

SENATE, No. 3480

STATE OF NEW JERSEY 220th LEGISLATURE

INTRODUCED JANUARY 12, 2023

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Senator NELLIE POU

District 35 (Bergen and Passaic)

SYNOPSIS

“The Small Business Health Insurance Affordability Act”; revises certain requirements for individual and small employer health benefits plans.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 1/19/2023)

1 AN ACT concerning small employer and individual health benefits
 2 plans, amending P.L.1992, c.161 and P.L.1992, c.162, and
 3 supplementing various parts of the statutory law.

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

7
 8 1. Section 3 of P.L.1992, c.161 (C.17B:27A-4) is amended to
 9 read as follows:

10 3. a. **【No later than 180 days after the effective date of this**
 11 **section of P.L.2008, c.38, a carrier shall, as a condition of issuing**
 12 **small employer health benefits plans in this State, also offer**
 13 **individual health benefits plans. The plans shall be offered on an**
 14 **open enrollment, modified community rated basis, pursuant to the**
 15 **provisions of this act and P.L.2008, c.38. Every carrier that issues**
 16 **small employer health benefits plans pursuant to P.L.1992, c.162**
 17 **(C.17B:27A-17 et seq.) shall make a good faith effort to market**
 18 **individual health benefits plans.】** (Deleted by amendment,
 19 P.L. , c. (pending before the Legislature as this bill).

20 b. A carrier shall offer to an eligible person a choice of at least
 21 three individual health benefits plans established by the board
 22 pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7).

23 c. (1) (Deleted by amendment, P.L.2019, c.359).

24 (2) (Deleted by amendment, P.L.2019, c.359).

25 (3) (Deleted by amendment, P.L.2019, c.359).

26 (4) (Deleted by amendment, P.L.2019, c.359).

27 (5) The provisions of section 13 of P.L.1985, c.236 (C.17:48E-
 28 13), N.J.S.17B:26-1, and section 8 of P.L.1973, c.337 (C.26:2J-8)
 29 with respect to the filing of policy forms shall not apply to health
 30 plans issued on or after the effective date of **【this act】** P.L.1992,
 31 c.161 (C.17B:27A-2 et al.).

32 (6) The provisions of section 27 of P.L.1985, c.236 (C.17:48E-
 33 27) and section 7 of P.L.1988, c.71 (C.17:48E-27.1) with respect to
 34 rate filings shall not apply to individual health plans issued on or
 35 after the effective date of **【this act】** P.L.1992, c.161 (C.17B:27A-2
 36 et al.).

37 d. Every group conversion contract or policy issued after the
 38 effective date of **【this act】** P.L.1992, c.161 (C.17B:27A-2 et al.)
 39 shall be issued pursuant to this section; except that this requirement
 40 shall not apply to any group conversion contract or policy in which
 41 a portion of the premium is chargeable to, or subsidized by, the
 42 group policy from which the conversion is made.

43 e. (Deleted by amendment, P.L.2008, c.38).

44 f. (Deleted by amendment, P.L.2019, c.359).

45 (cf: P.L.2019, c.359, s.2)

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

3 5. An individual health benefits plan issued pursuant to section
4 3 of **【this act】** P.L.1992, c.161 (C.17B:27A-4) is subject to the
5 following provisions:

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

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

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

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

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

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

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

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

41 (4) approval by the commissioner of a request by the individual
42 carrier to cease doing business in the individual health benefits
43 market. A carrier may not renew all individual health benefits plans
44 only if the carrier: (a) first receives approval from the
45 commissioner; and (b) provides notice to each individual of the
46 nonrenewal at least 180 days prior to the date of the expiration of
47 such coverage**【**. A carrier ceasing to do business in the individual
48 health benefits market may not provide for the issuance of any

1 health benefits plan in the individual or small employer markets
2 during the five-year period beginning on the date of the termination
3 of the last health benefits plan not so renewed】; and

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

11 (cf: P.L.2008, c.38, s.14)

12
13 3. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
14 read as follows:

