

[Fourth 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)

Assemblyman JOHN F. MCKEON

District 27 (Essex and Morris)

Assemblywoman ELLEN J. PARK

District 37 (Bergen)

Assemblywoman CAROL A. MURPHY

District 7 (Burlington)

Co-Sponsored by:

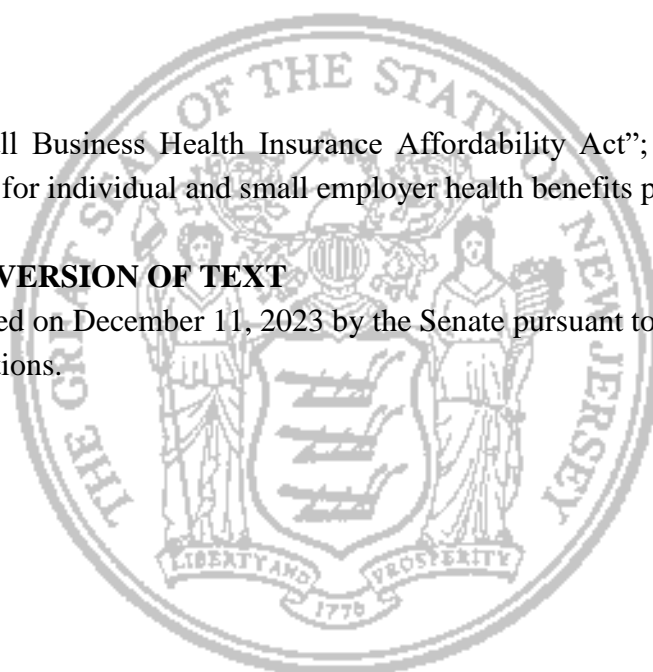
**Assemblywomen McKnight, Quijano, Speight, Assemblyman Tully and
Assemblywoman Swain**

SYNOPSIS

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

CURRENT VERSION OF TEXT

As amended on December 11, 2023 by the Senate pursuant to the Governor's recommendations.



(Sponsorship Updated As Of: 6/30/2023)

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 individual**
 13 **health benefits plans. The plans shall be offered on an open**
 14 **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.】** ²**【(Deleted by amendment,**
 19 **P.L. , c. (pending before the Legislature as this bill)】** Every
 20 carrier that offers individual health benefits plans shall make a good
 21 faith effort to market the individual health benefits plans. The
 22 department may impose fines against any carrier that violates the
 23 provisions of this subsection².

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

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

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

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

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

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

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

40 d. Every group conversion contract or policy issued after the
 41 effective date of **【this act】** P.L.1992, c.161 (C.17B:27A-2 et al.) shall
 42 be issued pursuant to this section; except that this requirement shall

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:

¹Senate floor amendments adopted February 27, 2023.

²Senate SBA committee amendments adopted March 16, 2023.

³Assembly floor amendments adopted May 25, 2023.

⁴Senate amendments adopted in accordance with Governor's
 recommendations December 11, 2023.

1 not apply to any group conversion contract or policy in which a
2 portion of the premium is chargeable to, or subsidized by, the group
3 policy from which the conversion is made.

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

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

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

7
8 2. Section 5 of P.L.1992, c.161 (C.17B:27A-6) is amended to
9 read as follows:

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

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

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

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

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

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

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

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

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

47 (4) approval by the commissioner of a request by the individual
48 carrier to cease doing business in the individual health benefits market.

1 A carrier may not renew all individual health benefits plans only if the
2 carrier: (a) first receives approval from the commissioner; and (b)
3 provides notice to each individual of the nonrenewal at least 180 days
4 prior to the date of the expiration of such coverage【. A carrier ceasing
5 to do business in the individual health benefits market may not provide
6 for the issuance of any health benefits plan in the individual or small
7 employer markets during the five-year period beginning on the date of
8 the termination of the last health benefits plan not so renewed】². The
9 commissioner may impose a five-year prohibition on the issuance of
10 any health benefits plan in the individual or small employer markets if
11 the commissioner determines the prohibition would be beneficial to
12 the small employer and individual health benefits markets²; and

