[Second Reprint]

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 reported by the Senate Budget and Appropriations Committee on March 16, 2023, with amendments.

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

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

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

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

3. a. **[**No later than 180 days after the effective date of this section of P.L.2008, c.38, a carrier shall, as a condition of issuing small employer health benefits plans in this State, also offer individual health benefits plans. The plans shall be offered on an open enrollment, modified community rated basis, pursuant to the provisions of this act and P.L.2008, c.38. Every carrier that issues small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall make a good faith effort to market individual health benefits plans.**]** [2]**[**(Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)**]** Every carrier that offers individual health benefits plans shall make a good faith effort to market the individual health benefits plans. The department may impose fines against any carrier that violates the provisions of this subsection[2].

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

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

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

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

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

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

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

d. Every group conversion contract or policy issued after the effective date of **[**this act**]** P.L.1992, c.161 (C.17B:27A-2 et al.) shall be issued pursuant to this section; except that this requirement shall not apply to any group conversion contract or policy in which a

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate floor amendments adopted February 27, 2023.
[2]Senate SBA committee amendments adopted March 16, 2023.

portion of the premium is chargeable to, or subsidized by, the group policy from which the conversion is made.

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) approval by the commissioner of a request by the individual carrier to cease doing business in the individual health benefits market. A carrier may not renew all individual health benefits plans only if the

carrier: (a) first receives approval from the commissioner; and (b) provides notice to each individual of the nonrenewal at least 180 days prior to the date of the expiration of such coverage[. A carrier ceasing to do business in the individual health benefits market may not provide for the issuance of any health benefits plan in the individual or small employer markets during the five-year period beginning on the date of the termination of the last health benefits plan not so renewed] [2]. The commissioner may impose a five-year prohibition on the issuance of any health benefits plan in the individual or small employer markets if the commissioner determines the prohibition would be beneficial to the small employer and individual health benefits markets[2]; and

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

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

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

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

(1) Basic inpatient and outpatient hospital care;

(2) Basic and extended medical-surgical benefits;

(3) Diagnostic tests, including X-rays;

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

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

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

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

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

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

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

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

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

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

federally qualified health maintenance organization, including any requirements concerning copayments by enrollees.

g. A carrier shall not be required to own or control a health maintenance organization or otherwise affiliate with a health maintenance organization in order to comply with the provisions of this section, but the carrier shall be required to offer at least three of the benefits plans which are formulated by the board and approved by the commissioner, including one plan which contains benefits and cost sharing levels that are equivalent to those required for health maintenance organizations.

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

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

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

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

j. (1) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued by or through a carrier, association, or multiple employer arrangement prior to January 1, 1994 or, if the requirements of subparagraph (c) of paragraph (6) of this subsection are met, issued by or through an out-of-State trust prior to January 1, 1994, at the option of a small employer policy or contract holder, may be

renewed or continued after February 28, 1994, or in the case of such a health benefits plan whose anniversary date occurred between March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated within 60 days of that anniversary date and renewed or continued if, beginning on the first 12-month anniversary date occurring on or after the sixtieth day after the board adopts regulations concerning the implementation of the rating factors permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of delivery of the health benefits plan, the health benefits plan renewed, continued or reinstated pursuant to this subsection complies with the provisions of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and section 7 of P.L.1995, c.340 (C17B:27A-19.3).

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

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

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

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

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

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

c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

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

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

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

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

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

(c) A health benefits plan issued by a carrier through an out-of-State trust shall be permitted to be renewed or continued pursuant to paragraph (1) of this subsection upon approval by the commissioner and only if the benefits offered under the plan are at least equal to the actuarial value and benefits coverage of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. For the purposes of meeting the requirements of this subparagraph, carriers shall be required to file with the commissioner the health benefits plans issued through an out-of-State trust no later than 180 days after the date of enactment of

P.L.1995, c.340. A health benefits plan issued by a carrier through an out-of-State trust that is not filed with the commissioner pursuant to this subparagraph, shall not be permitted to be continued or renewed after the 180-day period.

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

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

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

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

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

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

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

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

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

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

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

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection; however, with respect to a small employer health benefits plan that qualifies as a high deductible health plan for which qualified medical

expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 16 of P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

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

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

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

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

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

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that no deductible shall be applied for benefits provided pursuant to this subsection. This subsection shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.
(cf: P.L.2012, c.17, s.58)

