

SENATE, No. 4351

STATE OF NEW JERSEY
218th LEGISLATURE

INTRODUCED JANUARY 9, 2020

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)

SYNOPSIS

Revises certain requirements for individual and small employer health benefits plans and for small employer members of multiple employer welfare arrangements.

CURRENT VERSION OF TEXT

As introduced.



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2

1 AN ACT concerning rating factors for certain health benefits plans
2 and amending various 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. Section 1 of P.L.1992, c.161 (C.17B:27A-2) is amended to
8 read as follows:

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

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

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

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

24 "Commissioner" means the Commissioner of Banking and
25 Insurance.

26 "Community rating" means a rating system in which the
27 premium for all persons covered by a contract is the same, based on
28 the experience of all persons covered by that contract, without
29 regard to age, sex, health status, occupation and geographical
30 location.

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

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

Matter underlined thus is new matter.

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

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

13 "Dependent" means the spouse, domestic partner as defined in
14 section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as
15 defined in section 2 of P.L.2006, c.103 (C.37:1-29), or child of an
16 eligible person, subject to applicable terms of the individual health
17 benefits plan.

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

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

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

46 "Governmental plan" has the meaning given that term under Title
47 I, section 3 of Pub.L.93-406, the "Employee Retirement Income
48 Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental

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1 plan established or maintained for its employees by the Government
2 of the United States or by any agency or instrumentality of that
3 government.

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

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

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

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

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

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

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

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

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

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

38 "Modified community rating" means a rating system in which the
39 premium for all persons covered under a policy or contract for a
40 specific health benefits plan and a specific date of issue of that plan
41 is the same without regard to sex, health status, occupation,
42 geographical location or any other factor or characteristic of
43 covered persons, other than age.

44 The rating system shall provide that the premium rate charged by
45 the carrier for the highest rated individual or class of individuals
46 shall not be greater than **【350%】** 300% of the premium rate charged
47 for the lowest rated individual or class of individuals purchasing the
48 same individual health benefits plan. The rate differential among

1 the premium rates charged to individuals covered under the same
2 individual health benefits plans shall be based on the actual or
3 expected experience of persons covered under that plan; provided,
4 however, that the rate differential may also be based upon age. The
5 factors upon which the rate differential is applied shall be consistent
6 with regulations promulgated by the commissioner, which shall
7 include age classifications established [, at a minimum, in five-
8 year] in one-year increments. There may be a reasonable
9 differential among the premium rates charged for different family
10 structure rating tiers within an individual health benefits plan or for
11 different health benefits plans offered by the carrier.

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

25 "NJ FamilyCare" means the NJ FamilyCare Program established
26 pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

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

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

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

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

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

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

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

7 "Two-year calculation period" means a two calendar year period,
8 the first of which shall begin January 1, 1997 and end December 31,
9 1998.

10 (cf: P.L.2009, c.293, s.1)

11

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

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

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

16 (3) (a) For all policies or contracts providing health benefits
17 plans for small employers issued pursuant to section 3 of
18 P.L.1992, c.162 (C.17B:27A-19), and including policies or
19 contracts offered by a carrier to a small employer who is a member
20 of a Small Employer Purchasing Alliance pursuant to the provisions
21 of P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate
22 charged by a carrier to the highest rated small group purchasing a
23 small employer health benefits plan issued pursuant to section 3 of
24 P.L.1992, c.162 (C.17B:27A-19) shall not be greater than **[200%]**
25 300% of the premium rate charged for the lowest rated small group
26 purchasing that same health benefits plan; provided, however, that
27 the only factors upon which the rate differential may be based are
28 age**[, gender]** and geography. Such factors shall be applied in a
29 manner consistent with regulations adopted by the commissioner.
30 **[For the purposes of this paragraph (3), policies or contracts offered**
31 **by a carrier to a small employer who is a member of a Small**
32 **Employer Purchasing Alliance shall be rated separately from the**
33 **carrier's other small employer health benefits policies or contracts.]**