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

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

21

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

24 3. a. Except as provided in subsection f. of this section, every
25 small employer carrier shall, as a condition of transacting business
26 in this State, offer to every small employer at least three of the
27 health benefit plans established by the board, as provided in this
28 section【, and also offer and make a good faith effort to market
29 individual health benefits plans as provided in section 3 of
30 P.L.1992, c.161 (C.17B:27A-4)】. The board shall establish a
31 standard policy form for each of the plans, which except as
32 otherwise provided in subsection j. of this section, shall be the only
33 plans offered to small groups on or after January 1, 1994. One
34 policy form shall contain the benefits provided for in sections 55,
35 57, and 59 of P.L.1991, c. 187 (C.17:48E-22.2, 17B:26B-2 and
36 26:2J-4.3). In the case of indemnity carriers, one policy form shall
37 be established which contains benefits and cost sharing levels which
38 are equivalent to the health benefits plans of health maintenance
39 organizations pursuant to the “Health Maintenance Organization
40 Act of 1973,” Pub.L.93-222 (42 U.S.C. s.300e et seq.). The
41 remaining policy forms shall contain basic hospital and medical-
42 surgical benefits, including, but not limited to:

- 43 (1) Basic inpatient and outpatient hospital care;
44 (2) Basic and extended medical-surgical benefits;
45 (3) Diagnostic tests, including X-rays;
46 (4) Maternity benefits, including prenatal and postnatal care;
47 and

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

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

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

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

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

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

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

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

44 Notwithstanding the provisions of this section to the contrary, a
45 health maintenance organization which is approved pursuant to
46 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
47 benefits plans formulated by the board and approved by the
48 commissioner which are in accordance with the provisions of that

1 law in lieu of the plans required pursuant to this section, except that
2 the plans shall provide the same level of benefits as required for a
3 federally qualified health maintenance organization, including any
4 requirements concerning copayments by enrollees.

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

13 h. Notwithstanding the provisions of subsection a. of this
14 section to the contrary, the board may modify the benefits provided
15 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,
16 17B:26B-2 and 26:2J-4.3).

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

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

39 (2) The benefit riders provided for in paragraph (1) of this
40 subsection shall be subject to the provisions of section 2, subsection
41 b. of section 3, and sections 5, 7, 8, 9 and 11 of P.L.1992, c.162
42 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-
43 24, 17B:27A-25, and 17B:27A-27).

44 j. (1) Notwithstanding the provisions of P.L.1992, c.162
45 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
46 by or through a carrier, association, or multiple employer
47 arrangement prior to January 1, 1994 or, if the requirements of
48 subparagraph (c) of paragraph (6) of this subsection are met, issued

1 by or through an out-of-State trust prior to January 1, 1994, at the
2 option of a small employer policy or contract holder, may be
3 renewed or continued after February 28, 1994, or in the case of such
4 a health benefits plan whose anniversary date occurred between
5 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-
6 19.1 et al.), may be reinstated within 60 days of that anniversary
7 date and renewed or continued if, beginning on the first 12-month
8 anniversary date occurring on or after the sixtieth day after the
9 board adopts regulations concerning the implementation of the
10 rating factors permitted by section 9 of P.L.1992, c.162
11 (C.17B:27A-25) and, regardless of the situs of delivery of the health
12 benefits plan, the health benefits plan renewed, continued or
13 reinstated pursuant to this subsection complies with the provisions
14 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and
15 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,
16 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and
17 section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

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

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

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

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

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

42 (3) (a) A carrier, association, multiple employer arrangement, or
43 out-of-State trust may withdraw a health benefits plan marketed to
44 small employers that was in effect on December 31, 1993 with the
45 approval of the commissioner. The commissioner shall approve a
46 request to withdraw a plan, consistent with regulations adopted by
47 the commissioner, only on the grounds that retention of the plan
48 would cause an unreasonable financial burden to the issuing carrier,

1 taking into account the rating provisions of section 9 of P.L.1992,
2 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340
3 (C.17B:27A-19.3).