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

4. Plans required to be offered under **[**this act**]** P.L.1992, c.162 (C.17B:27A-17 et seq.) may be subject to coinsurance and deductibles, which may vary by selected portions of the coverage**[2]**, except that no**]2** **[**deductible applicable to any portion of the coverage shall exceed $250 for an individual or family unit during any benefit year, and no coinsurance applicable to any portion of the coverage shall exceed $500 for an individual or family unit during any benefit year, unless provided by the board pursuant to section 17 of P.L.1992, c.162 (C.17B:27A-33)**]** **2[**cost-sharing shall exceed the maximum out-of-pocket limits established in the federal Patient Protection and Affordable Care Act, Pub.L.111-148, as amended by the federal "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152**]** . The department and the boards of directors of the New Jersey Individual Health Coverage Program and New Jersey Small Employer Health Benefits Program may promulgate regulations to create standard plans or plan design requirements. The standard plans or plan design requirements may include minimum cost sharing standards, provided that the standards enable carriers to design and offer plans for the bronze, silver, gold, and platinum metal levels as defined under the actuarial value calculations pursuant to the federal "Patient Protection and Affordable Care Act," Pub.L.111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152. In promulgating these regulations, the commissioner and boards of directors shall consider the best interests of consumers, the health of the markets, and plan design that promotes utilization of high value primary and preventative care to improve the health of the State's population. Any minimum standard regulations and standard plans promulgated by the commissioner or boards of directors pursuant to this section shall be reviewed and adjusted annually to achieve the goals of this section**[2]**.
(cf: P.L.1993, c.162, s.3.)

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

7. Every policy or contract issued to small employers in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be renewable with respect to all eligible employees or dependents at

the option of the policy or contract holder, or small employer except that a carrier may discontinue or not renew a health benefits plan in accordance with the provisions of this section:

a. A carrier may discontinue such coverage only if:

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

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

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

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

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

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

(1) The carrier gives notice to cease doing business in the small employer market to the commissioner not later than eight months prior to the date of the planned withdrawal from the small employer market, during which time the carrier shall continue to be governed by **[**this act**]** P.L.1992, c.162 (C.17B:27A-17 et seq.) with respect to business written pursuant to **[**this act**]** P.L.1992, c.162 (C.17B:27A-17 et seq.) For the purposes of this subsection, "date of withdrawal" means the date upon which the first notice to small employers is sent by the carrier pursuant to paragraph (2) of this subsection;

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

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

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

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

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

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

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

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

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

[1]**[**6. 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%**]** <u>300%</u> 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 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**]** P.L.1992, c.162 (C.17B:27A-17 et seq.) 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**]** P.L.1992, c.162 (C.17B:27A-17 et seq.), 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**]** P.L.1992, c.162 (C.17B:27A-17 et seq.) 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 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, 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, 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, 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**]** P.L.1992, c.162 (C.17B:27A-17 et seq.) 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)**]**[1]

[1]**[**7.**]** 6.[1] Section 13 of P.L.1992, c.162 (C.17B:27A-29) is amended to read as follows:

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

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

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

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

(4) Two health maintenance organizations; and

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

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

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

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

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

In addition to the 10 elected public members, the**]** The board shall **[**include six**]** consist of **[**12**]** 13 public members appointed by the Governor **[**with the advice and consent of the Senate**]** who shall include:

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

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

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

(4) Two health care provider representatives;

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

(6) One representative of organized labor;

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

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

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

(8) **[**One person**]** Two persons with knowledge or expertise in New Jersey regulated health insurance markets who represents the general public.

The Commissioner of Health and the commissioner, or the commissioner's designee, shall serve on the board as **[**an**]** ex officio **[**member**]** members. No carrier shall have more than one representative on the board.

The public members shall be appointed for a term of three years, except that of the members first appointed, **[**two**]** **[**four**]** five shall

be appointed for a term of one year, ⟦two⟧ four for a term of two years and ⟦two⟧ four for a term of three years.

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

[2]The board shall continue in its existing form until there is established a quorum of members newly appointed pursuant to the provisions of P.L. , c. (C.) (pending before the Legislature as this bill).[2]

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

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

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

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

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

[1]⟦8.⟧ 7.[1] (New section) Sections [2]⟦8⟧ 7[2] through [2]⟦13⟧ 12[2] of P.L. , c. (C.) (pending before the Legislature as this bill) shall be known and may be cited as the “Small Business Health Insurance Affordability Act.”

[1]⟦9.⟧ 8.[1] (New section) a. The board shall annually review the small employer health benefits plans offered pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) to ensure that each plan meets the requirements of section 2 of P.L.2019, c.354 (C.17B:27A-19.30), provides consumer choice and affordability, and maintains a relative level of consistency compared to previous years and to other plans in the small employer market. The board shall publish the findings of its review on the website of the Department of Banking and Insurance.