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

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

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

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

- 1 (a) up to six geographic territories, none of which is smaller
2 than a county; and
- 3 (b) age classifications which[, at a minimum,] shall be in [five-
4 year] one-year increments.
- 5 b. (Deleted by amendment, P.L.1993, c.162).
- 6 c. (Deleted by amendment, P.L.1995, c.298).
- 7 d. Notwithstanding any other provision of law to the contrary,
8 this act shall apply to a carrier which provides a health benefits plan
9 to one or more small employers through a policy issued to an
10 association or trust of employers.
- 11 A carrier which provides a health benefits plan to one or more
12 small employers through a policy issued to an association or trust of
13 employers after the effective date of P.L.1992, c.162 (C.17B:27A-
14 17 et seq.), shall be required to offer small employer health benefits
15 plans to non-association or trust employers in the same manner as
16 any other small employer carrier is required pursuant to
17 P.L.1992, c.162 (C.17B:27A-17 et seq.).
- 18 e. Nothing contained herein shall prohibit the use of premium
19 rate structures to establish different premium rates for individuals
20 and family units.
- 21 f. No insurance contract or policy subject to this act, including
22 a contract or policy entered into with a small employer who is a
23 member of a Small Employer Purchasing Alliance pursuant to the
24 provisions of P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be
25 entered into unless and until the carrier has made an informational
26 filing with the commissioner of a schedule of premiums, not to
27 exceed 12 months in duration, to be paid pursuant to such contract
28 or policy, of the carrier's rating plan and classification system in
29 connection with such contract or policy, and of the actuarial
30 assumptions and methods used by the carrier in establishing
31 premium rates for such contract or policy.
- 32 g. (1) Beginning January 1, 1995, a carrier desiring to increase
33 or decrease premiums for any policy form or benefit rider offered
34 pursuant to subsection i. of section 3 of P.L.1992, c.162
35 (C.17B:27A-19) subject to this act may implement such increase or
36 decrease upon making an informational filing with the
37 commissioner of such increase or decrease, along with the actuarial
38 assumptions and methods used by the carrier in establishing such
39 increase or decrease, provided that the anticipated minimum loss
40 ratio for all policy forms shall not be less than 80% of the premium
41 therefor as provided in paragraph (2) of this subsection. The
42 commissioner may disapprove any informational filing on a finding
43 that it is incomplete and not in substantial compliance with
44 P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are
45 inadequate or unfairly discriminatory. Until December 31, 1996,
46 the informational filing shall also include the carrier's rating plan
47 and classification system in connection with such increase or
48 decrease.

1 (2) Each calendar year, a carrier shall return, in the form of
2 aggregate benefits for all of the standard policy forms offered by
3 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162
4 (C.17B:27A-19), at least 80% of the aggregate premiums collected
5 for all of the standard policy forms, **【other than】** including alliance
6 policy forms, and at least 80% of the aggregate premiums collected
7 for all of the non-standard policy forms during that calendar year.
8 **【A carrier shall return at least 80% of the premiums collected for all**
9 **of the alliances during that calendar year, which loss ratio may be**
10 **calculated in the aggregate for all of the alliances or separately for**
11 **each alliance.】** Carriers shall annually report, no later than August
12 1st of each year, the loss ratio calculated pursuant to this section for
13 all of the standard**【, other than alliance】** policy forms**【,】** and non-
14 standard policy forms **【and alliance policy forms】** for the previous
15 calendar year**【, provided that a carrier may annually report the loss**
16 **ratio calculated pursuant to this section for all of the alliances in the**
17 **aggregate or separately for each alliance】**. In each case where the
18 loss ratio fails to substantially comply with the 80% loss ratio
19 requirement, the carrier shall issue a dividend or credit against
20 future premiums for all policyholders with the standard**【, other than**
21 **alliance policy forms,】** and nonstandard policy forms **【or alliance**
22 **policy forms】**, as applicable, in an amount sufficient to assure that
23 the aggregate benefits paid in the previous calendar year plus the
24 amount of the dividends and credits shall equal 80% of the
25 aggregate premiums collected for the respective policy forms in the
26 previous calendar year. All dividends and credits must be
27 distributed by December 31 of the year following the calendar year
28 in which the loss ratio requirements were not satisfied. The annual
29 report required by this paragraph shall include a carrier's calculation
30 of the dividends and credits applicable to standard**【, other than**
31 **alliance policy forms,】** and non-standard policy forms **【and alliance**
32 **policy forms】**, as well as an explanation of the carrier's plan to issue
33 dividends or credits. The instructions and format for calculating
34 and reporting loss ratios and issuing dividends or credits shall be
35 specified by the commissioner by regulation. Such regulations shall
36 include provisions for the distribution of a dividend or credit in the
37 event of cancellation or termination by a policyholder. For
38 purposes of this paragraph, "alliance policy forms" means policies
39 purchased by small employers who are members of Small Employer
40 Purchasing Alliances.