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

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

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

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

28 (b) A health benefits plan filed with the commissioner pursuant
29 to subparagraph (a) of this paragraph may be amended as to its
30 benefit structure if the amendment does not reduce the actuarial
31 value and benefits coverage of the health benefits plan below that of
32 the lowest standard health benefits plan established by the board
33 pursuant to subsection a. of this section. The amendment shall be
34 filed with the commissioner for approval pursuant to the terms of
35 sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2,
36 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as
37 applicable, and shall comply with the provisions of sections 2 and 9
38 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7
39 of P.L.1995, c.340 (C.17B:27A-19.3).

40 (c) A health benefits plan issued by a carrier through an out-of-
41 State trust shall be permitted to be renewed or continued pursuant to
42 paragraph (1) of this subsection upon approval by the commissioner
43 and only if the benefits offered under the plan are at least equal to
44 the actuarial value and benefits coverage of the lowest standard
45 health benefits plan established by the board pursuant to subsection
46 a. of this section. For the purposes of meeting the requirements of
47 this subparagraph, carriers shall be required to file with the
48 commissioner the health benefits plans issued through an out-of-

1 State trust no later than 180 days after the date of enactment of
2 P.L.1995, c.340. A health benefits plan issued by a carrier through
3 an out-of-State trust that is not filed with the commissioner pursuant
4 to this subparagraph, shall not be permitted to be continued or
5 renewed after the 180-day period.

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

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

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

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

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

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

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

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

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

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

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

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

1 expenses are paid using a health savings account established
2 pursuant to section 223 of the federal Internal Revenue Code of
3 1986 (26 U.S.C. s.223), a deductible shall not be applied for any
4 benefits that represent preventive care as permitted by that federal
5 law, and shall not be applied as provided pursuant to section 16 of
6 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to
7 all small employer health benefits plans in which the carrier has
8 reserved the right to change the premium.

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

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

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

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

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

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

8
9 4. Section 4 of P.L.1992, c.162 (C.17B:27A-20) is amended to
10 read as follows:

11 4. Plans required to be offered under **[this act]** P.L.1992, c.162
12 (C.17B:27A-17 et seq.) may be subject to coinsurance and deductibles,
13 which may vary by selected portions of the coverage²**],** except that
14 no² **[**deductible applicable to any portion of the coverage shall
15 exceed \$250 for an individual or family unit during any benefit year,
16 and no coinsurance applicable to any portion of the coverage shall
17 exceed \$500 for an individual or family unit during any benefit year,
18 unless provided by the board pursuant to section 17 of P.L.1992, c.162
19 (C.17B:27A-33)**]** ²**[**cost-sharing shall exceed the maximum out-of-
20 pocket limits established in the federal Patient Protection and
21 Affordable Care Act, Pub.L.111-148, as amended by the federal
22 "Health Care and Education Reconciliation Act of 2010," Pub.L.111-
23 152**]** . The department and the boards of directors of the New Jersey
24 Individual Health Coverage Program and New Jersey Small Employer
25 Health Benefits Program may promulgate regulations to create
26 standard plans or plan design requirements. The standard plans or plan
27 design requirements may include minimum cost sharing standards,
28 provided that the standards enable carriers to design and offer plans for
29 the bronze, silver, gold, and platinum metal levels as defined under the
30 actuarial value calculations pursuant to the federal "Patient Protection
31 and Affordable Care Act," Pub.L.111-148, as amended by the "Health
32 Care and Education Reconciliation Act of 2010," Pub.L.111-152. In
33 promulgating these regulations, the commissioner and boards of
34 directors shall consider the best interests of consumers, the health of
35 the markets, and plan design that promotes utilization of high value
36 primary and preventative care to improve the health of the State's
37 population. Any minimum standard regulations and standard plans
38 promulgated by the commissioner or boards of directors pursuant to
39 this section shall be reviewed and adjusted annually to achieve the
40 goals of this section².

41 (cf: P.L.1993, c.162, s.3.)