15 3. a. Except as provided in subsection f. of this section, every
16 small employer carrier shall, as a condition of transacting business
17 in this State, offer to every small employer at least three of the
18 health benefit plans established by the board, as provided in this
19 section【, and also offer and make a good faith effort to market
20 individual health benefits plans as provided in section 3 of
21 P.L.1992, c.161 (C.17B:27A-4)】. The board shall establish a
22 standard policy form for each of the plans, which except as
23 otherwise provided in subsection j. of this section, shall be the only
24 plans offered to small groups on or after January 1, 1994. One
25 policy form shall contain the benefits provided for in sections 55,
26 57, and 59 of P.L.1991, c. 187 (C.17:48E-22.2, 17B:26B-2 and
27 26:2J-4.3). In the case of indemnity carriers, one policy form shall
28 be established which contains benefits and cost sharing levels which
29 are equivalent to the health benefits plans of health maintenance
30 organizations pursuant to the “Health Maintenance Organization
31 Act of 1973,” Pub.L.93-222 (42 U.S.C. s.300e et seq.). The
32 remaining policy forms shall contain basic hospital and medical-
33 surgical benefits, including, but not limited to:

34 (1) Basic inpatient and outpatient hospital care;

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

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

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

38 and

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

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

46 Notwithstanding the provisions of this subsection to the contrary,
47 the board also may establish additional policy forms by which a
48 small employer carrier, other than a health maintenance

1 organization, may provide indemnity benefits or health maintenance
2 organization enrollees by direct contract with the enrollees' small
3 employer through a dual arrangement with the health maintenance
4 organization. The dual arrangement shall be filed with the
5 commissioner for approval. The additional policy forms shall be
6 consistent with the general requirements of P.L.1992, c.162
7 (C.17B:27A-17 et seq.).

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

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

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

25 e. (Deleted by amendment, P.L.2008, c.38).

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

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

43 g. A carrier shall not be required to own or control a health
44 maintenance organization or otherwise affiliate with a health
45 maintenance organization in order to comply with the provisions of
46 this section, but the carrier shall be required to offer at least three of
47 the benefits plans which are formulated by the board and approved
48 by the commissioner, including one plan which contains benefits

1 and cost sharing levels that are equivalent to those required for
2 health maintenance organizations.

3 h. Notwithstanding the provisions of subsection a. of this
4 section to the contrary, the board may modify the benefits provided
5 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,
6 17B:26B-2 and 26:2J-4.3).

7 i. (1) In addition to the rider packages provided for in
8 subsection d. of this section, every carrier may offer, in connection
9 with the health benefits plans required to be offered by this section,
10 any number of riders which may revise the coverage offered by the
11 plans in any way, provided, however, that any form of such rider or
12 amendment thereof which decreases benefits or decreases the
13 actuarial value of a plan shall be filed for informational purposes
14 with the board and for approval by the commissioner before such
15 rider may be sold. Any rider or amendment thereof which adds
16 benefits or increases the actuarial value of a plan shall be filed with
17 the board for informational purposes before such rider may be sold.
18 The added premium or reduction in premium for each rider, as
19 applicable, shall be listed separately from the premium for the
20 standard plan.

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

29 (2) The benefit riders provided for in paragraph (1) of this
30 subsection shall be subject to the provisions of section 2, subsection
31 b. of section 3, and sections 5, 7, 8, 9 and 11 of P.L.1992, c.162
32 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-
33 24, 17B:27A-25, and 17B:27A-27).

34 j. (1) Notwithstanding the provisions of P.L.1992, c.162
35 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
36 by or through a carrier, association, or multiple employer
37 arrangement prior to January 1, 1994 or, if the requirements of
38 subparagraph (c) of paragraph (6) of this subsection are met, issued
39 by or through an out-of-State trust prior to January 1, 1994, at the
40 option of a small employer policy or contract holder, may be
41 renewed or continued after February 28, 1994, or in the case of such
42 a health benefits plan whose anniversary date occurred between
43 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-
44 19.1 et al.), may be reinstated within 60 days of that anniversary
45 date and renewed or continued if, beginning on the first 12-month
46 anniversary date occurring on or after the sixtieth day after the
47 board adopts regulations concerning the implementation of the
48 rating factors permitted by section 9 of P.L.1992, c.162

