ASSEMBLY, No. 1665

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:
Assemblywoman ANNETTE QUIJANO
District 20 (Union)

SYNOPSIS

Revises certain permissible rating factors for premiums charged for individual and small employer health benefits plans.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

AN ACT concerning rating factors for certain health benefits plans and amending P.L.1992, c.161 and P.L.1992, c.162.

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

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

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

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

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

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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 <u>thus</u> is new matter.

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

"Department" means the Department of Banking and Insurance.

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

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

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

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

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

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

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

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

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this act, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plan shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code

(10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

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

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

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

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

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

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

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

The rating system shall provide that the premium rate charged by the carrier for the highest rated individual or class of individuals shall not be greater than **[**350%**]** <u>300%</u> of the premium rate charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan. The rate differential among the premium rates charged to individuals covered under the same

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) up to six geographic territories, none of which is smaller than a county; and

(b) age classifications which[, at a minimum,] shall be in [five-year] one-year increments, except that a self-funded multiple employer welfare arrangement registered with the department pursuant to section 4 of P.L.2001, c.352 (C.17B:27A-4) may use age classifications which, at a minimum, may be in five year increments.

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

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

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

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

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

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

g. (1) Beginning January 1, 1995, a carrier desiring to increase or decrease premiums for any policy form or benefit rider offered pursuant to subsection i. of section 3 of P.L.1992, c.162 (C.17B:27A-19) subject to this act may implement such increase or decrease upon making an informational filing with the commissioner of such increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing such increase or decrease, provided that the anticipated minimum loss ratio for all policy forms shall not be less than 80% of the premium therefor as provided in paragraph (2) of this subsection. The commissioner may disapprove any informational filing on a finding that it is incomplete and not in substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are

inadequate or unfairly discriminatory. Until December 31, 1996, the informational filing shall also include the carrier's rating plan and classification system in connection with such increase or decrease.

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

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

P.L.1995, c.340 (C.17B:27A-19.3), for the purposes of meeting the requirements of this subsection.

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

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

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

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

(cf: P.L.2008, c.38, s.24)

3. This act shall take effect on the 90th day next following enactment.

STATEMENT

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 percent, instead of 350 percent 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 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.

The bill provides that a self-funded multiple employer welfare arrangement registered with the department may use age classifications which, at a minimum, may be in five year increments.

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.