42
43 5. Section 7 of P.L.1992, c.162 (C.17B:27A-23) is amended to
44 read as follows:

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

- 1 the option of the policy or contract holder, or small employer except
2 that a carrier may discontinue or not renew a health benefits plan in
3 accordance with the provisions of this section:
- 4 a. A carrier may discontinue such coverage only if:
- 5 (1) The policyholder, contract holder, or employer has failed to
6 pay premiums or contributions in accordance with the terms of the
7 health benefits plan or the carrier has not received timely premium
8 payments; or
- 9 (2) The policyholder, contract holder, or employer has
10 performed an act or practice that constitutes fraud or made an
11 intentional misrepresentation of material fact under the terms of the
12 coverage;
- 13 b. (Deleted by amendment, P.L.1997, c.146).
- 14 c. The number of employees covered under the health benefits
15 plan is less than the number or percentage of employees required by
16 participation requirements under the health benefits policy or
17 contract;
- 18 d. Noncompliance with a carrier's employment contribution
19 requirements;
- 20 e. Any carrier doing business pursuant to the provisions of
21 **【this act】** P.L.1992, c.162 (C17B:27A-17 et seq.) ceases doing
22 business in the small employer market, if the following conditions
23 are satisfied:
- 24 (1) The carrier gives notice to cease doing business in the small
25 employer market to the commissioner not later than eight months
26 prior to the date of the planned withdrawal from the small employer
27 market, during which time the carrier shall continue to be governed
28 by **【this act】** P.L.1992, c.162 (C.17B:27A-17 et seq.) with respect
29 to business written pursuant to **【this act】** P.L.1992, c.162
30 (C.17B:27A-17 et seq.) For the purposes of this subsection, "date
31 of withdrawal" means the date upon which the first notice to small
32 employers is sent by the carrier pursuant to paragraph (2) of this
33 subsection;
- 34 (2) No later than two months following the date of the
35 notification to the commissioner that the carrier intends to cease
36 doing business in the small employer market, the carrier shall mail a
37 notice to every small business employer insured by the carrier, and
38 all covered persons, that the policy or contract of insurance will not
39 be renewed. This notice shall be sent by certified mail to the small
40 business employer not less than six months in advance of the
41 effective date of the nonrenewal date of the policy or contract;
- 42 (3) **【Any carrier that ceases to do business pursuant to this act**
43 **shall be prohibited from writing new business in the small employer**
44 **and individual health benefits plan markets for a period of five**
45 **years from the date of termination of the last health insurance**
46 **coverage not so renewed】** (Deleted by amendment,
47 P.L. ,c. (pending before the Legislature as this bill)).

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

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

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

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

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

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

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

26
27 ¹【6. Section 9 of P.L.1992, c.162 (C.17B:27A-25) is amended to
28 read as follows:

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

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

31 (3) (a) For all policies or contracts providing health benefits
32 plans for small employers issued pursuant to section 3 of P.L.1992,
33 c.162 (C.17B:27A-19), and including policies or contracts offered
34 by a carrier to a small employer who is a member of a Small
35 Employer Purchasing Alliance pursuant to the provisions of
36 P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged
37 by a carrier to the highest rated small group purchasing a small
38 employer health benefits plan issued pursuant to section 3 of
39 P.L.1992, c.162 (C.17B:27A-19) shall not be greater than **【200%】**
40 300% of the premium rate charged for the lowest rated small group
41 purchasing that same health benefits plan; provided, however, that
42 the only factors upon which the rate differential may be based are
43 age**【, gender】** and geography. Such factors shall be applied in a
44 manner consistent with regulations adopted by the commissioner.
45 For the purposes of this paragraph (3), policies or contracts offered
46 by a carrier to a small employer who is a member of a Small
47 Employer Purchasing Alliance shall be rated separately from the
48 carrier's other small employer health benefits policies or contracts.

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

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

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

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

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

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

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

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

21 d. Notwithstanding any other provision of law to the contrary,
22 **【this act】** P.L.1992, c.162 (C.17B:27A-17 et seq.) shall apply to a
23 carrier which provides a health benefits plan to one or more small
24 employers through a policy issued to an association or trust of
25 employers.

26 A carrier which provides a health benefits plan to one or more
27 small employers through a policy issued to an association or trust of
28 employers after the effective date of P.L.1992, c.162 (C.17B:27A-
29 17 et seq.), shall be required to offer small employer health benefits
30 plans to non-association or trust employers in the same manner as
31 any other small employer carrier is required pursuant to P.L.1992,
32 c.162 (C.17B:27A-17 et seq.).

