that these factors be applied in a manner  
37 consistent with regulations promulgated and adopted by the  
38 Commissioner of Banking and Insurance. In developing the rating  
39 factor for geography, the bill provides that carriers may use counties  
40 as the smallest permissible rating territory.

41 In addition, the bill provides that the commissioner shall prescribe  
42 through regulation age classifications which, at a minimum, shall be in  
43 five-year increments.

44 In order to eliminate any potential conflicts of interest and  
45 streamline the process of issuing health benefits plans in New Jersey,  
46 the bill transfers the regulatory oversight of individual and small

1 employer health benefits plans, with respect to the approval of policy  
2 contracts and forms and review of premium rate filings, from the New  
3 Jersey Individual Health Coverage (IHC) and Small Employer Health  
4 Benefits (SEH) Program Boards, to the commissioner.

5 In order to guarantee that premium rates for individual health  
6 benefits plans are appropriate, and not excessive, the bill imposes  
7 heightened oversight of the carrier's rate setting process and makes  
8 provisions that have always been applicable in the small employer  
9 market applicable to that process in the individual market, as well.  
10 These provisions include the following:

11 1. No contract or policy subject to the provisions of the bill may be  
12 entered into unless and until the carrier has made an informational  
13 filing with the commissioner of: (a) a schedule of premiums, not to  
14 exceed 12 months in duration, to be paid pursuant to the contract or  
15 policy; (b) the carrier's rating plan and classification system in  
16 connection with the contract or policy; and (c) the actuarial  
17 assumptions and methods used by the carrier in establishing premium  
18 rates for the contract or policy;

19 2. A carrier desiring to increase or decrease premiums for any  
20 contract or policy form must make an informational filing with the  
21 commissioner of the increase or decrease, along with the actuarial  
22 assumptions and methods used by the carrier in establishing the  
23 increase or decrease; provided, however, that carriers cannot  
24 implement an increase in premiums in excess of 15% per year for any  
25 contract or policy form unless the increase has been approved by the  
26 commissioner; and

27 3. Establishes that the instructions and format for annually  
28 calculating and reporting the carrier's minimum loss ratio of 75%, and  
29 issuing dividends or credits shall be specified by the commissioner by  
30 regulation and imposes the requirement that the carrier's annual report  
31 shall include the carrier's calculation of the dividends and credits  
32 applicable to all policy forms, as well as an explanation of the carrier's  
33 plan to issue dividends or credits.

34 The bill eliminates including investment income losses in the two-  
35 year calculation of its net losses, which losses are reimbursable to the  
36 carrier through assessments of all the other carriers writing health  
37 insurance business in the marketplace. In addition, the bill eliminates  
38 any future assessments for sharing of losses under the Individual  
39 Health Coverage Program and resolves all preliminary and disputed  
40 assessments pending.

41 As to carriers that issue small employer health plans, the bill: (1)  
42 revises the definition of eligible employee, so that employees who  
43 work 20 or more hours per week are eligible for coverage by these  
44 plans; (2) allows employers the option, in meeting their minimum  
45 participation rate under the law, to calculate that rate using either the  
46 number of eligible employees, which may include part time employees,

1 or the number of employees working a normal work week of 35 or  
2 more hours; (3) requires carries to obtain approval from the  
3 commissioner before implementing premium increases in excess of  
4 15%.

5 The bill requires health insurance carriers, as a condition of issuing  
6 health benefits plans in this State, to offer both individual and small  
7 employer health benefits plans. A carrier shall offer individual and  
8 small employer health benefits plans that it chooses to actively market  
9 in this State and those plans shall include at least one standard plan  
10 developed by the board, consistent with the type of health benefits  
11 plans that the carrier offers.

12 A carrier may elect to convert any contract or policy form in force  
13 on the effective date of the bill to any of its currently marketed plans  
14 as long as the replacement plan is of no less actuarial value than the  
15 policy or contract being replaced, consistent with the requirements of  
16 the federal "Health Insurance Portability and Accountability Act of  
17 1996" (HIPAA), and may elect to convert any contract or policy form  
18 after that date to any of its currently marketed plans subject to the  
19 prior approval of the commissioner.

20 A carrier may offer, in connection with the individual health benefits  
21 plan, a rider which may revise the coverage, provided that any rider  
22 which decreases benefits or decreases the actuarial value of a standard  
23 plan be approved by the commissioner prior to sale.