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

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

- 1 i. The provisions of this act shall apply to health benefits plans
2 which are delivered, issued for delivery, renewed or continued on or
3 after January 1, 1994.
- 4 j. (Deleted by amendment, P.L.1995, c.340).
- 5 k. A carrier who negotiates a reduced premium rate with a
6 Small Employer Purchasing Alliance for members of that alliance
7 shall provide a reduction in the premium rate filed in accordance
8 with paragraph (3) of subsection a. of this section, expressed as a
9 percentage, which reduction shall be based on volume or other
10 efficiencies or economies of scale and shall not be based on health
11 status-related factors.
12 (cf: P.L.2008, c.38, s.24)
13
- 14 3. Section 8 of P.L.2001, c.352 (C.17B:27C-8) is amended to
15 read as follows:
- 16 8. a. Except as provided by this act, the insurance laws of this
17 State do not apply to the operation of self-funded multiple employer
18 welfare arrangements. A self-funded multiple employer welfare
19 arrangement is not an insurance company or insurer under the laws
20 of this State.
- 21 b. Any self-funded multiple employer welfare arrangement
22 shall offer all products that it is actively marketing to any employer,
23 and accept any employer and any employee of that employer who
24 applies for any of those products; provided, however that a self-
25 funded multiple employer welfare arrangement may limit
26 participation to members of the association.
- 27 c. Assessments payable by small employer members, except
28 for dental plans, shall **be established in accordance with the rating**
29 **requirements of section 9 of P.L.1992, c.162 (C.17B:27A-25) and**
30 **regulations promulgated thereunder] not be greater than 300**
31 **percent of the assessment charged to the lowest rated small**
32 **employer member of the self-funded multiple employer welfare**
33 **arrangement.**
- 34 d. **(1)** If the member is a small employer, the **[health]**
35 **coverage of mandated hospital and medical** **[to be]**
36 **provided by the self-funded multiple employer welfare arrangement**
37 **shall at all times be equal to or greater than the hospital and medical**
38 **benefits required to be **[provided in] covered under** the lowest**
39 **benefit level standard plan promulgated by the New Jersey Small**
40 **Employer Health Benefits Program pursuant to P.L.1992, c.162**
41 **(C.17B:27A-17 et seq.). The provisions of this subsection shall not**
42 **require a self-funded multiple employer welfare arrangement to**
43 **provide small employer members with any plan provisions**
44 **applicable under the New Jersey Small Employer Health Benefits**
45 **Program, other than coverage of mandated hospital and medical**
46 **benefits.**

1 (2) As used in this subsection:

2 “Hospital and medical benefits” means benefits provided
3 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) that:

4 (a) cover certain persons or certain illnesses, procedures, or
5 prescription drugs;

6 (b) require coverage of benefits without or with limited cost-
7 sharing; or

8 (c) require reimbursement of care by certain providers, if the
9 care is a covered expense.

10 “Plan provisions” shall include, but shall not be limited to, any
11 rules, requirements, and payment provisions, including any cost-
12 sharing requirements, designed to implement those plans.

13 e. A large employer participating in a multiple employer
14 welfare arrangement shall not be required to adhere to the plan or
15 design elements, or any required coverage offerings applicable to
16 small employers, including but not limited to deductibles, co-pays,
17 and co-insurance amounts. After the effective date of
18 P.L.2015, c.172, large employer members of a multiple employer
19 welfare arrangement shall continue to offer all health benefits
20 mandated by State law and in effect on October 1, 2014. Any new
21 or additional health benefits mandated by State law required to be
22 offered after October 1, 2014 shall not be required to be offered by
23 large employers participating in a multiple employer welfare
24 arrangement. Except as provided in P.L.2001, c.352 (C.17B:27C-1
25 et seq.) as amended by P.L.2015, c.172, multiple employer welfare
26 arrangements with large employers shall be otherwise subject to the
27 requirements of State and federal law.