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

36 f. No insurance contract or policy subject to **【this act】**
37 P.L.1992, c.162 (C.17B:27A-17 et seq.), including a contract or
38 policy entered into with a small employer who is a member of a
39 Small Employer Purchasing Alliance pursuant to the provisions of
40 P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be entered into unless
41 and until the carrier has made an informational filing with the
42 commissioner of a schedule of premiums, not to exceed 12 months
43 in duration, to be paid pursuant to such contract or policy, of the
44 carrier's rating plan and classification system in connection with
45 such contract or policy, and of the actuarial assumptions and
46 methods used by the carrier in establishing premium rates for such
47 contract or policy.

1 g. (1) Beginning January 1, 1995, a carrier desiring to increase
2 or decrease premiums for any policy form or benefit rider offered
3 pursuant to subsection i. of section 3 of P.L.1992, c.162
4 (C.17B:27A-19) subject to **【this act】** P.L.1992, c.162 (C.17B:27A-
5 17 et seq.) may implement such increase or decrease upon making
6 an informational filing with the commissioner of such increase or
7 decrease, along with the actuarial assumptions and methods used by
8 the carrier in establishing such increase or decrease, provided that
9 the anticipated minimum loss ratio for all policy forms shall not be
10 less than 80% of the premium therefor as provided in paragraph (2)
11 of this subsection. The commissioner may disapprove any
12 informational filing on a finding that it is incomplete and not in
13 substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et
14 seq.), or that the rates are inadequate or unfairly discriminatory.
15 Until December 31, 1996, the informational filing shall also include
16 the carrier's rating plan and classification system in connection with
17 such increase or decrease.

18 (2) Each calendar year, a carrier shall return, in the form of
19 aggregate benefits for all of the standard policy forms offered by
20 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162
21 (C.17B:27A-19), at least 80% of the aggregate premiums collected
22 for all of the standard policy forms, other than alliance policy
23 forms, and at least 80% of the aggregate premiums collected for all
24 of the non-standard policy forms during that calendar year. A
25 carrier shall return at least 80% of the premiums collected for all of
26 the alliances during that calendar year, which loss ratio may be
27 calculated in the aggregate for all of the alliances or separately for
28 each alliance. Carriers shall annually report, no later than August
29 1st of each year, the loss ratio calculated pursuant to this section for
30 all of the standard, other than alliance policy forms, non-standard
31 policy forms and alliance policy forms for the previous calendar
32 year, provided that a carrier may annually report the loss ratio
33 calculated pursuant to this section for all of the alliances in the
34 aggregate or separately for each alliance. In each case where the
35 loss ratio fails to substantially comply with the 80% loss ratio
36 requirement, the carrier shall issue a dividend or credit against
37 future premiums for all policyholders with the standard, other than
38 alliance policy forms, nonstandard policy forms or alliance policy
39 forms, as applicable, in an amount sufficient to assure that the
40 aggregate benefits paid in the previous calendar year plus the
41 amount of the dividends and credits shall equal 80% of the
42 aggregate premiums collected for the respective policy forms in the
43 previous calendar year. All dividends and credits must be
44 distributed by December 31 of the year following the calendar year
45 in which the loss ratio requirements were not satisfied. The annual
46 report required by this paragraph shall include a carrier's calculation
47 of the dividends and credits applicable to standard, other than
48 alliance policy forms, non-standard policy forms and alliance policy

1 forms, as well as an explanation of the carrier's plan to issue
2 dividends or credits. The instructions and format for calculating
3 and reporting loss ratios and issuing dividends or credits shall be
4 specified by the commissioner by regulation. Such regulations shall
5 include provisions for the distribution of a dividend or credit in the
6 event of cancellation or termination by a policyholder. For
7 purposes of this paragraph, "alliance policy forms" means policies
8 purchased by small employers who are members of Small Employer
9 Purchasing Alliances.

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

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

16 i. The provisions of **【this act】** P.L.1992, c.162 (C.17B:27A-17
17 et seq.) shall apply to health benefits plans which are delivered,
18 issued for delivery, renewed or continued on or after January 1,
19 1994.