1 (C.17B:27A-25) and, regardless of the situs of delivery of the health
2 benefits plan, the health benefits plan renewed, continued or
3 reinstated pursuant to this subsection complies with the provisions
4 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and
5 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,
6 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and
7 section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

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

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

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

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

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

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

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

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

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

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

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

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

44 (7) Notwithstanding the provisions of P.L.1992, c.162
45 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
46 employer arrangement or out-of-State trust may offer a health
47 benefits plan authorized to be renewed, continued or reinstated
48 pursuant to this subsection to small employer groups that are

1 otherwise eligible pursuant to paragraph (1) of subsection j. of this
2 section during the period for which such health benefits plan is
3 otherwise authorized to be renewed, continued or reinstated.

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

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

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

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

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

46 Notwithstanding the provisions of subparagraph (b) of paragraph
47 (6) of this subsection to the contrary, a small employer who changes
48 its health benefits plan's issuing carrier pursuant to the provisions of

1 this paragraph, shall not, upon changing carriers, modify the benefit
2 structure of that health benefits plan within six months of the date
3 the issuing carrier was changed.

4 k. Effective immediately for a health benefits plan issued on or
5 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
6 and effective on the first 12-month anniversary date of a health
7 benefits plan in effect on the effective date of P.L.2005, c.248
8 (C.17:48E-35.27 et al.), the health benefits plans required pursuant
9 to this section, including any plans offered by a State approved or
10 federally qualified health maintenance organization, shall contain
11 benefits for expenses incurred in the following:

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

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

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

33 The benefits provided pursuant to this subsection shall be
34 provided to the same extent as for any other medical condition
35 under the health benefits plan, except that a deductible shall not be
36 applied for benefits provided pursuant to this subsection; however,
37 with respect to a small employer health benefits plan that qualifies
38 as a high deductible health plan for which qualified medical
39 expenses are paid using a health savings account established
40 pursuant to section 223 of the federal Internal Revenue Code of
41 1986 (26 U.S.C. s.223), a deductible shall not be applied for any
42 benefits that represent preventive care as permitted by that federal
43 law, and shall not be applied as provided pursuant to section 16 of
44 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to
45 all small employer health benefits plans in which the carrier has
46 reserved the right to change the premium.

47 l. The board shall consider including benefits for speech-
48 language pathology and audiology services, as rendered by speech-

1 language pathologists and audiologists within the scope of their
2 practices, in at least one of the standard policies and in at least one
3 of the five riders to be developed under this section.

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

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

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

24 n. Effective immediately for a health benefits plan issued on or
25 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
26 and effective on the first 12-month anniversary date of a small
27 employer health benefits plan in effect on the effective date of
28 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
29 required pursuant to this section that qualify as high deductible
30 health plans for which qualified medical expenses are paid using a
31 health savings account established pursuant to section 223 of the
32 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including
33 any plans offered by a State approved or federally qualified health
34 maintenance organization, shall contain benefits for expenses
35 incurred in connection with any medically necessary benefits
36 provided in-network that represent preventive care as permitted by
37 that federal law.

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

44 (cf: P.L.2012, c.17, s.58)

45
46 4. Section 4 of P.L.1992, c.162 (C.17B:27A-20) is amended to
47 read as follows:

1 4. Plans required to be offered under **【this act】** P.L.1992, c.162
2 (C.17B:27A-17 et seq.) may be subject to coinsurance and
3 deductibles, which may vary by selected portions of the coverage,
4 except that no **【deductible applicable to any portion of the coverage**
5 **shall exceed \$250 for an individual or family unit during any**
6 **benefit year, and no coinsurance applicable to any portion of the**
7 **coverage shall exceed \$500 for an individual or family unit during**
8 **any benefit year, unless provided by the board pursuant to section**
9 **17 of P.L.1992, c.162 (C.17B:27A-33)】** cost-sharing shall exceed
10 the maximum out-of-pocket limits established in the federal Patient
11 Protection and Affordable Care Act, Pub.L.111-148, as amended by
12 the federal "Health Care and Education Reconciliation Act of
13 2010," Pub.L.111-152.
14 (cf: P.L.1993, c.162, s.3.)
15