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

c. The board shall annually review the appropriateness of geographic rating areas [2]and may adjust, by rule, as needed to achieve the goals of this subsection[2].

d. The board shall examine and, to the extent practicable, track where small employers who do not continue coverage through a small employer health benefits plan offered pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) elect to purchase coverage. The board shall have the authority to develop a sample survey that insurance [2][brokers may] producers shall[2] provide to clients. [2][Brokers who elect to provide the survey to clients] Insurance producers[2] shall report to the board [2][any] all[2] information received through the survey[2], which shall be de-identified by the insurance producer[2]. The sample survey shall include, but may not be limited to, information concerning where small employers purchase health benefits coverage. The board shall publish [2]a report on[2] the [2][findings of the] results of the[2] surveys received from [2][brokers] insurance producers[2] pursuant to this subsection on the website of the Department of Banking and Insurance.

[1][10.] 9.[1] (New section) a. Except as provided in subsection b. of this section, a carrier that offers an individual health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs and is delivered, issued, executed, or renewed in this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), may use a prescription drug formulary to limit or exclude coverage for prescription drugs, provided that [1]the carrier offers at least one plan with an open formulary and[1] the carrier demonstrates to the satisfaction of the board that utilization and medical review panels are in place to allow formulary flexibility as necessary in the best interest of the insured person.

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

[2]c. Notwithstanding the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary, the department shall, as appropriate and in time for plan year 2024, update rules and regulations to ensure consistency with the provisions of this section and P.L. , c. (C.) (pending before the Legislature as this bill) immediately upon filing with the Office of Administrative Law. The rules and regulations adopted pursuant to this subsection shall be in effect only for plan year 2024. The rules and regulations shall thereafter be adopted, amended, or readopted for plan years 2025 and thereafter by the department in accordance with the requirements of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[2]

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

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

[2]c. Notwithstanding the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary, the department shall, as appropriate and in time for plan year 2024, update rules and regulations to ensure consistency with the provisions of this section and P.L. , c. (C.) (pending before the Legislature as this bill) immediately upon filing with the Office of Administrative Law. The rules and regulations adopted pursuant to this subsection shall be in effect only for plan year 2024. The rules and regulations shall thereafter be adopted, amended, or readopted for plan years 2025 and thereafter by the department in accordance with the requirements of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[2]

[1]**[**12.**]** [2]**[**11.[1] (New section) a. The department shall establish a clinically sound and well-communicated exceptions and appeals process for any carrier that uses a prescription drug formulary pursuant to sections 10 and 11 of P.L. , c. (C.) (pending before the Legislature as this bill). The exceptions and appeals process shall allow insureds to appeal to an independent, objective third party which shall render a decision as promptly as the patient's condition mandates.

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

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

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

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

c. The department shall collect the information it requires to conduct an annual evaluation of the exceptions and appeals process established pursuant to this section with regard to the appropriateness of the burden of the process on consumers and clinicians and the effects on patient health outcomes.**]**[2]

[2]11. (New section) a. A carrier that uses a prescription drug formulary pursuant to sections 9 and 10 of P.L. , c. (C.) (pending before the Legislature as this bill) shall establish a clinically sound and well-communicated exceptions and appeals process, or incorporate into the carrier's existing appeals process, the requirements of this section.

b. The process shall provide insureds with step-by-step directions to initiate the exceptions and appeals process and, for a prescription drug that is nonpreferred, not require an insured who obtains that prescription drug to pay an amount greater than the cost sharing tier level associated with the preferred prescription drug, if the prescriber determines that therapeutically similar drug is medically inappropriate.

c. A carrier shall show cause before denying payment for a prescription drug when a prescriber has deemed the carrier's recommended substitute medically inappropriate.

d. An insured may apply to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) to appeal a carrier decision, and the program shall render a decision as promptly as the patient's condition mandates.

e. The department shall collect information from each carrier subject to this section to conduct an annual evaluation of the exceptions and appeals processes established pursuant to this section with regard to the appropriateness of the burden of the process on consumers and clinicians and the effects on patient health outcomes.[2]

[1]**[**13.**]** 12.[1] (New section) The department shall, in time for plan year 2024 [2]and immediately upon filing with the Office of Administrative Law[2], adopt rules and regulations, [2]**[**pursuant to**]** notwithstanding the provisions of[2] the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) [2]to the contrary[2], requiring [2]**[**the minimum standards**]** no additional limitations on copayments, coinsurance, or deductibles[2] for small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) [2]**[**be no greater than the minimum standards**]** beyond those[2] set forth in the federal Patient Protection and Affordable Care Act, Pub.L.111-148, as amended by the federal "Health Care and Education Reconciliation

Act of 2010," Pub.L.111-152 for plans issued pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.). [2]The rules and regulations adopted pursuant to this section shall be in effect only for plan year 2024. Rules and regulations shall thereafter be adopted, amended, or readopted for plan years 2025 and thereafter by the department in accordance with the requirements of section 4 of P.L. , c. (C.) (pending before the Legislature as this act) and the requirements of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[2]

[1]**[**14.**]** 13.[1] This act shall take effect immediately.