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

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

28 (cf: P.L.2008, c.38, s.24)**】¹**

29
30 **¹【7.】6.¹** Section 13 of P.L.1992, c.162 (C.17B:27A-29) is
31 amended to read as follows:

32 13. a. **【**Within 60 days of the effective date of this act, the
33 commissioner shall give notice to all members of the time and place
34 for the initial organizational meeting, which shall take place within
35 90 days of the effective date. The members shall elect the initial
36 board, subject to the approval of the commissioner. The board shall
37 consist of 10 elected public members and two ex officio members
38 who include the Commissioner of Health and the commissioner or
39 their designees. Initially, three of the public members of the board
40 shall be elected for a three-year term, three shall be elected for a
41 two-year term, and three shall be elected for a one-year term.
42 Thereafter, all elected board members shall serve for a term of three
43 years. The following categories shall be represented among the
44 elected public members:

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

47 (2) One carrier whose principal health insurance business is in
48 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~~ ²13 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) ²One person ²Two persons with knowledge or expertise in New Jersey regulated health insurance markets who ³represents represent ³the general public.

The ²Commissioner of Health and the ²commissioner, or the commissioner's designee, shall serve on the board as ²an ²ex officio ²member members². 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~~ ²four ²five

1 shall be appointed for a term of one year, **two** four for a term of
 2 two years and **two** four for a term of three years.

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

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

10 b. **If** the initial board is not elected at the organizational
 11 meeting, the commissioner shall appoint the public members within
 12 15 days of the organizational meeting, in accordance with the
 13 provisions of paragraphs (1) through (7) of subsection a. of this
 14 section. **(Deleted by amendment, P.L. , c.) (pending before**
 15 **the Legislature as this bill).**

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

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

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

22 ³f. To the extent that any provision of P.L. , c. (C.)
 23 (pending before the Legislature as this bill) is in conflict with any
 24 provision of section 2 of P.L.2019, c.141 (C.17B:27A-58), the
 25 provisions of section 2 of P.L.2019, c.141 (C.17B:27A-58) shall
 26 govern.³

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

28
 29 ¹**[8.] 7.**¹ (New section) Sections ²**[8] 7**² through ²**[13]**
 30 ⁴**[12²] 11**⁴ of P.L. , c. (C.) (pending before the Legislature
 31 as this bill) shall be known and may be cited as the "Small Business
 32 Health Insurance Affordability Act."
 33

34 ¹**[9.] 8.**¹ (New section) a. The board shall annually review the
 35 small employer health benefits plans offered pursuant to P.L.1992,
 36 c.162 (C.17B:27A-17 et seq.) to ensure that each plan meets the
 37 requirements of section 2 of P.L.2019, c.354 (C.17B:27A-19.30),
 38 provides consumer choice and affordability, and maintains a relative
 39 level of consistency compared to previous years and to other plans in
 40 the small employer market. The board shall publish the findings of its
 41 review on the website of the Department of Banking and Insurance.

42 b. The board shall annually adjust the design of the small
 43 employer health benefits plans, including the out-of-pocket limits
 44 under those plans, to ensure premium affordability and to align the
 45 plans with the requirements of section 2 of P.L.2019, c.354
 46 (C.17B:27A-19.30). The adjustment shall be based on the annual
 47 review conducted pursuant to subsection a. of this section. The board

1 may consider proposals for adjustments to plan design to improve
2 affordability from carriers offering small employer health benefits
3 plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

4 c. The board shall annually review the appropriateness of
5 geographic rating areas ²and may adjust, by rule, as needed to achieve
6 the goals of this subsection².

7 d. The board shall examine and, to the extent practicable, track
8 where small employers who do not continue coverage through a small
9 employer health benefits plan offered pursuant to P.L.1992, c.162
10 (C.17B:27A-17 et seq.) elect to purchase coverage. The board shall
11 have the authority to develop a sample survey that insurance ²[brokers
12 may] producers shall² provide to clients. ²[Brokers who elect to
13 provide the survey to clients] Insurance producers² shall report to the
14 board ²[any] all² information received through the survey², which
15 shall be de-identified by the insurance producer². The sample survey
16 shall include, but may not be limited to, information concerning where
17 small employers purchase health benefits coverage. The board shall
18 publish ²a report on² the ²[findings of the] results of the² surveys
19 received from ²[brokers] insurance producers² pursuant to this
20 subsection on the website of the Department of Banking and
21 Insurance.