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

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

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

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

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

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

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

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

40 e. Any carrier doing business pursuant to the provisions of
41 **【this act】** P.L.1992, c.162 (C17B:27A-17 et seq.) ceases doing
42 business in the small employer market, if the following conditions
43 are satisfied:

44 (1) The carrier gives notice to cease doing business in the small
45 employer market to the commissioner not later than eight months
46 prior to the date of the planned withdrawal from the small employer
47 market, during which time the carrier shall continue to be governed

1 by **【this act】** P.L.1992, c.162 (C.17B:27A-17 et seq.) with respect
2 to business written pursuant to **【this act】** P.L.1992, c.162
3 (C.17B:27A-17 et seq.) For the purposes of this subsection, "date
4 of withdrawal" means the date upon which the first notice to small
5 employers is sent by the carrier pursuant to paragraph (2) of this
6 subsection;

7 (2) No later than two months following the date of the
8 notification to the commissioner that the carrier intends to cease
9 doing business in the small employer market, the carrier shall mail a
10 notice to every small business employer insured by the carrier, and
11 all covered persons, that the policy or contract of insurance will not
12 be renewed. This notice shall be sent by certified mail to the small
13 business employer not less than six months in advance of the
14 effective date of the nonrenewal date of the policy or contract;

15 (3) **【Any carrier that ceases to do business pursuant to this act**
16 **shall be prohibited from writing new business in the small employer**
17 **and individual health benefits plan markets for a period of five**
18 **years from the date of termination of the last health insurance**
19 **coverage not so renewed】** (Deleted by amendment,
20 P.L. .c. (pending before the Legislature as this bill)).

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

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

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

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

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

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

45 (cf: P.L.2008, c.38, s.23)

46

47 6. Section 9 of P.L.1992, c.162 (C.17B:27A-25) is amended to
48 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) (a) For all policies or contracts providing health benefits
- 4 plans for small employers issued pursuant to section 3 of P.L.1992,
- 5 c.162 (C.17B:27A-19), and including policies or contracts offered
- 6 by a carrier to a small employer who is a member of a Small
- 7 Employer Purchasing Alliance pursuant to the provisions of
- 8 P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged
- 9 by a carrier to the highest rated small group purchasing a small
- 10 employer health benefits plan issued pursuant to section 3 of
- 11 P.L.1992, c.162 (C.17B:27A-19) shall not be greater than **[200%]**
- 12 300% of the premium rate charged for the lowest rated small group
- 13 purchasing that same health benefits plan; provided, however, that
- 14 the only factors upon which the rate differential may be based are
- 15 age**[, gender]** and geography. Such factors shall be applied in a
- 16 manner consistent with regulations adopted by the commissioner.
- 17 For the purposes of this paragraph (3), policies or contracts offered
- 18 by a carrier to a small employer who is a member of a Small
- 19 Employer Purchasing Alliance shall be rated separately from the
- 20 carrier's other small employer health benefits policies or contracts.
- 21 (b) A health benefits plan issued pursuant to subsection j. of
- 22 section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be rated in
- 23 accordance with the provisions of section 7 of P.L.1995, c.340
- 24 (C.17B:27A-19.3), for the purposes of meeting the requirements of
- 25 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
- 28 small employer who was not previously covered by a health
- 29 benefits plan issued by the issuing small employer carrier, shall be
- 30 subject to the same premium rate restrictions as provided in
- 31 paragraph (3) of this subsection, which rate restrictions shall be
- 32 effective on the date the policy or contract is issued.
- 33 (6) The board shall establish, pursuant to section 17 of
- 34 P.L.1993, c.162 (C.17B:27A-51):
- 35 (a) up to six geographic territories, none of which is smaller
- 36 than a county; and
- 37 (b) age classifications which, at a minimum, shall be in five-
- 38 year 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,
- 42 **[this act]** P.L.1992, c.162 (C.17B:27A-17 et seq.) shall apply to a
- 43 carrier which provides a health benefits plan to one or more small
- 44 employers through a policy issued to an association or trust of
- 45 employers.
- 46 A carrier which provides a health benefits plan to one or more
- 47 small employers through a policy issued to an association or trust of
- 48 employers after the effective date of P.L.1992, c.162 (C.17B:27A-