28 f. Notwithstanding any other provision to the contrary, if the
29 member is a large employer, the rate manual used to calculate
30 program rates may include appropriate classification factors such as
31 claims experience and utilization, age, gender, tobacco use, and
32 geography, and such specific underwriting adjustments as may be
33 certified in accordance with subsection d. of section 6 of
34 P.L.2001, c.352 (C.17B:27C-6).

35 g. The self-funded multiple employer welfare arrangement may
36 provide to its members a health and wellness program consistent
37 with the United States Department of Labor's requirements.

38 h. The self-funded multiple employer welfare arrangement may
39 provide to its members an internet-based system for the
40 administration, billing and claims processing of its benefits.
41 (cf: P.L.2015, c.172, s.5.)

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43 4. This act shall take effect on the 90th day next following
44 enactment.

STATEMENT

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This bill revises certain requirements for individual and small employer health benefits plans and for small employer members of multiple employer welfare arrangements.

This bill would bring New Jersey statutes that govern the rating factors used by health insurance carriers to charge premiums for health benefits plans in the individual and small employer markets into compliance with certain provisions of the federal Affordable Care Act (ACA). Current New Jersey statutes allow premiums for health benefits plans offered in these markets to vary according to certain factors and within certain ranges in ways that are not in compliance with the requirements of the ACA.

Specifically, with respect to plans offered through the New Jersey Individual Health Coverage Program, the bill: (1) provides that the premium rate charged by a carrier for the highest rated individual or class of individuals shall not exceed 300%, instead of 350% as provided in current law, of the premium rate charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan; and (2) requires rate differentials based on age to use classifications established in one-year increments, instead of five-year increments as provided in current law.

With respect to plans offered through the New Jersey Small Employer Health Benefits Program, the bill: (1) removes gender as a permissible rating factor; (2) eliminates separate rating treatment for small employer purchasing alliances for determining permissible rate differentials between the highest rated and lowest rated plans, and for determining compliance with medical loss ratios; and (3) requires rate differentials based on age to use classifications established in one-year increments, instead of five-year increments as provided in current law.

By amending these statutes that govern the offering of individual and small employer plans in the State, the bill brings New Jersey law into conformance with certain provisions of the ACA.

With respect to plans offered through the Small Employer Health Benefits Program, the bill also provides that the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan may not be greater than 300% of the premium rate charged for the lowest rated small group purchasing that same health benefits plan.

A multiple employer welfare arrangement, or MEWA, is a self-funded or partially self-funded multiple employer welfare arrangement that provides for health benefits plans and that has one or more of the employer members either domiciled in New Jersey or its principal headquarters or principal administrative office located in the State.

1 Under current law, the assessments payable by small employer
2 members of MEWAs are required to be in accordance with the
3 rating requirements of the New Jersey Small Employer Health
4 Benefits Program. Pursuant to this requirement, assessments
5 payable by small employer members may not be greater than 200%
6 of the premium rate charged for the lowest rated small employer
7 member. Under the bill, assessments payable by small employer
8 members would be required to be no greater than 300% of the
9 assessment charged to the lowest rated small employer member of
10 the self-funded multiple employer welfare arrangement.

11 The bill also clarifies the requirements for small employer
12 members of MEWAs concerning mandated health benefits. Under
13 current law, small employer members are required to provide health
14 benefits that are equal to or greater than benefits required to be
15 provided by the New Jersey Small Employer Health Benefits
16 Program. Under the bill, small employer members would be
17 required to provide hospital and medical benefits that are equal to
18 or greater than the hospital and medical benefits required to be
19 provided by the New Jersey Small Employer Health Benefits
20 Program. The bill clarifies this coverage requirement and also
21 makes it clear that a self-funded multiple employer welfare
22 arrangement is not required to provide small employer members
23 with any plan provisions applicable under the New Jersey Small
24 Employer Health Benefits Program other than coverage of
25 mandated hospital and medical benefits. As used in the bill, plan
26 provisions include, but are not limited to, any rules, requirements,
27 and payment provisions, including any cost-sharing requirements,
28 designed to implement those plans.