22
23 ¹[10.] ⁴[9.¹ (New section) a. Except as provided in subsection
24 b. of this section, a carrier that offers an individual health benefits
25 plan that provides benefits for expenses incurred in the purchase of
26 prescription drugs and is delivered, issued, executed, or renewed in
27 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), may
28 use a prescription drug formulary to limit or exclude coverage for
29 prescription drugs, provided that ¹the carrier offers at least one plan
30 with an open formulary and¹ the carrier demonstrates to the
31 satisfaction of the board that utilization and medical review panels
32 are in place to allow formulary flexibility as necessary in the best
33 interest of the insured person.

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

43 ²c. Notwithstanding the provisions of the “Administrative
44 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.) to the
45 contrary, the department shall, as appropriate and ³no later than³ in
46 time for plan year ³[2024] 2025³, update rules and regulations to
47 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 ³[2024] 2025³. The rules and regulations shall thereafter be adopted, amended, or readopted for plan years ³[2025] 2026³ 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.).²⁴

¹[11.] ⁴[10.¹] 9.⁴ (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 ¹the carrier offers at least one plan with an open formulary and¹ 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.

²c. 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 ³no later than³ in time for plan year ³[2024] 2025³, 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 ³[2024] 2025³. The rules and regulations shall thereafter be adopted, amended, or readopted for plan years ³[2025] 2026³ 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

1 before the Legislature as this bill). The exceptions and appeals
2 process shall allow insureds to appeal to an independent, objective
3 third party which shall render a decision as promptly as the
4 patient's condition mandates.

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

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

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

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

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

22

23 ⁴【²11.】 10.⁴ (New section) a. A carrier that uses a prescription
24 drug formulary pursuant to ⁴【sections】 section⁴ 9 ⁴【and 10】⁴ of
25 P.L. , c. (C.) (pending before the Legislature as this bill)
26 shall establish a clinically sound and well-communicated exceptions
27 and appeals process, or incorporate into the carrier's existing
28 appeals process, the requirements of this section.

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

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

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

44 e. The department shall collect information from each carrier
45 subject to this section to conduct an annual evaluation of the
46 exceptions and appeals processes established pursuant to this
47 section with regard to the appropriateness of the burden of the

1 process on consumers and clinicians and the effects on patient
2 health outcomes.²

3
4 ¹[13.] ⁴[12.¹] ^{11.}⁴ (New section) The department shall, ³no
5 later than³ in time for plan year ³[2024] ^{2025³} ²and immediately
6 upon filing with the Office of Administrative Law², adopt rules and
7 regulations, ²[pursuant to] notwithstanding the provisions of² the
8 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
9 seq.) ²to the contrary², requiring ²[the minimum standards] no
10 additional limitations on copayments, coinsurance, or deductibles²
11 for small employer health benefits plans pursuant to P.L.1992,
12 c.162 (C.17B:27A-17 et seq.) ²[be no greater than the minimum
13 standards] beyond those² set forth in the federal Patient Protection
14 and Affordable Care Act, Pub.L.111-148, as amended by the federal
15 “Health Care and Education Reconciliation Act of 2010,”
16 Pub.L.111-152 for plans issued pursuant to P.L.1992, c.161
17 (C.17B:27A-2 et seq.). ²The rules and regulations adopted pursuant
18 to this section shall be in effect only for plan year ³[2024] ^{2025³}.
19 Rules and regulations shall thereafter be adopted, amended, or
20 readopted for plan years ³[2025] ^{2026³} and thereafter by the
21 department in accordance with the requirements of section 4 of
22 ⁴[P.L. , c. (C.) (pending before the Legislature as this act)]
23 P.L.1992, c.162 (C.17B:27A-20)⁴ and the requirements of the
24 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
25 seq.).²

26
27 ¹[14.] ⁴[13.¹] ^{12.}⁴ This act shall take effect immediately.