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

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

8 f. No insurance contract or policy subject to **[this act]**
9 P.L.1992, c.162 (C.17B:27A-17 et seq.), including a contract or
10 policy entered into with a small employer who is a member of a
11 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
15 in duration, to be paid pursuant to such contract or policy, of the
16 carrier's rating plan and classification system in connection with
17 such contract or policy, and of the actuarial assumptions and
18 methods used by the carrier in establishing premium rates for such
19 contract or policy.

20 g. (1) Beginning January 1, 1995, a carrier desiring to increase
21 or decrease premiums for any policy form or benefit rider offered
22 pursuant to subsection i. of section 3 of P.L.1992, c.162
23 (C.17B:27A-19) subject to **[this act]** P.L.1992, c.162 (C.17B:27A-
24 17 et seq.) may implement such increase or decrease upon making
25 an informational filing with the commissioner of such increase or
26 decrease, along with the actuarial assumptions and methods used by
27 the carrier in establishing such increase or decrease, provided that
28 the anticipated minimum loss ratio for all policy forms shall not be
29 less than 80% of the premium therefor as provided in paragraph (2)
30 of this subsection. The commissioner may disapprove any
31 informational filing on a finding that it is incomplete and not in
32 substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et
33 seq.), or that the rates are inadequate or unfairly discriminatory.
34 Until December 31, 1996, the informational filing shall also include
35 the carrier's rating plan and classification system in connection with
36 such increase or decrease.

37 (2) Each calendar year, a carrier shall return, in the form of
38 aggregate benefits for all of the standard policy forms offered by
39 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162
40 (C.17B:27A-19), at least 80% of the aggregate premiums collected
41 for all of the standard policy forms, other than alliance policy
42 forms, and at least 80% of the aggregate premiums collected for all
43 of the non-standard policy forms during that calendar year. A
44 carrier shall return at least 80% of the premiums collected for all of
45 the alliances during that calendar year, which loss ratio may be
46 calculated in the aggregate for all of the alliances or separately for
47 each alliance. Carriers shall annually report, no later than August
48 1st of each year, the loss ratio calculated pursuant to this section for

1 all of the standard, other than alliance policy forms, non-standard
2 policy forms and alliance policy forms for the previous calendar
3 year, provided that a carrier may annually report the loss ratio
4 calculated pursuant to this section for all of the alliances in the
5 aggregate or separately for each alliance. In each case where the
6 loss ratio fails to substantially comply with the 80% loss ratio
7 requirement, the carrier shall issue a dividend or credit against
8 future premiums for all policyholders with the standard, other than
9 alliance policy forms, nonstandard policy forms or alliance policy
10 forms, as applicable, in an amount sufficient to assure that the
11 aggregate benefits paid in the previous calendar year plus the
12 amount of the dividends and credits shall equal 80% of the
13 aggregate premiums collected for the respective policy forms in the
14 previous calendar year. All dividends and credits must be
15 distributed by December 31 of the year following the calendar year
16 in which the loss ratio requirements were not satisfied. The annual
17 report required by this paragraph shall include a carrier's calculation
18 of the dividends and credits applicable to standard, other than
19 alliance policy forms, non-standard policy forms and alliance policy
20 forms, as well as an explanation of the carrier's plan to issue
21 dividends or credits. The instructions and format for calculating
22 and reporting loss ratios and issuing dividends or credits shall be
23 specified by the commissioner by regulation. Such regulations shall
24 include provisions for the distribution of a dividend or credit in the
25 event of cancellation or termination by a policyholder. For
26 purposes of this paragraph, "alliance policy forms" means policies
27 purchased by small employers who are members of Small Employer
28 Purchasing Alliances.

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

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

35 i. The provisions of **【this act】** P.L.1992, c.162 (C.17B:27A-17
36 et seq.) shall apply to health benefits plans which are delivered,
37 issued for delivery, renewed or continued on or after January 1,
38 1994.

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

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

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

1 7. Section 13 of P.L.1992, c.162 (C.17B:27A-29) is amended
2 to read as follows:

3 13. a. **【**Within 60 days of the effective date of this act, the
4 commissioner shall give notice to all members of the time and place
5 for the initial organizational meeting, which shall take place within
6 90 days of the effective date. The members shall elect the initial
7 board, subject to the approval of the commissioner. The board shall
8 consist of 10 elected public members and two ex officio members
9 who include the Commissioner of Health and the commissioner or
10 their designees. Initially, three of the public members of the board
11 shall be elected for a three-year term, three shall be elected for a
12 two-year term, and three shall be elected for a one-year term.
13 Thereafter, all elected board members shall serve for a term of three
14 years. The following categories shall be represented among the
15 elected public members:

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

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

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

24 (4) Two health maintenance organizations; and

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

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

27 (7) Three persons representing small employers, at least one of
28 whom represents minority small employers.

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

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

39 In addition to the 10 elected public members, the **】** The board
40 shall **【**include six**】** consist of 12 public members appointed by the
41 Governor **【**with the advice and consent of the Senate**】** who shall
42 include:

43 (1) Two carriers that sell plans in the small employer market;

44 (2) One carrier that sells plans in the individual market or the
45 small employer market;

46 (3) Two representatives of or individuals employed by
47 businesses that purchase in small employer health benefits plans;

48 (4) Two health care provider representatives;

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

3 (6) One representative of organized labor;

4 **【One physician licensed to practice medicine and surgery in this**
5 **State; and**

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

8 (7) One representative of an association representing small
9 business in the State; and

10 (8) One person with knowledge or expertise in New Jersey
11 regulated health insurance markets who represents the general
12 public.

13 The commissioner, or the commissioner's designee, shall serve
14 on the board as an ex officio member. No carrier shall have more
15 than one representative on the board.

16 The public members shall be appointed for a term of three years,
17 except that of the members first appointed, **【two】** four shall be
18 appointed for a term of one year, **【two】** four for a term of two years
19 and **【two】** four for a term of three years.

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

23 b. **【If the initial board is not elected at the organizational**
24 **meeting, the commissioner shall appoint the public members within**
25 **15 days of the organizational meeting, in accordance with the**
26 **provisions of paragraphs (1) through (7) of subsection a. of this**
27 **section.】** (Deleted by amendment, P.L. , c.) (pending before
28 the Legislature as this bill).

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

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

33 e. At least two copies of the minutes of every meeting of the
34 board shall be delivered forthwith to the commissioner.

35 (cf: P.L.2012, c.17, s.60.)

36

37 8. (New section) Sections 8 through 13 of
38 P.L. , c. (C.) (pending before the Legislature as this bill)
39 shall be known and may be cited as the "Small Business Health
40 Insurance Affordability Act."

41

42 9. (New section) a. The board shall annually review the small
43 employer health benefits plans offered pursuant to P.L.1992, c.162
44 (C.17B:27A-17 et seq.) to ensure that each plan meets the
45 requirements of section 2 of P.L.2019, c.354 (C.17B:27A-19.30),
46 provides consumer choice and affordability, and maintains a
47 relative level of consistency compared to previous years and to

1 other plans in the small employer market. The board shall publish
2 the findings of its review on the website of the Department of
3 Banking and Insurance.

4 b. The board shall annually adjust the design of the small
5 employer health benefits plans, including the out-of-pocket limits
6 under those plans, to ensure premium affordability and to align the
7 plans with the requirements of section 2 of P.L.2019, c.354
8 (C.17B:27A-19.30). The adjustment shall be based on the annual
9 review conducted pursuant to subsection a. of this section. The
10 board may consider proposals for adjustments to plan design to
11 improve affordability from carriers offering small employer health
12 benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

13 c. The board shall annually review the appropriateness of
14 geographic rating areas.

15 d. The board shall examine and, to the extent practicable, track
16 where small employers who do not continue coverage through a
17 small employer health benefits plan offered pursuant to P.L.1992,
18 c.162 (C.17B:27A-17 et seq.) elect to purchase coverage. The
19 board shall have the authority to develop a sample survey that
20 insurance brokers may provide to clients. Brokers who elect to
21 provide the survey to clients shall report to the board any
22 information received through the survey. The sample survey shall
23 include, but may not be limited to, information concerning where
24 small employers purchase health benefits coverage. The board shall
25 publish the findings of the surveys received from brokers pursuant
26 to this subsection on the website of the Department of Banking and
27 Insurance.

28

29 10. (New section) a. Except as provided in subsection b. of this
30 section, a carrier that offers an individual health benefits plan that
31 provides benefits for expenses incurred in the purchase of
32 prescription drugs and is delivered, issued, executed, or renewed in
33 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), may
34 use a prescription drug formulary to limit or exclude coverage for
35 prescription drugs, provided that the carrier demonstrates to the
36 satisfaction of the board that utilization and medical review panels
37 are in place to allow formulary flexibility as necessary in the best
38 interest of the insured person.

39 b. A carrier that offers an individual health benefits plan that
40 provides benefits for expenses incurred in the purchase of
41 prescription drugs and is delivered, issued, executed, or renewed in
42 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall
43 not adopt a protocol, policy, or program that establishes the specific
44 sequence in which prescription drugs for a specified medical
45 condition, and medically appropriate for a particular patient, are
46 required to be administered in order to be covered by a health
47 benefits plan.

1 11. (New section) a. Except as provided in subsection b. of this
2 section, a carrier that offers a small employer health benefits plan
3 that provides benefits for expenses incurred in the purchase of
4 prescription drugs and is delivered, issued, executed, or renewed in
5 this State, pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), may
6 use a prescription drug formulary to limit or exclude coverage for
7 prescription drugs, provided that the carrier demonstrates to the
8 satisfaction of the board that utilization and medical review panels
9 are in place to allow formulary flexibility as necessary in the best
10 interest of the insured person.

11 b. A carrier that offers a small employer health benefits plan
12 that provides benefits for expenses incurred in the purchase of
13 prescription drugs and is delivered, issued, executed, or renewed in
14 this State, pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), shall
15 not adopt a protocol, policy, or program that establishes the specific
16 sequence in which prescription drugs for a specified medical
17 condition, and medically appropriate for a particular patient, are
18 required to be administered in order to be covered by a health
19 benefits plan.

20

21 12. (New section) a. The department shall establish a clinically
22 sound and well-communicated exceptions and appeals process for
23 any carrier that uses a prescription drug formulary pursuant to
24 sections 10 and 11 of P.L. , c. (C.) (pending before the
25 Legislature as this bill). The exceptions and appeals process shall
26 allow insureds to appeal to an independent, objective third party
27 which shall render a decision as promptly as the patient's condition
28 mandates.

29 b. A carrier subject to the exceptions and appeals process
30 established pursuant to this section shall:

31 (1) show cause before denying payment for a prescription drug
32 when a prescriber has deemed the carrier's recommended substitute
33 medically inappropriate;

34 (2) provide insureds with step-by-step directions to initiate the
35 exceptions and appeals process; and

36 (3) for a prescription drug that is nonpreferred, not require an
37 insured who obtains that prescription drug to pay an amount greater
38 than the cost sharing tier level associated with the preferred
39 prescription drug, if the prescriber determines that therapeutically
40 similar drugs are medically inappropriate.

41 c. The department shall collect the information it requires to
42 conduct an annual evaluation of the exceptions and appeals process
43 established pursuant to this section with regard to the
44 appropriateness of the burden of the process on consumers and
45 clinicians and the effects on patient health outcomes.

46

47 13. (New section) The department shall, in time for plan year
48 2024, adopt rules and regulations, pursuant to the "Administrative

1 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.), requiring the
2 minimum standards for small employer health benefits plans
3 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) be no greater
4 than the minimum standards set forth in the federal Patient
5 Protection and Affordable Care Act, Pub.L.111-148, as amended by
6 the federal "Health Care and Education Reconciliation Act of
7 2010," Pub.L.111-152 for plans issued pursuant to P.L.1992, c.161
8 (C.17B:27A-2 et seq.).

9
10 14. This act shall take effect immediately.

11
12
13 STATEMENT

14
15 This bill revises various requirements for individual and small
16 employer health benefits plans.

17 The bill removes a provision of law that requires health
18 insurance carriers to offer individual health plans, through the
19 Individual Health Coverage Program, as a condition of participation
20 in the small employer health insurance market. The bill removes a
21 provision of law that requires health insurance carriers that
22 participate in the small employer health insurance market to
23 participate in the Individual Health Coverage Program.

24 The bill also removes a 5-year prohibition on carriers re-entering
25 the individual and small employer health insurance markets if the
26 carrier ceases to offer either plan.

27 The bill modifies the age rating band by requiring that the
28 premium rate charged by a carrier to the highest rated small group
29 purchasing a small employer health benefits plan may not be greater
30 than 300% of the premium rate charged for the lowest rated small
31 group purchasing that same health benefits plan; provided, however,
32 that the only factors upon which the rate differential may be based
33 are age and geography. Current law provides that the rate of the
34 highest rated small group may not be greater than 200% of the
35 premium rate charged for the lowest rated small group.

36 The bill removes provisions of current law that provide certain
37 caps on cost-sharing amounts in small employer health plans. The
38 bill instead provides that cost-sharing may not exceed the maximum
39 out-of-pocket limits established in the federal Patient Protection and
40 Affordable Care Act. This bill also requires the board of directors
41 of the New Jersey Small Employer Health Benefits Program to
42 annually review and adjust certain requirements, including out-of-
43 pocket limits, for small employer health benefits plans. In addition,
44 the bill requires the board to examine and track where small
45 employers who do not continue coverage through a small employer
46 health benefits plan elect to purchase coverage.

47 The bill provides that a carrier that offers an individual or small
48 employer health benefits plan that provides benefits for expenses

1 incurred in the purchase of prescription drugs may use a
2 prescription drug formulary to limit or exclude coverage for
3 prescription drugs, provided that the carrier demonstrates to the
4 satisfaction of the board that utilization and medical review panels
5 are in place to allow formulary flexibility when necessary, provided
6 that the carrier may not adopt a protocol, policy, or program that
7 establishes the specific sequence in which prescription drugs for a
8 specified medical condition, and medically appropriate for a
9 particular patient, are required to be administered in order to be
10 covered by a health benefits plan.

11 The bill requires the department to establish a clinically sound
12 and well-communicated exceptions and appeals process for any
13 carrier offering an individual or small employer health benefits plan
14 and that uses a prescription drug formulary pursuant to the bill. The
15 exceptions and appeals process is to allow insureds to appeal to an
16 independent, objective third party which shall render a decision as
17 promptly as the patient's condition mandates.

18 The bill requires the department to adopt rules and regulations,
19 for plan year 2024, requiring the minimum standards for small
20 employer health benefits plans to be no greater than the minimum
21 standards set forth in the federal Patient Protection and Affordable
22 Care Act, for individual health benefits plans.

23 The bill revises the membership of the New Jersey Small
24 Employer Health Benefits Program Board. The bill provides that
25 the board will consist of the following members:

- 26 (1) One carrier that sells plans in the small employer market;
- 27 (2) Two carriers that sell plans in the small employer market or
28 the individual market;
- 29 (3) Two representatives of or individuals employed by
30 businesses that purchase in small employer health benefits plans;
- 31 (4) Two individuals who are licensed insurance brokers;
- 32 (5) Two health care provider representatives;
- 33 (6) One individual representing organized labor; and
- 34 (7) One individual representing an association that represents
35 small businesses in the State; and
- 36 (8) One person with knowledge or expertise in New Jersey
37 regulated health insurance markets who represents the general
38 public.